



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

**Inquest:** Inquest into the death of KE

**Hearing dates:** 24-25 October 2017 - Young Local Court

**Date of findings:** 25 October 2017

**Place of findings:** Young Local Court

**Findings of:** Magistrate Harriet Grahame, Deputy State Coroner

**Catchwords:** CORONIAL LAW – Death in a police operation, self-inflicted death.

**File numbers:** 2015/254391

**Representation:** Ms J Hopper, counsel assisting the coroner, instructed by Ms K Lockery, solicitor, Crown Solicitor's Office

Mr B Haverfield of counsel, instructed by Mr G Willis, solicitor, for Sergeant Paul Colefax

Mr P Madden of counsel, instructed by Mr K Madden, solicitor for Inspector Ashley Holmes

Ms Wooldridge, solicitor, Office of General Counsel for the NSW Commissioner of Police

**Findings:****Identity**

The person who died was KE.

**Date of death**

The date of death was 29 August 2015.

**Place of death**

KE died outside the Young Police Station at 30 Cloete Street, Young, NSW.

**Cause of death**

KE died of a shotgun wound to the head.

**Manner of death**

KE shot himself with the clear intention of taking his own life. Police were actively engaged in trying to diffuse and calm the situation at the time of the shot.

**Non-Publication Orders**

Pursuant to section 74(1)(b) of the *Coroners Act 2009* I order that there be no publication of the following material:

1. The various NSW Police Force policies contained in Exhibit 1, Volume 3 and the oral evidence of Detective Inspector Gillies touching upon those policies (see court file for full list of exclusions);
2. Paragraph 144 of the statement of Detective Inspector Gillies (Tab 5); and
3. The contents of the directed interviews of Inspector Holmes (Tab 8) and Sergeant Colefax (Tab 7), except as referred to in these written findings.

Pursuant to section 75 of the *Coroners Act 2009*, I order that there be no publication of the name of the deceased or his family members. Initials may be used as pseudonyms.

Pursuant to section 75(5) of the *Coroners Act 2009*, I permit publication of the information contained in these findings, in accordance with the above restrictions.

Pursuant to section 75(6) of the *Coroners Act 2009*, I have formed the opinion that it is desirable in the public interest to permit a report of the proceedings of the inquest to be published, subject to the below redactions.

## Table of Contents

Introduction .....	1
The role of the coroner and the scope of the inquest.....	1
The evidence .....	2
Background.....	2
Contact with police and subsequent bail conditions.....	3
The weeks leading up to KE's death.....	4
The events of 28 and 29 August 2015 .....	4
Preparations and arrangements made during the negotiation .....	6
The firearm .....	7
Were the actions of the police officers present appropriate, in all the circumstances? .....	7
What mental health support was available in Young? .....	8
How did KE die and was his death self-inflicted?.....	8
Conclusion .....	9
Findings .....	10
Identity.....	10
Date of death.....	10
Place of death .....	10
Cause of death .....	10

*This decision was written without the benefit of a transcript. Section 81(1) of the Coroners Act 2009 (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. Formal findings were delivered orally at Young Local Court on 25 October 2017. This is a written record of my findings as delivered on that day, incorporating my reasons for the conclusions then expressed.*

## **Introduction**

1. Late in the evening of 28 August 2015 KE attended the vicinity of the Young Police Station. He was holding a single barrel shotgun. Despite police attempts to calm and speak with KE, he remained distressed. After about twenty minutes he put the gun into his mouth and shot himself. It was immediately clear that he was dead. Ambulance officers who had been waiting nearby on standby were unable to assist. KE's death is tragic and the loss and pain felt by his family is both significant and ongoing.

## **The role of the coroner and the scope of the inquest**

2. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.<sup>1</sup> In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.<sup>2</sup>
3. In this case there is no dispute in relation to the identity of KE, or to the date and place or medical cause of his death. For this reason the inquest focused on the manner or circumstances surrounding KE's death. In particular, the inquest examined the actions of the New South Wales Police officers who responded to the crisis.
4. This is a mandatory inquest because KE's death occurred "during the course" or "as a result" of a police operation. Parliament requires that inquests of this kind are conducted by a senior coroner.<sup>3</sup> This statutory position reflects the importance of independence and transparency when it comes to investigating deaths in this category. There is a significant public interest in understanding how it is that a person died on the veranda of a police station, so soon after engaging with police. The circumstances surrounding a death such as this should be carefully scrutinised and care must be taken to ensure that all relevant police policies and practices are most carefully reviewed. Any opportunities for improvement should be identified and explored, particularly if they have the capacity to save lives in the future.
5. At the same time it is important to remember that operational policing can be highly unpredictable and stressful. Police are often required to face great personal danger in the course of their work. One must always be careful when reviewing decisions made in the field from the relative comfort of the courtroom. The purpose of this inquest is not to lay

---

<sup>1</sup> Section 81 *Coroners Act 2009* (NSW).

<sup>2</sup> Section 82 *Coroners Act 2009* (NSW).

<sup>3</sup> See sections 23 and 27 *Coroners Act 2009* (NSW).

blame on any individual, but rather to see if it is possible to identify opportunities to reduce the risk of tragedy in situations of this nature.

6. I am satisfied that, after the shooting, a proper investigation of the events surrounding KE's death took place pursuant to the relevant critical incident guidelines and that the necessary information was gathered by non-involved officers so that these matters can now be properly and fully reviewed in an independent manner.
7. The inquest explored the NSW Police Force's policies and procedures in relation to a number of matters relevant to the events in this case. A guiding list of identified issues was circulated prior to the inquest commencing. These issues included:
  - Whether the applicable NSW Police Force policies and procedures were followed by police attending the 'concern for welfare' job relating to KE on the evening of 28 August 2015.
  - What mental health services, if any, were available as at 28 August 2015 and what mental health services, if any, are now available to the greater community of Young, including how members of the community may access those services.
8. Following a brief outline of the chronological events, I intend to deal with each of these issues.

### **The evidence**

9. The court heard oral evidence and received extensive documentary material including witness statements, expert reports, photographs and recordings. A view was conducted around the vicinity of the police station to place the CCTV footage and written statements in context. In setting out the brief chronology I intend to rely heavily on the summary of events reproduced in counsel assisting's opening remarks.<sup>4</sup>

### **Background**

10. KE was born on 31 March 1979 in Hull, United Kingdom. He met KA in England in 2004 and moved to Australia with her in March 2006, eventually settling in Canberra. KE and KA married in October 2007 and their daughter TI was born in 2012. KE had two other children living in the United Kingdom from earlier relationships.<sup>5</sup>
11. The records show that KE had a troubled childhood in many respects. He lost his father at an early age and experienced care in a number of foster homes. He appears to have had his first contact with mental health treatment at approximately 11 years of age.<sup>6</sup>
12. KE had a long standing history of psychiatric treatment. He had been admitted as an inpatient in the UK and later received mental health treatment in the ACT and New South Wales. He had been prescribed a range of medication by various mental health

---

<sup>4</sup> I thank those assisting me for their detailed and thorough summary of the background material.

<sup>5</sup> This information was included in KA's oral family statement on 24/10/17.

<sup>6</sup> Report of Dr Barker, Exhibit 1, Volume 2, Tab 41.

professionals. He was not always compliant and from time-to-time stopped taking his prescribed medication as directed.

13. KE also had a history of drug and alcohol abuse. Around the time of his death, he was reportedly drinking alcohol and smoking cannabis on a daily basis. Post mortem toxicology results also indicate the presence of prescription drugs and amphetamines.
14. KE had a long history of self-harm and had reportedly attempted suicide on a number of occasions. Some of the documented incidents include the following examples. In October 2007, KE was involved in an incident, whilst at his own wedding, where the police were called in response to him threatening self-harm. In July 2009, police located KE locked inside a caravan on his own property in the ACT, where he was reportedly making or intending to make an attempt at suicide. On 18 June 2015, KE again threatened self-harm as a result of which police were notified and conducted a welfare check. Police conveyed KE to Young Hospital for assessment and he was discharged the following day. KA told the inquest that she had also been present on a number of other occasions when KE had attempted or threatened to take his own life.
15. On 7 July 2015, KE was assessed by Dr Anthony Barker on behalf of the ACT Forensic Services, Court Assessment and Liaison Services. This was the last known psychiatric assessment undertaken. Dr Barker diagnosed KE with borderline personality disorder, antisocial personality disorder, substance use disorder and possible neurocognitive disorder, due to traumatic brain injury with behavioural disturbance.

#### **Contact with police and subsequent bail conditions**

16. KE Logan had a limited criminal history. In 2012 KE and his wife were allegedly involved in a dispute with a neighbour in the ACT. An interim apprehended violence order (AVO) was subsequently granted in the ACT Magistrates Court protecting KE's neighbour. It appears that the situation did not improve and a final order was made in 2014.
17. On 31 March 2015, KE was involved in an altercation with the same neighbour. During the incident he allegedly used a crossbow to fire an arrow at his female neighbour.
18. KE was arrested, charged and refused bail. On 13 May 2015 he was granted conditional bail by the ACT Magistrates Court. One of the conditions of bail was that he reside in Young with his wife's mother and stepfather, NA and PH. Another condition was that he report to the Young Police Station on a regular basis.
19. Whilst living with his parents-in-law KE threatened to self-harm and was taken to Young Hospital on 18 June 2015 for assessment. He was discharged the next day.
20. On 27 August 2015, KE appeared before the ACT Magistrates Court again in relation to the allegation relating to the crossbow incident. At that time he made an application to vary his bail conditions. Although the application was granted in part, it was unsuccessful with respect to the residential condition and KE was unable to move back to Canberra to live with his wife and then three year-old daughter, as he had wished. After the hearing KE returned to Young and resumed living with his parents-in-law on their property.

### **The weeks leading up to KE's death**

21. It is clear that in the weeks prior to his death, KE was in a distressed and depressed state. His mental health was unstable and deteriorating. As has been indicated he was assessed at the Young Hospital on 18 June 2015. Although he presented from time-to-time in emergency situations it appears that KE was somewhat resistant to engaging in long term therapeutic counselling and had not developed a strong rapport with a mental health provider.
22. KE had been extremely hopeful that he would be able to go back to live with his partner and child in the ACT and when the bail variation application was refused he became distressed. He was reported to have been concerned about his wife and child living in the ACT without him. Despite the support shown to him by his parents-in-law, he also felt somewhat isolated and adrift.

### **The events of 28 and 29 August 2015**

23. On 28 August 2015, KA and TI came from the ACT to visit KE on her parent's property in Young. They arrived around 3.20pm and went straight to the caravan where he was staying.
24. That evening KA and KE talked about their relationship. She reported that he seemed depressed and in retrospect there were aspects of the conversation which indicated that he was unwell. TI was asleep at the house and KA got ready to join her. KE told her how much he loved her and that he was going back to the caravan to get a beer. Shortly after this, KA heard the car start. KA had a slightly uneasy feeling. Later she checked the position of his telephone, using an application on her own telephone. On seeing that it was at the caravan, she thought KE must have fallen asleep in the caravan. She nodded off herself and early the next morning, about 1.26am, she checked again. His phone still appeared at the caravan. She sent a message, which read "Where are you babe – are you ok xx".<sup>7</sup> There was no reply.
25. It appears that KE left the property at approximately 10.30pm that night, leaving his telephone in the caravan. He was next seen in the town of Young, near the police station. It is not known if he drove directly there.
26. That evening Inspector Ashley Holmes was rostered on a night shift. Young Police Station comes under the Cootamundra Local Area Command, where Inspector Holmes worked in the role of Duty Officer. The Young detective's office, where he had been working, is located on Cloete Street, directly across the road from the Young Police Station.
27. At 11.44pm, when Inspector Holmes was leaving his office, he noticed a man standing near the marked police car which was parked outside Young Police Station. At that time

---

<sup>7</sup> Statement of KA, Exhibit 1, Volume 1, Tab 29.

Inspector Holmes saw that the man was holding “a length of something”.<sup>8</sup> We now know that this man was KE. Inspector Holmes thought he might be trying to break the driver’s door window and so he called out to KE, something like “Oi, what are you doing?”<sup>9</sup>

28. Inspector Holmes continued to move closer to KE, who he now thought may be holding a stick. Shortly afterwards there was a loud bang and Inspector Holmes realised that KE had discharged a firearm. Using a police radio, Inspector Holmes called in a foot pursuit. He followed KE, calling on him again to drop his firearm. At some stage Inspector Holmes drew his own gun.

29. Around this time Sergeant Paul Colefax walked out of the Young Police Station and moved onto the roadway of Cloete Street, where Inspector Holmes was situated. KE reloaded the firearm, walked into the grounds of the police station and placed the muzzle of the firearm into his mouth, his hand was on the trigger. He walked up a ramp at the front of the police station. KE initially knelt on the veranda, before moving to a seated position beside the public entry door to the police station.

30. Inspector Holmes spoke with KE for a period of approximately 20 minutes. During the conversation Inspector Holmes tried to convince KE to put the firearm down. Inspector Holmes did not know KE, but he tried his best to engage him in non-threatening conversation. Inspector Holmes asked KE what the problem was and whether he could help. It was obvious to Inspector Holmes that KE “didn’t want to talk”.<sup>10</sup> Eventually he managed to get KE to say a few things. KE explained that all he wanted was to be a husband and father, but that there was an AVO against him. Inspector Holmes engaged him on this issue and eventually KE told him a little more. According to Inspector Holmes KE “told me he had a three year old daughter TI and in an effort to try and get him, to...drop the firearm and to I suppose feel better about himself so...he didn’t want to harm himself I engaged him about, um, his three year old daughter...I recall saying that his daughter would want him in her life. That it might look bad at the moment but in years to come...I’m sure that his daughter would want him in her life and that in the passage of time things will get better”.<sup>11</sup> Inspector Holmes did all he could to engage and build rapport with KE. While he had no formal negotiation training he worked intuitively in an attempt to help KE focus on the future and look for hope.

31. While he did not say much, Inspector Holmes described KE’s tone when he spoke as “just very sad, very sorrowful”.<sup>12</sup> At one point KE apologised for having fired the gun earlier and Inspector Holmes tried to reassure him, telling him “that’s ok. That’s in the past”.<sup>13</sup> I had the opportunity to observe Inspector Holmes give evidence and I am confident his gentle manner offered some brief solace to KE at that difficult time.

32. The conversation continued, with Inspector Holmes continually trying to calmly engage KE and KE not saying too much in reply. Inspector Holmes assured KE that he would not be “Tasered” as he feared. He offered to try to assist him in any way he could. At one point KE

---

<sup>8</sup> Inspector Holmes’s directed interview at A 23.

<sup>9</sup> Inspector Holmes’s directed interview at A 24.

<sup>10</sup> Inspector Holmes’s directed interview at A 34.

<sup>11</sup> Inspector Holmes’s directed interview at A 34.

<sup>12</sup> Inspector Holmes’s directed interview at A 110-111.

<sup>13</sup> Inspector Holmes’s directed interview at A 124-129.

blamed the police for keeping him from his wife and daughter, but he did not express personal hostility towards Inspector Holmes. During this conversation Inspector Holmes had re-holstered his gun and in doing so he placed himself at considerable risk.

33. At one point Inspector Holmes believed that he was gaining a bit of trust. KE asked him for a cigarette and Sergeant Colefax, who was by that stage somewhere behind Inspector Holmes assisted. He came onto the front veranda and placed a cigarette on the concrete floor. He also took the opportunity to give Inspector Holmes a ballistic vest for his protection. It was Sergeant Colefax's belief that Inspector Holmes was establishing some rapport and he did not wish to interrupt the flow.
34. Unfortunately, shortly after KE finished his cigarette, he discharged the firearm. Inspector Holmes was about eight metres from him at that time. Police approached KE. His head was slumped and there was a considerable amount of blood on his chest. Ambulance officers attended, but it was abundantly clear that KE had not survived his significant injury.

### **Preparations and arrangements made during the negotiation**

35. While Inspector Holmes tried to establish rapport with KE, Sergeant Colefax involved himself in coordinating a range of other necessary tasks. He provided a situation report via police radio and kept police radio updated as the incident unfolded. He arranged for Young 25 (Senior Constable Aston Williams and Constable Thomas Marshall) to block the intersection of Cloete and Zouch Streets, to the east of the Young Police Station. Slightly later Senior Constables Dreverman and Senior Constable Mitchell arrived. They were in body vests and took up position near the fence. Senior Constable Dreverman drew his firearm to provide cover and protection. Senior Constable Sirol arrived and took a concealed position at the front of the police Station with his Taser drawn. The vest he brought for Sergeant Colefax was given to Inspector Holmes.<sup>14</sup>
36. Sergeant Colefax busied himself organising these resources and making contact with the State Protection Support Unit (SPSU) and negotiators from Goulburn and Junee. He made immediate arrangements for them to start making their way to Young. He attempted to make a safe exclusion zone, using crime tape so that no member of the public could be hurt. He tasked Constable Watts to commence a crime scene log. Sergeant Colefax also contacted the local Ambulance Officers and had them on standby. All of this was achieved in a timely manner.
37. Although he assisted Inspector Holmes by providing a cigarette to KE, it was Sergeant Colefax's view that he should hold back and not disturb the building of rapport. I accept his decision in this regard was correct.

---

<sup>14</sup> See statement of Detective Inspector Chad Gillies for a summary of these actions, Exhibit 1, Volume 1, Tab 5, paragraph 40 onwards.

## **The firearm**

38. The firearm used by KE to inflict the fatal wound upon himself was legally registered to his mother-in-law NA. KE did not have his mother-in-law's permission to use the gun. It appears that the firearm had been removed from an approved gun safe at her home. NA told the court that the key to the gun safe was always hidden and to her knowledge KE did not know where the key was kept. It remains somewhat of a mystery as to how KE came to find a key to the safe. I accept NA's evidence that the gun safe had not otherwise been opened for some months before KE's death.
39. The ammunition used does not appear to have any connection to NA or her husband. There is nothing to suggest that their ammunition safe had been opened. The court heard evidence that KE had an interest in guns and ammunition and sometimes purchased ammunition from garage sales.

## **Were the actions of the police officers present appropriate, in all the circumstances?**

40. Sergeant Shayne Irwin of Weapons & Tactics Policy and Review (WTPR) attached to the Operations and Skills Command, New South Wales Police Force, reviewed the circumstances of the police response to KE's death from a standpoint of operational safety. He examined the conduct of both officers against existing NSW Police Force policy. He confirmed that the situation was clearly a "high risk" situation. He was of the opinion "that the overall management of the incident is consistent with NSWPF Standard Operating Procedures for the resolution of High Risk incidents"<sup>15</sup>. In his view the police present understood and executed a strategy to contain and negotiate. At the same time there was timely management of the logistics of the situation. Within five minutes of the incident commencing, negotiators and the State Protection Support Unit had been notified. Sergeant Colefax had also commenced creating an exclusion zone for the safety of the public.
41. Sergeant Irwin carefully reviewed whether or not it would have been appropriate for officers to have used weapons in response to the situation they faced. It was his view that the officers were severely limited in the range of tactical options available to them. I accept without reservation that the use of weaponless control, OC Spray, baton, or Taser would have been inappropriate in all the circumstances. I agree that tactical disengagement would also have presented considerable danger to the police and community and was not an option.
42. Inspector Holmes drew his gun at an early stage of the initial interaction. The fact that he re-holstered it at a later point, in an attempt to try to calm KE and establish rapport showed enormous bravery. If anything, he put himself at risk in an attempt to establish rapport. I offer no criticism of Inspector Holmes or of any of the police officers who supported him in responding to this incident. I note that during her family statement to the Court, KE's wife, KA expressed directly to the involved officers that they were in no way to blame for what had happened. Her approach to them, under such difficult circumstances, was extremely generous and I commend her for it.

---

<sup>15</sup> Statement of Sergeant Shane Irwin, Exhibit 1, Volume 3, Tab 55.

### **What mental health support was available in Young?**

43. Throughout his life it appears that KE showed some reluctance to seek help, except perhaps in emergency situations. Unfortunately at the time of his death he is likely to have needed drug and alcohol counselling and other therapeutic intervention. However, it appears that even after his brief admission to Young Hospital in June 2015, he was unwilling to engage and instead focussed his energy on returning to the ACT.
44. The court heard that Young had a number of relevant services at the time of KE's death, including a number of general practitioners, private psychologists and the Mental Health Emergency Service located at Young Hospital. The Murrumbidgee Local Health District Mental Health Team also offered assessment, ongoing case management and referral services. Those services remain in existence today.<sup>16</sup>
45. It is worth noting, that seeking help in a small town can sometimes be confronting and those needing assistance can also have access to more anonymous telephone services such as Lifeline, Beyond Blue, Black Dog and Men's Health care services.<sup>17</sup>

### **How did KE die and was his death self-inflicted?**

46. An autopsy was conducted after KE's death. It clearly identified that his death was caused by a single gunshot wound to the head. The bullet hit the hard palate of his mouth and entered the brain. His death would have been instantaneous.
47. Toxicological findings revealed a blood alcohol level of 0.057 g/100mL. Codeine and its metabolites, benzodiazepines and oxycodone were all present at therapeutic levels. An anti-depressant medication was present in slightly supratherapeutic levels. Illicit drugs were detected including cannabinoids and amphetamine. The amphetamine was not at a high or toxic level.
48. KE's clear cause of death was the single gunshot wound.
49. A finding that a death is intentionally self-inflicted should not be made lightly. The evidence should be extremely clear and cogent in relation to intention. In my view the weight of authority suggests that the proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard.<sup>18</sup>
50. There is overwhelming evidence that KE intended to die that evening. The evidence includes;
  - KE had committed self-harm and threatened suicide before. He is reported to have spoken of killing himself on many occasions.

---

<sup>16</sup> For discussion of this issue see the Statements of Inspector Francis Brown at Exhibit 1, Tabs 53 and 54.

<sup>17</sup> The numbers for those organisations are also set out in Inspector Brown's statement. Lifeline 13 11 14, Beyond Blue 1300 224 636, Black Dog 9382 4530, MensLine 1300 789 978.

<sup>18</sup> *Briginshaw v Briginshaw* 60 CLR 336.

- In hindsight, KE's wife KA saw indications that something was wrong when he parted from her that evening.
- Inspector Holmes spoke to KE during the twenty minutes before his death and clearly understood that he was suicidal.
- KE had taken a gun from his parents-in-law's gun cabinet with the intention of killing himself. It appears that he obtained ammunition from another source in preparation for using the weapon.
- Although distressed, it does not appear that KE was suffering from psychosis at the time of his death. He appears to have understood what was happening.
- While KE would have been affected to some degree by the substances he had consumed, it is not likely that his ability to reason or make decisions was seriously altered. KE's wife spoke to him shortly before he arrived at the Police Station and does not report him being seriously affected by drugs or alcohol. Neither does Inspector Holmes who spoke with him during the twenty minutes before his death.

51. I am satisfied KE's death by gunshot wound to the head was intentionally self-inflicted.

## **Conclusion**

52. KE's death is a tragedy and it continues to affect his wife and children. It is apparent that the profound despair KE felt that evening had been with him on and off since childhood. He had come back from the brink on many occasions and focused himself on the joy his family brought him. Unfortunately, in the early hours of 29 August 2015, he lost all hope.
53. In my view, Inspector Holmes made a valiant attempt to dissuade KE from the action he eventually took. He reached out to a fellow human who was in deep despair and he did it at great personal risk, with bravery and compassion. I commend his courage and his humanity.
54. Sergeant Colefax recognised Inspector Holmes's attempt to build rapport. He assisted with a cigarette and a ballistic vest for Inspector Holmes. Importantly, Sergeant Colefax also commenced the necessary planning, the radio contact, the request for police back up and the contact with trained negotiators that was required. Both men then had to face the horror of the tragic outcome.
55. I have carefully considered whether there are any recommendations arising directly from the evidence. I have no criticism of the conduct of the police involved and think it unlikely that a trained negotiator, even if available in Young in the middle of the night, could have established stronger rapport than Inspector Holmes did. Unfortunately, there is no simple solution to prevent the despair KE felt. While the court's decision to bail him away from Canberra and his family was a trigger, the pain and anger he felt had, on all accounts, been brewing for many years.

56. I make no recommendations arising from the evidence I have heard. However, it is worth reiterating that KE's death should remind us all to encourage those in need to seek professional help wherever possible and to reach out to others in our own communities who are suffering.
57. Finally, I once again offer my sincere condolences to KE's wife, children and extended family. I acknowledge their great loss. I strongly urge that any published report of this death include relevant references to suicide prevention and mental health treatment contact points. I thank the involved officers for their open and honest cooperation with these proceedings.
58. I close this inquest.

## **Findings**

59. I make the following findings under section 81(1) of the *Coroners Act 2009* (NSW),

### ***Identity***

The person who died was KE.

### ***Date of death***

The date of death was 29 August 2015.

### ***Place of death***

KE died outside the Young Police Station at 30 Cloete Street, Young, NSW.

### ***Cause of death***

KE died of a shotgun wound to the head.

### ***Manner of death***

KE shot himself with the clear intention of taking his own life. Police were actively engaged in trying to diffuse and calm the situation at the time of the shot.

Magistrate Harriet Grahame  
Deputy State Coroner  
14 November 2017  
NSW State Coroner's Court, Glebe