CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of G
Hearing dates:	11 September 2019
Date of findings:	11 September 2019
Place of findings:	Lidcombe Coroners Court
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest - death of a person in the course of a police operation – police engaged in welfare check.
File number:	2017/124131
Representation:	Counsel Assisting the Coroner: R Mathur of Counsel i/b Crown Solicitor's Office. The NSW Commissioner of Police: S Robinson, Office of General Counsel. The NSW Commissioner of Police (application for non-publication orders): A Coffey, Crown Solicitor's Office.

Findings:	**Identity** The person who died is G. **Date of death**: G died on 25 April 2017. **Place of death**: G died at Old Lillypool Road, South Grafton NSW 2460. **Cause of death:** G died of multiple injuries when the car he was driving collided with a tree. **Manner of death:** G died in the course of a police operation, while suffering a depressive illness and having intentionally driven his car into a tree.

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The role of the Coroner

Pursuant to section 81 of the *Coroners Act 2009 (NSW)* [the Act], the Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

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

These are the findings of an inquest into the death of G.

Introduction

1. On the night of 25 April 2017 G aged 34 years died when his car crashed into a tree not far from his home at South Grafton on NSW's mid north coast.

2. An hour earlier G had driven away from his home and his wife C, concerned about his welfare, had rung police. Two police officers began to search for him in a police car. They sighted his car parked by the road, but when they pulled up beside it G immediately drove off. A minute later when the police officers rounded a bend in the road they saw that G's car had crashed head on into a tree. G was deceased.

3. Because G's death occurred in the course of a police operation, an inquest is required to be held pursuant to sections 23 and 27 of the Act.

G's life

4. G was born on 12 November 1982 in Sydney. He and his parents and older brother M moved to Grafton and then to Bellingen on NSW's mid north coast. His mother described him as a generally happy child who nevertheless had low self esteem. When he left school she became concerned about his low moods and encouraged him to see a doctor. This he did and was prescribed anti depressant medication. Unfortunately he suffered recurrent bouts of depression over the following years, at times seeking treatment for it. There was a previous suicide attempt by means of medication overdose in 2008, coinciding with a break up from his then girlfriend.

5. As an adult G worked as a tyre fitter in the mining industry, and in 2014 he commenced working as a 'fly in fly out' worker at a mine near Brisbane. He had met C soon after the suicide attempt in 2008 and they married in 2011. C was the mother of three children and she and G had a further two children together. They had plans to build a home on land near South Grafton which they owned.

6. In her statement given to police after his death, C described G as a good man who loved her three children as much as the two children he had with her himself. She noted however that he had always been inclined to dwell on

things that upset him, and that his mood had become increasingly low in the year leading up to his death.

7. On behalf of the family, G's older brother M provided a statement to the court in memory of his brother. As he lives in the United Kingdom M was unable to attend the inquest in person. He described G as a loving father and son, and a much missed brother. He was an affectionate and generous man who loved his family and missed them deeply when he was away from them on work.

8. G's death is a tragedy for his family and in particular his children.

Events leading up to G's death

9. G had always been very close to his father and he was deeply affected by his death from cancer in 2016. G and C had been experiencing tensions in their marriage for some time, and these worsened after his father's death. This culminated in their break up around Easter in 2017. Around this time G's colleagues in the mining industry noticed that he became increasingly moody and depressed.

10. In the days leading up to his death G sent messages to C and to her friends expressing an intention to take his own life. He also disclosed to C that he'd recently tried to hang himself with his belt. On 22 April he texted her that he planned to crash his car into a tree because he'd had enough. C urged him to get help but he expressed fear that if he did, he would be taken away by police and ambulance.

11. On the morning of 24 April C accompanied G to see a general practitioner, Dr Mohammed Qureshi who prescribed anti depressants for G. Dr Qureshi also prepared a mental health care plan for G to be seen by a psychiatrist who attended the clinic each month. Dr Qureshi's medical notes indicate that he assessed G as having severe depression with no serious suicidal plan or intent. It may be inferred that he did not consider G met the threshold to be treated as an involuntary patient.

Events of 25 April

12. After the visit to Dr Qureshi C thought G was in a more positive frame of mind. This was also the impression of G's brother M who had a phone conversation with him that evening. However by the following evening C was again concerned by G's low mood. Without her knowledge he drove away from their house at about 7.40pm, having consumed some or all the medication prescribed for him the previous day.

13. At 7.42pm C rang Grafton Police Station, telling a police officer that G was planning to kill himself, had taken some tablets and had left in the car. Then with the help of a friend she commenced to drive around the area searching for him.

14. Over the following hour G sent a series of texts to C, telling her he had '*just had all my meds so I'm good'*, was *'just about to hit some trees'* and to *'listen for the bang'*. He also texted *'I have to do it this time I can't keep doing this to you*'. He also posted a message on Facebook stating '*Sorry for the mess. But I'm out'.*

15. Shortly after 8.20pm police officers Senior Constable Clint Godfrey and Constable Ryan Martin left Grafton Police Station in a police car, responding to a further call from C that she had just sighted G driving in his car but he had not stopped. The police officers logged that they were responding to a '*Concern for Welfare'* call.

16. At about 8.39pm as they drove towards the end of Old Lillypool Rd the two officers saw G's car parked to the side of the road without its lights on. SC Godfrey pulled up beside the car and activated the red and blue lights on his vehicle. Before he and Constable Martin could get out of their car however, G drove off in the direction of his house. The police officers turned off their police lights and broadcast on VKG radio that G's car had gone and that they were not pursuing it. Within a minute they arrived at the site where seconds before G had crashed his car, a distance of about one kilometre from where he had driven away from them. Neither police officer had witnessed the collision.

17. They immediately called for further emergency services. G was found to have died in the crash.

The autopsy report

18. The examination performed by forensic pathologist Dr Brian Beer found G had died from multiple injuries. He had suffered fractures to his ribs and legs, and had a collapsed lung and pneumopericardium. Analysis of his post mortem blood sample showed a high level of his anti depressant medication.

Did G deliberately drive his car into the tree?

19. The site of the crash was examined by Crash Investigation Unit officer Senior Constable John Dunne. He concluded that the evidence was consistent with a finding that G had deliberately driven his car into the tree. He based this on the following:

- there was no evidence on the road that the car had undergone heavy braking or had swerved to avoid the tree

- the angle at which the car had left the road was not consistent with it having drifted from the road, indicating the driver had full control of it prior to impact

- damage to the car was consistent with a frontal impact, with the tree directly in front of the driver's seat.

20. An examination of the car revealed no mechanical faults that would have caused or contributed to the collision occurring.

21. I accept SC Dunne's opinion that G intentionally drove his car into the tree. I further find, on the basis of the evidence summarised above as to G's suicidal state of mind prior to the crash, that he did so with the intention of ending his life.

Did G's death occur in the course of, or as a result of a police operation?

22. The evidence supports the finding that G's death occurred in the course of a police operation. This finding is based on the broad interpretation of the term *'in the course of'* which has generally been adopted in the coronial jurisdiction. I note in passing that on 1 July 2017, three months after G's death, section 23 of the Act was amended to define a police operation as '*any activity engaged in by a police officer while exercising the functions of a police officer other than an activity for the purpose of a search and rescue operation'*.

23. It was submitted by Counsel Assisting that the court would not find that Glen died *as a result of* the police search for him. I accept this submission, which was adopted by Mr Robinson on behalf of the Commissioner.

24. While it was true that a police operation was underway at the time, there was ample evidence that G had formed an intention to take his own life before the police became involved. Counsel Assisting also based her submission on the very limited nature of the police interaction with G consisting of an attempt to stop and speak to him, an activation then de-activation of their police lights, then following in the direction in which he drove.

25. I therefore accept Counsel Assisting's submission that the police conduct cannot be said to have caused G's death, at most perhaps having expedited it. G's action of driving away upon seeing the police and almost immediately crashing his car into the tree supports the proposition that he wished to carry out his existing intention before they had a further opportunity to intervene.

26. Regarding the conduct of the police officers involved, there is no basis for criticism of their actions and decisions. They were performing their duty and in no way exceeded their authority or contributed to G's death other than, as noted above, perhaps expediting his execution of a plain intention to take his own life.

Conclusion

27. On behalf of us all at the Coroners Court I express my sincere sympathy to G's family for the loss of their son, brother, husband and father.

28. I thank the assistance given to the inquest by Counsel Assisting and the Crown Solicitor's Office, as well as that given by the legal representative for the Commissioner. I acknowledge also the comprehensive investigation undertaken by the Officer in Charge, Detective Sergeant Michael Smith.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died is G.

Date of death:
G died on 25 April 2017.

Place of death:
G died at Old Lillypool Road, South Grafton NSW 2460.

Cause of death:
G died of multiple injuries when the car he was driving collided with a tree.

Manner of death:
G died in the course of a police operation, while suffering a depressive illness and having intentionally driven his car into a tree.

I close this inquest.

E Ryan
Deputy State Coroner
Lidcombe

Date
11 September 2019

Non–publication Orders

Pursuant to ss. 65 and 74 of the *Coroners Act 2009*, and the coroner's incidental power, the Deputy State Coroner orders that:

1. In relation to the documents in Schedule A to these orders and information contained in those documents:
    1.1. There shall be no publication of the information described in Schedule B;
    1.2 The documents may be disclosed to the Deputy State Coroner, those assisting the Deputy State Coroner, the Officer in Charge of the coronial investigation, and the legal representatives of the interested parties to the inquest;
    1.3 The documents may be disclosed beyond the Deputy State Coroner, those assisting the Deputy State Coroner, the Officer in Charge of the coronial investigation and the legal representatives of the interested parties to the inquest, provided that the documents have been redacted to remove the information described in Schedule B.
2. In relation to the documents listed in Schedule A, the relatives of G may inspect un-redacted versions of those documents:
    2.1 in the case where they are legally represented, in the presence of their legal representatives; or
    2.2 in the case where they do not have legal representation, in the presence of those assisting the Deputy State Coroner.
3. In the event that the oral evidence contains information identified in Schedule B, there be no publication of that evidence.
4. Subject to Orders 1 and 2, the documents listed in Schedule A are not to be supplied or copied to any person seeking access to the Coroner's file without the Commissioner of Police (NSW) first being given a reasonable opportunity to be heard on an application for access made pursuant to s 65 of the *Coroners Act 2009.*
5. In relation to the confidential affidavit sworn 2 August 2019, and Confidential Exhibits MJC-1 and MJC-2:
    5.1. there be no disclosure of those documents beyond the Deputy State Coroner and those assisting the Deputy State Coroner;
    5.2. the confidential affidavit be returned to the Crown Solicitor at the conclusion of the hearing of this application, with the Crown Solicitor to make it available as required by the Court.
6. To the extent that reference is made to the information identified in Schedule B, the confidential affidavit sworn 2 August 2019 or Confidential Exhibits MJC-1 and MJC-2, there be no publication of the evidence or submissions of the hearing on 11 September 2019, or of the evidence or submissions in support of the protective orders application.
7. Within 14 days of the publication of the findings, all copies of the un-redacted documents in Schedule A that are held by the legal representatives of the interested parties are to be returned to representatives of the Commissioner of Police.

In addition the court orders pursuant to section 75(2)(b) of the *Coroners Act 2009* that publication be prohibited of evidence tending to identify the deceased, his wife, and his brother. In these findings their names have been anonymised.

The court further orders pursuant to section 75(5) of the *Coroners Act 2009* that publication be permitted of these findings.