STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Warren Maguire
Hearing dates:	**4-7-8 September 2016, 20 – 21 April 2017**
Date of findings:	**13 July 2017**
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate H Barry
Catchwords:	CORONIAL LAW – Critical Incident Computer Aided Dispatch (CAD) Training, identification of incident categories.
File number:	2015/00059013
Representation:	Ms E Sullivan, Counsel Assisting ,instructed by Ms J Geddes(Crown Solicitor's Office) Mr B Longville instructed by P Austin for Sergeant Thomas Kirk Mr P Madden instructed by P Austin for Constable Britt Miezitis Mr B Haverfield for Commissioner of Police and NSW Police Force

Findings:	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 **Warren Maguire** **I find that Warren Joseph Maguire died on 24 February 2015 in the rear yard of his unit at 126 Tamar Street Ballina. The cause of death was multiple injuries. The manner of his death was exiting a bathroom window, and colliding with the concrete ground. I am unable to find, on balance that Warren intended to end his life.**

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

Introduction

1. The role of the coroner as set out in section 81 of the *Coroners Act* 2009, (the Act) is to make findings as to:

(a) the identity of the deceased;

(b) the date and place of the persons death;

(c) the physical or medical cause of death; and

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

The focus of this inquest is the manner of Warren Maguire's death and the response by the police who were called to the location where Warren's body was ultimately found.

There is also an issue surrounding the circumstances of Warren's death, in particular, whether there were any suspicious circumstances surrounding his death.

A further issue relates to the manner of Warren's death and whether or not it can be found that Warren intended to take his own life.

Warren's death was reported to the Coroner because it occurred during the course of a police operation. In these circumstances an inquest is mandatory pursuant to the combination of ss. 27 and 23 of the *Coroner Act 2009.*

"The purpose of a s.23 inquest is to fully examine the circumstances of a death… in order that the public, relatives and the relevant agencies can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post death investigation. If appropriate and warranted in a particular case, the State or Deputy State coroner will make recommendations pursuant to s.82." (Waller, Coronial Law and Practice in New South Wales, p.106)

Pursuant to s.37 of the *Coroners Act 2009* a summary of the details of this case will be reported to Parliament.

Background

Warren Joseph Maguire was born on 21 July 1974 at Casino. At the time of his death he was 40 years old. He was found deceased on the morning of 24 February

2015 outside his unit in Ballina, having fallen from a bathroom window onto the concrete below.

Warren was the youngest of 7 siblings and as a child he resided in a happy and stable home environment. According to his elder brother Barry, Warren was a happy and well -adjusted child, full of energy with ”potential to burn”. Tragically when Warren was only 10 years old his mother passed away and understandably this was to have a deep and continuing impact on Warren’s young life.

The care for the family was left to his father who took long service leave from his employment in order to raise the family. Warren completed primary school in Casino and completed his school certificate in 1990 at Casino High School.

From May 1991 until April 1996 Warren worked at the Casino Meat Works but this was the only period of continuous employment that Warren experienced. He was considered a good worker with a strong work ethic.

In 2005 Warren entered into a relationship and as a result of that relationship his son Alexander was born in March 2006. The relationship was a troubled one and the parties separated in 2010. Warren remained interested in his son’s welfare but had difficulties in gaining access to him and this was to cause considerable concern for Warren and to have a major impact upon his mental health.

Warren struggled with alcoholism and mental health problems and had been involved in rehabilitation programs over the last decade. He was involved with the Salvation Army, which played a crucial role in his rehabilitation. In the week prior to his death Warren had made arrangements to re-enter “Moonyah” a rehabilitation unit run by the Salvation Army.

Captain Kingston-Kerr, a caseworker with the Salvation Army who was close to Warren, stated that Warren remained positive and focused about going into rehabilitation. He last spoke with Warren on 19 February 2015 when he had a 17 minute conversation. He stated that Warren was upbeat and still motivated but knew there was a long road ahead.

Warren’s brother Barry, told the court that Warren could be ‘polite engaged witty and charming with ‘normal’ pursuits during his alcohol free periods’. Tragically his alcoholism and mental health issues gave rise to periods of long-term unemployment and some estrangement from a number of family members. At times he experienced suicidal ideation.

Warren’s family find it difficult to reconcile Warren’s happy and carefree childhood with his unhappy and troubled adult life. He was loved by his family and a number of his quiet and dignified siblings attended the hearing.

Autopsy and cause of death

An autopsy report was prepared by Dr Allan Cala, senior staff specialist in forensic pathology. Dr Cala opines that the direct cause of death was ‘multiple injuries’.

Dr Cala further noted;

1. extensive skull bruising in occipital region

2. right occipital base of skull fracture

3. right sided subarachnoid haemorrhage and cerebral contusions

4. left haemothorax – 110 mls

5. multiple rib fractures

6. pulmonary contusions

Dr Cala further commented;

1. Autopsy examination showed a full thickness laceration of the scalp in the left parietal region which would have bled significantly after infliction. The skull immediately under the laceration was normal, however there was a right sided occipital skull fracture associated with subarachnoid haemorrhage and cerebral contusions in the right cerebral hemisphere along the base of the brain. There was atlanto–occipital dislocation but no obvious evidence of spinal cord injury.

2.There were multiple rib fractures, particularly on the left side associated with a large left haemothorax (blood in pleural cavity). These fractures would have caused immediate and severe inability to breathe normally. The pattern of injuries is consistent with a fall from a height with heavy impact.

Dr Cala noted “the deceased need not have died immediately after infliction but could have survived for approximately 30 - 45 minutes after falling and impacting the ground”

When considering Ms Christina Smith’s evidence (a witness living in Warren’s unit block) to the effect that Warren was still making a gurgling/breathing noise at 1:45 AM, Dr Cala opined that had Warren been found at an earlier time, it was theoretically possible that he may have survived. Notwithstanding that comment Dr Cala considered that Warren’s death was”almost inevitable”.

Toxicological analysis

Toxicological analysis returned a zero blood alcohol level. However there were non-toxic levels of other drugs identified, being drugs used to treat mental health conditions (such as citalopram and mirtazapine). Olanzapine was found to be in the high range but Dr Cala stated"toxicity would not necessarily be expected to occur at that level".

Dr Cala concluded that in his view drugs played no role in Warren's death.

Manner of death

Was there any suspicion surrounding Warren's death?

Detective Senior Sergeant Sgt Peter O'Reilly investigated Warren's death and it was his view that Warren died as a result of injuries sustained during the fall which was 'probably an act of self- harm.' This cause of death aligned with the opinion of Dr Cala who noted that the injuries suffered by Warren were consistent with a fall from a height with heavy impact.

Written and oral evidence of crime scene officer, Senior Constable Gerry Kemp, was that there was no evidence received of any obvious struggle inside Warren's unit, nor any evidence of forced entry to Warren's unit. Warren's wallet, money and mobile phone were located inside his unit.

The bathroom window from which Warren exited was 69 cm wide by 53 cm high and the window was 152cm higher that the bathroom floor. It is unlikely that a person could be compelled against their will to exit in the manner that Warren apparently did falling 4.59m from the bathroom window sill to the concrete patio below. There is no suggestion of involvement by any other person.

Did Warren intend to take his life?

Warren's history of suicidal ideation and attempts.

There had been a number of previous suicide attempts made by Warren in the years prior to his death. Whilst living with his brothers in Casino, Warren overdosed on his prescription medication and passed out; almost daily, he spoke of committing suicide and had once tried to hang himself in the shed and was saved by his brother Barry.

Warren's medical records, between March 2011and December 2014, identify ten occasions of attempts by Warren to self- harm. On some occasions he was taken to hospital by ambulance and on other occasions he contacted the mental health helpline presenting as intoxicated and overwhelmed.

The last occasion of self-harm prior to Warren's death was between 5 – 8 December 2014. On this occasion Warren was taken to Ballina hospital by ambulance, having

overdosed by taking 24 diazepam tablets with alcohol. He stated that he wanted to kill himself.

On 21 February 2015 Warren visited another resident, Mr Saebsch, who resided in the unit next to his own. Warren had been drinking beer, but it is noted that toxicology testing detected no alcohol in Warren's blood following his death.

Captain Kingston-Kerr, from the Salvation Army, gave evidence that Warren would go through cycles of anxiety, depression and suicidal thoughts and that these cycles would be at the tail end of a drinking session and revolve around Warren not being allowed access his son.

As someone who knew Warren well, he told the court what happened to Warren on the night of his death did not fit Warren's previous pattern of self- harm attempts. He did indicate that in the past after Warren had been heavily drinking he had suffered hallucinations, believing that there was someone in his room. He stated that Warren could misinterpret things and at times he was anxious, but he also said it was Warren's practice to "cry out" for help from ambulance, police or call –centres, during these episodes.

When the mode of Warren's death is noted, that is, exiting a quite narrow bathroom window, in circumstances in which he had previously attempted other modes of suicide such as hanging or medication overdose, it would be reasonable to assume that Warren's exit from the bathroom window was not in relation to a suicide attempt. Indeed it would have been far easier if that was the mode of suicide to be attempted by Warren, for him to simply jump from the front of his unit over the balcony.

In addition, both Captain Kingston- Kerr and Warren's brother Stephen, believed that Warren, in the hours before his death, was sounding positive and happy and in fact Stephen commented that Warren was "the best he had sounded for a long time."

What is compelling is that there was no alcohol or drugs of any significance in Warren's system. It may well be that Warren was in the throes of detoxification and suffering some psychotic event with hallucinations, as had happened in the past, and this led him to climb out the window.

What drove Warren to exit this small window is purely speculative. As his brother Barry stated the" circumstances that led to his death are a mystery and may well remain a mystery known only to God."

Suicide may not be presumed – it must be proved by evidence. There must be clear cogent and exact proof of evidence before such a finding can be made.

The lack of clarity about Warren's intent raises a doubt about whether Warren intended to take his own life. I am not satisfied that there is sufficient evidence to establish that Warren intended to end his life.

The telephone call by Ms Christina Smith.

Ms Smith was a resident of unit 9/126 Tamar Street Ballina. At about 12:15 AM on 24 February 2015 she heard a "commotion" in the rear common area of the unit block. She stated that it sounded as though things were" being knocked over or something". She heard a sound that she described as sounding "like a large dog panting." This sound was followed by a "gurgling" sound.

She went to her back door and turned on the outside light– she could see legs and a pair of patterned boxer shorts two doors up but she could not see the person's head nor torso as her view was obstructed. She continued to hear laboured breathing and "gurgling".

At about 12:23 AM Ms Smith telephoned Ballina police station and spoke with then Probationary Constable Miezitis (now Constable Miezitis). The content of that conversation is contained in Ms Smith's statement that was taken by police on the morning of the incident at around 10 or 10:30 AM at the police station. Her statement was adopted in sworn evidence to the court:

"I have heard a commotion out the back of my place. The address is misleading. It's 126 Tamar Street that you enter from Winton Lane. Directly behind the back door of Domino's. There are often noises but this one has gone a bit further. I have gone outside and I can see a pair of legs laying on the ground. I can hear gurgling. I'm not too sure if its medical or intoxication but either way the person doesn't sound too good. Clearly they've had a fall something has taken place, I can tell because of the commotion was taken place.

The officer said" Can you tell me again where you are"

I said "The front of our units are in Winton Lane, behind Domino's however the person is behind the units near the clothes line."

This conversation lasted 2 minutes and 59 seconds.

Ms Smith stated that the police officer asked her name and phone number which was provided but her unit number was not requested. Ms Smith was told that someone would be sent out. Ms Smith told the court she had included in her statement the fact that the officer did not ask her unit number because after she hung up from the conversation with the officer she had thought it was "strange she didn't ask."

In order to assist and direct the police to the correct location, Ms Smith opened her front door and turned her front light on so that the police could see there was some activity in that unit.

During the almost 3 minutes of conversation, Ms Smith stated that she repeated the information about having to go behind the units to the clothesline “more than 3 times” because she thought that she was not being heard. In fact, she thought the officer was “skimming over” the information that she was providing.

Ms Smith knew that the units were well known to police as they did not have a good reputation. She was also aware of the complicated layout of the block of units. She was seeking to stress to the officer the need to go behind the units - to drive by Winton Lane would serve no purpose at all as the person would not be visible.

Ms Smith left her front door open for approximately half an hour waiting for the police to arrive but she did not hear the police come past. During that half hour she could hear a loud male voice” talking but not making any sense”. Ms Smith was too scared to go outside as she did not have a torch and did not know if there was anyone else in the vicinity.

At about 1:45 AM, Ms Smith lay down and could still hear the “gurgling” and the breathing noise, then must have dozed off. At all times she believed that the police would respond to her telephone call.

The next morning Ms Smith went out into the back yard area of the units and was horrified and ”livid” to find that the man was still there.

Constable Miezitis’ evidence of receiving the call from Ms Smith

Constable Miezitis gave a version of events at odds with the version given by Ms Smith. She said she had been at the station desk at the front counter of the police station when Ms Smith telephoned. She was on her own.

She explained that her usual practice in recording information taken from callers was to write onto a piece of blank paper all information that she could gather from the phone call and then at some point enter that information into the Computer Aided Dispatch (CAD) system after the call. After the end of the shift, the paper would go into the bin.

Her evidence as recorded in a different set of notes of the conversation with Ms Smith (being notes recorded after Warren was found deceased) was as follows:

“At approximately 12.30 I got a call from a Christina. She said she heard a loud noise and can now see a man laying on the ground. I asked is he ok is he hurt? She said I can’t tell but he is growning (sic). I said have you gone outside to see if he is ok? She said no I was too scared. I said where is he? She said outside the units in Winton Lane the ones behind Domino’s Pizza. I asked what number? She said the ones in Winton Lane 126 Tamar Street address. I asked her to describe the male

age/clothing? She said she couldn't really see because there was a basket like a washing basket like a washing basket in her way.
I asked if she could tell if he was hurt? She said she couldn't tell. I asked what had woken you did you hear an argument, voices? She said no not voices just loud noise like banging. I asked did you see or hear anyone else around? She said no. I asked are you able to check on him? She said no she is too scared. I said just confirming the units in Winton Lane behind Domino's Pizza 126 Tamar. She said yes. I said I'll put a job on we will have a look."

In her directed interview recorded on 29 April 2015 Constable Miezitis, stated that the conversation with Ms Smith was a four to five minute conversation that "went round and round in circles as "she wasn't very forthcoming with detail." Her assessment of the information given to her by Ms Smith was that there was nothing urgent about the information as "the caller was very calm. Nothing in her tone made me think anything else was happening".

Constable Miezitis stated that Ms Smith did not say that the incident was at the back of the units –"she just said it was the unit block at the back of Dominoes Pizza in Winton Lane" and that although Ms Smith confirmed the unit block as being 126 Tamar Street, she was not forthcoming with a unit number.

In her oral evidence Constable Miezitis agreed that she was at pains to confirm the address given was 126 Tamar Street because she accepted that the address was of considerable importance. She maintained that she did ask Ms Smith the unit number and claimed that Ms Smith was not forthcoming with this information. In addition she stated that she had a clear memory of asking Ms Smith whether she had called an ambulance and was certain that Ms Smith did not refer to a clothesline at the back of the units - had she in fact done so she would have included that in the CAD message.

Constable Miezitis maintained that Ms Smith did not refer to the matter being either medical or intoxication nor would she accept, in her oral evidence, that Ms Smith may have said that. However, she accepted under cross-examination that the response" I'm not sure if it's medical or intoxication" was a response consistent with the question she agreed that she had asked the caller, that is:-"is he hurt is he okay."

Constable Miezitis was insistent that the only evidence given by Ms Smith as to the location of where this gentleman could be found was in "the units in Winton Lane, the ones behind Domino's pizza"

She also insisted that Ms Smith had not used the word "gurgling" and in fact had that word been used she would have immediately called an ambulance. Her recollection and her evidence was that the only word used was that the man was "groaning". According to her evidence, had Ms Smith mentioned that there could have been a medical issue, that would also have prompted her to call an ambulance.

There is a clear factual dispute between the evidence of Ms Smith and the evidence of Constable Miezitis.

Ms Smith was a compelling witness. She used the word “gurgling” because she said she had heard the sound before. Her son’s girlfriend had fallen from a balcony and that is the exact sound that she made as a result of that fall. That young woman was seriously injured. It was this sound that Ms Smith described as the “trigger” to her making the call to police. This is a powerful explanation for the use of that word and is highly credible.

In addition she was insistent that she told Constable Miezitis that the male was behind the units near the clothesline. She knew that was a crucial piece of information that needed to be conveyed to the police. Ms Smith was aware that if that information was not received then the police may simply drive down Winton Lane in a ”drive by” and as a consequence not discover the male person. That of course is exactly what took place.

Ms Smith gave a statement to the police that morning, a matter of hours after the event and her statement was confirmed by her oral evidence to the court. Her evidence was clear and forceful. She was able to explain why the message given to the police during the telephone call had taken 3 minutes saying she was insistent on trying to have them understand exactly where the male was lying because of the difficult configuration of the block of units and because of her concern for the male person. This was the first time she had contacted police about any matter. She was calling police about a matter that was out of the ordinary for the type of commotion that she was used to in the unit block.

Constable Miezitis’ account of events was set out in notes she prepared after the incident, (as extracted above) specifically on the afternoon of 24 February after she became aware from Facebook that there had been a death of a man in Winton Lane. Her evidence changed in that initially she maintained she had prepared her notes in her notebook at home, although it was not normal for her to take home her official police notebook. Later she stated that she had attended the police station on 24 February and it was possible she prepared her notes there. She agreed she had access to the CAD entry when she prepared her notes. Further, Constable Miezitis had initially told the court she was new to policing and did not know that a critical incident investigation would take place. She later agreed she was aware that any note she made would be significant in relation to the critical incident investigation.

I do not accept her evidence regarding when she took notes and when she became aware of the critical incident investigation. She was given notice as an “involved officer” at 2.00pm on 25 February and at that time, according to her evidence, she was still in the process of preparing her notes. Her preparation of notes took place over a period of two to three days, noting they were signed and dated 26 February 2015.

Constable Miezitis claimed that her notes recorded a verbatim account of the conversation she had with Ms Smith. She would not accept the possibility that other matters were said during the phone call but not included in the notes. In her oral evidence she was emphatic that there were no matters mentioned by Ms Smith that did not appear in her notes.

Her insistence on this issue is disturbing. She claims to have excellent recall about the conversation with Ms Smith. She was asked:

"Q. Do you accept that other information was given that you can't recall. Do you accept other things were said that do not appear in your notes.

A. No

Q. You don't accept that?

A. No

Q. You don't accept other things were said and not included?

A. No".

When her notes, which she claims contained a' verbatim' account of the conversation with Ms Smith, were read out in open court, her account fell short of the almost 3 minute conversation that Ms Smith stated took place. The note reading fell short by about 1 ½ minutes.

Constable Miezitis claimed that the missing 1 ½ minutes of conversation in her verbatim account could be explained by Ms Smith repeating the address saying "She kept saying the unit block behind Domino's pizza".

She maintained that the repetition lasted one and a half minutes.

This explanation is ludicrous. I do not accept that Ms Smith repeated the same words to that effect for that period of time.

Even on her own evidence, Constable Miezitis' version cannot be relied upon. Despite insisting she had excellent recall, in her oral evidence she told the court she had a clear memory of asking Ms Smith if an ambulance had been called. This does not appear in her verbatim account of the conversation recorded in her notes.

Further, in her oral evidence she stated she had done a Google search of the location because she was "confused" about the location. However, later in her evidence she agreed she was not "confused" because she had in fact confirmed the location as 126 Tamar Street with Ms Smith and she was aware of that unit block because she had been to those premises before.

She agreed she was at pains to ensure the correct address and location was recorded because she knew how important that information was. She maintains she asked Ms Smith for her unit number, but Miss Smith was not forthcoming with the unit number. She agreed that the unit number would have been an important piece of information in pinpointing the exact location.

Ms Smith gave her statement to the police the morning immediately following the incident and stated she was not asked for her unit number. In her oral evidence Ms

Smith thought it “strange” that she was not asked this detail, and she sought to remedy the situation by turning on the lights of her unit and opening the front door.

Again, I find it ludicrous to suggest, as Constable Miezitis suggests, that Ms Smith would not have been forthcoming in relation to disclosing her unit number. Ms Smith provided her name and her mobile telephone number. She was keen for police to attend. She believed it was essential that police attend. To suggest that she was not forthcoming with the information concerning her unit number, having taken the trouble to call the police and disclose her mobile phone number and her address, defies belief.

It is accepted that there was some confusion about the configuration of the unit block on Tamar Street.

Both Ms Smith and Constable Miezitis attest to this. That is why Ms Smith states she was adamant about explaining the exact location of the male. She stated “the front of our units are in Winton Lane behind Dominoes, however the person is behind the units near the clothesline”.

Ms Smith was convincing in her oral evidence that this was a detail she was keen to impress upon Constable Miezitis. She knew that it would be difficult to locate the male without that piece of information and yet Constable Miezitis maintains that that piece of information was not given to her by Ms Smith. It is noted that Constable Miezitis does make reference in her notes to the presence of a “washing basket”, but makes no reference to the vital piece of information concerning the area near the clothesline that Ms Smith is adamant she disclosed.

Constable Miezitis did not enter the details of the conversation into the CAD system until approximately 25 minutes after receiving the call. Regrettably the best evidence as to what was said in that phone call has been destroyed. Constable Meizitis destroyed the notes she had taken at the time of the telephone call.

Counsel for the NSW Commissioner for Police submitted that the CAD entry was the best evidence, the notes merely being “tangential”. Clearly that is not the case. On any understanding of the rules of evidence, the best evidence would be the notes being a contemporaneous record of the conversation.

In the absence of such notes, I am left with having to determine the dispute between the evidence of Ms Smith and Constable Miezitis.

Constable Miezitis relies on her recollection and the entry in CAD system. I have already found on the evidence that Constable Miezitis’ evidence is not acceptable on a number of issues:

1 Her evidence as to when she took notes in the notebook and when she became aware that it was to be called a ‘critical incident’.

2 Her denial that she heard the use of the word “gurgling” by Ms Smith.

3 The purported failure of Ms Smith to provide her unit number.

4 The purported failure by Ms Smith to pinpoint the exact location of the male person behind the clothesline.

Ms Smith was an impressive witness. She has nothing to gain by not speaking the truth. She was a concerned member of the public who was clear in her evidence about the importance of the information that she wanted to give to the police. She knew it was vital that this information was given precisely.

Constable Miezitis relies on an entry made 25 minutes later into the CAD system, following a period in which she states was busy taking other calls in relation to other matters. Her recollection has been shown to be faulty.

For the reasons outlined above I find that the evidence of Constable Miezitis is not credible and I accept the evidence of Ms Smith.

The Computer Assisted Dispatch (CAD) system

The CAD system is the NSW Police Force's resource and incident management system. It is used to manage and support deployment of police resources in response to incidents generated by the community and other NSW response agencies.

Each CAD message requires an incident type assigned to it. This is an incident description relating to the nature of the incident based on the information to hand. There are 108 primary CAD incident types and 115 secondary incident types.

The 2 incident types relevant in this matter are:

i (105) check bona fides - this relates to tasking police to check persons who are acting suspiciously in some way to make sure their reasons for being there or whether they are acting in a manner that is genuine.

ii (017) concern for welfare - this relates to where police or a member of the public have concerns for another person, for example where an elderly person has not been seen for a number of weeks.

Each of these incident types is given a priority 3 (non-urgent) incident number by default. Priority 3 indicates a non- urgent response and suggests that a response be made as soon as possible. This priority relates to matters concerning noise complaints, break and enter complaints, motor vehicle accidents, et cetera.

Constable Miezitis classified the job as a check bona fides job. She explained she had done this because she saw the category as “something that can't be categorised by something else.” She had previously used this category in creating CAD jobs. She thought that because the person was outside and there was no clear evidence

that he was hurt and from the calm tone in which the information was given, she could presume the person was intoxicated and that it was nothing serious.

Constable Miezitis stated that she had a “basic understanding of CAD” and explained that she had only had very brief training in relation to the CAD system. Detective Senior Sergeant O’Reilly noted that Constable Miezitis was a ”relatively inexperienced officer” and that there were a lot of things happening on the night of this incident. He further stated that”using a system which, unless you are very proficient with it, would take some time to be able to complete a CAD”

Constable Miezitis, in her oral evidence stated that in hindsight she should have contacted VKG to put the CAD job on given she was busy and was not in a position to complete the CAD for 25 minutes. In addition she conceded that the information should have been entered into the system sooner.

There seems little doubt that the training provided to young officers such as Constable Miezitis in the use of the CAD system was inadequate. However, Detective Senior Sergeant O’Reilly stated that even on Constable Miezitis’ own account of the telephone conversation the job should have been classified as a “concern for welfare”. Again with the benefit of hindsight Constable Miezitis acknowledged that this should have been the classification.

Response by Sergeant Kirk

At 12.53 am Sergeant Kirk responded to a VKG broadcast. The information that had been contained in that broadcast was:

“V.1 Ok. Ballina vehicle, check bona fides… Winton Lane at Ballina crossed with Kerr Street, caller says she was woken by loud noises, now she can see a male laying on the ground groaning at the unit block in Winton Lane behind Domino’s Pizza. The address of the unit block is possibly 126 Tamar Street, entry via Winton Lane, caller was too scared to go outside and check on the male, Ballina vehicle.”

This message was broadcast at 12.50.30.

The VKG broadcast essentially contained the same information as in the CAD job. The broadcast was the only information known to Sergeant Kirk regarding the job.

He said he believed that the “check bona fides” incident related to a concern about a person lying on the ground. It was his assumption that the person “had come out of a hotel…taken drugs and passed out”. Given the nature of the information, he did not consider it to be a ‘concern for welfare’ job.

Because the reference to the address being “possibly 126 Tamar Street”, there was a doubt in Sergeant Kirk’s mind about whether it was the unit block with which he was familiar.

In his directed interview, Sergeant Kirk gave an account of his response to the VKG broadcast:

"…I turned left into Kerr Street. I did a u-turn at the end of the concrete median strip. I've come back along Kerr Street and turned left into Winton Lane. That's where I called off the job, at the end of the lane…I've put the high beam on and the alley and take down lights on the light bar, put the driver and passenger windows down and patrolled the section of Winton Lane between Kerr Street and Grant Street. When I got to the end of Grant Street, I called back on. I've then turned right into Grant Street and just to satisfy myself before I left I patrolled along River Street. Did a u-turn at the traffic lights in River Street, back along River Street to Grant Street. From Grant Street I went left into Tamar, left back into Kerr then left back into Winton Lane having another look."

At no time did Sergeant Kirk get out of the car. He believed that the person had gotten up and walked away.

He said he did not consider walking over to the unit block. He could see the rear of the yard from the car and there was no one visible. In the past when he had attended those units regarding noise complaints and other matters he understood that there was only one building.

Sergeant Kirk chose not to contact the informant, Ms Smith, because he assumed the person had walked away. He said he was also concerned about the late hour. Again, he made an assumption that if Ms Smith's concerns had not been addressed," there would have been another call".

In his oral evidence Sergeant Kirk agreed there was no requirement for Ms Smith to again call police; she was entitled to expect that police would respond. He further agreed that it was wrong to make an assumption that the job had resolved because there were no follow up calls.

In his oral evidence, Sergeant Kirk also conceded he could have contacted VKG and asked them to call the informant, noting that the lateness of the hour could not have been a real issue as the informant herself had called police at a late hour. He further conceded that with the benefit of hindsight, he "absolutely" thought he should have done so.

Sergeant Kirk told the court that:

(a) He would have had the same response to the job even if the word "possibly" had not been used in relation to the address. This is curious in light of his oral statement that that there was "absolutely" a doubt in his mind about whether it was in fact those units.

(b) If the information: "The front of our units are in Winton Lane behind Dominos, however the person is behind the units near the clothes line" had been broadcast, he still wouldn't have looked behind the unit block at 126 Tamar Street.

(c) If the CAD message had been prefaced by 'concern for welfare', his response would have been different in that he would have had VKG again contact the informant when he was unable to see anyone.

Sergeant Kirk stated that, whilst saddened that he did not locate Warren, he believed that based on all the information provided to him at the time he "took all reasonable steps to address the concern of the complainant"

Detective Senior Sergeant O'Reilly told the court that whilst it was "adequate" that Sergeant Kirk did not get out of the car, he would have expected a call to have been made at the time of the job or shortly after. Irrespective of the assumptions made by Sergeant Kirk, Detective Senior Sergeant O'Reilly stated that it was Sergeant Kirk's "responsibility… to acquit the job and to ensure that it had been resolved" and "for the sake of this job… a phone call should have been made to the informant."

Given the information that Sergeant Kirk was relying upon it is perhaps understandable that he proceeded in the way he did. What is highlighted by his actions, however, is the danger in making assumptions when a fairly easy response in the form of a call to the informant or to VKG may have resulted in a more positive outcome.

Conclusion

This case raises a number of failings by the individual police and by the system.

i. I have found there was a failure by Constable Miezitis to accurately record the information being given to her by Ms Smith.

ii. There was a failure by Constable Meizitis to promptly enter the information into the CAD system:

iii. There was a failure by Constable Miezitis to accurately categorise the incident type in the CAD system:

iv. There was a failure by Constable Miezitis to precisely convey the relevant address by her use of the word "possibly":

v. Sergeant Kirk failed to contact the informant to clarify the information as to the location and;

vi. Because of the assumptions made by Sergeant Kirk, he failed to properly 'acquit' the job.

Some of these failings may be characterised by inexperience in the case of Constable Miezitis and lack of training, but the cavalcade of failings had the effect of leaving Warren alone at a time when he most needed help.

Detective Senior Sergeant O'Reilly gave evidence as to what he considered to be "shortcomings" in the training provided to officers in relation to the CAD system.

He believed that the training previously in place - being only about one-and-a-half or under two hours, was inadequate.

Constable Miezitis gave evidence that she had completed an online tutorial and agreed there was a need for more detailed training.

Detective Inspector David Kay, a manager of the Constable Education Program at the NSW Police Academy in Goulburn, in a supplementary statement to the Court, detailed the developments in the training space relating to the CAD system.

i. Since 2014 there has been a doubling of the training provided to policing students on various police force computer systems.

ii. CAD training (delivered during the' compulsory on campus' study mode) consists of an overview of the CAD system and includes instructions on how to undertake the e-learning training for the system.

iii. The e-learning covers various subjects of the CAD system. A number of different subject areas are assessed and students cannot proceed to the next subject area without first passing the online assessment relating to each subject area. The training includes identifying the location of incidents and how to create incidents.

iv. The time taken to complete the CAD training outside of the timetable lessons is usually two to two and a half hours.

The 108 incident categories and their definitions are now printed in the student manual for future reference. The three main categories and their definitions – 'check bona fides', 'concern for welfare' and 'domestic' have been highlighted for discussion in the face to face component of CAD training.

Detective Senior Sergeant O'Reilly stated that he believed these measures to change training in CAD to be a "particularly beneficial improvement".

Confirmation has now been received from NSW Police (and specifically, Detective Inspector Kay) that consideration is to be given to the inclusion of 'case studies' into the CAD training module to illustrate and inform selection of CAD incident categories regarding the three most common incident types, previously mentioned.

As a result of these changes and noting the commitment from NSW Police concerning the implementation of these changes, I do not intend to make any recommendations in this matter.

Warren Maguire

Warren was a man who was troubled by longstanding mental health issues. It is not known what demons were in his mind to convince him to propel himself from the small bathroom window onto the ground below.

On the evidence it appears that no one could have foreseen Warren taking that action that night nor does it seem that it could have been prevented.

The tragedy of this matter is that Warren remained alive on the ground for a considerable period of time and that a concerned member of the public had contacted police and alerted them to his presence shortly after his fall. It should be expected that police would respond quickly and professionally to such an occurrence.

Although Dr Cala acknowledged that in theory Warren may have survived if found at an earlier time, he said his death was "almost inevitable" given the nature of his injuries.

What is particularly difficult for the family can be summed up in Barry's words: "The family's great sadness is that no one was with him to comfort him at the time of his death."

Formal Findings

I find that Warren Joseph Maguire died on 24 February 2015 in the rear yard of his unit at 126 Tamar Street Ballina. The cause of death was multiple injuries. The manner of his death was exiting a bathroom window, and colliding with the concrete ground. I am unable to find on balance that Warren intended to end his life.

I offer my sincere condolences to Warren's family for their loss.