CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Stephen Paul Hodge
Hearing dates:	12-16 February 2018
Date of findings:	20 April 2018
Place of findings:	State Coroner's Court, Glebe
Findings of:	**Deputy State Coroner Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death, mental health, police shooting, Mental Health Intervention Team (MHIT)
File number:	2015/265616
Representation:	Mr R. Ranken, Counsel Assisting, instructed by Ms J. Geddes of the Crown Solicitor's Office Mr R. Hood for the Commissioner of Police, instructed by Mr S. Robinson Mr P. Madden for Senior Constable Jamie Taylor and Senior Constable Darren Hamilton, instructed by Mr K. Madden Ms W. Thompson for Mr Brendan Hogan Mr C. Magee for Australian Postal Corporation, instructed by Ms N. Jessup Mr C. Jackson for Dr C. Morrissey, instructed by Mr J. Vijayaraj Mr A. Croxford for witness Mr S. Allison Mr C Murphy for witness Ms M. Staley

Findings:	**Identity of deceased**: The deceased person was Stephen Paul Hodge **Date of death**: Mr Hodge died on 9 September 2015 **Place of death**: He died at Warners Bay in New South Wales **Cause of death:** The medical cause of death was the combined effect of gunshot injuries to the chest and abdomen **Manner of death:** Mr Hodge died in the course of a police operation. The death was by police shooting in circumstances where Mr Hodge advanced upon police with a knife
Non-Publication orders:	There is to be no access to and no publication of exhibit 2, this being a folder of sensitive material. There is to be no access to and no publication of exhibit 4, this being the unredacted statement of Senor Constable Adrian Titmuss dated 24 November 2016
Recommendation:	**To The NSW Commissioner of Police** That consideration be given to the greater integration of mental health informed training into tactical options training with an emphasis on specific de-escalation techniques practiced by role play exercises.

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The Coroners Act 2009 (NSW) *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 Stephen Paul Hodge.

Introduction:

1. Mr Stephen Hodge was born on 10 December 1963 and died on 9 September 2015, aged 51 years. His death took place in circumstances of an apparent mental health crisis and in the context of having difficulties performing his role as an employee at Warners Bay Post Office. On 9 September 2015, Mr Hodge purchased a large kitchen knife and followed his manager, Mr Brendan Hogan, from the office area, through the public area of the Post Office and into a car park behind the building. Police were called and within a short time of arrival, two officers discharged their firearms resulting in Mr Hodge's death.

2. I extend my condolences to Mr Hodge's family.

The Inquest:

3. The role of a Coroner as set out in s. 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 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. Pursuant to s. 82 of the Act, a Coroner has the power to make recommendations, including concerning any public health or safety issue arising out of the death in question.

5. I am required to hold an inquest where there is a death as a result of a police operation pursuant to sections 23 and 27 of the Act. Those sections apply in this matter because two police officers attended Mr Hodge's location behind Warners Bay Post Office in response to a broadcast over the Police VKG radio and following a number of triple 0 calls from members of the public. Upon attending the location, and as events unfolded (which I will outline further below), the two attending police officers discharged their firearms resulting in Mr Hodge's death.

The Evidence:

Background:

6. Mr Hodge was born on 10 December 1963 in England and lived there until the age of 13 years at which time he immigrated to Australia with his parents and elder brother. He lived with his parents throughout his life and was reportedly close to his brother and nephew. In October 2014 Mr Hodge's father died from cancer having suffered for three years.

7. Medical records for Mr Hodge identify a history of mental health issues dating back to 1987. According to Mr Hodge's general practitioner of 29 years, Dr Christopher Morrissey, Mr Hodge suffered from anxiety and depression from 2008.

8. Mr Hodge was employed by the Australian Postal Corporation ("Australia Post") from 1992 and he worked at Warners Bay Post Office from 1999. Mr Hogan worked with Mr Hodge, as his Manager, from at least a time prior to July 2008.

9. Records indicate that in July 2008, Mr Hodge first notified Australia Post that he was suffering from depression, and he took a short period of time off work. From 2009, there were reported occasions of Mr Hodge behaving unusually or inappropriately at work. His employer sent Mr Hodge for psychiatric assessments to determine whether he was fit to return to work duties, on each occasion returning to his role in the Post Office.

10. Mr Hodge's mental health and behaviour appears to have deteriorated from 2013. As an example, in October 2013 he allegedly told a colleague that a book he had received at work was a book on how to kill the staff of Warners Bay Post Office. A short time later, on 22 November 2013, Mr Hodge was found in an agitated and intoxicated state in front of Warners Bay Post Office. He refused to leave, lay down in the loading dock and an ambulance was called to assist him. He was taken to John Hunter Hospital Emergency Department and transferred to James Fletcher (Mater Campus) with suicidal ideation.

11. Mr Hodge had further mental health and alcohol related admissions, including short admissions in November 2013, December 2013 for alcohol detoxification, in March 2014 and in May 2014. Mr Hodge's mental state appeared to deteriorate further following the death of his father in October 2014, with further mental health, alcohol and behavioural issues being documented by Dr Morrissey and by Australia Post.

The Fatal Incident: 9 September 2015

12. Mr Hodge's movements on 9 September 2015 have been captured in CCTV footage and at the time of the fatal shooting, through videos recorded on the mobile telephones of three members of the public.

13. At about 8:26am, before his shift at Warners Bay Post Office, Mr Hodge entered Nextra Newsagency, Warners Bay and purchased a 600 ml bottle of Solo, and a packet of Longbeach Mild cigarettes where he shared a joke and a laugh with the sales assistant. He arrived at the Post Office just before 9:00am in time for his shift.

14. At around 10:00am, Mr Hodge went into Liquorland and bought a two litre cask of Lachlan Ridge Pinot Grigio. The sales assistant asked if he was "finished for the day" to which he replied, "Yes". He also told the sales assistant his job was going well and he was slowly building his hours back up.

15. At about 12:15pm, Mr Hodge took his lunch break at a nearby café. A lady he served in the Post Office earlier that day offered to buy him some apple pie and, when he declined the offer, she paid for his meal. Another customer in Lena's Café, Tracey Kidd, observed Mr Hogan surreptitiously drink from the silver bladder of a wine cask 2-3 times whilst seated at the café. She also saw Mr Hodge put the silver bladder to his coffee cup at least five times. She noticed that the silver bladder was almost empty.

The argument with Mr Hogan and departure from work

16. Sometime prior to about 2:19 pm, Mr Hodge had returned late from his lunch break. Mr Hogan had been looking for Mr Hodge and eventually found him in a cubicle in the male staff toilets. Mr Hodge exited the toilet and the two had an argument. This argument was loud enough to be partially heard by other staff and customers in the front of the Post Office. Mr Hodge allegedly said to Mr Hogan, "You don't respect me, you don't care about me", "I've got mental problems, I've got bipolar, I've got depression. What do you know about depression?"

17. Mr Hogan told Mr Hodge to go home. Mr Hodge swore several times at Mr Hogan and walked out to the back whilst Mr Hogan returned to the counter to serve customers. Mr Hodge returned to the counter to "finish up"; count his money, hand over his cheques and place his money in the safe. He then left, and staff assumed he was finished for the day.

18. At around 2:45 pm, Mr Hodge was seen sitting alone on the concrete wall "at the back of Coles" on Lymington Way, which is in the Warners Bay Village Shopping Centre (opposite the Post Office on John Street). Civilian witness Heather Jones saw Mr Hodge walking up the ramp from the Warners Bay Shopping Centre car park. Ms Jones said Mr Hodge appeared to be under the influence, dishevelled in appearance and was "staggering and unsteady on his feet". Mr Hodge said hello to Ms Jones and asked if she was going home. Ms Jones said he was slurring his words and "was not himself".

The purchase of the knife and confrontation in the Post Office

19. Also around 2:45 pm, Mr Hodge purchased a large kitchen knife from the Warners Bay Coles Supermarket. The attendant was drawn to the self-serve checkout as Mr Hodge had placed the knife in the bag without scanning it. The attendant has said that Mr Hodge did not seem stressed or panicked, just "over the top happy". She thought he appeared drunk.

20. At about 3:10 pm, CCTV cameras captured footage of Mr Hodge talking on a mobile phone as he left the shopping centre and while on the steps outside the Post Office main entrance. Call charge records indicate that the call was made to his home landline and lasted for a little over 2 minutes. It is apparent that the other party to that telephone call was his mother. Regrettably, Mrs Hodge did not provide any detail as to the content of the conversation to give insight into Mr Hodge's state of mind and his motivations immediately following the purchase of the knife. However, Mrs Hodge did later tell a police officer that during the course of the conversation, Mr Hodge had said to her words to the effect, "You're going to see me on the news tonight".

21. Shortly before about 3:15 pm, Mr Hogan called the Australia Post area office to inform them Mr Hodge was going home sick. Whilst on the telephone, Mr Hogan heard a knock on the "middle door" of the Post Office. He opened the door and saw Mr Hodge pointing a knife at him. Mr Hogan noticed Mr Hodge's right hand had blood on it and he thought Mr Hodge must have cut himself. Mr Hodge followed Mr Hogan out the front doors of the Post Office, along the cement footpath and around the side to the car park at the rear of the Post Office, via Postmans Lane.

22. Mr Hogan ran to the back door of the Post Office (which opens onto the car park), entered the combination lock and entered the back entrance, closing the door behind him. Mr Hogan then held himself up against the door from the inside and heard/felt Mr Hodge slam into it from the outside twice.

23. Mr Hodge was seen to hold the knife to his throat, and then "slash" his wrist, which civilian witness Mark Dolbel described as "fairly deep", to the point of "arterial spurts". At this time, several witnesses attempted to close the gate to the loading dock. Civilian witnesses describe Mr Hodge as "pacing around erratically" giving "the impression he was distressed about something", and pacing around "like he couldn't decide what to do", and that Mr Hodge "seemed to be talking to himself and moaning and groaning".

The police broadcast and events in the Post Office car park

24. Members of the public made calls to 000. Shortly after the first of the numerous 000 calls were received, the police VKG broadcast an urgent call (preceded by 2 beeps) seeking available Lake Macquarie cars in the vicinity to attend Warners Bay Post Office in response to information that "Employee Steve Hogan [sic] has a large knife and he's trying to stab the Postmaster there".

25. The first car to acknowledge the broadcast was Lake Macquarie 180, which was manned by Constables Jamie Taylor and Darren Hamilton. They advised the police radio that they were proceeding code red (that is, lights and sirens) and estimated they were 5 minutes away.

26. Less than a minute after the first broadcast, VKG provided further information concerning the job. That further information was limited to the following:

> *"POI described as male, Caucasian appearance, with white hair, about sixty years old, skinny and scrawny. Wearing a white shirt with a black jumper and a black backpack. He's got black glasses on."*

27. Twenty seconds later, Lake Macquarie 180 advised they had arrived in John Street. Less than a minute had elapsed since they first acknowledged the job.

28. In response to their notifying they had arrived, the Police VKG operator reminded them, "he's armed with a large knife".

29. Constables Taylor and Hamilton parked at the front southern corner of the Post Office and ran down the side of the Post Office to the car park area, where there were several civilians directing them to Mr Hodge's location, who they saw holding a knife.

30. Much of the following is taken from a close viewing of the footage captured by witnesses David Turton and to a lesser extent Reece Burnett on their mobile telephones.

31. Constable Taylor was the first to arrive at the car park area. He immediately drew his firearm and pointed it at Mr Hodge stating in a loud, clear and commanding voice, "Police. Put it down!" Constable Hamilton also drew his firearm and pointed it at Mr Hodge.

32. It is apparent from the mobile phone footage that immediately prior to the arrival of the involved officers, Mr Hodge had both of his hands down by his side with the knife in his right hand. Upon Constable Taylor announcing his office,

drawing his firearm and commanding Mr Hodge to “put it down”, Mr Hodge took two small backward steps away from Constable Taylor, who said in a loud, clear commanding voice, “Put the knife on the ground, right now!”

33. At that point, Mr Hodge raised his right hand in which he held the knife to about head height and commenced to take a number of steps towards the police officers with the knife in that position. As he moved towards the police officers, they moved backwards, continuing to hold their firearms pointed at Mr Hodge. Constable Taylor can then be heard to say, “Put it down mate! Don’t make me have to shoot ya!”

34. Mr Hodge continued to advance towards the police officers with the knife in his right hand and his right arm raised to about shoulder height. Constable Taylor can be heard repeatedly calling upon Mr Hodge to “Put it down! Put it down! Put it down! Put it down or we will shoot. Put the knife on the ground!”

35. After motioning to civilians and calling upon them to “Get out of the way! Get back!” Constable Taylor again called upon Mr Hodge to “Put it down! Come on mate, stop muckin’ around. You don’t wanna do this. Mate, put it on the ground!”

36. At that point, Mr Hodge turned away from the officers and walked further into the car park area with both hands down by his side and the knife in his right hand.

37. The police officers can be heard to again ask him to put the knife down and as Mr Hodge moved further into the car park area, both officers followed him, continuing to hold their firearms pointed in Mr Hodge’s direction. One of the officers can be heard to say, “Put it down mate! We’re here to help you!”

38. At that point, Mr Hodge pivoted to face the police officers and began moving towards Constable Taylor in what might be described as a striding manner, raising his right hand with the knife to about head height and extending his left arm towards Constable Taylor.

39. Both of the officers moved backwards while continuing to hold their firearms pointed at Mr Hodge. As he moved backwards, Constable Taylor found himself being backed into a corner of the car park area with his egress via the entrance blocked by one of the gates that was opened inwards. He repeatedly called upon Mr Hodge, “Put it down! Put it down! Put it down!”

40. Mr Hodge continued to advance on Constable Taylor and both officers discharged their firearms. Ballistics evidence establishes that Constable Taylor fired two shots, both of which struck Mr Hodge. Constable Hamilton fired three

shots, two of which struck Mr Hodge (although one only superficially) and one of which missed Mr Hodge completely.

41. The time that had elapsed between the arrival of the officers at the car park area and the discharge of their weapons was only 40 seconds.

42. CPR was commenced, and ambulance officers arrived shortly after to take over. Unfortunately, Mr Hodge did not respond to medical intervention and at about 3:45pm, CPR was ceased and he was pronounced dead.

Autopsy Report

43. Dr Brian Beer, Senior Staff Specialist in Forensic Pathology, performed an autopsy on Mr Hodge at the Newcastle Department of Forensic Medicine on the morning of 11 September 2015. He concluded that Mr Hodge died as a result of the combined effect of gunshot injuries to the chest and abdomen.

44. There is a further matter to note from Dr Beer's post mortem examinations. Screening of a preserved blood specimen of Mr Hodge's abdominal cavity blood determined that it had 0.46grams of alcohol per 100mL as well as 1.0mg per litre of citalopram, which is a metabolite of Escitalopram, the medication Mr Hodge had recently commenced. In addition, screening of samples of Mr Hodge's vitreous humour and urine were found to contain alcohol at concentrations of 0.310g per 100mL and 0.355g per 100mL respectively.

45. Consultant forensic pharmacologist, Dr John Farrar, also provided an expert opinion concerning the concentrations of these substances. Briefly:

    (1) Dr Farrar concluded that the result of the analysis of alcohol in the sample of abdominal cavity blood may not represent Mr Hodge's blood-alcohol concentration at the time of his death because it may have been affected by contamination by alcohol arising from the intestinal tract and/or the liver as well as by post-mortem changes;

    (2) It is highly probable that Mr Hodge's blood-alcohol level at the time of his death was not less than the concentration of alcohol in the vitreous humour and not more than the concentration measured in the blood taken from the abdominal cavity – that is, between 0.31 and 0.46 g per 100 mL;

    (3) As a result of the blood-alcohol concentration, there would have been profound impairment of Mr Hodge's cognitive and psychomotor function and his ability to make judgements and to form rational decisions would have been substantially impaired or entirely absent;

    (4) There may have been increased aggression;

(5) The reported concentration of citalopram was toxic and it is probable that Mr Hodge had consumed a supratherapeutic dose of citalopram or escitalopram;

(6) However, any toxicity caused by the high dose of citalopram or escitalopram is not likely to have contributed significantly to his demeanour immediately prior to his death.

The appropriateness of the tactical response and actions of Police

46. There was little controversy over the evidence that the injuries that caused Mr Hodge's death were inflicted by Constable Jamie Taylor and Constable Darren Hamilton when they intentionally discharged their police issue Glock-9 self-loading pistols in the direction of Mr Hodge at or shortly before 3:19 pm on 9 September 2015. The evidence is sufficient to comfortably conclude that the two bullets that caused the fatal injuries to the chest and abdomen were discharged from Constable Taylor's firearm; and that the two bullets fired by Constable Hamilton that hit Mr Hodge did not have any more than a minor contributory role in the cause of death.

47. The evidence of the eyewitnesses and the mobile telephone footage also establishes that at the time the police officers discharged their firearms, Mr Hodge had a large kitchen knife in his right hand, which he was holding in a manner consistent with what Constable Taylor described as a stabbing position – that is, with his index finger and thumb closest to the bottom of the knife handle and his little finger closest to the point where the handle meets the blade of the knife; and that Mr Hodge was advancing towards Constable Taylor with the knife raised at least to shoulder height such that the tip of the blade of the knife was pointed in the direction of Constable Taylor.

48. At the time the Constables discharged their weapons, Mr Hodge was just 2.4 metres away from Constable Taylor.

49. It was Constable Taylor's evidence that he believed that if he didn't discharge his firearm he was going to be stabbed. I accept that evidence and further accept that certainly at that point, there was no other available tactical option to Constable Taylor and, to the extent that Constable Hamilton considered Constable Taylor to be in immediate danger, it was also the only tactical option available to him.

50. One reason for that was that Constable Taylor found himself in a position where his back was almost up against the cyclone wire fence of the car park

area with his egress via the car park entrance blocked by the open gate. How he came to be in that position was one of the matters that was explored in this inquest. In that regard, it was acknowledged by Senior Constable Titmuss of the Weapons and Tactics Policy Review Unit that police officers are instructed to avoid getting themselves into a position in which they find themselves trapped. Senior Constable Titmuss agreed that one reason they are given that instruction is because it removes the availability of disengagement as a tactical option, but more pointedly, by allowing him or herself to be placed in a position of danger, it increases the likelihood of a fatal outcome.

51. It was Senior Constable Titmuss' evidence, however, that the prospect of avoiding becoming trapped will depend on the individual circumstances, including, in particular the actions of the offender.

52. In this case, the evidence was that very soon after the officers initially challenged Mr Hodge, he advanced towards the two officers and they both moved backwards to maintain a degree of distance between themselves and Mr Hodge. Mr Hodge then stopped and turned away from the officers moving back into the car park area in a direction towards the loading dock area. Up to that point, the officers had not been able to see the entire area of the car parking area or the loading dock; they had not been able to establish whether there was any other person – whether injured or not – who may have been out of their view; or whether there was some other means of escape from the area available to Mr Hodge. It was their evidence that they followed Mr Hodge into the car park in order to ascertain what was in the area beyond their initial view. In the case of Constable Hamilton he was also concerned about a red and black backpack that came to his notice as they moved into the car park area.

53. Constable Taylor's evidence was that as he moved into the car park area he effectively continued along the line of the open gate to his right in order to maintain a degree of distance between himself and Mr Hodge. However, when Mr Hodge pivoted to face him and then commenced his advance upon him, Constable Taylor's options as far as his direction of movement were limited. He could not move further to his right (and further into the car park area), because he says he was aware that to do so could place him in a cross-fire position relative to Constable Hamilton and to his left could place him in a position where he was between Constable Hamilton and Mr Hodge. This left a backwards retreat as the only (and perhaps most instinctive) alternative, but with the consequence that he came to be in a position where his back was almost against the fence and his way to the car park entrance blocked by the gate itself.

54. It is to be noted that the time that elapsed from the time that Mr Hodge pivoted to face Constable Taylor and Constable Taylor's discharge of his firearm was only two seconds. In that time:

- Mr Hodge pivoted to face Constable Taylor;
- Mr Hodge began moving towards Constable Taylor in a striding manner, raising his right hand with the knife to about shoulder to head height and extending his left arm towards Constable Taylor;
- Mr Hodge took six to seven strides towards Constable Taylor; and
- Constable Taylor took approximately five steps backwards away from Mr Hodge.

55. It is true that the final circumstances limited the ability of Constable Taylor and Constable Hamilton to implement an alternative option to the use of lethal force and that the fact that Constable Taylor came to be "trapped" behind the gate was a significant aspect of those circumstances. However, it is also true that an equally significant aspect of those circumstances was brought about by the actions of Mr Hodge in advancing upon Constable Taylor; knife in hand and raised with the tip pointed forwards in a stabbing position.

56. I am satisfied that Constables Taylor and Hamilton identified themselves to Mr Hodge as police officers. This is evident from the mobile phone footage in which Constable Taylor is heard to say, "Police" in a loud clear voice as soon as he arrives at the entrance to the Post Office car park area.

57. The extent to which Mr Hodge was able to rationally process that information is not so clear. The evidence of Dr Farrar and Dr Kerri Eagle (the latter being a forensic psychiatrist who conducted an expert psychiatric review) was to the effect that the extent of Mr Hodge's intoxication at the time was such that his cognitive functioning was severely impaired. That evidence is also supported by observations of witnesses such as Mr Mark Dolbel and Ms Lyn Sartori. Mr Dolbel and Ms Sartori were speaking with Mr Hodge prior to the arrival of police. They said that at times Mr Hodge looked like he might faint. Ms Sartori also gave evidence that after pleading with Mr Hodge to put down the knife and talk about it, Mr Hodge said, "I know you". It would appear from that evidence that Mr Hodge was experiencing some difficulties in processing information, but was not entirely devoid of cognition.

58. Certainly, upon the Constables arriving, Mr Hodge was cognisant of their presence. It is apparent from the video footage that upon the officers announcing their office, drawing their firearms and calling upon him to put the knife down, Mr Hodge took one or two steps backwards and then moved towards the officers, raising the knife at the same time. That does not mean that he appreciated they were in fact police officers.

59. The evidence establishes that the nature of the initial engagement with Mr Hodge consisted of the announcement of their office as police coupled with a simultaneous drawing of their firearms and pointing them at Mr Hodge and issuing repeated demands that he drop the knife. It seems it soon became apparent that engagement was not working as Mr Hodge did not comply with the demand and in fact moved towards the officers. The officers then added a further level to their communication, which comprised of statements as to the consequence of continued noncompliance with the demand to drop the knife: "Put it down mate! Don't make me have to shoot ya!", "Put it down or we will shoot!"

60. It is a curious aspect of the officers' evidence that they both seemed reluctant to accept those descriptions of their interactions and in particular demurred to the suggestion that the act of pointing their firearms was a threatening act on their part. In that regard, their evidence seemed to be focused on their own subjective intention and betrayed a lack of appreciation for how those actions may have been perceived by Mr Hodge.

61. That said, it must be acknowledged that the evidence also establishes that when Mr Hodge turned away from the officers and walked back into the car park area, the officers did alter their approach – if only slightly, by suggesting, "We're here to help you". Constable Hamilton also says he took his left hand off his firearm and motioned to Mr Hodge to drop the knife, and used a softer voice to ask Mr Hodge to "please drop the knife".

62. Nevertheless, both the officers continued to keep their firearms trained on Mr Hodge. Constable Taylor explained that was because their training provides that once they have drawn their firearms, they are required to hold it in one of two positions, both of which involve the firearm effectively being pointed at the suspect and they considered the risk that Mr Hodge presented with the knife was such that it was not considered appropriate to re-holster their firearms.

63. The evidence of Senior Constable Titmuss was that the police officers' actions were consistent with training in the tactical options model. That model is predicated upon the officers' subjective assessment of the risk posed to the community and themselves and the need to meet the encountered resistance with an equal or greater level of force (to paraphrase the evidence of Constable Taylor). In the present case, the risk the officers encountered was that posed by Mr Hodge being in possession of the large knife.

64. In so far as the tactical options they had available to them, the evidence was that Constables Taylor and Hamilton did not have Tasers because they were in plain clothes and there are no Tasers that are able to be concealed when

working in plain clothes. For the same reason, they did not have batons with them. Although Constable Hamilton had his pepper spray in his cargo pants, he deemed that to be an inappropriate tactical option due to its limited range. There was also some evidence that the fact Mr Hodge was wearing sunglasses would also have adversely affected the effectiveness of capsicum spray. Thus, the only tactical options available to the officers were their presence, communication, the possibility of disengagement or the use of their firearms.

65. The nature of the officers' communications with Mr Hodge was explored in the course of their evidence as well as the evidence of Dr Eagle, Senior Constable Titmuss and Acting Sergeant Dawn Pointon of the Mental Health Intervention Team (MHIT).

66. Senior Constable Titmuss considered the initial manner of communication employed by the officers to be appropriate in the circumstances and consistent with their training in the tactical options model. He accepted that the approach used was one that was based around a concept of control based on the offender submitting to the will or authority of the police officer.

67. For her part, Acting Sergeant Pointon said that the training provided by the MHIT was focused on communication that is based around things such as taking time, empathy, respect and dignity. She acknowledged that there is a tension between the approach of the tactical options model which is directed to stopping the immediate threat and the MHIT approach. Acting Sergeant Pointon also considered there would be some benefit in greater integration of de-escalation communication techniques in the tactical options model training.

68. Nevertheless, Acting Sergeant Pointon also said that there may be circumstances where an officer does not have the opportunity to employ the kinds of de-escalation techniques that are favoured by the MHIT approach, such as where the immediacy of the risk precludes such an approach. This suggests that where an officer is faced with a person suffering from a mental disturbance, they may be encouraged to consider a more empathic approach to communication, but in the event of any doubt, the tactical options approach is to be preferred. Furthermore, the mental health training that is offered to the majority of frontline officers is the one-day course. This course does not provide any instruction as to specific de-escalation techniques that may be used.

69. The problem with the prioritising or bias towards the tactical options approach is that it is contrary to current thinking in respect of communication techniques when dealing with persons in the midst of a mental health crisis. As Dr Eagle said in her evidence, the use of de-escalation techniques has been shown to reduce the likelihood of a fatal outcome. Dr Eagle also gave evidence that forensic psychiatrists are trained in specific de-escalation techniques aimed to

reduce heat or emotion or arousal. She said that where a person is distressed or agitated, aggressive, or suicidal, the goal is to buy some time. Sometimes the level of arousal might reduce of itself because the body can only burn adrenaline for a short time. The emphasis is on engagement rather than shock and intimidation to reduce the person's emotion and reduce one's own emotion and then reorientate by asking the person's name, acknowledging their state ("I can see you're in distress"). The person might listen if they feel they are being heard and their distress has been recognised.

70. It is noted that Dr Eagle's evidence was that the use of de-escalation techniques may not have altered the ultimate outcome in this case and it was submitted by those representing the Police that the fact that witnesses such as Mr Dolbel and Ms Sartori had been attempting to de-escalate the situation without success would suggest de-escalation techniques would not have worked. In fact the de-escalation techniques employed by Ms Sartori and Mr Dolbel had some success. For a number of minutes they had managed to keep Mr Hodge from leaving the car park area; he had not lunged at anyone with the knife; and they had elongated the incident to the point where the police arrived. There had also been at least the start of some re-orienting of Mr Hodge as evidenced by his response to Ms Sartori, "I know you".

71. In any event, it remains a source of disquiet that as soon as Constables Taylor and Hamilton arrived on scene the nature of the communication being attempted with Mr Hodge changed dramatically in terms of volume, tone and content and was coupled with the visceral threat of death or serious injury presented by the drawing and pointing of firearms at Mr Hodge.

72. In the circumstances, I will make a recommendation to the Commissioner of Police directed to greater integration of mental health informed training into tactical options training with an emphasis on specific de-escalation techniques practiced by role play exercises.

Evidence of suicidal ideation / intent

73. It was Dr Eagle's evidence that there was some evidence of suicidal ideation on the day and in the period leading up to Mr Hodge's death. As to the former, that comprised of evidence of suicidal gestures such as cutting at his throat and wrists with the knife. As to the latter, Dr Eagle placed some emphasis on the detail of Mr Hodge's final consultation with Dr Morrissey. However, that evidence needs to be considered against the qualification that Dr Eagle did not have the opportunity to assess Mr Hodge in person and the evidence of Dr Morrissey that he did not consider Mr Hodge to be suicidal at the time of his final consultation on 4 September 2015. Dr Eagle also noted that while it was

likely Mr Hodge was considering ending his life on 9 September 2015, he remained ambivalent about his suicidal gestures.

74. Dr Eagle was asked about the reference in her supplementary report to the hypothesis that Mr Hodge intended to provoke the shooting. Dr Eagle was not prepared to come to a conclusion that he did so. She acknowledged that for the purposes of research there are accepted criteria for suspect provoked shootings, but cautioned against the use of those criteria in individual circumstances. In any event, Dr Eagle was of the view that there was no evidence of one of those criteria, namely, that Mr Hodge wanted to be shot by police.

75. On the evidence before me, I could not conclude that it was Mr Hodge's intention to provoke the police to end his life by shooting him.

Effect of alcohol and citalopram

76. The evidence establishes that Mr Hodge's blood alcohol level was such that there would have been profound impairment of Mr Hodge's cognitive and psychomotor function and his ability to make judgements and to form rational decisions would have been substantially impaired or entirely absent.

77. In so far as the low toxic level of citalopram in his system is concerned, Dr Eagle hypothesised that Mr Hodge could have taken an increased dose of his Lexapro in an attempt to medicate his distress. In that regard, there was evidence that for a period of approximately five months prior to August 2015, the only medication Mr Hodge was taking for his anxiety and depression was the benzodiazepine alprazolam (Xanax), which has an immediate effect upon the patient. While Mr Hodge had commenced on Lexapro in August 2015 and, according to Dr Morrissey, had increased his dose to 20 mg by 4 September 2015, at least as at that date (4 September 2015) Mr Hodge had not yet got his dosage to the desired 40 mg per day.

78. Having regard to the evidence that, unlike Xanax, Lexapro does not provide an immediate effect upon the patient, but only works once it has been slowly increased to the desired dosage, it is a reasonable hypothesis that Mr Hodge sought to compensate for not having got his level of Lexapro up to the desired level by taking an excessive amount, possibly in a misconceived attempt to feel more of an effect from it. However, given the evidence in his medical records of prior occasions where he had taken deliberate overdoses, I am not able to come to a concluded view as to what his motivations were in doing so.

Mental health status

79. The various psychiatric assessments of Mr Hodge's fitness for duty prepared over the years from 2009 up to as recently as August 2015 all note Mr Hodge's history of recurrent episodes of depression, but also raised the possibility of some form of bipolar disorder.

80. Mr Hodge's treating GP, Dr Morrissey, considered Mr Hodge to have anxiety and depression related to that anxiety as well as an alcohol use disorder, although the latter had developed more recently.

81. Dr Eagle's view was that Mr Hodge suffered from a major depressive disorder that was moderate to severe, noting the evidence of recurrent depressive episodes that predated his harmful and problematic use of alcohol. Dr Eagle considered that it was possible that Mr Hodge may have had a bipolar II disorder, but he did not appear to have the necessary symptoms of a manic or hypomanic episode. She acknowledged that the retrospective nature of her assessment as well as Mr Hodge's excessive use of alcohol and his treatment with mood stabilisers complicated the interpretation of his symptoms.

82. Perhaps the greatest barrier to Mr Hodge's treatment was his severe alcohol use disorder over the last 10 years.

83. It is clear from Dr Morrissey's evidence that Mr Hodge was a most difficult patient to treat. He was very sensitive to criticism and to engaging with any treatment that might involve an acceptance that he had a problem. Mr Hodge was not willing to subject himself to any voluntary assessment by an expert psychiatrist and was reportedly resentful of the questions asked by those psychiatrists who conducted the assessments of his fitness for duty. He was also non-compliant with medications prescribed for him by Dr Morrissey and difficult to follow up.

84. It is clear that over the course of his treatment of Mr Hodge, Dr Morrissey continued to try different medications with a view to getting the right one.

85. There is a consensus in the evidence that the prolonged use of Xanax in the treatment of Mr Hodge's depression and anxiety was not appropriate, particularly having regard to the fact of his alcohol use disorder. Dr Morrissey accepted this and it is apparent that he did not intend it to be so. Dr Morrissey's evidence was that at the time he prescribed Xanax to Mr Hodge in March 2015, it was only intended for the short term as it was his intention to review Mr Hodge's medication three days' time. Dr Morrissey gave evidence that it

was his intention at that time to commence Mr Hodge on Lexapro, although he accepted he did not record as much in his notes.

86. As it happened, Mr Hodge did not present to Dr Morrissey's rooms for another three months. Over that time, the only medication Mr Hodge had been taking for his depression and anxiety was the Xanax. There is also a suggestion in the fitness for duty assessment of Dr Vickery prepared in April 2015 that Mr Hodge may have been taking more than what had been prescribed and that this may have been contributing to his troubling behaviour in the workplace.

87. In any event, Dr Morrissey did cease the prescription of Xanax and commence Mr Hodge on Lexapro in August 2015. Dr Eagle considered that to be an appropriate course of treatment.

The significance of the management of his behaviour in the workplace

88. It is apparent from material before me and from the evidence of Mr Hogan that Mr Hodge was a difficult employee to manage in the workplace. While this inquest did not seek to explore the rights or wrongs of the particular incidents of concern, it did seek to explore the significance of the manner in which Mr Hodge's workplace behaviour was being managed, to his thinking and motivations on 9 September 2015.

89. It is apparent that prior to late 2013, Mr Hodge's problematic behaviours were managed as a medical issue only, with occasions where he was required to subject himself to assessments as to his fitness for duty; assessments that he invariably passed and was either determined fit to return to full duties or fit to undertake a graduated return to work.

90. It is also apparent from Dr Morrissey's evidence that Mr Hodge's employment was the only thing in his life that was a source of self-esteem and that Mr Hodge resented being subjected to the fitness for duty assessments. Dr Morrissey also said Mr Hodge's level of resentment towards those processes had increased over the last two years of his life, which incidentally (and unknown to Dr Morrissey) coincided with his employer dealing with his problematic behaviour variously as both a medical issue and a matter to be dealt with under its Employee Counselling and Discipline Policy ("ECDP").

91. According to Dr Morrissey, it was only in 2015 that Mr Hodge appeared to have directed the focus of his resentment towards his "boss", Mr Hogan, who he perceived as "dobbing him in".

92. The evidence establishes that Mr Hogan was given little information as to the underlying medical issues that may have been impacting upon Mr Hodge's performance and behaviour in the workplace. His role in that regard was limited to counselling Mr Hodge in respect of minor matters but otherwise simply notifying others in Head Office of behaviours of more serious concern and then taking guidance from them as to what was required.

93. Notwithstanding there had been previous occasions of counselling Mr Hodge under the ECDP for unacceptable workplace behaviour and performance, there was an elevated response in 2015 in the form of a Disciplinary Inquiry that resulted in a determination that Mr Hodge be subject to a 2-increment pay reduction for 12 months. It is reasonable to infer that the gravity of the penalty imposed would have created in Mr Hodge a concern about the prospect of his employment being terminated in the event of any further workplace incidents and that may have heightened the focus of his resentments upon Mr Hogan.

94. The significance of that to his motivations and actions on 9 September 2015 is evident from the nature of his verbal attack upon Mr Hogan that day after returning late from his lunch break. It is also evident from Mr Hodge making comments to Mr Hogan about contacting head office to inform them that he was going home sick.

95. Exactly what Mr Hodge intended to do that afternoon is difficult to discern. His level of intoxication was such that his judgment and capacity for reasoning would have been significantly impaired. I do not know the full detail of what he told his mother or what he meant when he told her "You're going to see me on the news tonight". Whilst Mr Hodge purchased the knife and then pursued Mr Hogan with it, he did not lunge at him and there appeared to be some ambivalence in his actions in that regard.

96. Nevertheless, it does appear that his perception of Mr Hogan as a threat to his continued employment was a catalyst or lightning rod around which his impaired thinking coalesced into the actions that led him to be armed with a large knife in the car park area of the Post Office where Constables Taylor and Hamilton would encounter him in the course of their duties as police officers.

Conclusion

97. Mr Hodge's death was tragic. It has deeply affected his family, his work colleagues and the police involved in the incident. It is clear that no one wanted such a tragic outcome for Mr Hodge and attempts were made to avoid it.

98. I intend to make a recommendation to the NSW Commissioner of Police directed to greater integration of mental health informed training into tactical

options training with an emphasis on specific de-escalation techniques. Police have an extremely difficult job to do and often very little time to plan and find out all the information they need, particularly about someone's mental health.

99. Any education and training to better assist police in handling a situation such as this one can only be a positive and important step in the efforts to reduce such tragic outcomes occurring in the future.

100. I would like to thank my counsel assisting, Mr Rob Ranken and his instructing solicitor, Ms Johanna Geddes from the Crown Solicitor's Office for the enormous effort they put into this matter and for their professionalism.

101. I thank the officer in charge, Detective Chief Inspector David Laidlaw for the excellent work he has done in the investigation and in preparing such a thorough brief.

102. Finally, I offer my heartfelt condolences to Stephen's family. Stephen was very much loved and cared for by them and their loss is immense.

Findings required by s. 81(1)

103. 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:

The identity of the deceased

The deceased person was Stephen Paul Hodge

Date of death

Mr Hodge died on 9 September 2015

Place of death

Warners Bay in New South Wales

Cause of death

The medical cause of death was the combined effect of gunshot injuries to the chest and abdomen

Manner of death

Mr Hodge died in the course of a police operation. The death was by police shooting in circumstances where Mr Hodge advanced upon police with a knife.

Recommendation

To The NSW Commissioner of Police

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

Non Publication Orders

105. The non-publication orders and non-access orders made over exhibits 2 and 4 continue. On the first day of the inquest I made a further non-publication order pursuant to s.74 of the *Coroners Act 2009* over the supplementary report of expert psychiatrist Dr Kerri Eagle and over two express phrases. As I indicated to the interested parties at the conclusion of the inquest, having heard the evidence, I do not consider that order is necessary and I lift that order.

I close this inquest.

Teresa O'Sullivan
Deputy State Coroner

Date 20 April 2018