1. 1740 of 2006 Gary Kelso

Inquest into the death of Gary Kelso at Surry Hills. Finding handed down by Deputy State Coroner MacPherson on 13 December 2010

Introduction

Gary David Kelso was arrested on 8 November 2006, refused bail and eventually taken to the Surry Hills Cells Complex where he remained, spending much of his time in his bed, suffering, as a lot of other inmates at the Complex were, from heroin withdrawal.

Just over twenty-four hours after his arrival at that Complex he was dead.

Role of Coroner

My role as Coroner is to establish, if possible, the identity, the date of death, the place of death and the manner and cause of death. The formal finding will be recorded at the Registry of Births, Deaths and Marriages

A Coronial Inquest is essentially an enquiry. It is not a criminal or civil trial in which two opposing parties engage in legal combat. It is not the role of the Coroner to attribute fault or make findings in relation to negligence or breach of duty of care

Another important function of an inquest is the making of recommendations, which are necessary or desirable in relation to any matter connected with a death. In this way the coronial proceedings can be forward looking, aiming to prevent future deaths, rather than allocating blame.

I say this not so much for the benefit of learned counsel, but more for the benefit of Julie Kelso, Gary's sister and Graeme Kelso, Gary's brother who may not always appreciate and understand the role of a Coroner or the Coronial Inquest.

Background

Surry Hills Police *arrested Gary David Kelso* just after 9am on 8 November, on a charge of larceny allegedly committed at Sullivan's Hotel, 21 Oxford Street Paddington. He was conveyed to the Surry Hills Police Station for processing.

Following his appearance later that same day at the Central Local Court, he was remanded in custody, bail refused, to re-appear on 10 November 2006.

Gary Kelso had a lengthy criminal history, particularly in relation to property theft offences, which, were suspected to have been committed to facilitate his illicit drug (heroin) dependency.[4]

Gary Kelso was placed into the custody of Corrective Services Officers at Central Local Court and conveyed to Surry Hills Cells Complex ("SHCC"). He arrived at SHCC at about 16:55 hours, 8 November (2006) and was place in cell 20 with three (3) other

[4] *Statement Detective Senior Constable Robyn Fraser page 11 paragraph 6*

inmates and at other subsequent times, five (5) inmates.[5]

On arrival at SHCC a "*New Inmate Lodgment & Special Instruction Sheet"* for Gary Kelso was completed by Correctional Officer *Osman* Zerdo on which was recorded "*… heroin addict, withdrawing".*[6]

From that time, 16:55 hours 8 November 2006, until shortly after 19:30 hours on Thursday 9 November 2006 Gary Kelso was not seen, reviewed, nor triaged, by any Justice Health professional/nurse.[7]

Evidence from inmates suggests that during the course of Thursday 9 November 2006 Gary Kelso was unwell and that he was vomiting and suffering diarrhea. The inmates say that Gary spent much of the time during that Thursday lying on a mattress in cell 20.

Shortly after 19:30 hours on the 9 November, Gary Kelso was observed as having some form of seizure. Corrective Officers along with the Justice Health Nurse on duty on the day at SHCC were called on the intercom system by inmates and thereafter attended cell 20 and found Gary Kelso in *cardiac arrest*.

The Officers immediately began CPR and NSW Ambulance was called. On arrival the Ambulance Officers/Paramedics proceeded with attempts to resuscitate him without success. He was transferred to St Vincent's Hospital where medical staff continued with attempts to resuscitate but he remained in cardiac arrest. With the resuscitation attempts being unsuccessful Gary Kelso was pronounced deceased by Dr Melinda Berry at 20:37 hours on 9 November 2006.[8]

A Death in Custody

At the time of his death Gary Kelso was at St. Vincent's Hospital, however, he was otherwise lawfully detained and in the custody of the *Corrective Services NSW*. Accordingly his death occurred when he was in lawful custody.[9]

As such an Inquest into his death was and is mandatory by virtue of *ss.13A* and *14B* of that (now repealed) Act.

On 1 January 2010 the *Coroners Act 2009* ("the 2009 Act") came into effect, the *Coroners Act 1980* having been then repealed. Pursuant to *Schedule 2* to the 2009 Act ("*SAVINGS, TRANSITION AND OTHER PROVISIONS"*) and particularly *cl.14*, this Inquest is a *part completed* Inquest before the repeal day of the *Coroners Act 1980*. Accordingly, from 1 January 2010, the Inquest was subject to the 2009 Act in same way as that Act applies to an Inquest commenced on or after 1 January 2010.

In any event it is observed that the provisions of *ss.23* and *27* of the 2009 Act, in large measure, replicate the provisions of *ss.13A* and *14B* of the *Coroners Act 1980* (now repealed).

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5 *Statement of Detective Senior Constable Robyn Fraser page 11 paragraph 9*
6 *Volume 1 page 264*
7 *Volume 2 page 289*
8 *Volume 1 pages 86 and 124*
9 *See section s**13A (1)(c)** of the **Coroners Act 1980(Repealed)***

THE CRITICAL INCIDENT INVESTIGATION, THE CORONIAL INVESTIGATION AND THE SHCC

Following the death of Gary Kelso, and as part of the mandatory system of the investigation of the death in custody of Gary Kelso, the critical incident protocols, as instigated by NSW Police, where then set in place on the 9 November 2006.

Detective Senior Constable Robyn Fraser was appointed as the Officer-in-Charge of the Critical Incident and of the coronial investigation. Detective Senior Constable Fraser compiled a detailed and comprehensive brief of evidence a fact I have already conveyed to her superiors.

The Inquest received evidence with a view to considering the conduct of various *Corrective Services NSW* Officers as well as Officers/professional personnel in the employ of *Justice Health* together with the procedures in place at the time to determine whether, and to what extent, the actions of the various personnel together with protocols for the SHCC relating to the care of inmates were appropriate/had been complied with.

In addition, a significant factual issue for determination concerned whether inmates in and adjacent to cell 20 had in fact attempted to alert Correctional Officers to the perceived deteriorating medical condition of Gary Kelso during the course of Thursday 9th November 2006.

The evidence indicates that at the time of Gary Kelso's death, there were 54 inmates in custody at SHCC with five (5) Corrective Service Officers on duty at that time (David *Walker, Leonie Gale, Craig Hayden, Bettina Edwards-Cvetkovski and David Burton*) and one (1) Justice Health Nurse Elizabeth Angel.[10]

Importantly Detective Senior Constable Fraser reported that,

> *"Many of the prisoners there [at SHCC] are suffering illicit drug withdrawal and due to there being only one nurse, not all inmates are able to be seen. Inmates are triaged according to their conditions. ".* [11]

Further, William Beale, who was at the relevant time a Principal Investigator with Corrective Services NSW and who attended SHCC at about 9.30pm on 9 November 2006 to assist Investigator Paul Coyne with the departmental investigation into the death of Gary Kelso, noted that the scene that confronted him as being "*… like the place struck more like a sick bay than a watch house"*[12].

In November 2006, and for some considerable time beforehand, it was not uncommon for prisoners entering the SHCC to be carrying a "*heroin use and withdrawal"* alert. According to Acting Assistant Superintendent David Walker, 85% of inmates brought into custody and detained at SHCC at that point of time had a similar alert, as did Gary Kelso.[13]

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10 *Volume 1 pages 11at paragraph 10, 152 and 212*
11 *Ibid page 11 paragraph 10*
12 *Transcript 15/9/08 page 12 lines 33-34*
13 *Volume 2 page 421 at Q/A 211*

Gary Kelso was detained in cell 20 at the SHCC on 8 and 9 November 2006. Cell 20 was a "*6 out"*, that is the cell could be used to detain and house six (6) inmates. There were no security or observation cameras in cell 20 and, as at 9 November 2006, a limited number of cells within the complex had cameras installed, these being cells 17, 21, 22, 11 and 6. These were the particular cells that were generally used for inmates assessed as being a risk of self-harm or suicidal.[14]

On the day in question, Gary Kelso remained in cell 20 and was detained, at various times, with inmates *Kim Spouse, Donny Tomkins, Jim Filipovski,* with inmates *Brian Smith (Moran)* and *Fadi El-Farra* being placed in cell 20 at a latter point in time.[15]

In each cell at SHCC, including cell 20, there was an alarm system device, which inmates could activate to get the attention of Correctional Officers on duty at the time. This process is referred to by the inmates and also some Corrective Officers, as being "*knock ups"*.

It was the case that Correctional Officers were often asked, by way of "*knock ups"*, to attend to various matters for the inmates and often for "*non-emergency"* matters.

In this respect inmates often misused the "knock up" system. However a number of the inmates have stated that they used the call button inside cell 20 for the specific purpose of getting the attention of Correctional Officers to what was seen as the deteriorating health (medical) condition of Gary Kelso, but without success.

It is acknowledged that all Correctional Officers on duty on Thursday 9 November together with Justice Health professional staff have indicated the contrary, namely that they had no notice nor were otherwise informed by inmates, in or proximate to cell 20, that Gary Kelso required medical attention. This is so despite the fact that he remained throughout that particular day, Thursday 9 November, on the triage (priority) list but had not been seen as at 7.30pm.[16].

On Thursday 9 November at about 7.40pm *Acting Assistant Superintendent David Walker* was seated in the Officer's Station at SHCC. There was a call on the intercom from cell 20. Correctional Officers *Craig Hayden* and *David Burton* entered the Officer's Station from the cellblock and informed Assistant Superintendent *David Walker* that an inmate (Gary Kelso) in cell 20 had fitted.

Those three (3) Officers, *Walker, Burton* and *Hayden* along with the Justice Health Nurse on duty at that time, *Elizabeth Angel*, attended cell 20 observed Gary Kelso and then commenced treatment protocols.

As indicated earlier, NSW Ambulance was called and Officer Walker instigated protocols (i.e. a critical incident response) to have certain other inmates removed from the general area as well as all "*uninvolved*" personnel.

Thereafter, with the arrival of the Ambulance Service Paramedics, resuscitation attempts were continued. However Gary Kelso appears never to have regained consciousness.

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14 *Vol 1 page 28 paragraph 128*
15 *Ibid page 17 paragraph 48*
16 *Volume 2 page 289*

Issues for determination

A. The cause and manner of death of Gary David Kelso.

B. Did inmates in and adjacent to Cell 20 at the SHCC make any, or indeed numerous, 'knock ups' specifically for the purpose of attempting to alert Correctional Officers to the observed deteriorating medical condition of Gary Kelso during the course of 9 November 2006 and prior to 7.30pm that day.

C. Characteristics of and use made of SHCC by *Corrective Services NSW* up to and including 9 November 2006.

D. Procedures and protocols utilised at SHCC at relevant times up to and including 9 November 2006.

E. The cooperation and relationship between Justice Health and *Corrective Services NSW* as regards fulfilling statutory responsibility of both entities at SHCC in the period up to November 2006; and

G. The Way Forward/Recommendations.

The First Issue

A. Cause and manner of death of Gary David Kelso

Dr Istvan Szentmariay, Forensic Pathologist, Department of Forensic Medicine Glebe, prepared an interim report[17] and then provided his full post-mortem report into the death of Gary Kelso[18]

Dr Szentmariay gave as the direct cause of death – DILATED CARDIOMYOPATHY. In his report Dr Szentmariay noted;

> *"The lungs were congested (combined weight 1500g). All four chambers of the heart were dilated; the major coronary arteries showed up to 20% narrowing. Histopathological evaluation of the heart muscle showed a small, microscopic area of ischaemia (as a result of lack of adequate blood supply to the heart) No other significant gross pathological changes were observed. Toxicological examination showed presence of marijuana metabolites (Delta-9 – tetrahydrocannabinol and Delta-9 – THC Acid) and no alcohol in his blood….."*[19]

The Inquest was also benefited with the additional evidence provided by Dr Michael Kennedy as to the cause and manner of death. Dr Kennedy is a Consultant Physician in Internal Medicine with a sub-specialty practice in Clinical Pharmacology and Cardiology.

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17 *Volume 1 page 216*
18 *Exhibit "3" supplementary folder no.2 at TAB 5*
19 *Ibid page 3 of his report*

Dr Kennedy prepared a report, dated 4 March 2009[20] and in that report he observed that;

> *"The correct diagnosis of a **withdrawal syndrome** can be difficult particularly as there is commonly polydrug use.*
>
> *Skilled medical attention is required as other illnesses may cause similar symptoms and drug abusers often suffer from intercurrent medical problems".* (Emphasis added)[21]

Then, against the background that Gary Kelso had not received any medical attention or review whilst he was detained at SHCC on 8 and 9 November 2006,

Dr Kennedy records that Gary Kelso had indicators of Hepatitis C and a dilated cardiomyopathy.[22]

Whilst Dr Kennedy makes clear that he could not make a precise diagnosis as to the cause of Gary Kelso's dilated cardiomyopathy, he otherwise concluded;

> *"A drug related cause would be a definite possibility with hepatitis C a less likely cause".* [23] (Emphasis added)

In response to a question of what impact upon the health of Gary Kelso would have been occasioned by the fact that he was not reviewed by a Justice Health Nurse (or any medical personnel) following his transfer into SHCC on the evening of 8 November until he fell into unconsciousness on 9 November 2006, Dr Kennedy stated;

> *"Review of his clinical condition by a registered nurse (RN) or similarly trained person, would have revealed a very unwell individual. A quick assessment would be made as to how he felt, his mental state and what were his symptoms. This initial information is very important and provides a good guide to a trained nurse (RN).*
>
> *It is within the purview of a nurse to have then commenced a physical examination. This would include measuring the heart rate by taking the pulse at the wrist and probably using a stethoscope to check the heart rate if irregularities were detected at the wrist … blood pressure would be measured and a clinical assessment of hydration by examining the dryness of the tongue, skin turgor and ancillary moisture as well as ascertaining his output of urine. Additional observations be made such as the size of his pupils, involuntary muscle activity, respiratory rate … All this can give a guide as to the condition of his peripheral circulation.*
>
> *If an RN had assessed Mr Kelso, he or she would have found him to be in need of fluid replacement, hypertensive (low blood pressure) or detected cardiac irregularities. He or she would (or should) know that haemodynamic monitoring was required (measurement of blood pressure*

[20] *Exhibit 21*
[21] *Exhibit 21 paragraph 3.6 at page 5*
[22] *Ibid paragraph 5.0 at page 7*
[23] *Exhibit 21 paragraph 5.0 at page 7*

and heart rate as well as rhythm by ECG) so transfer to hospital would have been recommended."[24] *(Emphasis added)*

Also in response to questions regarding any connection, or relationship between, the deceased's reported medical deterioration and not being reviewed by a Justice Health Nurse prior to his collapse, Dr Kennedy further observed that;

"Mr Kelso became unwell shortly after his arrival. Had he been assessed by a medically training person such as a registered nurse, the potential seriousness of the situation would (or should) have been recognised and responded to appropriately".[25]

Dr Kennedy also gave the following additional evidence before me at the Inquest by way of elaboration of the opinions he expressed in the report he provided;

"Q. Doctor, the facts that you've been given are that shortly after 7.30pm on 9 November, Mr Kelso collapsed and was subsequently found unconscious and later was pronounced deceased. The cause of death being given by the forensic pathologists as being diluted (sic) cardiomyopathy. Against that background if on coming into custody the previous late afternoon on 8 November just after half past 4 in the afternoon, the deceased was reviewed, assessed by a registered nurse, are you able to comment what, if any, symptoms may have been exhibited after such or during an assessment in circumstances where the deceased gave a history of undergoing withdrawal for heroin?

A. It might be best if I give it as an overview rather than specific times, which obviously would be difficult. A person who is a heroin addict or a lot of people are poly-drug addicts and often have excess alcohol, there are many factors, and they can walk into a room and be as – look as healthy as any of us and within a short period of time multiple things can happen or they can have an intercaradilis (?). Once a person develops some of the symptoms of withdrawal, which can be nausea, vomiting, diarrhoea, abdominal pains, which can occur in a very large number, clearly that's a time when it requires someone with skill to look at it. I don't have nursing qualifications, I have worked with nurses for a very long period of time, and the assessment of a sick person by a qualified nurse is exceedingly valuable. In the emergency room situation, which is the one I have most dealings with, and other circumstances, a good registered nurse is exceedingly good in saying who is sick and who isn't

They are very good in that non-specific thing, this person looks sick. We then have a person who has vomiting, diarrhoea, might have abdominal

[24] *Ibid paragraph 6.0 at page 8*
[25] *Exhibit 21 paragraph 6.0 at page 9*

pains, altered levels of consciousness. They would then see them, talk to them, get some sort of history, and nurses are very good at getting histories; quick, precise, to the point, how do you feel, what's going on, et cetera. Are they communicating well, are they not communicating well, do they have muscle twitches. They'll examine them, generally look at them all over. If somebody has persistent vomiting and diarrhoea what you worry about is how much fluid is onboard and they do a standard examination, look at the tongue, the usual to look at the skin to see if they're sweaty in the axilla, to see if their tongue's dry. Ask if they're passing a lot of urine, and so forth. These are things every nurse would do.

Q. Including taking temperature?

A. And then on examination they take the pulse, see if was weak; thready, irregular. They may then take the temperature, which usually these days is done by sticking something in the ear, not in the mouth. They may take the blood pressure, and so forth. Stethoscope as well. A lot of nurses even tend to listen to the heart to and they may hear a lot of irregularities. Because taking the pulse is the risk you will simply miss a lot of irregular beats and see it's different. A skilled nurse would do a good assessment of someone and come to a good conclusion and decide whether they need to call for help, vis-à-vis some sort of treatment, transfer or whatever.

Q. If this examination assessment by a nurse took place at just after 4.30pm on 8 November and against the background of a history being given of withdrawing from heroin, can you comment at all?

A. It would depend on what symptoms. If the nurse saw him she would ask him how he was feeling, had he withdrawn before and what are his symptoms. And then would make an assessment of what she saw at the time.

Q. If we move forward to the next day, the 9th when the observations are being made, as seen by or observed by inmates, of which you have read, and on the assumption that there was an initial assessment by a nurse and then these further symptoms drawn to the attention of a registered nurse, can you further comment upon such further examination if it's in fact done?

A. At this time we're talking – we have a history of a person who's had a considerable amount of vomiting, a considerable amount of diarrhoea.

If the level of consciousness has decreased and if I get the timing right, there's a report of a convulsion was (sic) well.

Q. Yes.

A. This is what I would say would be a red light to anyone. That would be very serious, potentially very serious.

Q. In terms of such an initial assessment being done with perhaps a further assessment had it occurred once these symptoms were observed, are you able to comment about what would follow by way of such initial and earlier assessment then what in fact occurred in this current situation?

A. If we were at the stage where people have reported a convulsion that would certainly be a red light basically for anyone. And persistent vomiting and diarrhoea is of considerable concern. And if you then saw the person and they had signs of being low in fluid and dehydrated and not getting any good fluid input, possibly not passing any wee particularly, you would think this person is in need of fluid, which is one of the basic means of treating these people if they come to hospitals, emergency departments, whatever. Very simple treatment.

Q. So earlier attention, earlier assessment necessarily are you saying lead to perhaps the likelihood of earlier intervention by way of hospitalisation and perhaps blood tests and the like?

A. Blood tests, examining the person and for someone who is clearly vomiting and has a lot of diarrhoea, fluid and electrolyte replacement is the cornerstone of therapy. We're not look at high power cardiology.

HIS HONOUR

Q. Just in relation to the cause of death, would any symptoms be obvious on a nurse doing an initial assessment of pulse, blood pressure, temperature?

A. On initial assessment the nurse may have diagnosed the cardiomyopathy. She may have found he had a very irregular pulse when he came in, which he may have had. She may have found he had a very abnormal blood pressure and he may have told her that he has some

cardiac symptoms. An initial assessment may have given them answers straightaway.

LONERGAN

Q. But the longer one delays what I will describe as you have used the expression, the initial assessment, the more difficult it becomes?

A. Yes." [26] (Emphasis added)

FINDING

I am satisfied that the direct cause of death of Gary Kelso was DILATED CARDIOMYOPATHY and that the cause of that cardiomyopathy was drug related – he not receiving any, or appropriate, medical attention for that particular ailment after he arrived at the SHCC at 16:55 hours on 8 November 2006.

With Gary Kelso having DILATED CARDIOMYOPATHY together with the combination of events that occurred following his admission, principally not having been seen, reviewed, or triaged by a registered nurse, resulted in his developing a fatal arrhythmia.[27] .

There is no doubt that the death of Gary Kelso can be directly attributed to the lack of access and the failure to provide health services to him in a timely manner whilst at SHCC, such lack of access and the failure to provide health services arose from the breakdown in the cooperation and relationship between the Department of Corrective Services and Justice Health at SHCC in the period of time leading up to November 2006.

The Second Issue

B. Did inmates in and adjacent to Cell 20 at the SHCC make any, or indeed numerous, 'knock ups' specifically for the purpose of attempting to alert Correctional Officers to the observed deteriorating medical condition of Gary Kelso during the course of 9 November 2006 and prior to 7.30pm that day

Various inmates detained at SHCC on 8 and 9 November 2006 have asserted that they utilised the "*knock up"* system on 9 November 2006 in an attempt to alert, without success, Correctional Officers to attend cell 20 and arrange for medical attention to be provided to Gary Kelso.

Inmate *Jim Filipovski*, in his ERISP record of interview with Corrective Services NSW Investigators, claims that he used the intercom ("*knock up"*) three (3) times during the day to call for medical attention for himself and Gary Kelso.[28] Former Inmate Filipovski,

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26 *Transcript 19/3/09 pages 66 to 68*
27 *Exhibit "21" paragraph 5.0 at page 7*
28 *Volume 3 page 739 Q/A 81*

confirmed this assertion in his oral evidence on 2 December 2009. [29]

Inmate *Nick Hatzistergos*, who was detained in cell 15 at SHCC on 9 November 2006, which cell was adjacent/opposite to cell 20, stated in his ERISP record of interview of 9 November 2006 that he had seen Gary Kelso vomit on a couple of occasions and that, from his observations, inmates in cell 20 used the "*knock up"* system in an attempt to get Correctional Officers to come and attend to Gary Kelso he stated this occurred between three (3) to eight (8) times.[30]

In oral evidence he admitted that he did not actually see Gary vomit but had been asked to pass cleaning material through to the cell so others could clean it up.[31]

Inmate *Kim Spouse* in his ERISP record of interview stated that whilst he was in cell 20 he and other inmates in that cell used the "*knock up"* system on at least ten (10) occasions to call for assistance to Gary Kelso.[32]

Brian Francis Moran/Smith in a statement he gave to NSW Police gave a similar account.[33] He further alleged that a "*senior screw"* informed him that Gary Kelso was on the list to see the nurse.[34] Inmate Moran/Smith gave similar evidence on 10 September 2008.[35]

On the other hand it is acknowledged that Correctional Officers, in essence, disputed the assertion that various inmates had utilised the "*knock up"* system during the day of Thursday 9 November in an attempt to get the attention of these Officers to arrange medical attention for Gary Kelso for his deteriorating medical condition.

Acting Assistant Superintendent David Walker was the Officer-in-Charge as from 14:00 hours on 9 November 2006. Officer Walker completed his shift on the previous day, Wednesday 8 November 2006 at 22:00 hours. He commenced his next shift at 14:00 hours on Thursday 9 November 2006. Officer Walker participated in a lengthy ERISP with Detective Senior Constable Fraser and Detective Senior Constable Spence on the morning of 10 November 2006.[36]

Officer Walker stated that it was his usual practice to conduct 20 to 30 cell inspections per shift at SHCC.[37]That evidence was confirmed during his oral testimony.

Specifically Officer Walker gave evidence to the effect that he looked in every cell. Including cell 20[38] Further his recollection with respect to Gary Kelso was;

> *"That he was lying on the bed on the left hand side of the cell"* [39]

Officer Walker stated in evidence that he was made aware of the allegation to the effect that an inmate, the name of whom he was unaware, had alleged that he did "*knock up"* to get the attention of Correctional Officers to inform that Gary Kelso was not well during

29 *Transcript 3/12/09 page 19 lines 5 to 20*
30 *Volume 3 pages 760 to 764*
31 *Transcript 3/12/09 page 53 lines 20 to 45*
32 *Volume 3 page 815 Q/A 91,92*
33 *Volume 3 page 892-893*
34 *Volume 3 page 892 paragraph 6*
35 *Transcript 10/9/08 pages 9 to 12*
36 *Volume 2 pages 384 to 557*
37 *Volume 2 page 444 Q/A 361*
38 *Transcript 25/3/09 page 44 line 35 and page 45 lines 1-6*
39 *Ibid page 45 line 43*

the day.

However, Officer Walker stated that he wasn't aware of such request(s) for assistance or "*knock ups"* whilst he was on duty between the hours of 14:00 hours and 19:40 hours on 9 November 2006. Further he indicated that he received no "*knock ups"* himself nor was he contacted by anyone detained in that cell for assistance to be provided to Gary Kelso because of his medical condition.[40]

Correctional Officers, Leonie Dylan (nee) Gale and Bertina Edwards-Cvetkovski also denied being aware of any requests for assistance of "*knock ups"* .

Also on the issue as to whether Correctional Officers were in fact made aware of the deteriorating medical condition of Gary Kelso on 9 November 2006 and prior to 19:30 hours, regard must be had to the relevant patient health card record where it was recorded, inter alia, "*… PT [patient] looking unwell today …"*.[41]

Such a notation might be generally indicative of an assessment having been made of Gary Kelso's (medical) condition on the day in question and prior to 19:30 hours.

In relation to the patient health card NSW Ambulance Paramedic Christine Cook provided the Inquest with a statement,[42] where she confirmed, that the words recorded on the patient health card were said to her by a Correctional Officer just after she arrived at SHCC on the evening of 9 November and whilst she was walking down the hallway towards cell 20. Officer Cook could not recall nor identify that Correctional Officer or whether that Officer was male or female but she remembers that these words were spoken.[43]

As just noted, at face value the words are evidence that at least one (1) Correctional Officer was aware that Gary Kelso looked unwell during Thursday 9 November 2006 and before 19:30 hours. If that was the position, this could be contrary to the assertions put forward by Officer Walker and other Correctional Officers to the effect that no Correctional Officer was not aware of Gary Kelso being unwell or otherwise requiring medical attention prior to 19:40 hours on 9 November 2006.

It also has to be recalled that a number of these inmates who have asserted that they did use the "*knock up"* system to call for Correctional Officers to attend to Gary Kelso and more particularly his medical conditions, were themselves unwell and indeed seeking their own medical attention at the times they say they made calls ("*knock ups"*) for assistance for Gary Kelso.

Reference should be made to the Corrective Services NSW (Suspension Request) Report of Paul Coyne, Investigator, Investigations Branch and dated 4 August 2007.[44]

On the issue as to whether or not inmates did in fact "*knock up"* in order to get assistance to Gary Kelso prior to 19:30 hours, it is relevant to note the observation made by Investigator Coyne that inmate Tomkins had apparently "*knocked up"* from cell 20, as he was unwell

40 *Ibid pages 64 and 65 lines 45 and thence 1-13 and 34*
41 *Volume 1 page 75*
42 *Exhibit "3" Supplementary Folder No. 2 at TAB 9*
43 *Transcript 9/9/08 page 33 lines 35-40*
44 *Exhibit "3" Folder 2, TAB 12*

by reason of withdrawing from alcohol. This occurred at approximately 14:50 hours on 9 November 2006. As a consequence he was placed in cell 11, which was monitored by cameras. Also on the same day an entry on the log indicates that inmate *Fadi* El-Farra was also moved from cell 20 on 9 November 2006 after he "*knocked up"* by reason of apparent "*self-harm and assault inmate*". He was placed on a Risk Intervention Team.[45]

These observations of cell movements following "*knock ups"* emanating from cell 20, indicate that Correctional Officers did in fact respond on two (2) occasions, to "*knock ups"* emanating from cell 20.

This suggests that if during these "*knock ups"*, where Corrections Officers responded positively, mention was made of the need for medical attention, that attention would have been forthcoming.

FINDING

Issues of credibility inevitably arise because the evidence of the Corrective Services Officers stands in stark contrast to that of the inmates. However, some of those inmates were themselves withdrawing from the effects of illicit drug use/alcohol, and there is simply insufficient credible and probative evidence to refute the firm assertions of Correctional Officers that they were not alerted by the "*knock up"* system or otherwise to the deteriorating health of Gary Kelso during 9 November 2006 and prior to 19:30 hours.

That does not mean that the observations of the various inmates of Gary Kelso's deteriorating medical condition were inaccurate or unreliable.

In reaching the above finding, I have given careful consideration to the submissions made on behalf of Julie Kelso (at pages 5 to 7 of the those submissions) on this particular issue.

The Third Issue

C. *Characteristics of and use made of SHCC by Department of Corrective Services up to an including November 2006*

Judith Leyshon, General Manager Court Escorts Security Unit, Corrective Services NSW, provided a statement to the Inquest.[46]

Ms Leyshon indicated that the SHCC is contained with the facility owned by NSW Police and confirmed that it was a Correctional Centre for the purposes of the Crimes (Administration of Sentences) Act.[47] She also indicated that the SHCC was not a Remand and Reception Centre and that it received "*fresh"* custody inmates from the Sydney Central Business District Police Local Area Commands. Importantly she indicated that the SHCC was a "*catchment"* area that extended on weekends to include the Eastern Suburbs and Northern Beaches Police Local Area Commands.[48]

At all relevant times SHCC operates 24 hours 7 days a week. There are three (3) shifts per day. The "A" watch works 6.00am to 2.00pm; the "C" watch from 2.00pm to 10.00pm

45 *Ibid paragraphs 30 to 40*
46 *Exhibit "7" dated August 2008*
47 *Ibid paragraph 4*
48 *Ibid paragraph 5*

and the "B" watch from 10.00pm to 6.00am.[49]

Another important issue covered in her statement was that of staffing levels which were described as "*custodial staffing levels vary depending upon the number of inmates being detained at the complex and the number of inmates who have been identified as at risk of self-harm*". [50]

Officer in Charge David Walker provided similar evidence[51]. However, in answer to a question from Detective Senior Constable Fraser in his record of interview, Officer-in-Charge Walker indicated: -

> *"The Surry Hills Cells Complex also receives offenders who are in excess to the capacity able to be held at the Metropolitan Remand and Reception Centre. The cell complex at Surry Hills Cells, at Surry Hills, rather, has a maximum inmate capacity of 86 prisoners and the staffing levels increase in proportion to the number of inmates at, and risk factors associated with any of those inmates".*[52]

Further in the same record of interview Officer in Charge Walker also indicated that the difference between other Remand Centres and SHCC was that at the Metropolitan Remand and Reception Centre all inmates are screened by medical and nursing staff prior to being allowed into that Centre.[53]

The Fourth Issue

D. Procedures and protocols utilised at SHCC at relevant times up to and including 9 November 2006

Part 10 of the Standard Operating Procedures Manual for Corrective Services NSW deals specifically with the reception of inmates from NSW Police/Court and as well as the role and responsibility of Corrective Services Officers.[54]

Paragraph 10.1.11 headed "Inmates Detoxing from Drugs or Alcohol" provides;

> *"Any inmate held at a Court/Police Cell Complex, managed by Departmental Officers, who is identified or is believed to be detoxing from drugs or alcohol, is to have all items that could potentially be used to self-harm removed … CHS [i.e. Justice Health] is to be notified immediately and consulted in relation to the inmates care in placement. Where it is determined that an inmate detoxing from drugs or alcohol is at risk of self-harm, the procedures outlined above in 10.1.10 are to be applied."*[55]

Detective Senior Constable Fraser notes that the first notification that Gary Kelso was withdrawing from heroin was recorded by Correctives Officer Zerdo on 8 November 2006 whilst he was at the Central Local Court Cells and prior to transfer to the SHCC. Such

49 *Exhibit "7" paragraph 6*
50 *Ibid*
51 *Volume 2 page 389*
52 *Ibid Q/A 29*
53 *Ibid page 457 Q/A's 458-462*
54 *Volume 1 page 220*
55 *Volume 1 page 233*

notification was recorded on Gary Kelso's file, upon arrival at SHCC, and was acted by the Acting Assistant Superintendent David Walker who forwarded the file to Justice Health.

Notwithstanding this position, the evidence is to the effect that, Gary Kelso was not seen, assessed nor triaged by Justice Health from that point of time on the 8 November and prior to 19:30 hours on 9 November 2006.[56]

The Fifth Issue

E. Cooperation and relationship between Justice Health and Corrective Services NSW as regards fulfilling statutory responsibility of both entities at SHCC in the period up to November 2006

Firstly, it is noted that the objects of the *Crimes (Administration of Sentences) Act 1999* ("the CAS Act") are set out in *s.2A*: -

> *"(1) This Act has the following objects:*
>
> *(a) to ensure that those offenders who are required to be held in custody are removed from the general community and placed in a safe, secure and humane environment,*
>
> *(b) to ensure that other offenders are kept under supervision in a safe, secure and humane manner,*
>
> *(c) to ensure that the safety of persons having the custody or supervision of offenders is not endangered,*
>
> *(d) ….*
>
> *(2) …*
>
> *(3) …".*

Corrective Services NSW is defined to mean *"… that part of the Department of Justice and Attorney General comprising the group of staff who are principally involved in the administration of this Act*".[57]

In the circumstances, it falls to *Corrective Services NSW* to fulfill the objects of the Act referable to the custody of inmates/offenders and that includes the object of ensuring that those offenders/inmates who are required to be held in custody are removed from the general community and placed in a safe, secure and humane environment.

Once transferred and removed from the community it also falls to *Corrective Services NSW* to ensure that such offenders are kept under supervision in a safe, secure and

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56 *Ibid pages 268 to 270*

57 *Section 3(1) of CAS Act*

human environment (see generally definitions of "*offender"* and "*inmate"*). [58]

A "*Correctional Centre"* is defined as:

> *"(a) any premises declared to be a correctional centre by a proclamation in force under section 225, including any juvenile correctional centre or periodic detention centre, and*
>
> *(b) any police station or court cell complex in which an offender is held in custody in accordance with this or any other Act,*
>
> *but in Part 2 does not include a periodic detention centre, except to the extent provided by the regulations referred to in section 98."*[59]
> *(Emphasis Added)*

Accordingly the SHCC is a *Correctional Centre* for the purpose of the *CAS Act*.

The statutory responsibility of Justice Health is also documented in the *CAS Act*. Justice Health has the statutory responsibility to provide health services to offenders and other persons in custody.[60] The Act states that;

> *"Justice Health, in addition to any other functions conferred on it by or under this or any other Act or law, has the following functions:*
>
> *(a) to provide health services to offenders and other persons in custody within the meaning of section 249,*
>
> *(b) to monitor the provision of health services in managed correctional centres,*
>
> *(c) to prevent the spread of infectious diseases in, or in relation to, correctional centres,*
>
> *(d) to keep medical records of offenders and other persons in custody within the meaning of section 249,*
>
> *(e) to provide advice to the Commissioner on the diet, exercise, clothing, capacity to work and general hygiene of inmates*". [61]

Ultimately, it is the Commissioner of *Corrective Services NSW* who is responsible for the supervision of offenders who are in custody. As well the primary obligation of ensuring the security of inmates falls to Corrective Services NSW.

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58 *Ibid*
59 *Ibid*
60 *Section 236A of the CAS Act*
61 *Section 236A of the CAS Act*

Whilst Justice Health have a statutory duty as regards the provision of health services to offenders and other persons in custody it would appear to be subject to the statutory obligations of the Commissioner of Corrective Services NSW.

It is clear that for the SHCC to work and provide for the health and well-being of inmates and for that matter staff of both entities of Corrective Services New South Wales and Justice Health have to operate as a team.

Detective Senior Constable Fraser had obtained, as part of her investigation, numerous statements and accessed many documents for the purposes of preparing the brief of evidence and supplementary material that was tendered before the Inquest. But it was not until the Inquest had in fact commenced that I was provided with a statement of *Jenny Graham*, Director, Adult Clinical and Nursing Operations, Justice Health, consisting of 31 paragraphs together with the 13 voluminous annexures.[62]

It was at that point that the extent of the "*difficult"* relationship, and all that that entailed, so far as it affected SHCC, first began to emerge. Until such time as exhibit "11" surfaced, there were only "*hints"* of the "*difficult*" relationship between the two (2) entities so far as it affected access to, and the provision of health services for, inmates detained at the SHCC in the period leading up to November 2006.

With the benefit of hindsight, the first "*hint"* came during Officer Walker's ERISP interview of 10 November 2006 when indirect reference was made to what was subsequently documented in the statement of *Jenny Graham* [63] together with the other "*new"* evidence.

In response to a question put by Detective Senior Constable Fraser to Officer-in-Charge Walker as to whether he would prefer inmates coming into SHCC be seen by a nurse *prior to* being admitted, Officer-in-Charge Walker made reference to the fact that Correctional staff and Justice Health staff would "*… keep very open lines of communication between us and the medical staff, so that we can bring it [medical risk factors] to their attention and have it dealt with"*[64]

Officer-in-Charge Walker then said;

> *"Also we've had meetings with the Justice Health Service, who is the, the agency that operates the medical side of it. We've had meetings with the Justice Health Service and all the nurses and we've discussed these issues. And the outcomes of those meetings were that basically the, <u>the system was failing and it was a matter of time before what occurred last night occurred</u>".*
>
> *Q. Why was the system failing?*
>
> *A. <u>Because the inmates just weren't getting medically screen</u> <u>prior to going to bed, prior to going into cells. They were coming straight off the street unknown and placed in cells</u>"*[65]*.*
>
> *(Emphasis added)*

62 *Exhibit "11"*
63 *Ibid*
64 *Volume 2 page 535 at Q/A 1019*
65 *Volume 2 page 535 Q/A 1021*

In response to the material that was contained in the statement of Jenny Graham[66]further material/evidence was produced. This included the evidence of Rosemary Terry who was employed at relevant times by Justice Health as the *After Hours Inmate Flow Manager*[67] and the evidence of Judith Ann Leyshon who is employed by Corrective Services NSW as the *General Manager Court Escort Security Unit.*[68]

Specifically, it was the provision of this additional evidence, brought to the attention of the Inquest after it had commenced regarding "*access issues*" to inmates at SHCC, that the specific difficulties of the relationship between Justice Health and Corrective Services NSW become fully apparent.

The Department of Corrective Services NSW and Justice Health should be congratulated on reaching an agreement that ensures inmates at SHCC can be seen by a health professional in a timely fashion.

Whilst I acknowledge that agreement it has to be said that it took some time to reach it.

At an "*Informal Conference"* on 9 December 2009 attended by the various parties granted leave to appear at the Inquest, representatives of Corrective Services NSW and Justice Health provided an overview of strategies that were then being developed so as to improve the access of Justice Health Staff to patients/inmates for the purpose of conducting health assessments.

Such update and proposed implementation of these new arrangements were to be specific to SHCC. A report was then provided on 10 March 2010 at an adjourned "*Informal Conference"* along with the "*Agreed Arrangements"* document.

The "Agreed Arrangements" document is dated 10 March 2010 and is adopted by the Chief Executive for Justice Health Julie Babineau and the Deputy Commissioner of Corrective Services NSW, Don Roger.

I have been told that the arrangements that have been put in place with a dedicated officer assigned to escort nurses to inmates after the number reach 21 is working after trialling the new arrangements for the period from December 2009 to March 2010.

I intend to bring to the attention of the respective Ministers the *"New Arrangements" that* have been implemented at SHCC so as to ensure that all necessary funding arrangements for additional staff, including funding arrangements to meet the inevitable peaks in inmate population at SHCC, can be catered for.

Ideally funding should be made available so that a dedicated officer can be on duty all the time to assist the Justice Health Nurses to see inmates but that is a matter for the Minister.

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66 *Exhibit "11"*
67 *Exhibits "16 and "17"*
68 *Exhibits "7", "13" and "14"*

The Sixth Issue

E. The way forward/Recommendations

Detective Senior Constable Fraser suggests that the following recommendations should be made;

> That it would be appropriate that a log be kept and maintained by Corrective Services NSW to record calls made via the cell intercom system. Secondly, that all cells at the SHCC be fitted with CCTV cameras. Finally that consideration be given to Corrective Services NSW maintaining a log similar to that utilised by the NSW Police management system with respect to all cell and prisoner observations as is required of NSW Police under the *Law Enforcement (Powers and Responsibilities Act 2002.* [69].

Counsel for the Department of Corrective Services Michael Spartalis submits that it is unnecessary to make any recommendations relating to cameras in cells or maintaining logs similar to that utilised by the NSW Police Force. He makes the point that cameras would be unable to monitor inmates at night. Of course that could be overcome with the technology that is available nowadays and whilst it would be ideal, given the fact that most of the inmates will be withdrawing from drugs or alcohol, it is a funding issue, which I will leave up to the Department to determine.

In other words it might be more effective to have a full time officer made available and for the nurses quarters to be enlarged than to spend money on expensive CCTV equipment with infra-red capabilities.

As I understand it the '*knock up'* system that is now in place records electronically when an inmate uses it so the necessity of making recommendations in relation to keeping a log of calls made via the cell intercom system is unnecessary.

David Barrow for the family of Gary Kelso submits that the SHCC is unfit to hold people for any length of time and I agree particularly where persons are suffering from the effects of withdrawal from drugs or alcohol, however, deciding what the maximum length of time that a person should be detained at the SHCC is a matter to be determined by the two Departments there is simply not enough evidence on the subject for me to make any recommendation.

Finally, what was obvious is the pressure that is placed on SHCC whenever there is an increase in prisoner population brought about by, for example, changes to the Bail Act, or special police operations. The Corrective Services NSW has difficulty under current funding arrangements to meet this demand particularly with regard to SHCC and the type of prison population. So that inmates can be seen in a timely manner, by Justice Health Staff, a different funding arrangements needs to be put in place.

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[69] *Volume 1 pages 59 and 60 paragraphs 352 to 359*

FORMAL FINDING

I find that Gary David Kelso died on the 9th November 2006 at St Vincent's Hospital, Darlinghurst from Dilated Cardiomyopathy.

RECOMMENDATION

The annual budget allocation to Corrective Services ought be escalated on the basis of increases in the full time inmate population. The population has significantly increased over the past decade. Variations in the budget to accommodate increases in the inmate population are based on the average daily full time inmate population. This approach to determining the increase in the budge does not have regard to fluctuations in the inmate population. Neither does it recognise that a funded vacancy buffer is required to enable the front end of the correctional system to manage spikes in the inmate population and absorb all receptions. I therefore recommend that NSW Treasury Officials should meet with Corrective Services NSW Executive to discuss changes to the funding model that recognises the need to maintain a funded vacancy buffer as a contingency to absorb increases in the inmate population.

2. 749 of 2007 Jason Mark Callaghan

Inquest into the death of Jason Mark Callaghan at Penrith. Finding handed down by Deputy State Coroner Mitchell at Glebe on the 12 February 2010

This is an Inquest into the death of Jason Mark Callaghan (whose family has indicated they prefer that he be known in these proceedings by his Christian name *"Jason"*). Jason was born on 19 November 1978 and, while still a young man, died at Nepean Hospital at about 1917 hours on 30 July 2007. The Forensic Medicine Final Report prepared by Dr. Dianne Little on 7 November 2007 cites *"gunshot wound to the head"* as the direct cause of death.

Jason left behind him, a loving family consisting of his wife, Veronica Callaghan, their infant child, Jasmine, then three months of age, and her two older children, Amber 9 and Aiden 7, his parents James Callaghan and Hazel Callaghan and a sister, Debbie, and a half-brother, Jamie Callaghan, together with two children of a previous relationship who are being brought up by Mrs. Hazel Callaghan. Each of those adult family members played a part in the preparation of the inquest and, apart from Mr. James Callaghan, each attended both days of the hearing. They were not formally represented but Mr. Eckhold, Solicitor/Advocate of the Crown Solicitor's Office who assisted me, instructed by Ms. Murty, was punctilious in consulting them, asking questions on their behalf and generally representing their concerns. Mr. S. Robinson, Solicitor, appeared for the Commissioner of Police and the police officers concerned in this matter.

In many respects, Jason Callaghan lived a troubled and far from easy life. His antecedents are before me and disclose a good many problems with the law and long periods of incarceration. He had many issues to deal with including drug dependency, although he had fought against it bravely, Hepatitis C and the need, after a long period in custody, to gain and keep a job and to become established in the community. On the other hand, he

had many wonderful qualities. He deeply loved and was loved by his family, his mother, his siblings and his wife and his children and step-children. He was desperate not to be separated from them. He was appalled by what he had done to Veronica on the day of his death. He was not a violent man by nature and his attack on her was out of character and troubled him deeply. He wanted what was best for his children and the evidence of Messrs. Phillips and Baker is enriched by his references to the children's importance in his life. He tried hard to defeat his drug habit and his efforts in that regard should be seen as a *"work in progress"* on which there is no reason to think he had given up.

His marriage to Veronica and the seriousness with which he viewed his responsibilities to his family are matters of pride to them and, despite his troubles, his nature seems to have been open, friendly and trusting as the impressions of police witnesses Phillips, Baker, Heyward, Dyson and Camilleri suggest. His passing will be a lasting sadness in the lives of all his family but they will have the comfort of remembering his good and loveable qualities.

I accept what Counsel Assisting said in his opening address, namely that this inquest cannot hope to present a balanced picture of Jason Callaghan or portray him fully as a person and must, instead, focus on his tragic death. Its primary task must be to identify and make findings as to the date, place and direct cause of Jason's death and then to consider the manner and circumstances surrounding his passing. And so the inquest must look at whether Jason's death was deliberate or accidental, whether it could have been avoided, whether the police response was appropriate and whether there are any lessons to emerge from these sad events, which might serve to help others in our community.

Exhibit 1 consisted of the *Police Report of Death to Coroner*, an *Identification Statement* and a *(form A)Hospital Report of Death to the Coroner* while Exhibit 2 was a four volume Brief of Evidence, copies of which were made available to the family. In addition, I heard evidence from Detective Sergeant Jeffrey Walsh who appeared in lieu of Detective Sergeant Robert Allan Shankelton, the Officer in Charge of the investigation who was prevented by reasons of health from appearing at the inquest and whose lengthy and comprehensive statement is contained in the brief, Leading Senior Constable Duane Phillips and Constable Malcolm Baker, Sergeant, now Inspector, Anthony Heyward, their superior officer, Detective Senior Constable Gregory Camilleri then a trainee and now a qualified negotiator who, on 30 July, 2007, assisted Detective Sergeant Belinda Dyson who is now on long term sick leave and was unable to appear personally, Detective Senior Sergeant Wayne Kelly who was in charge of the police negotiators on that occasion and Detective Chief Inspector Graeme Abel, then and still the Commander of the Negotiations Unit, State Protection Group and a qualified and accredited police negotiator since 1990.

Jason's death is one, which occurred in the course of police operations, and, accordingly, an inquest is mandated by sections 23(c) and 27(1)(b) of the *Coroners Act, 2009.*

During the morning of 30 July 2007, there was a minor argument between Jason and his wife, prompted by her belief that he may recently have used *speed*. At about 11am, Jason left the home at 34A Landy Avenue, Penrith without telling Veronica where he was going and at about 2.30 that afternoon, he returned home with an acquaintance by the name of Garry Markham whom she barely knew and who, as far as she was aware, had never before been to their home. The three of them fetched the children from

school and, when they returned, there was a further argument between husband and wife concerning Jason's use of her *Mitsubishi Pajero.*

In the course of that argument, Jason became violent, overturning and, in some instances, breaking furniture. When Veronica Callaghan tried to call police, Jason took the phone from her, knocked her to the dining room floor and punched her a number of times while she was down. Garry Markham pulled him away and Jason asked him to take the children out of the home and go for a walk. When Veronica Callaghan objected to a stranger taking charge of the children and tried once again to phone police, Jason followed her to the bedroom and once again assaulted her, smashing and upturning furniture. Veronica later told Detective Sergeant Dyson that she had been *"fairly badly flogged."* For a second time, Garry Markham pulled Jason off his wife and the two men left the home, driving off her *Pajero*. Alone in the house with the three children, Veronica Callaghan telephoned police to report an assault.

Shortly afterwards, Jason and Garry Markham drove up to the home in a silver *Tarago* van, which, it transpires, had been stolen. A later search of the vehicle revealed that it contained two balaclavas and cable ties and a quantity of ammunition. Jason alighted carrying a .22 rifle to the front porch of the house. The intended use of the various items later found in the vehicle and the stolen vehicle itself is not clear. Mrs. Veronica Callaghan again phoned police to warn them that her husband had returned home and was now armed, crying, very upset, threatening to kill himself and repeatedly pointing the rifle at his head and placing the barrel in his mouth. Although the evidence at inquest is that at no time did Jason utter a threat against or point the rifle towards his wife or the children, police or, indeed, anybody other than himself, the apparent danger of the situation is obvious.

Jason seems to have been extremely remorseful for having assaulted his wife, which, as I understand it, was very uncharacteristic behavior on his part. All the evidence before me points to a very strong and loving marriage and to a young man who loved his wife and children and wanted what was best for them. He repeatedly said that he had never done anything like assaulting his wife before. Further Jason, who had spent very significant periods in custody, was determined not to return to gaol and, evidently, he believed that, because of his violent attack on his wife and his possession of a firearm, further imprisonment was almost inevitable. Repeatedly he indicated that he would rather die than go back to gaol.

Police in the shape of Leading Senior Constable Duane Phillips and (then Probationary) Constable Malcolm Baker arrived at the home within about five minutes of Veronica's phone call. They approached to within about three metres of the front porch and then gradually fell back to a position, which afforded them some cover. They engaged Jason in conversation and their dialogue with him continued for a matter of hours, even after Detective Sergeant Dyson commenced her negotiations with him. The evidence indicates that Mr. Phillips and Mr. Baker managed to establish a degree of rapport and trust with Jason who has fairly been described as *"a man in crisis"* and, in the ebb and flow of dialogue, it sometimes seemed to police officers that the crisis might pass and that Jason might put down his gun. I think the efforts of Messrs Phillips and Baker and Mr. Heyward, their superior officer, deserve special mention.
They arrived to find a dreadful situation of great danger and an armed man in extreme distress apparently threatening the life and safety not only of himself but also of his wife

and three young children. His intentions were unclear and unpredictable. Phillips and Baker were not trained negotiators. It was cold and, later, it grew dark and they were engaged in their task for the best part of three hours.

Throughout, they found themselves working against a background of sometimes quite feverish *"off-stage"* events and activities such as the participation of police negotiators, Detective Sergeant Dyson and others, the arrival of the police tactical unit, the arrival of Ms. Hazel Callaghan, her availability to speak to Jason and his anxiety to speak to her and apparent belief that he was unfairly being prevented doing so, the unexpected intervention of Veronica Callaghan when, at Jason's invitation, she emerged from the home to bring him something to wear and a portable telephone and, at his request, to give him a cuddle, the presence in the home of the three vulnerable children and the preparation and superb execution of the supremely important police plan to evacuate them.

There were a great many comings and goings of police officers and others, the useful intervention of Jason's brother, Jamie, who tried by telephone to reassure his brother and negotiate his surrender, the use of loud speaker equipment which sometimes seemed to agitate Jason and the failing light. At one stage, Jason had two mobile phones and the portable phone and was conducting at least two conversations at once.

I dare say all of these were well meant and some were absolutely necessary in the circumstances which presented themselves but they must have been distracting and very trying and, through them all, Mr. Phillips and Mr. Baker conducted themselves with bravery and humanity, building a rapport with Jason in an effort to defuse the situation and bring it under control. I think both Jason's wife and his mother are very appreciative of their efforts and Detective Sergeant Dyson told her superiors, at A116 of her *ERISP* that, in her opinion, Messrs.

Phillips and Baker had done "*an exceptional job."* Inspector Heyward told the Inquest that, in his view, the performance of Phillips and Baker was *"impressive"* and *"exemplary"* and I respectfully agree with him.

Leaving aside the continuing conversation involving Messrs. Phillips and Baker which commenced at about 3.30pm when they arrived on the scene, police negotiations with Jason were commenced by Detective Senior Sergeant Wayne Kelly using an electronic loud hailer but, from about 6.45 that afternoon, the police officer primarily involved in negotiating with Jason was Detective Sergeant Belinda Dyson. This occurred when, in the course of a phone conversation between Ms. Dyson and Veronica Callaghan, the latter unexpectedly handed the phone to Jason. It had not been planned that Detective Sergeant Dyson would take so prominent a part in the negotiations but she was trained and ready to do so and, on the evidence, she discharged her responsibilities with great skill and sensitivity.

Both she and Mr. Camilleri who accompanied her believed that she was making considerable progress in her negotiations with Jason, which continued to be conducted by mobile telephone. Shortly before 7pm, Ms. Dyson had been speaking to Jason about his importance to his family and about his potential in the future and it seemed to Mr. Camilleri that Jason was calmer and more settled. Indeed, Mr. Camilleri told me that his voice had sounded *"drowsy"* and that *"Belinda seemed to have rapport with him."*

Then Jason said, *"I'm going to get a drink"* to which Ms. Dyson replied, *"We'll be here. We'll hang on."* At that stage, Jason was holding at least one telephone and possible more than one, together with the rifle. It was cold and he was wearing a wet shirt and the light was failing. I think he must have been extremely tired. Mr. Phillips recollects Jason *"talking with two phones on the porch and then obviously one, he hung up one of the phone calls and then still had the gun under his arm and he was still talking to the negotiator. Then he stepped off the porch, I heard a pop and I watched him fall back and then I ran forward and he was, he'd basically been shot."*

Mr. Baker's recollection of the final moments of this business differs somewhat from his partners view. According to Mr. Baker, the rifle discharged, not as Jason was stepping down from the porch but after he had done so. According to Mr. Baker, Jason stepped down and he seemed calm *"and he's put the gun down and at that point, I've said 'Jase, role a smoke mate, roll me one' and he's gone 'OK'…"*

Almost everyone seems to have been surprised when the rifle discharged. Certainly, the context in which it occurred – Jason pausing in negotiations in order to get a drink and, perhaps, contemplating rolling a cigarette for himself and Mr. Baker - seems inconsistent with a decision at that time to pull the trigger and take his own life. Ms. Dyson told police investigators *" I didn't see it coming. You could have pushed me over with a feather. I just sat there and went 'Oh my God' …"* Mr. Camilleri told me he had been surprised when the rifle had discharged. Mr. Baker told police that, by that stage, Jason, who had been *"highly agitated,"* had *"calmed"* again.

Mr. Phillips' view is that Jason did not intentionally pull the trigger and kill himself. He told police *"just before he shot himself… …he appeared pretty good. He just took a step off the, he stepped down off the porch… I heard a pop and then I saw through the window, him fall backwards. He appeared normal"* I think it is not surprising, much less sinister, that there is some discrepancy between the recollections of Mr. Phillips and Mr. Baker but the important point is that, on both versions as on the versions of Ms. Dyson and Mr. Camilleri, the tension seems to have relaxed rather than heightened and Jason seems to have achieved a certain degree of calm immediately before the rifle discharged.

From his less advantageous position about 19 meters from the house, Mr. Heyward's impression was that, although he was no doubt agitated, cold and perhaps distracted, Jason deliberately took his own life.

Mr. Heyward's view is that at no time was Jason play-acting or merely putting on a show and that, throughout; he was actively considering taking his own life.

Taking all this evidence into account, I think there is significant doubt as to whether Jason intended to pull the trigger and take his own life or whether the crisis was passing and the rifle discharged accidentally. Suicide is so grave and serious a matter that, for a long time, the law has insisted on a higher standard of proof than the mere *"balance of probabilities."*

There is a presumption against suicide and, if it is to be found, it must be *"positively proved."* A coroner must be *"comfortably satisfied"* before such a finding can be made. In the present case, that degree of certainty is not available and I am unable to determine whether or not Jason intended to take his own life.

In the course of the inquest, a number of concerns came to light, which I think deserve some comment. In the first place, some doubts were expressed about the use of the electronic loud hailer initially employed by Police in their negotiations with Jason and later superseded by phone.

Both Leading Senior Constable Phillips and Constable Baker told the Inquest that the use of the loud hailer was distracting and seemed to agitate Jason and they were supported in this view by Inspector Heyward and Mrs. Veronica Callaghan. Although Detective Senior Sergeant Kelly did not express similar reservations regarding the loud hailer, it is easy to visualise the unsettling impact of the loud hailer and its use in delicate and complex negotiations is perhaps not ideal. Nevertheless, the evidence, including the evidence of Detective Chief Inspector Abel, is that loud hailers have been used successfully in hundreds of similar situations.

As Detective Senior Sergeant Kelly explained, amplification equipment is sometimes necessary to enable conversation without needless exposure to danger and, of course, at the point where he opened his negotiations, Jason was armed and Mr. Kelly did not have phone contact with him so that the loud hailer was his only option.

It was suggested in the course of the Inquest that negotiations in situations such as this might usefully be sound recorded.

It is not clear to me that the advantages of such a practice would outweigh the disadvantages but, at any event, I accept the submissions of Mr. Robinson that, as things presently stand, such a venture would contradict the provisions of the *Surveillance Devices Act (NSW)* or, in the case of telephone communications, the *Telecommunications (Interception and Access) Act 1979* and that amendments to the NSW legislation have previously been considered but are not favored by the Attorney General.

A more significant concern is the issue of third party intervention in negotiations and, in particular, intervention by family members. In Jason's case, his mother, Hazel Callaghan attended the vicinity of the home and was stopped at a perimeter roadblock. Sometime later, two police negotiators who I take to be Ms. Dyson and Mr. Camilleri spoke to Mrs. Callaghan and her perception is that Ms. Dyson *"wouldn't listen much at all"* and was reluctant to allow Mrs. Callaghan any phone contact with her son. Reading Ms. Dyson's *ERISP,* it is clear that, in her perception, Mrs. Callaghan was rude, aggressive and abusive and that her own refusal of Hazel Callaghan's request was based on considerations of safety.

I do not need to determine whose version is the more accurate and I accept that this was a moment of great anguish for Mrs. Callaghan and great tension for Ms. Dyson and the real question which arises is the degree to which, as a matter of policy, police should embrace or discourage third party intervention in negotiations.

The evidence of Detective Chief Inspector Abel is instructive on this point. He reminded the Inquest of the context in which police were operating and, in particular, of the presence in the home of Veronica Callaghan and the three children and of their apparent vulnerability. We now know that Jason's only threat was to himself but, at the time, police were not to know that.

While not denying that sometimes the intervention of a third party, usually a family member, may be useful, Mr. Abel told the inquest that third party intervention is generally to be avoided. *"Containment of high risk situations,"* he explained, is a *"paramount consideration"* in these types of negotiations where police are dealing with persons *"in crisis"* and, while lay people such as family members may believe, as Mrs. Hazel Callaghan clearly did believe, that they are better placed than police to deal with their loved one, *"world-wide experience shows that there are grave dangers."* One reason for this, Mr. Abel explained, is that, in an emergency situation, there is no time and no facilities to assess whether the particular family member is likely to have a calming and settling or a destructive impact on the negotiations.

As a rule, little will be know about the real relationship of the family member with the person in crisis so there will be little opportunity to judge these things in advance. Furthermore, Mr. Abel spoke of a *"soul cleansing"* effect where the person in crisis will use contact with a family member to say his or her goodbyes and make his or her peace, thus promoting rather than diminishing the likelihood of suicide. Again he warned that the person in crisis might use contact with the family member to *"offload guilt"* so that, again, the path to suicide is eased.

In Detective Chief Superintendent Abel's professional opinion, the risks involved in third party intervention by no doubt loving and well-intentioned but untrained family members are too great unless there is time, which in Jason's case there was not, to professionally assess the likely impact of the contact and to give at least some rudimentary training and instruction.

I think that the sad consequence of this is that police acted prudently and properly in discouraging Hazel Callaghan's intervention in the negotiations but I recognise the pain and sadness and the continuing uncertainty in her heart as to whether, in other circumstances, she could have made a difference.

If, as Mrs. Hazel Callaghan obviously feels, Ms. Dyson failed adequately to explain the reasons underlying her reluctance to promote phone contact between Jason and his mother, I think the reason is likely to be the pressure of the moment and, as Mr. Abel explained it, the need to prioritise direct dealings between police negotiators and Jason.

Mr. Camilleri who accompanied Ms. Dyson and whom Mrs. Hazel Callaghan saw as *"really nice"* told police investigators that he volunteered to explain things to Jason's mother because *"Belinda (Dyson) obviously had a few other things on her mind."*

Much the same can be said regarding the possibility of *"phone isolation."* The evidence is that, while he was on the porch, Jason had phone contact not only with police but with a variety of people including his wife, his mother, his brother and his father's message bank and the question arises whether this was useful or might properly have been avoided. Detective Chief Inspector Abel told the inquest that while he may have had it in his power to isolate Jason by disabling his phones, one would generally not take that step until satisfied of its impact on the person in crisis.

Phone isolation might or might not have had a calming effect on Jason. It might have limited his contact with police to his dialogue with Mr. Phillips and Mr. Baker, which we may now see as the most effective contact available. But at the time it appeared

that Detective Sergeant Dyson was making good progress, which ought not have been interrupted.

Clearly, Police could not have been certain that phone isolation might not have escalated the situation, further agitating Jason and prompting him to direct action. Mr. Abel's opinion is that, given the state of knowledge at the time, phone isolation would have involved too great a risk and it is difficult not to agree with him.

Two further very unhappy matters remain to be discussed. One is the failure of anybody to clean up the house and, in particular, the front yard after Jason's death so that, when Veronica Callaghan returned to the home, she was confronted with the physical signs of what had happened to her husband including a quantity of his blood. The other is the failure of police promptly to advise the family of what had happened to Jason.

Evidently, Veronica Callaghan was not told that her husband was dead until some hours after she arrived at the police station and Mrs. Hazel Callaghan, who had seen the ambulance carrying Jason leave the Landy Avenue premises and had assumed that Jason had survived and was being taken to a hospital where he could receive psychiatric care, did not learn even that her son had been shot until later informed by her daughter-in-law.

I think it is fair to say that these two matters went some way to marring what otherwise had been excellent work on the part of police. Mr. Abel explained that the need to protect the integrity of investigations means that police negotiators and others involved in a police critical incident or what might be called a *"suicide siege"* are quickly isolated from their colleagues once the crisis is past in order to preserve the integrity of the critical incident investigation and, thus, are unavailable to perform such important tasks as cleaning a crime scene or providing information and comfort to the family.

I was referred to recommendations of His Honour Magistrate MacMahon, Deputy State Coroner, made on 13 February 2008 in *the Inquests into the Deaths of Caroline Jane Gray and Charles Edward Woodhouse, 1494 and 1496/04.* On that occasion, His Honour recommended to the Attorney General and the Minister for Police *"that consideration be given to the state of New South Wales bearing the cost of forensic cleaning of a crime scene where a person has died."*

On behalf of Police, Mr. Robinson handed up an extract from *Guidelines* issued by the Commissioner of Police, possibly in response to His Honour's recommendations, which indicate that it is the responsibility of the Local Area Commander *"to manage the welfare needs of the persons involved in, or affected by, critical incidents."*

Further, the Local Area Commander has the responsibility, personally or through the agency of a *"a fully briefed senior officer,"* of informing the family of their loved one's death, assisting them in the matter of viewing the body and the scene (something to which, in the ordinary course, they have a right) and of participation in the *post mortem* process and in making contact with appropriate counselling, *Victims of Crime* services and grief support services. In his evidence, Detective Chief Inspector Abel expressed his regret at the shortcomings in police communications with the family after Jason's death. Those shortcomings were extremely distressing, particularly to Jason's wife and his mother and arose, as far as I can tell, not out of deliberate policy but by apparent

inadvertence on the part of local police not primarily involved in the siege.

Although Mr. Robinson indicated that the Commissioner's *Guidelines* are intended to benefit families such as Jason's family, the version handed up to me seems to be geared predominantly to the welfare needs of police officers rather than those families, which might go someway to explaining the failure of communications in this case.

It is not clear to me that the duty to attend to a family's welfare needs as specified in the *Guidelines* extends to cleaning up the scene of a critical incident so as to avoid a repetition of the need, faced by Veronica Callaghan of cleaning up a crime scene after her own husband's death.

However, on 16 July, 2008, the then Minister for Police wrote to the State Coroner in response to Magistrate McMahon's recommendations reminding Her Honour of the Attorney-General's advice that *"the Victims Support and Rehabilitation Act 1996 allows the family of a person who has died as a result of a violent act to make a claim for the cost of the clean up of the crime scene"* which the Minister observed *"appears to satisfy the intent of (Magistrate McMahon's) recommendation."* The Minister went on to say that *"to ensure police will be in a position to advise the families of their eligibility for compensation, I have requested the NSW Police Force to amend its policy for forensic crime scene cleaning up so that the family of a person who has died as a result of a violent act is informed that they may make a claim, including an interim claim under section 16 of the Victims Support and Rehabilitation Act for the cleaning costs. This should increase awareness of the compensation scheme by the families of victims of violent crime."* In the present case, that information may not have been conveyed to Mrs. Veronica Callaghan, as it should have been.

In the course of the inquest, I made a non-publication order under section 75 prohibiting publication of any of the evidence in this matter until publication of my findings. That order has now expired and there is no reason why it should be renewed. I made a further order under section 74 (1) prohibiting publication of any evidence in this Inquest, including documentary evidence, disclosing police policy and protocols governing police negotiations and the use of lethal force in high risk situations and sieges.

Mr. Robinson submitted that there is a high public interest in these matters remaining confidential to police and others who may have to invoke them in the future and in not being made available to the public and, for obvious reasons, I think that is the case. On the other hand, I am conscious of the general undesirability of admitting *"confidential"* evidence and of the principle that judicial proceedings should be open to public scrutiny.

In this case, the evidence was admissible and central to the issues being explored so that, even though its disclosure would be inimitable to the public interest, it was appropriate to receive it. I take into consideration what I conceive to be the public interest including the safety of members of the public and of police officers in dealing with high-risk situations and sieges, which may arise in the future. I take into account, too, the limited nature of the order I propose to make and I have considered the decisions in *Nicopoulos v Commissioner for Corrective Services,* (2004) NSWSC 562, *Husssain v. Minister for Foreign Affairs,* 248 ALR 456 and *Mirror Newspapers Ltd. V. Waller,* (1985) 1 NSWLR 1. I propose to continue the prohibition indefinitely.

For the foregoing reasons, I make the following findings, recommendation and order:-

Formal Finding

I find that Jason Mark Callaghan, born on 19 November,1978, died at Nepean Hospital, Penrith, New South Wales at approximately 1917 hours on 30 July, 2007 of the effects of a self-inflicted gunshot wound to the head but, whether he intended to take his own life, I am unable to tell;

Recommendations

I recommend to the Commissioner of Police that recognition be given to the bravery and professionalism of Leading Senior Constable Duane Phillips and Constable Malcolm Baker for the manner in which they discharged their duties on 30 July, 2007;

I make an order pursuant to section 74 prohibiting publication of any evidence in this Inquest, including documentary evidence, disclosing police policy and protocols governing police negotiations and the use of lethal force in high risk situations and sieges.

3. 1020 of 2007 Name suppressed non-publication order

Inquest into the death of AA at Kooraingha t on the 14th June 2007. Finding handed down by Deputy State Coroner MacPherson on 16 April 2010.

NOTE: These findings and reasons are subject to a Non-publication Order pursuant to s.75 (1),(2), (3) and (4) of the Coroners Act 2009.

A report of these findings may be made on condition that no material is published that identifies the deceased or his family.

Introduction

AA died sometime after 2.36pm on the afternoon/evening of the 14th June 2007 at his home at 72 Link Road, Kooraingha t and although it appeared that he was alone at the time of death, in life he had the support of family and his employer, Les Page who was like a second father to AA.

Police had been called to the property after AA had earlier fired a shot over the head of Greg Knight, a psychiatric social worker with the Taree Community Mental Health Team, who had gone to speak to AA and turned his mentor Les Page away shortly after the incident with Greg Knight

AA died from a single bullet wound to the right side of his head. This Inquest has looked at the circumstances, which lead that bullet being fired and whether it was self-inflicted, and, if it was self inflicted, why?

The Inquest has also examined whether Police were present when AA died, in other words was the death during a police operation and did the actions of police have any effect on AA's death?

Evidence regarding the firearm

The evidence from Scientific Officer and ballistics expert Lucas Van Der Walt concluded that the gun did not discharge accidentally.[70]

The wound was a close contact wound with the gun pressing against the skin at the time of death. Doctor Nadesan gave evidence that the skin surrounding the wound "did not show any evidence of burning. This is caused when the gun is close to but not in contact with the skin.[71]There was blackening around the cracks in the skull caused by the entry of the bullet, consistent with the smoke coming from the end of the gun.[72]

Doctor Nadesan could conclude with 100% certainty that the gun was pressed up against the head and described it as a "contact firing".[73]

The high velocity blood splatters on the end of the gun indicates that the blood moved backwards at the time the bullet was fired, onto the end of the gun.[74]The blood flow patterns showed he fell over immediately and was in that position when the blood dried.[75]

Les Page, experienced in guns, identified the gun from AA's lap as the same one AA possessed on the day[76] That same gun was found in AA's lap upon police entering into the homestead.[77] No officer had removed that gun from his lap.[78]

The bullet or projectile, which entered AA's brain, was collected by Doctor Nadesan at autopsy and given to police for examination.[79] Doctor Nadesan identified the bullet taken from the brain.[80]

Ballistic tests have matched that bullet with the same type of bullets for that gun[81]. Thus, the evidence shows that he was in possession of the gun used to kill him hours before he died.

The gun on his lap was examined and shown to be capable of 4 rounds. It had only three with one missing projectile that is the one that entered AA's brain.[82]

Suicide Notes and other behaviour suggesting suicide

AA left two suicide notes.[83]

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70 *See the transcript on 6/11/09 at pg 62-63*
71 *See the transcript on 6/11/09 at pg 39*
72 *See the transcript on 6/11/09 at pg 40-41*
73 *See the transcript on 6/11/09 at pg 41*
74 *See the evidence of SOCO Williams - transcript on 6/11/09 at pg 10.15.*
75 *See the transcript on 6/11/09 at pg 23.*
76 *See the transcript on 2/11/09 from page 67-68*
77 *See the evidence of Insp M Heap on 2/11/2009 from page 20.42 & Kevin Day - see the transcript on 5/11/09 at pg 32.*
78 *See the transcript on 5/11/09 at pg 33-37.*
79 *See the chain of possession - see the evidence of Insp M Heap on 2/11/2009 from page 24.33 & See the transcript on 6/11/09 at pg 34*
80 *See the transcript on 6/11/09 at pg 42.45*
81 *See the transcript on 6/11/09 at pg 66.40*
82 *See the transcript on 6/11/09 at pg 21.*
83 *Exhibits 4 and 5*

One read, *"2:45 on the 14 June 2007…. Matt Landsdowne sold me the gun"*.[84] This connotes ownership of the gun and thus it was not a gun left at the scene by a third person. It was AA's gun.

Secondly, there is a sense in that note of suicide and, if that is true, it implies that suicide was shortly after 2:45pm and that the gun was used in the suicide. William Baines and Les Page[85] have identified the writing as AA's.

The second note was written on an envelope and read; *"MUM, AT THE END OF MY BED, UNDER THE CARPET, IS SOME MONEY. USE IT BUY (SIC) MUM, AA"*[86]. Fingerprints were on this envelope on which this message was written, and they were matched to AA.[87] AA's brother and Les Page testified that writing his name in capitals was typical of AA. This note is clearly evidence of AA's intention to suicide.

AA's contact with his friends on the day he died implies a "goodbye". As Doctor Dudley puts it "he appeared to be clearly cutting ties with everyone …":

When he spoke with his brother on the evening of 13 June 2007 he told Him "Thanks ". he knew from this, AA was saying goodbye to him.

At 12.31pm[88] on 14 June 2007 AA called Jody Chalkey and told him, "I've had enough. A couple of blokes around town are pissing me off. One bloke snotted me and I've just about had enough about everything going on and this might be the last time you hear from me".[89]

There is no evidence of AA having had a fight that day, so this could be a paranoid delusion.

Importantly, his language is one of finality and of saying goodbye.

At 1:50pm he left a message at Purnell's home: "I've had enough of this crap that is going on. I'm sick of the whole lot. Thanks for being a so-called fucking mate. Youse can all rot in hell."[90]

By contrast on the morning of 14 June 2007, at 9:50am, AA went shopping at "BI-LO" and bought normal groceries; bread, chicken, pasta and one packet of cigarettes[91]. This would appear to be a contra-indication for suicide. Why does a person buy food on the day they are going to kill themselves?

Before 9am on the same day, Kelly Isaacs received a call from AA who wanted to see that Doctor Healey received "the paperwork" and that his medication needed changing.[92] Certainly no suggestion he was contemplating taking his own life at that time.

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84 *See ERISP with Landsdowne from Q&A 165*
85 *See the transcript on 2/11/09 from page 74 (ex 5) and pg 75.20 (ex 4)*
86 *See photo 13 attached to the statement of SOCO Glenn Williams*
87 *See the statement of McKillop-Davies dated 4/9/07 from par 7.*
88 *See the telephone records of calls to and from 0429019546 at 12.31*
89 *See the statement of Jody Chalkey dated 27 June 2007 from par 8*
90 *See the statement of Gavin Purnell from par 14.*
91 *See the synopsis of from page 7.8 and receipt annexed.*
92 *See Kelly Isaacs from page 453.*

Doctor Dudley explained that suicidal thinking is usually associated with ambivalence about living or dying. As Doctor Dudley says, "the balance appears to have been in favour of living in the morning, but not so by lunchtime".[93]

The toxicology report indicates that AA had stopped taking all his medication by the afternoon on 13 June 2007, an indicator of "Giving Up"

AA's prescriptions for Effexor and Seroquil called on him to take his medication at night. The toxicology results and Dr Perl's evidence show that he had no trace of either drug in his body, and thus he did not take any of his drugs for at least 24-36 hours before death. Certainly, he *intentionally* did not take his medication on the evening of 13 June 2007 and Doctor Healey agrees with this conclusion.[94]

He had also consumed a large amount of alcohol immediately before his death. Doctor Dudley said that alcohol can be used as a "facilitator" to "enhance impulsivity and recklessness" it helps lower inhibitions and critical thinking so that it is easier to kill oneself.[95]

AA's brothers evidence that AA had been drunk before he drove his only car into the stationary prime mover on his property and his father's experience of AA sniffing thinners, shows that AA drinks before he attempts suicide.

There is evidence that indicates he was probably affected by alcohol at the time he fired the shot near Greg Knight and told Les Page to leave. Les Page thought he had taken too much medication but the evidence is that he had stopped taking it the day before.

After the confrontation with Greg Knight and Les page there is evidence he then consumed vast amounts of alcohol given his reading. There were 15 cans of beer "Carlton Cold" in his fridge, 69 crushed cans in his wardrobe and one in front of him.

The use of alcohol is an indicator of suicide it can be used, as I have stated, as a "facilitator" – to "enhance impulsivity and recklessness" – it helps lower inhibitions and critical thinking so that it is easier to kill oneself.

As Dr Dudley explains: "(alcohol) may have predisposed to and/or precipitated or facilitated his fatal action, either directly, through enhancing impulsivity and recklessness, or indirectly, through worsening his depression. [96]

Return of Paranoia and Depression

The evidence suggests the onset of his mental illness in 2000 -2002 and recovery was difficult and long. He had to be approved for work and could only work part time. AA knew he'd have to go through this again.[97]

On the Sunday night 10 June, AA called Les Page and told him that he was "crook like way back".

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93 *See Dr Dudley's report at page 7.9*
94 *See the transcript on 3/11/09 from pg 5.35-6.30*
95 *See Dr Dudley's report at page 7.6*
96 *See Dr Dudley's report at page 7.6*
97 *See transcript on 2/11/09 from pg 54.05*

At the time of death he was also hopeless; as Doctor Healey says "he couldn't really believe that treatment was going to help him" and "he didn't think he would get better again even if he submitted himself to treatment and … he was afraid that if he did get better, he was always going to relapse again."[98]

Doctor Dudley is in agreement that one of the reasons AA suicide was that "it was all too hard to face it all again".[99]A sense of hopelessness is a clear predictor of suicide.

FACTORS RELEVANT TO THE POLICE OPERATION

Was the death during a police operation

If I find that AA died during a police operation, then this has consequences; both on this inquest and as to the procedure police should have followed.

Thus, it is important to know when police were called and arrived at the farmhouse and when AA died.

Greg Knight called police when he left AA's home, shortly after his arrival at 2:02pm. The first police arrived at the scene at about 2.29pm[100]

Time of Death:

The last telephone call by AA was at 2:23pm to Doctor Healey, which lasted for 12 minutes and 44 seconds.[101] This is the same time Page was calling the family after police have moved him on, so AA was still alive after the police arrived.

AA must have drunk more alcohol after the call with Doctor Healey finished at 2.36pm on 14 June 2007, as he had 0.242 g/ml in his blood at the time of death. Doctor Perl has given evidence that, at this level of intoxication, there are clear signs of intoxication, such as "slurred, incoherent and confused speech".[102] However, AA was "coherent" with Doctor Healey.

This was the last call AA received; Les Page *thought* AA could receive calls when he left the phone next to the fridge[103], where Senior Constable Glen Williams, the Crime Scene Investigator, found it.

That would indicate that he was able to receive calls after that time, but had decided not to receive them. However, when Glen Williams picked up the phone and moved it towards the TV, the phone then received a large number of missed call messages[104].

This suggests that AA had no phone reception after he finished his call to Doctor Healy and had been totally unaware of the attempts to contact him after he put down the phone

98 *the transcript on 3/11/09 at pg 10.40*
99 *See Dr Dudley's report at page 7.5*
100 *See the transcript on 2/11/09 from pg 48.15*
101 *See the table of Critical Incident Calls at 14:23*
102 *See Dr Perl at page 1107*
103 *See the transcript on 2/11/09 at pg 56.25*
104 *See SOC Williams at Vol 3, Tab 77 page 880.*

with Doctor Healey.

Police at about 2.32pm moved on Les Page, who had been waiting at the gate,[105] when AA was still on the phone to Doctor Healey.

Jodi Chalkey called at 2.45pm and AA did not answer this, if indeed the phone rang.. There is a line of thinking that, because he did not pick up the phone that he was dead by then however, Doctor Healey is clear that AA was "coherent" when he spoke to him at 2.36pm and by the time he was dead he had .242 in his blood.

That means that unless AA was one of the 5% of the population who have such a high tolerance of alcohol that he showed no signs or symptoms of drunkenness[106] he must have consumed more alcohol after that phone call ended.

The evidence of William Baines is that he got "loud and obnoxious" and Matt Lansdowne that he got "yappy" and was unco-coordinated when drunk so he clearly does not fall into the 5% category referred to above.

Assuming he had a zero alcohol level at 2.36pm, it would have been impossible for him to absorb .242 g/ml of alcohol by 2.45pm[107] so he must have continued to drink after 2.36pm and beyond 2.45pm.

He was alive at 2.45pm, because that was the time when he wrote the note accusing Matt Lansdowne of selling him the gun.

Detective Senior Constable Craig Ryan and Plain Clothes Senior Constable Broadfoot, say when they were some distance from AA's home that they heard a coughing sound coming from the house, at about 3:25pm[108]. Ryan heard one cough[109], Broadfoot two[110]. The experiment showed that this sound was not the sound of the gun. Dr Nadesan's evidence was to the effect that a person couldn't cough after they are shot in the head, although he did take a couple of breaths after entry of the bullet.[111]

By 3.20pm, Plain Clothes Senior Constable Broadfoot and Detective Senior Constable Ryan had set up in a perimeter on the fence line, some 150m from the house. They had the homestead under constant[112] surveillance, Detective Senior Constable Ryan with binoculars,[113] and were listening intently for any sounds; they heard no sound of a gunshot[114].

The experiment showed that Ryan and Broadfoot were listening intently for just this sort of sound and that they would have heard the sound of the contact shot inside the house, with the wooden door open, if the shot which killed AA, was after 3.20pm[115].

Darkness descended at 5.20pm[116] and the lights did not go on[117], another indication that

105 *See the transcript on 3/11/09 at pg 60.30*
106 *See Dr Perl at page 1116*
107 *See Dr Perl at 1116.8*
108 *See the transcript on 4/11/09 at pg 58.35*
109 *See the transcript on 4/11/09 at pg 61.20*
110 *See the transcript on 4/11/09 at pg 70*
111 *See the transcript on 6/11/09 at pg 49.*
112 *See the transcript on 4/11/09 at pg 66.10*
113 *See the transcript on 4/11/09 at pg 65.45*
114 *See the transcript on 4/11/09 at pg 66*
115 *Evidence that the wooden door was open came from Kevin Day - transcript on 6/11/09 at pg 3*
116 *Ex 21*
117 *See the transcript on 5/11/09 at pg 18.00*

AA was dead by this time.

AA was certainly deceased by 8.57pm the time the beanbag was shot into the house because the glass that was broken by the beanbag rounds was still on his lap when they entered the premises.[118]

Ambulance officer Zuiderwyk checked the body at 10:08pm and found that there was evidence of dependant lividity on the bottoms of both forearms, and that AA's skin was cold.[119] Doctor Nadesan uses this evidence to put the time of death, "about eight hours, plus".[120] This is consistent with a time of death of between 3pm and 3.25pm.

As a result of the experiment one can confidently conclude that Detective Senior Constable Ryan and Plain Clothes Senior Constable Broadfoot would have heard the sound of the shot inside the house, as they were listening for it after 3.20pm.[121]

Les Page also participated in the experiment and said that he would have heard that sound too[122], but he was moved on by Constable Sheddon before Robert had finished talking with Doctor Healey, so he would have been there to hear it if it had occurred at that time.

Thus the likely time of death is between the time it took to take in an additional amount of alcohol after 2.36pm and before 3.20pm, which is after police arrived but before they were in position near the fence line. There was no one nearby at this time as Les Page was moved on at 2.32 pm. The only persons nearby between 2.32 and 3.20pm were Constable Sheddon and his partner Senior Constable Russell who were well up the road, with the windows up and the radio on.

As a result the death occurred in the course of a police operation and falls within the provisions of Section 23(c) of the Coroners Act 2009 and subject to 'Critical Incident Protocols'.

Did Police Follow the Proper Procedure?

According to that protocol, a team of investigators was then called from a separate Local Area Command to those who were involved in the subject police operation to create as much transparency as possible.

The police involved in the investigation of the circumstances surrounding the death of AA's were from Manning Great Lakes Area Command and Inspector Heap and Detective Bayley were from Mid North Coast Area Command.

Another independent officer, Inspector Vaughan, who found the Critical Incident Investigation had been carried out in a professional manner, oversaw the investigation itself.[123]

Did the Actions Of Police Have Any Effect On AA's Death?

118 *See the transcript on 2/11/09 from page 31.28 & See the transcript on 6/11/09 at pg 24.00*
119 *See the transcript on 5/11/09 at pgs 40-42 & 43*
120 *See the transcript on 6/11/09 at pg 46*
121 *See the transcript on 6/11/09 at pg 76. 15*
122 *See the transcript on 6/11/09 at pg 77*
123 *See the evidence of Insp M Heap on 2/11/2009 from page 17 & transcript on 2/11/09 from pg 50.18.*

This inquest raised the issue of whether the presence of police had some affect on AA's decision to take his own life.

Les Page did not tell AA that the Police were on their way.[124]

Charles Gillfillan was working on his gate throughout the afternoon, sounds carry and he was not aware of police being present via the sound of cars or sirens[125], though he thought he heard voices.

Police who kept the house under surveillance from 3.20pm kept out of sight and spoke only in whispers. The State Protection Support Unit (SPSU) similarly remained invisible.[126]

The Police did not have any effect on AA's death. As I have already indicated, the evidence clearly establishes that AA was dead by the time that the police commenced surveillance at 3.20pm and thus anything they did or not do after that time could have no effect on AA.

The Response by Police – Was it a Proportional Response?

Les Page suggested that the response by police was out of proportion to the threat posed by AA at that time[127].

The police response was quick and with good quality police; they got the call from Greg Knight at about 2:10-2:15 and arrived at about 2.29pm.

Senior Constable Wiggers started taking notes by 2.35[128]. Initially, Det Senior Constable Stone took command and then soon after handed over to three Inspectors who arrived at 2.45pm, and a police negotiator arrived at 3.05pm; an ideal situation to deal with the situation.[129]

Inspectors Able[130] and McKenna explained that this was a "High Risk Situation" because AA was in possession of a gun, had threatened self harm and had threatened Greg Knight firing a shot from the gun he possessed over Greg Knight's head.

The appropriate response to a High Risk Incident is to "Contain and Negotiate"[131] and this is exactly what was done:

One of the first jobs was to provide a perimeter to contain the threat. At approximately 3:10pm, Detective Inspector McKenna left to go to the fence line of AA's home with Detective Senior Constable Ryan, Detective Sergeant Williamson, Plain Clothes Senior Constable Broadfoot and Constables Cumberland and McLean and established a perimeter.

The plan was to talk to AA and get him to come out without a firearm.[132] If he tried to crash

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124 *See the transcript on 2/11/09 from page 66.15*
125 *See the transcript on 3/11/09 at pg 52.20*
126 *See the transcript on 5/11/09 at pg 28.20*
127 *See Les Page - the transcript on 2/11/09 from page 78.25 and see XX from pg 79*
128 *See the transcript on 4/11/09 at pg 23.35*
129 *See the transcript on 4/11/09 at pg 70.15*
130 *See the transcript on 3/11/09 from page 66. See "National Guidelines for Deployment of Police to High Risk Situations" by the Australian Centre for Policing Research, from pages 728-751*
131 *See Abel's evidence - the transcript on 3/11/09 at pg 6.22.*
132 *See the synopsis of the interview with Insp McKenna from page 4.5*

through, the second containment line, two police cars blocking the road, would stop him.

Police made an effort not to be heard and not to be seen[133]. From the time the perimeter was in place, there is no way anyone could get out of or into the homestead without police knowing.

Once the perimeter was firmly in place, and after John Mundey failed to make contact with AA, they gradually escalated the use of force starting with the lowest risk to police by use of phone calls to a loudhailer.

The telephone log suggests the first call was at 3:54pm but in fact the first call by Detective Senior Constable John Mundey, the first police negotiator was at 3.35pm.[134]

Mundey could not commence negotiations until the containment was in place, which was 3.25pm. At that time, he talked to Inspector Abel and they decided it was time to make the call, which was done at 3.35pm followed by 33 calls or more.[135]

A decision was made 4.55pm to use a loudspeaker to raise a response from a safe location.[136]/[137] To achieve this, to be within speaking distance of an armed person, the police had to provide protection for the negotiator.

To use a CHAYO (loudspeaker) closer to the house, police needed an Armed Response Vehicle (ARV) to get closer to the house, and the State Protection and Support Unit (SPSU) and Tactical Operations Unit (TOU), according to Detective Senior Constable Mundy.[138]

Because of the delay in getting the ARV[139] this did not occur until 8.22pm. At 8.47pm the ARV moved into position, approaching the stronghold to get closer and closer. By 8:57pm when Robert did not respond, a beanbag rounds[140]was used, authorised by Region Command.[141]

Police then jemmied open AA's locked door and then and by 10:03pm confirmed that AA was deceased.

The Question of Police Errors

Police admit that they made various errors and apologised for the same to the family at the time and again in the inquest.

Police left a gate opened and as we know in the country you leave gates as you find them because stock can wander and Inspector Michael Heap gave an apology about that issue.[142]

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133 *See the synopsis of the interview with Const Ryan from page 3-4*

134 *See the transcript on 4/11/09 at pg 4*

135 *See the transcript on 5/11/09 at pg 4-5 & pg 6*

136 *See the crime scene log maintained by Const Newton – the person on the radio was negotiator Mundey - See the statement of John Mundey dated 2/8/07 at par 12*

137 *See the transcript on 3/11/09 at pg 70.15.*

138 *See the transcript on 5/11/09 at pg 12*

139 *Able decided that it was not safe to go near the house without the protection of the SPSU and/or TOU – it took all that time for them to arrive.*

140 *See the transcript on 3/11/09 at pg 72.25*

141 *See the crime scene log maintained by Const Newton. See synopsis of interview with Superintendent Peter Thurtell p5 14.04 and see Clark See the transcript on 4/11/09 at pg 87*

142 *See the evidence of Insp M Heap on 2/11/2009 from page 33.28 & transcript on 2/11/09 from pg 33.30*

An electric fence was cut (in order to secure the perimeter) and the family were not notified of that, however, an appropriate apology was made by Inspector Michael Heap.[143] According to Inspector Heap, there is a policy that, after police enter a private property in the course of an operation, there should be a formal handover where police check with the owner that all is in order and he acknowledged that this was not done.[144]

In securing vital evidence when AA's brother went out to the homestead the next day, he found some important evidence that was not secured by Police. The original pills, spare keys in the door, receipts container, etc. However, it is noted that police took photos of the medication

Apart from these errors Inspector Abel was of the view that the police response was appropriate in the circumstances.[145] Detective Inspector McKenna has stated that all police there were there for a specific purpose.[146]

Whilst it did take some time for Police to finally enter the home I am satisfied that their actions were appropriate in the circumstances.

Use of "Third Party" Negotiators

Les Page expressed a desire to go back down to AA to have a talk to him, after police arrived. Throughout the night, Les Page "pleaded with them several times" and offered to sign a release.[147]

AA's father wanted to go and talk to his son and Senior Constable Wiggers stopped him.[148]

We heard evidence that it is the policy of NSW Police not to use "third party negotiators" because they do not work. As Inspector Abel explained, "it doesn't help and sometimes exacerbates the situation".

In fact neither Greg Knight nor more importantly his mentor and employer Les Page could not talk AA out when they tried earlier in the day.

I am satisfied that the police were not in error in refusing to allow Les Page or AA's father to negotiate with AA.

Formal Finding

I find that AA died on the 14th June 2007 in accommodation at 72 Links Rd, Koorrainghat via Old Bar from a gunshot wound to the head self inflicted with the intention of taking his own life.

Recommendations for Training of Medical Practitioners:

Various persons spoke to AA in the hours before his death; Greg Knight, Les Page,

143 *See the evidence of Insp M Heap on 2/11/2009 from page 34.10 & transcript on 2/11/09 from pg 34.02*
144 *See the evidence of Insp M Heap on 2/11/2009 from page 34.24 & 35.04*
145 *See the transcript on 3/11/09 at pg 72.35.*
146 *See the transcript on 4/11/09 at pg 85.*
147 *See the transcript on 2/11/09 from page 72.35-73*
148 *See the transcript on 4/11/09 at pg 28.45 and 29.18 & see Mc Kenna at pg 82*

Christine Caldwell and the last person to talk to him was his doctor, Doctor Healey.

AA told Doctor Healy he had a gun to his head and that he wanted to shoot himself because "everyone's, everything's going against me, it all going wrong again". Doctor Healy tried to calm him and AA told him Knight had been out to see him and he had shot over his head and that Les Page had been there too[149].

Doctor Healey was asked in the course of the inquest whether he had training in dealing with people who are suicidal and he deposed that "You get training throughout your medical course but I haven't had any further specific training in that time, I haven't done a course on suicide prevention or anything like that."[150]

Doctor Dudley has given evidence that the training of Australian General Practitioners is optional and there is no provision for regular refreshers in this training[151]. The evidence of Doctor Healey reflects this.

Doctor Dudley states that "there is a public interest in all General Practitioners being literate in suicide prevention, crisis management and actively using documented, standard crisis and well-being plans with their patients. To our best knowledge, this is not widely happening. It needs to be dealt with separately with detailed, accredited and repeated suicide prevention, intervention and postvention training, as part of the training programs promoted for example by Divisions of General Practice, and as part of maintenance of professional standards".

Many people who are suffering from mental illnesses will first consult their General Practitioners before possibly being referred to a psychiatrist or psychologist – about 60% of persons planning to commit suicide and 20% of those who attempt it use their General Practitioners as their primary contact point[152]. Given those close ties that a patient has with his or her family General Practitioner at the time of experiencing suicidality, it is not unlikely that the patient may turn to their General Practitioner in times of crisis, as AA did to Doctor Healey. In a sense they are the "gatekeepers" of suicide in NSW and Australia. Thus, it is important that General Practitioners be prepared with the necessary skills to provide support when they are confronted with a person who has an immediate and present intention to suicide.

Studies have shown that structured training is required to help General Practitioners be effective in this situation and that their capacity to assist can diminish without regular refresher training.[153]

149 *See the synopsis of the interview with Dr David Healey page 6.8*
150 *See the transcript on 3/11/2009 at page 13.35*
151 *See Dr Dudley's report on the second last page.*
152 *See " Draft Position Statement of Suicide Prevention Australia on Crisis Response and the Role of Emergency Services and First Responders to Suicide and Suicide Attempts" at pg 13.1.*
153 *See " Draft Position Statement of Suicide Prevention Australia on Crisis Response and the Role of Emergency Services and First Responders to Suicide and Suicide Attempts" at pg 13.2.*

I THEREFORE RECOMMEND THAT THE AUSTRALIAN MEDICAL ASSOCIATION AND THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

> **INCLUDE MANDATORY TRAINING OF SUICIDE PREVENTION AND CRISIS MANAGEMENT IN THE REGULAR TRAINING OF MEDICAL PRACTITIONERS SHOULD SO THAT THEY CAN EFFECTIVELY AND COMPASSIONATELY TREAT PATIENTS EXPERIENCING SUICIDALITY.**
>
> **AND THAT THIS TRAINING SHOULD BE A REGULAR PART OF GENERAL PRACTICE PROFESSIONAL DEVELOPMENT AND ACCREDITED BY AN INDEPENDENT BODY.**

<u>Other Recommendations</u>:

Detective Inspector Michael John Heap has been of tremendous assistance particularly organising the experiment with the subject firearm and I intend to send a letter of commendation to his superiors.

Finally I extend my sincere sympathies to AA's family and his mentor Les Page for their sad loss.

4. 2303 of 2008 Craig Raymond Wade

Inquest into the death of Craig Raymond Wade at Wilberforce. Finding handed down by Deputy State Coroner Mitchell on the 23rd August 2010.

On 12 to16 April, 2010 I conducted an inquest into the death of Craig Raymond Wade who was born on 8 June 1963. He died on Christmas Day, 25 December 2007 as a result of head injuries together with chest and pelvic injuries, which he sustained in a motor vehicle accident at a little after 2am on 20 December 2007 at Wilberforce Road, Wilberforce, NSW.

At the time of the collision which caused his death, Craig Wade was the driver and sole occupant of a Ford *Laser* motor vehicle, Registration # *YXE 319*, traveling along Wilberforce Road, on the northern bank of the Hawkesbury River, towards the township of Windsor. A short time prior to the accident, about 4.1kms closer to the village of Wilberforce, Craig Wade had attracted the attention of Sgt. Michael Madgwick, then of Windsor Police, who was driving a fully marked NSW Police station wagon, Registration # *AR 43 VA.*

The call sign of the Police vehicle was *HB 14*. Mr. Madgwick told the *Critical Incident Investigators* shortly after the collision that, while he was driving along Wilberforce Road in a generally northerly direction his attention was drawn to the *manner* in which the Ford *Laser* was being driven, prompting him to make a *U-turn* and follow Mr. Wade's motor vehicle.

Sgt. Madgwick followed Craig Wade for 4.1kms before the latter collided with a tree outside a house at 63 Wilberforce Road. Mr. Madgwick told the inquest that, in the

course of that distance, he travelled up to about 130km/h in order to catch up and then keep up with the Ford *Laser*. Further, he told the inquest that, having brought the police vehicle to within about 100 metres of the Ford *Laser*, he decided to stop it and, consequently activated his roof warning lights. Almost immediately, according to Mr. Madgwick, the Ford *Laser* turned violently to the left and then overcorrected *"a couple of times"* in a *"fishtail*" fashion before leaving the roadway and colliding with the tree. According to Sgt. Madgwick *"I don't think I even got my hand back on the steering wheel after pressing the button to turn the (roof warning) lights on that* (the Ford *Laser*) *turned violently to the left… …it shook and swerved and all of a sudden, the arse-end came around."*

Police and Ambulance Paramedics attended the scene. Craig Wade was removed from the Ford *Laser* and transferred to Hawkesbury Hospital and later airlifted to Westmead Hospital where he was admitted to the Intensive Care Unit. At 2.55pm on 25 December 2007, he died. A post-mortem examination was undertaken by a forensic pathologist, Dr. Dianne Little, on 27 December 2007 who pronounced the cause of death as *Head Injury (Clinical)* and nominated *Chest and Pelvic Injuries* as other conditions possibly contributing to death. The Autopsy Report recorded *"a history of very significant head injury. CT scans showed a right subdural haematoma, bilateral subarachnoid haemorrhage, multiple intracerebral contusions, intraventricular blood and cerebral swelling. There was a fracture of the right petrous temporal bone. At autopsy, the skull fracture was confirmed. A large right subdural haemorrhage was present with patchy haemorrhage on the left side also. The brain was extremely soft and swollen and was unable to be adequately examined in the fresh state"* and, because permission to retain the brain for fixation prior to examination was denied, the brain was not further examined.

Among the chest and pelvic injuries noted at autopsy were fractured ribs (predominantly on the right side) with subcutaneous emphysema and lung lacerations, a fractured right clavicle and a fractured pelvis. Perhaps not surprisingly, pneumonia had developed secondary to his unconscious state with lung injuries and mechanical ventilation.

There was no evidence of significant pre-existing natural disease to cause or accelerate death.

The Autopsy Report went on to report that *"toxicological analysis of samples taken on the day after admission to* (Hawkesbury) *hospital… … detected marijuana breakdown products, methylamphetamine (and its breakdown product amphetamine) and drugs given during treatment in hospital (thiopentone, midazolam). Morphine was also detected and was administered to him in hospital but it is also a breakdown product of heroin. The source of the morphine in this case is not certain as no urine was available to look for specific heroin breakdown products (eg monoacetylmorphine)."*

As will be seen, there is some controversy as to whether Craig Wade was being *pursued* by police at the time of the accident but there can be no doubt that he was being *followed* and, for that reason, this is a case which falls within the provisions of sections 23(c) and 27 where an inquest before the State Coroner or a Deputy State Coroner is *mandatory.* Almost immediately after the accident, a *critical incident* was declared and Detective Sergeant Michael Sparkes was appointed to lead the Critical Incident Investigation Team.

A Coronial Inquest is not a criminal proceeding. It is not concerned with ascribing blame much less prescribing punishment. It is an inquiry directed to discovering the facts regarding the identity of the deceased and the time, date, place and manner and cause of his death. It is also a forum, which allows a coroner to make recommendations to Government and others with a view to avoiding similar tragedies in the future. Because the accident leading to Mr Wade's death occurred *"in the course of a police operation"* so that the rights and protection of an individual citizen against possibly excessive state power may be involved, Parliament and the community have seen fit to demand that an inquiry into the circumstances of this tragedy be undertaken by a senior coroner, that is to say the State Coroner or a Deputy State Coroner.

This inquest sat from Monday 12 to Friday 16 April 2010 at Parramatta. Mr. Lonergan of Counsel appeared to assist the Coroner and he was instructed by Ms. Lazzarini of the Crown Solicitor's Office. Mr. B Haverfield of Counsel appeared for the Police Commissioner and, initially, for all Police officers called to give evidence. On Thursday, 15 April, Mr. L. Nicholls of Counsel was granted leave to appear for Sgt. Madgwick and Mr. Andrew Miller of Counsel appeared for Craig Wade's family and, in particular, for Ms. Joanna Wade, Mr. Wade's partner.

A view of the relevant stretch of Wilberforce Road was undertaken on 12 April in which all Counsel, other than Mr. Nicholls participated.

In addition, I requested and Craig Wade's family were good enough to provide me with a short description of his personality and his life. Craig was the son of Margaret and Max Wade. Sadly, his father died just before the inquest commenced but Mrs. Wade, his sister and his long-term partner, Jo, and others attended the inquest and participated in the proceedings.

In so doing they paid their respects and expressed their love of Craig and their continuing grief at his passing. Craig Wade has been described as "a fiercely loyal and passionate person" with a deep devotion to his family and especially his parents. His partner of over twenty two years, Jo, and he are described by the family as *"soul mates"* and they told me that, when Craig died, part of Jo died as well.

It is a testimony to Craig Wade's love and devotion to his family that he and Jo cared for his grandmother, Vera, for many years and, together with Max Wade, built a granny flat for his other grandmother, Nana Cookie.

Craig Wade is remembered as an extremely hard worker; skilled with his hands and a perfectionist in everything he did, dedicated and loyal with a love and enthusiasm for life. He was a man of integrity, intelligent and passionate, *"who accepted responsibility for his own actions and accepted the consequences of them."* It is a tragedy, deeply felt by his family, that Craig died in so untimely a fashion. The loss and pain felt by his family were obvious to me when I met them at the inquest and it was obvious that he is deeply, deeply missed and will always be in their hearts.

The formal documents presented to the inquest including the *Hospital Report of Death* to the Coroner and the Autopsy report, the *I.D*. Statement and the Certificate of Analysis issued by the *Division of Analytical Laboratories* are Exhibit 1 and a full brief of evidence including statements of all witnesses is Exhibit 2. Other exhibits include an

aerial photograph and a computer generated diagram of the scene, *UBD* maps, a *DVD* of a *walkthrough/drive through* depicting the events leading up to the accident, crime scene photographs, Mr. Madgwick's diagram of the scene, the *NSW Police Safe Driving Policies* and hospital records.

There is no controversy in this case regarding the identity of the deceased and the time, date and place of his death or for that matter the *cause of his death* when that term is understood as a *physiological* concept as opposed to the *manner* of death. On the uncontested evidence before me I am able to find that Craig Raymond Wade died at 2.55pm on 25 December, 2007 at Westmead Hospital, Westmead, NSW of "*HEAD INJURY (CLINICAL)")* sustained in a motor vehicle accident at Wilberforce Road, close to # 63 Wilberforce Road, Wilberforce NSW shortly after 2am on 20 December, 2007. It is the *manner* of Mr. Wade's death – the circumstances in which the death took place, which provided most of the controversy in this inquest.

Leaving aside Sgt. Madgwick, there was no eyewitness to the accident and, accordingly, the specialist investigations of crash investigator,

Sgt. Lyall and crime scene officer, Const. Summerfield were likely to be particularly significant. So it is disappointing to find that their work fell significantly short of what I believe might reasonably have been expected.

Both Sgt. Lyall and Ms. Summerfield had substantially completed their work by the time Det. Sgt. Sparkes, the Officer-in-Charge, arrived at the scene on the morning of the accident. Neither was able to assist the inquest by offering any useful evidence as to the speed at which Craig Wade was traveling along Wilberforce Road, Ms. Summerfield because, as she explained it, *"that was not my job at the time"* and Sgt. Lyall because, in specifying a speed *"in excess of 80km/h,"* she appears to have relied on photographs showing white dots on the road surface which were said to represent skid marks, the origin of which were uncertain and which, she admitted, could have been *"wrong."* Although she was prepared to rely on them as demonstrating the path taken by Craig Wade and the speed at which he was travelling, Sgt. Lyall was unable to say who had painted the white dots on the roadway which were supposed to mark what were put forward as Mr. Wade's skid marks other than to say that *"it would either have been me or Sen. Con. McIntyre but I can't remember to this day which of us did it."* Furthermore she ultimately admitted that the pathway demonstrated by the paint marks could not possibly have been his. Sgt. Lyall explained that she had never been asked to undertake any calculation or measurement of the speed or the range of speed at which Mr. Wade had been travelling when his Ford *Laser* left the road and impacted with a tree and she added that, had she been asked to make such calculation, she might not have been able to do so because *"I don't think we were 100 % sure of the skid mark length or which vehicle it was from."* From what I can make out, no or only inadequate measurements of skid marks were undertaken. No friction measurements were taken, apparently because nobody ordered them and the photographs of the roadway at the scene of the accident were of such poor quality as to be quite uninformative. Ms. Lyall admitted the inferior and unhelpful quality of the photographs but explained that *"crash investigators take photographs, not crime scene."*

Det. Sgt. Sparkes conducted an electronically recorded interview with Sgt. Madgwick from 7.45am to 8.44am on the morning of the accident. Mr. Madgwick stated that,

when he first saw the Ford *Laser,* it was travelling in a *"50Km/h sign posted"* area at an estimated speed of 60Km/h. But, according to Mr. Madgwick in his *ERISP*, it was the *manner* of driving rather than the speed that attracted his attention and interest and he considered that Mr. Wade might be intoxicated. In those circumstances, he made a U-turn and followed.

The *ERISP* indicates that Sgt. Madgwick watched the Ford *Laser* speed away so that he had to reach a speed of 130Km/h in order to catch up in what was an 80Km/h stretch of road. Occasionally, Madgwick told Sparkes, he slowed down to 100 or 110Km/h in order to negotiate some *"corners"* but, on those occasions, he did not observe Mr. Wade to slow down and the latter's break lights were never activated. In fact, both the view which I attended and the aerial map tendered at the inquest establish that there are no significant corners or bends in the approximately 4.1 kilometre stretch of road between the point at which Mr. Madgwick made his U-turn and the point at which Mr. Wade ran off the road.

In his *ERISP,* Sgt. Madgwick described the difficulty he had in keeping pace with Mr. Wade who *"was accelerating well over the speed limit at the time… …If I'm sitting on the speed limit and he was constantly pulling away from me, he was nowhere near, neither of us was travelling at the same speed. He was way faster than the speed limit."*

At that point, Mr. Madgwick told Police, *"I thought he was a madman. My initial observations [were] that he was intoxicated. This guy needs to be stopped before he does somebody serious danger, injury."* So, when he was about 100 metres behind Mr. Wade, Mr. Madgwick decided to pull the Ford *Laser* over and, accordingly, he activated his roof-mounted warning lights. Up to that time, for almost 4.1 kilometres, Sgt. Madgwick had contented himself with following, chasing and keeping pace or attempting to keep pace with Mr. Wade and he had not informed Police *VKG* that he was *in pursuit* seeking first, he explained, to check the Ford *Laser's* speed before pulling it over. His evidence is that he did not consider that he was engaged in a *pursuit*. He told Det. Sgt. Sparkes that, had Mr. Wade refused to pull over, he would have advised *VKG* and would then have engaged in a *pursuit*.

Whatever might be the technical description of it and whether or not it was a *pursuit* as understood by police, I would have thought that Mr. Madgwick, who admitted before the inquest that, at one point, he achieved a speed of about 140km/h, was well and truly in pursuit of Mr. Wade from the time he made his U-turn and commenced following the Ford *Laser*.

Sgt. Madgwick told Det. Sgt Sparkes that it took him only *"thirty, forty seconds, maybe a little bit more maybe a little bit less…"* to travel from the point where he made his U-turn to the scene of the accident but this is plainly incorrect. The distance is 4.1kms and Mr. Sparkes' best reasonable time estimate, which I would accept, is about 2 ½ minutes.

Police conducted a video-recorded *walkthrough* on 21 December, 2007 in the course of which Mr. Madgwick explained his decision not to activate his warning lights until the last minute by saying *"I'd only just caught up and maintained and was able to observe his manner of driving at that time in regards to whether he was still intoxicated or what his ulterior motive was to be able, to taking off from Police. Then coming into these bends, I didn't want to make…coming into the corners, I didn't want to put the lights on and so*

he's observing me and missed the corner or cause an accident on the bend. I knew there was a big open space just around these corners and it was a safer point to be able to pull the vehicle over." Admitting that he did not notify *VKG* until after the accident, Mr. Madgwick explained *"I didn't have an opportunity (to notify Police radio)…I wanted to observe and …record…his speed at the time,…I still thought he was intoxicated which goes into his manner of driving at the time."*

I repeat that there were no significant *"corners"* or *"bends"* in the stretch of Wilberforce Road over which Mr. Madgwick chased Mr. Wade. Instead, the roadway describes a broad, sweeping and shallow curve through open country.

When asked by Mr. Lonergan why he chased Mr. Wade for so long and at such speed without activating his roof-mounted warning lights, Sgt. Madgwick offered a number of reasons. *"…I've had it before and it's quite common, that when people are doing excessive to the speed limit there's not much more for them to accelerate harder when you put your lights on – you're in a pursuit at high speed already. Secondly, I wanted to find a safe location in regards to I'm an Alpha unit, I have nobody else in the vehicle with me. I don't know how this guy is behaving, he's already – his manner of driving has already come under my notice, he's accelerating hard, breaking the road rules and I'm driving fast to catch up to him so he's still a couple of hundred of metres ahead of me I'm looking for somewhere safe where I can stop him and know that I'll hopefully be safe and I don't want him to react especially because going around some of those bends there, I don't want him to react adversely and drive off the road…."*

It was clear from the answers to a number of questions, some of them put by Mr. Miller for the family, that Sgt. Madgwick took into account the possibility that, once the warning lights were activated, Mr. Wade might have reduced his speed so that efforts to gather evidence for a conviction would be frustrated. As Mr. Madgwick said *"I took the avenue of he's committed an offence, I gather the proof and then investigation and establish that he was doing 130 in a 80 kilometre an hour zone"* and he went on to explain that *"There's a number of variables…I performed hundreds and hundreds and hundreds of motor vehicle stops, something like this had never happened."*

A great deal of time was taken up with evidence and argument as to whether Sgt. Madgwick was engaged in a *pursuit* as he chased after Mr. Wade along Wilberforce Road that morning. Exhibit 11 is the 2004 version of the *NSW Police Force Safe Driving Policy* which was current as at 20 December, 2007 and which describes a *pursuit* in the following terms:-

"A pursuit commences at the time the police officer decides to pursue a vehicle that has increased speed or ignored a direction to stop. An attempt by a police officer in a vehicle to stop and apprehend the occupant(s) of a moving vehicle when a driver of the other vehicle is attempting to avoid apprehension or appears to be ignoring police attempts to stop them."

The policy goes on to provide that:-

"A pursuit is deemed to continue if you follow the offending vehicle or continue to attempt to remain in contact with the offending vehicle, whether or not your police vehicle is displaying warning lights or sounding a siren."

Snr. Sgt. Dorrough, Commander, Traffic Policy Section, Traffic Services Branch, NSW Police, gave evidence to the inquest both by way of a written statement and orally. In the former, he put the view that Sgt. Madgwick had not been engaged in a pursuit while he was following Mr. Wade, merely in an attempt to catch up with him and conduct a speed check. Mr. Dorrough thought that a *pursuit* – together with the obligation to advise *VKG* - would commence only once Mr. Wade refused a direction to stop or indicated an attempt to avoid apprehension.

In his opinion, it was only when Sgt. Madgwick activated his warning lights that a direction to stop was given and, in the present case, there was no question of a refusal or an attempt to evade because the accident occurred almost immediately the lights were activated.

But, at the inquest, Snr. Sgt. Dorrough seemed to adopt a somewhat different attitude to the *pursuit* when he was asked to comment on Mr. Madgwick's answer to Det. Sgt. Sparkes' question (# 92 in the *ERISP)* that, as he commenced to accelerate after Mr. Wade, Madgwick *"thought he was a madman, my initial observations that he was intoxicated this guy needs to be stopped before he does somebody serious danger, injury."* Mr. Lonergan then asked Dorrough *"Doesn't that indicate that shortly after doing the U-turn and observing the (Ford Laser) vehicle accelerating away, Sgt, Madgwick has determined to stop him, wouldn't you agree with that proposition?"* to which Snr. Sgt. Dorrough replied *"Based on that, yes."*

Mr. Lonergan went on … *"At that point, ought he (Madgwick) not, in your opinion, have placed his roof warning lights on to signal the driver to stop?"* to which Dorrough replied *"He could have."* When I reminded Mr. Dorrough that *"the question is not 'could he have' but 'should he have',"* Mr. Dorrough replied *"I can't answer that."* Of course, he could have answered my question perfectly easily and the impression I gained was of Snr. Sgt. Dorrough's disappointing preference to obfuscate in this regard rather than assist the Coroner.

While I make no criticism of Sgt. Madgwick's decision to commence a pursuit or, if it were not a pursuit, to chase and stop Mr. Wade, I respectfully agree with the submission of Counsel Assisting that it would have been more appropriate at a much earlier point in time, indeed immediately upon making his U-turn, to activate the roof-mounted warning lights thus announcing his presence as a police officer, possible prompting Mr. Wade to slow down, and calling on him to pull over.

Unless there was absolutely no choice, it is hard to see that the potential benefits of a high-speed chase justified the risks and dangers involved. Those potential benefits included the possibility of gathering evidence which might have secured the conviction of a traffic offender who, at the time immediately before Mr. Madgwick made his U-turn and gave chase, was travelling at an estimated speed of 60Km/h in a 50Km/h zone but who Sgt. Madgwick thought, rightly as it transpired, might have been driving whilst intoxicated. Mr. Nicholl's submission is that, at the time he made his U-turn and commenced chasing Mr, Wade, Sgt. Madgwick *"had observed sufficient facts to raise his suspicions about the manner of driving being undertaken by the deceased."* Those *"sufficient facts"* included his observation that Mr. Wade was exceeding the speed limit, albeit by only 10Km/h and also, as he told Mr. Sparkes in his record of interview of 20 December, 2007 :-

"He came past and as he came past me he went off the road with his near side wheels and crossed the breakdown line, emergency line on the edge of the bitumen and went across the driveway onto the gravel, the dirt. Half his vehicle was off the road."

As a motorist exceeding the speed limit by only 10Km/h, Mr. Wade might have appeared to pose only limited danger to himself and to others, keeping in mind that these events occurred at about 2.10am in a relatively quiet area. There is no suggestion of the presence of any other traffic, much less any pedestrian traffic and, on Mr. Madgwick's evidence, it was only after the chase had commenced that Mr. Wade picked up speed. But, accepting Mr. Nicholl's submission in that regard, I think Sgt. Madgwick was entitled to take steps to stop Craig Wade on the basis, as he told Mr. Sparkes, that *"my observations stated he's possibly intoxicated so I did a U-turn to… …pull him over."*

The *downside* of a high-speed chase is the danger, which it posed for the participants and for any unfortunate citizens who happened to get in the way. It is not possible to say that Mr. Madgwick's participation in a high speed chase (whether or not it constituted a *pursuit*) contributed to Mr. Wade's death just as we cannot know whether the sudden illumination of police warning lights at a time when both vehicles had achieved alarming speed distracted Mr. Wade, causing him to loose control of his vehicle. But in Det. Sgt. Sparkes' judgment, it is *"very possibly the case"* that the deceased was momentarily distracted when the roof- mounted warning lights on *Hawkesbury (HB) 14* were suddenly activated, resulting in him losing control of the Ford *Laser* and running off the road.

We cannot know whether Mr. Wade increased his speed because he thought he was being pursued by police or others but being followed at night on a lonely road by an unknown motor vehicle, at that time unidentified, might have been very frightening to him and might have caused him to flee. Neither can we know that Mr. Wade would have increased his speed had he been left alone but driving through a hamlet like Wilberforce in the very early hours of the morning at a speed only 10Km/h above the speed limit does not suggest so. It seems to me that Mr. Madgwick giving chase as he did is as likely to have prompted Mr. Wade's excessive speed as to have discouraged it.

Mr. Sparkes suggested that, once Sgt. Madgwick decided to give chase, he would have been well advised to have activated his warning lights. Det. Sgt. Sparkes reminded the inquest that Mr. Wade, despite his poor driving record, had always been compliant in his interactions with police and had never attempted to elude them. Indeed, Mr. Sparkes told the inquest *"…I am of the opinion that the deceased did not attempt to elude Sgt. Madgwick on 20 December, 2007."* Perhaps early activation of warning lights before the chase reached outrageous and dangerous speeds - early identification that it was a police officer rather than a stranger who was following him, might have prompted Craig Wade to reduce his speed and even pull over so that his death could have been avoided.

Dr. Judith Perl was called to give evidence regarding the toxicology readings obtained from blood samples taken from Mr. Wade while he was still at Hawkesbury hospital early in the morning of 20 December, 2007 and in particular the readings *amphetamine 0.07mg/L and methylamphetamine 0.62mg/L*.. These are high concentrations and, according to Dr. Perl, provide the best and most reliable information as to influence which recent drug use had on Mr. Wade's death. In her written evidence, Dr. Perl stated:-

"9. The blood concentration of methylamphetamine detected in the sample… …would strongly suggest very recent usage of a very high dose of methylamphetamine or of the deceased using repeated doses within a short time.

The concentration of methylamphetamine and amphetamine found in this blood sample would have been very close to his concentration at the time of the collision.

The concentration of methylamphetamine found in the Deceased's blood is well within the reported toxic to lethal range (stead and moffant, 1983; TIAFT 1996) and a naïve user would suffer significant toxic effects due to this concentration of methylamphetamine. Tolerance to toxic effects however does develop although impairment of driving ability will still be very significant impairment at a blood methylamphetamine concentration of 0.62mg/l and the alleged manner of driving (speeding and allegedly risk-taking behaviour) is consistent with such a methylamphetamine concentration.

In summary, the impairment due to methylamphetamine would have been very significant and thus I am of the opinion that it would have been a major factor in his manner of driving and his ability to control the vehicle."

In an exchange with Mr. Lonergan of Counsel, Dr. Perl went on to explain:-

The effect of all drugs on the brain is to impair or overload the ability of the brain to process information, to make decisions. Drugs can alter your perceptions. Methylamphetamine does all of those. The ability to concentrate is increased by stimulants so, in other words, you can concentrate on a simple, one-function task and hence some of the reports in the literature that indicate that low dose methylamphetamine actually improves performance. It does improve reaction skills at low doses but, as you increase the dose of methylamphetamine, the ability to process information is sacrificed at the expense of speed of performance so that the individual becomes selective in their…in what they choose to do and if somebody is under the influence of methylamphetamine, the ability to concentrate on two or three or four tasks or whatever is involved becomes diminished. Driving always involves more than one task.

In this regard, Dr. Perl thought that driving is to be distinguished from normal everyday tasks*. "Normal everyday tasks like typing where, if you are a typist, you practice and you can do it over and over again but, if you have distractions, then your performance diminishes. It's the same with driving. You can control your vehicle, you know the controls.*

You can handle your vehicle if it is a practiced route, practiced speed and there's nothing else. (But) the road and the conditions of the driving situation are never the same, they are variable and if something unexpected, unforeseen occurs, then a pothole or an unexpected bend in the roadway that you haven't previously noticed or some other object, obstacle, another vehicle distracts your attention, then the impairment comes to the surface. So you may initially perform reasonably well but, once the demands change and there are more things to concentrate on, then, of course, the impairment is there. It always was there but it becomes more important.

Mr. Lonergan asked Dr. Perl *"What we then factor into the equation is that police roof warning lights are then activated. Now on the assumption that Mr. Wade was, saw that*

through a read vision mirror, would that be an unexpected event?" Dr. Perl's reply was *"That would be a distraction which would require an additional amount of processing of information, judgment and perception so, yes, that would be an unexpected sudden change in the conditions that have to be processed and dealt with and that would detract from driving skills."*

I recognise that Sgt. Madgwick was in the position of making a *split second* decision whether to turn and follow Mr. Wade and then a hurried decision as to how to proceed. I think there can be no criticism as to the first decision but his evidence assists me little in determining why he took his second decision that is his decision not to activate his warning lights until the last minute. Mr. Madgwick's explanation was, firstly, that the lights might have prompted Mr. Wade to increase his speed rather than to slow down and, secondly, that, as an unaccompanied police office, he was looking for a place along Wilberforce Road where it would be safe for him to stop Mr. Wade. And thirdly, he was looking for a safe place where Mr. Wade could stop safely, he told the inquest, because he didn't want him to react *"going round some of those bends"* and drive off the road. I am unable to accept those explanations. Firstly, at the time Mr. Madgwick made his decision to chase Mr. Wade, the latter was travelling at about 10Km/h above the speed limit and there was nothing to suggest that police warning lights would prompt him to go any faster and seek to elude police. In fact, his background suggests the contrary. Det. Sgt. Sparkes made it clear in his evidence that Mr. Wade had always been compliant in his interactions with police. As to the second, there was nothing of substance to suggest that Mr. Wade might attack or threaten Sgt. Madgwick should he have the opportunity to do so. Further, there were no bends in the road, which might have rendered it unsafe for Mr. Wade to pull over. In the result, while I accept that Mr. Madgwick's decision not to activate his warning lights was taken quickly, it is unclear why he took it.

We now know that the high concentration of methylamphetamine in Mr. Wade's system and the consequential impairment of his perception and judgment and ability to process information, as outlined by Dr. Perl, rendered it important, in the interests of his own safety and the safety of the public, that he be stopped and removed from his vehicle. But it seems to me that that, having decided to chase and stop Mr. Wade, Sgt.

Madgwick would have done well to activate his warning lights and so identify himself before matters got out of hand. The dangers involved in a high-speed chase, especially where the quarry is alcohol or drug affected, are obvious and have been amplified by Dr. Perl. A tragedy might have been avoided had this chase been brought to a very early close.

But all of that said, because of the high concentration of methylamphetamine in Craig Wade's system and the debilitating effects of the drug and because I cannot know what would have been Mr. Wade's behaviour had Mr. Madgwick behaved differently in announcing his presence and identifying himself as a police officer by promptly activating his warning lights and indicating, before matters got out of hand, that he was a police officer and that Mr. Wade should stop, I am unable to find that Mr. Madgwick's decisions contributed to Craig Wade's death or that, without them, Mr. Wade would have been alive today.

Formal Finding:

That Craig Raymond Wade died at 2.55pm on 25 December, 2007 at Westmead Hospital, Westmead, NSW of head injuries (clinical) sustained in a motor vehicle accident on Wilberforce Road, when he ran off the road close to # 63 Wilberforce Road, Wilberforce, NSW shortly after 2.10am on 20 December, 2007. At the time of death, the motor vehicle, which Mr. Wade was driving, was being chased by police.

5. 63 of 2008 Cristy Joanne Moffitt

Inquest into the death of Cristy Joanne Moffitt at Mullumbimby. Finding handed down by Deputy State Coroner Mitchell at Byron Bay on the 10th September 2010.

Cristy was only 2 years of age in 1973 when she moved to the Mullumbimby area with her parents Cheryl and the late Edward Tulloh. She spent most of her life in the north coast area. At 21 years of age she married Robert Maxwell Moffitt but they separated in about 2003. They never divorced. There are three children of the marriage namely Lucas Jack Moffitt (dob 30/1/95), Jayden Matthew Moffitt (dob 31/7/97) and Kalinda Jasmine Moffitt (dob 8/1/99). After Cristy's separation from her husband, the children initially lived with her. There was what was described as *"constant bickering"* regarding the children and, ultimately, there was litigation and orders were made placing the children with their father. Apparently Cristy was not in frequent contact with the children whom, according to her husband, she had seen only once in the four or five months immediately preceding her death.

Cristy was last in touch with her mother by telephone on 3 January 2008.

Cristy worked as a cleaner. For some time her health had been indifferent and she was being treated by Dr. Tim Devine of the Mullumbimby Medical Centre. He had diagnosed her as suffering from *"chronic pain syndrome which was poorly defined but probably due to anxiety symptoms leading to chronic muscle and back pain, and chronic anxiety/ emotional instability."* In his report of 29 January, 2008 which is part of the brief, Dr. Devine reported that, at the time of her death, Cristy Moffitt was on an anti-depressant, namely *Effexor* (150mg daily), slow release morphine known as *MS Contin* (5mg twice daily) and *Valium* (5mg *"as needed occasionally for extreme anger or anxiety.")* Dr. Devine was not aware that Cristy was seeing another doctor or therapist and the above medications *"should have been her only medications"* although, in the event, the toxicological examination showed the presence of an additional medication, namely Sertraline.

Dr. Devine reported that Cristy Moffitt was referred on several occasions to see counsellors for psychological support and therapy but *"was non-compliant with that request."* Cristy figured in a number of incidents described in the NSW police *COPS* system as "*Mental Health Act"* including an event on 28 August 2007, when she informed police who had been called to her home that she intended to harm herself. I think that, for reasons, which are not clear, Cristy was finding life quite difficult but there is no suggestion and no reason to think that she intended any self-harm on 4/5 January 2008.

Although she was in dispute with her landlord and in the process of moving to premises at 14 Gardenia Street, Mullumbimby, at the time of her death, Cristy was living in rented premises at *Palmwoods* near Main Arm. For some 4 months before her death, she had possession of her mother's white 1989 Toyota Camry station wagon, registered no. *254BZH*(Qld), and it was her practice to drive it on her frequent trips between *Palmwoods* and Mullumbimby.

Cristy Moffit was a member of the Mullumbimby Ex-Services Club where she was regarded as a popular member. Because, in the operation of its *loyalty programme,* that club keeps close records of transactions and purchases on the premises, it is possible to say that, on 4 January 2008, Cristy was in the club for about 8 1/2 hours from no later than 2.30pm when she made her first bar purchase until 11.06pm when *CCTV* footage shows her leaving the club for the evening. In that period she bought and, I think, consumed eight cans of premixed *Jim Beam and Cola*. I was told by those who know about these things that each can contained 375mls and that there are two types of *Jim Beam and Cola*, namely *black* which is 7% alc./vol. and *white* which comes in at 5.5% alc./vol. There is no way of knowing which type Cristy Moffitt drank that night and I note that these drinks were consumed over an eight hour period but it is unlikely that Cristy made any food purchases at the club during that period and, even if she chose the *white* version, she must have been well affected by alcohol when she set out to drive home.

Cristy may have been an experienced drinker and may have developed a certain level of tolerance to alcohol. Mr. Barnes, the club manager, told the inquest that she had not drawn attention to herself that night. But, according to Dr. Perl, tolerance acts only in the area of *"the visible signs of intoxication."* In other words, if one has a high level of tolerance, one will not readily show some of the obvious outward signs of drunkenness. One might not speak with slurred words. One might not appear glassy eyed. One might more readily walk a straight line and the like. One may even perform learned, habitual tasks without any obvious difficulty. But, according to Dr. Perl, tolerance has no application in the area of driving or, indeed, in any area where one is called upon to deal with unexpected situations, perform tasks to which one has not become habituated or for which one has not trained and has not rehearsed in close detail.

Driving is one of those tasks. Because it demands perception, processing, decision-making and judgment it cannot be rehearsed in detail. The driver can be trained to only a limited degree and after that, he or she must observe, process, react and respond to ever-changing circumstances and perform the particular tasks, which those ever-changing circumstances demand. According to Dr. Perl, no matter whether the heavy and experienced drinker is able to appear sober and avoid the obvious signs of intoxication, he or she cannot avoid alcohol's debilitating effect on driving ability because, irrespective of the outward signs, alcohol slows down the brain processes *physiologically*. One is not able to drive safely because, physiologically, one has lost some or all of the mental flexibility necessary to perceive, process, react and respond.

Further, Dr. Perl pointed out that alcohol acts on the brain to increase aggressive and risk-taking behaviours and invariably produces marked disinhibition no matter how practiced a drinker one may be. This is not simply a behavioural matter to do with outward appearance but a physiological effect of alcohol on the brain. Again, according to Dr. Perl, alcohol reduces the peripheral vision and produces muscle floppiness.

When she was asked to revise her calculations of alcohol concentration in Cristy Moffitt's system on the night of her death, Dr. Perl said that, if the drinks were all of the *white* variety, Cristy's reading would have been 0.146, just a trifle under the high range concentration of alcohol prescribed in the *Road Transport (General) Act 2005.* And, if they were all *black,* she would have been well within the high range at 0.239.

An added complication is the presence of various medications in Cristy's system, which, in Dr. Perl's opinion, could only serve to amplify the debilitating effect of the alcohol.

The *CCTV* footage at the *Mullumbimby Ex- Services Club* shows Cristy Moffitt leaving the club at 11.06pm and walking to her car and it appears that she then set out for home.

The weather that night was appalling. Between late December 2007 and early January 2008, the entire northern rivers region of the state of which Mullumbimby and Main Arm form part experienced one of the biggest floods on record. According to Mr. Hanckel, in the period from 4 to 11 January, 2008, three of the five river systems in the region experienced major level flooding affecting eight major communities and many minor communities and rural areas. On the night of 4/5 January 2008, the *NSW* Government had declared 8 disaster areas across the state of which 6 were in the Richmond/Tweed area. Three river systems, the Richmond, the Wilson and the Tweed were in flood. According to Mr. McAviney, between 26 December 2007 to 5 January 2008, the Mullumbimby *SES* received 64 calls for assistance relating to flooding including 12 calls relating to motor vehicles having been washed into creeks.

The coronial brief contains extensive accumulated rainfall readings for the whole of January 2008 taken at rainfall gauges at Chincogan and Upper Main Arm and water level readings during the same period at Sherry's Bridge. Throughout 4 January 2008 and into the night, it rained very, very heavily in Mullumbimby and in the hinterland and, although some relief that night had been forecast, it failed to develop and the heavy rain continued.

The path from Mullunbimby apparently taken by Cristy Moffitt is this. She drove from the township along Main Arm Road, described by Mr. King as *"a major local road,"* past the point known variously as *Leeson's* and *Johnson's Lane.* Then, about 50 metres further on, she drove across *Sherry's Bridge* and then the *Williams Bridge*, which Mr. McAviney described as *"usually the last bridge to go underwater because it is elevated"* and, finally, on to the Main Arm causeway the distance from *Leeson's* to the causeway is a little less than 5 kilometres.

It is not clear whether any part of Main Arm Road along which Cristy Moffitt travelled had been *closed* in any real sense. In a proper case, the local shire, in this instance the Byron Shire, has authority to close a road and the evidence is that, between 3 and 6 January 2008, The Pocket Road and Upper Main Arm Road (and, from at least 8.30am on 5 January 2008, Main Arm Road) were *closed* and local media were advised. But Mr. King's evidence is that Council has no power to enforce its road closures and, from what Mrs. Rapley reported, it seems that traffic was using Main Arm Road between Mullumbimby and Main Arm village more or less whenever the road was passable. Mr. King told the inquest that, whenever a road is closed, appropriate signage is provided but, in emergency conditions such as those which prevailed in the northern rivers area in late December 2007 / early January 2008, signage was not always available. It might be

suggested that, in a modern community, all roads and crossings should be appropriate for *all weather* use but Mr. King reminded the inquest that Byron Shire is responsible for many, many kilometres of country road and more than a dozen bridges and crossings. There is a programme of constant repairs and upgrades but in Byron Shire as throughout regional and rural Australia, resources are necessarily limited.

Essentially, it seems that, in each of these matters, a great deal is left to the practical good sense of local residence that tend to understand the roads and river crossings and the local conditions. Cristy Moffitt was a local resident whom I think had some experience of these matters and, judging from the evidence of Mrs. Rapley, Mr Evans and Mr Pearson as to the state of Blindmouth Creek could hardly have failed to notice the risks to which she was exposing herself.

On the admittedly limited material that was put before me, I could make no criticism of Byron Shire in regard to this matter.

The *Main Arm Causeway* is a low lying crossing which carries Main Arm Road across *Blindmouth Creek* just before the road sweeps up towards the Main Arm village. Below the causeway, the creek eddies in a quite deep pool but, otherwise, makes a left hand curve and describes a semicircle, flowing under the Williams Bridge about 800 metres downstream, ultimately joining the Brunswick River.

Approached from the Mullumbimby side, the causeway is around a right hand corner and at the foot of a quite steep dip. The causeway is built of concrete and is quite narrow. Two cars would have trouble passing each other. At each entrance to the causeway there are two rigid plastic markers about a metre tall, one on either side of the road, each with a red reflective strip at the top. According to Mr. McAviney, about 12" of water passing over the causeway is the *"absolute maximum"* at which it would be safe to cross the causeway while the creek is in flood. Clive Pearson, a local resident, told the inquest that he would never drive across the causeway once the water level was half way up his wheels. Mr. McAviney thought one would need to keep one's wits about one crossing the causeway while water was flowing across it because the causeway is narrow, the edges drop steeply into the water, the force of the water can be very, very fast and strong and logs and other *debris* are often washed down during flooding.

Clive Pearson who has extensive experience with the Brunswick Valley Rescue Squad told the inquest that, on the night of 4/5 January 2008, the rain was *"very heavy."* He had crossed the creek at about 5.30pm when the water was already about 4" above the Main Arm Causeway and when, shortly after midnight, he returned in his *4WD* truck, he *"saw there was a lot of water over the causeway." "I drove about a foot and a half into the water"* he said *"but I couldn't go any further. It was too dangerous."* Mr. Pearson said that, by that stage, the water was *"roaring"* across the causeway and *"was about an inch and a half below the red reflectors on the top of the guideposts on the causeway… …I knew that I would not be able to drive my car any further."*

Matthew Evans who was helping out that night spoke of *"extremely bad weather"* on the night of 4/5 January 2008. He went to observe the crossing that night and said there was *"pitch black"* darkness and *"pouring… intense rain."*

Sometime after 11pm on 4 January 2008, Lisa Joy Rasmussen, a visitor from Canada

who was holidaying at The Pocket near Main Arm with Mike Grenby, a property owner, drove to the Main Arm causeway but decided that it was too dangerous to cross. She was alone in her car. While she was at the crossing, she heard a female who may or may not have been Cristy Moffitt crying *"Help, Help, Help."* It was dark and raining heavily and, in her statement, Ms. Rasmussen described it as *"the scariest scream that I have ever heard."* She wasn't sure what she should do so she drove up to where she had reception and telephoned Mr. Grenby on her mobile saying *"Mike, I have gone back to the crossing and I heard screams coming from the area around the crossing. Can you ring for help?"* Later, Mr. Grenby told her that he had telephoned for help and spoken to *"somebody in Sydney."* He told Ms. Rasmussen that the person he had telephoned had asked for her mobile number but he had replied that her battery was dying and that he should be the contact person.

Evidently it was sometime about 11.30pm when Cristy Moffitt reached the Main Arm causeway. Janet Mary Rapley was at her home at 871 Main Arm Road, Main Arm on a slight rise about 100 metres from the causeway and she told the inquest that, on that night, traffic continued to cross the creek until about 9.30 or 10pm when it had ceased. She thought that, by that time, the floodwaters were too deep. At about 11pm, she noticed there had been *"no let up"* in the rain. She was reading and she says it was about 11.30pm or perhaps 11.45 when she thought she heard screaming, which she took to be the little boy suffering from autism, who lives nearby. By this time, she says, the water over the causeway was *"really roaring"* and she knew the causeway was impassable and she described the scene as *"quite frightening."*

Meanwhile, significant flooding was taking place right across the district and at Tweed Heads Police station, then Probationary Constable Graham Holiday was busy, with Constable Jarrod Cutler, *"fielding telephone calls, counter inquiries and general correspondence."* At 11.20pm Mr. Holiday received a telephone call from *"John"* from the Murwillumbah *SES* who was enquiring about a woman said to be stranded in floodwater on the roof of her car. Mr. Holiday consulted the police *CAD* (computer aided dispatch) system that was already open and he provided the caller with a general location in the Murwillumbah area where he understood that woman might be.

Michael Drylie is a communications operator at *VKG*, the *NSW* police radio network. He is a civilian, highly experienced in his field and a former police officer of some 16 years. On the night of 4/5 January 2008, he was on duty at *VKG 3* at Newcastle, commencing shortly after 6pm. At about 10pm, he was allocated *Channel P*, which is the radio channel for the far north coast including the Richmond and Tweed/Byron Local Area Commands. Very detailed records are maintained at *VKG* so that Mr. Drylie was able to refresh his memory and be very precise regarding radio traffic, which passed through his hands on that night.

At 11.42pm on 4 January 2008, Mr. Drylie opened a job on the *CAD* system which he numbered *#030858*, regarding a phone call to *000* from a civilian who I think was Mr. Grenby, who was relaying a message he had received from a female friend, who I infer was Lisa Rasmussen.

Mr. Drylie's recollection of the matter was that the informant *"had received a phone call from a female friend who had heard someone screaming in the vicinity of the causeway at the intersection of Main Arm Road and Pocket Road, at Main Arm. The female was*

worried that someone had been washed away in the torrential rain. The informant also requested that the SES be contacted" and Mr. Drylie understood that *000* had contacted *SES* direct. Mr. Drylie broadcast that message over *VKG* at 11.43pm, which a police vehicle at Mullumbimby, namely *MUL20,* acknowledged at 11.44pm. At 11.52pm, *MUL20* reported, *"driven along Main Arm Road. Can't get to Pocket Road. Unable to continue due to flooding."* Mr. Drylie typed this information into the police *CAD* system.

At 11.57pm, Mr. Drylie broadcast another job, # *031028* for Murwillumbah police vehicle *MW18.* This job related to a female swept off the road that had managed to climb on to the roof of her car and was calling for help. The location was 5 to 6 kilometres along the Eungella Road, near Tyalgum Rd, Murwillumbah. *MW18* acknowledged at 11.58pm.

Michael Evans who is the owner of a towing business was in his truck tuned to *VKG* when he heard an alarm signal to the effect that *"a woman was stuck on the roof of her car in flood water."* Mr. Evans is unable to pin point the time other than to say that it was sometime after 11pm. The location provided was Tyalgum Road, Eungella and he went to see if he could be of assistance. When he arrived there, he was told the lady had been rescued and, in fact, he spoke to her and she told him that she had been stranded on the roof of her car and that she had been alone.
Once Mr. Evans saw that everyone was safe, he telephoned *MW18* and reported that the lady who had been stranded on the roof of a car was safe so that no further action would be necessary and he added that, at any event, the road was blocked by floodwater. Mr. Evans heard *MW18* broadcast a message to that effect.

Sometime shortly before midnight, according to Mr. Holiday, *"John"* from the Murwillumbah *SES* rang Tweed Heads Police once again and reported *"We found her and we rescued her off the car"* or something to that effect. It is now clear that he was referring to the *Murwillumbah job* rather than the *Mullumbimby job*, which related to Cristy Moffitt. So Mr. Holiday telephoned *MW18* to say *"John from SES just called and said the woman was OK"* and entered an update on to the *CAD* reading "**John from SES just called to say woman rescued (or woman Okay)**". He denies, however, that he was responsible for the update which at 12.06am found its way onto the *CAD* in job # 030858 reading *"Towies update woman has been saved by locals. No longer in danger. Confirmed only one person."*

Back at *VKG*, at 12.06 am Mr. Drylie *"received an update via the CAD system on the same Main Arm job, from police officer registered number 41237."* This is the identifier number allocated to Constable Jarrod Cutler, then of Tweed Heads Police but is by no means clear that he was the person who entered the update into the system.

Evidence emerged at the inquest that, due to the delays involved in logging on and off, police officers tend to use their particular identifier number to open the *CAD* system and then simply leave the system open, allowing other officers to make entries and add updates without the necessity of logging on and logging off. A downside of that practice, if it is a downside, is the difficulty in identifying just whom it was who may have made a particular entry. In the present instance, although Const. Cutler's identifier appears in connection with the update of 12.06am, he is quite clear that it was not he who made the entry. Mr. Cutler appeared to be very, very competent and careful and, when the inquest visited Byron police station to view the *CAD* system in operation, he demonstrated those qualities. Anybody can make a mistake in the course of a busy day but I would be inclined

to believe him when he told the inquest that he was not responsible for the update of 12.06am.

No police officer with access to the *CAD* screen terminal at Tweed Heads, which had been opened by Const. Cutler on 4 January 2008, has admitted entering the update of 12.06am regarding the rescue of a lady from the roof of a car into job # *030858.* Like Const. Cutler, Mr. Holiday is adamant that it was not he who made that entry. He was, he told the inquest, aware of two distinct jobs, namely the *"Mullumbimby job"* involving Cristy Moffitt and the *"Murwillumbah job"* involving the lady on the roof of the car and he did not confused them. Moreover, he told the inquest that it was his invariable practice, when making an update, to precede and follow his text with two asterisks so that his handiwork might be distinguished from that of others. No asterisk appears on the entry made at 12.06am. In # *030858.*

On the other hand, Mr. Holiday went on to describe two matters which went some way to confirming his own self-description as an *"amateur"* with regard to the *CAD* system as at 4 January, 2008. Firstly, he said that it was his practice, when entering an update, to place it at the head of the screen but Sgt. Thompson in charge of *VKG* at Newcastle and an expert in the operation of the *CAD* system told the inquest that there is no facility for altering the sequence by which updates appear on the screen and that they appear one after the other in the chronological order in which they are entered. Secondly, Mr. Holiday told the inquest that on the night of 4/5 January 2008, which he said, was a very busy night; he placed a number of jobs on the *CAD* system. Sgt. Thompson was good enough to examine records of all *CAD* entries at Tweed on that night and was recalled to tell the inquest that from 7 pm on 4 January until 7 am on 5 January, 2008, only one entry to the *CAD* system, namely the entry of 12.06am, had originated at Tweed Heads police station.

But at least seven officers may have had access to the *CAD* terminal at the relevant time and, as Mr. Biggins pointed out, I have heard from only two of them, namely Mr. Cutler and then Probationary Constable Graham Holiday. On that basis I could not possibly make a finding as to the ownership of that entry.

At any event, the update read, *"towies update woman has been saved by locals. No longer in danger. Confirmed only one person."* The information for this update seems to have originated from a tow truck driver, presumably Mr. Evans.

In point of fact, this information properly belonged to job # *031028,* dealing as it did with the Murwillumbah incident where a lady was saved from the roof of her car but mistakenly found its way into Cristy Moffitt's case, job # *030858*. A misled Mr. Drylie relayed the update to *MUL20,* which was dealing with the Mullumbimby incident and at 12.14am he completed job # *030858* by altering in the *CAD* entry from *"acknowledged"* to *"finished."* .

Mr. McAviney as head of the Mullumbimby *SES* was called out 12.12am on 5 January 2008 regarding *"a female who was screaming for help and may have washed from the causeway."* The locality was the Main Arm Causeway and he was asked, *"to get out there quickly."* So, with lights and sirens, he set out with three other members of the local Mullumbimby *SES* unit in two vehicles, one a 4WD vehicle, *"equipped with rescue equipment including life jackets, ropes throw bags and first aid kits."* When they arrived

at *Lessons*, they found floodwater across the road and they saw a fawn coloured vehicle, which had apparently been abandoned. Mr. McAviney and his companions assessed their chances of proceeding further and reckoned that they would not be able to do so and Mr. McAviney was aware that, even if they could successfully negotiate the flooding near *Leesons*, their 4 Km progress to Main Arm causeway would certainly be blocked by further areas of even more extensive flooding, particularly nearer Williams bridge. At this time, the *SES* crew were joined at *Leesons* by Sgt. Steward and another police officer that confirmed that the road to Main Arm was impassable. They considered an attempt by boat but concluded that such a crossing would be too dangerous and that, if they did manage to get across the flood waters at *Leesons*, they would still have to carry their boat about 4 kilometres towards Main Arm and then get across floodwaters near William's Bridge.

Mr. McAviney and his crew then attempted to get to Main Arm Causeway by going around to the north and attempting to drive through Billinudgel. They found *"the road was well and truly blocked off at Billinudgel and there was no way of getting through to the Main Arm village."* At about 4am, Mr. McAviney stood his crews down to get a couple of hours sleep because *"the creeks were still too high to get anywhere near the Main Arm village."*

Mrs. Rapley was disturbed shortly before midnight when a man named Shaun, dripping wet and dressed only in his underpants, knocked at her door to announce that *"There's a car in the creek with their lights on."* Together Mr. and Mrs. Rapley and Shaun walked down towards the creek and saw a white car with its lights still on, submerged up to the top of its doors about 20 or 30 metres down stream from the causeway. Nobody was in sight. They could get no closer to the car than about 15 or 20 metres, so deep and fast was the flowing water, and Mrs. Rapley returned to her house, phoned *000* and asked for both Police and the *SES "because the police car will not get through."*

At 12.49am on 5 January 2008, Mr. Drylie opened job # *031483.* This job had also come through *000* and related to a car with its lights on in the creek near 871 Main Arm Road, Main Arm. The informant had reported, *"hearing somebody screaming earlier."* It is clear that the informant in this instance was Mrs. Rapley.

She had not been sure an hour or so before when she first heard what she thought might have been a child screaming but now, after Shaun's visit and their sighting of Cristy Moffitt's motor vehicle in the creek, she was certain that a car had been washed off the causeway and the driver had cried out for help and, now, was nowhere to be seen. Mr. Drylie broadcast this job at about 12.50am.

At about 12.55am, it occurred to Mr. Drylie that job # 031483 (the job activated by Mrs. Rapley's phone call) and job # 030858 (the job prompted by Ms. Rasmussen and Mr. Grenby) referred to one and the same incident involving a female stuck in floodwaters on the Main Arm Causeway. But, as he understood it, the lady involved had been rescued by locals as notified to him at 12.06am, almost 50 minutes earlier. Prompted by the update bearing Const. Cutler's identifier, which he had received at about 12.06am, Mr. Drylie telephoned Mrs. Rapley *"to confirm her location in relation to The Pocket Road and also to confirm with her if it was the same vehicle from the earlier job (# 030858)."* Then, at 12.55am, he updated #031483 by adding the comment *"same job as earlier where a female was saved from the top of her vehicle and the vehicle was left at the causeway."* Mr. Drylie spoke to Ambulance Control to advise that an ambulance would

not be needed and was informed that, because of flooding, an ambulance was unable to get out to the causeway at any event.

Mrs. Rapley's take on this phone call is that *"someone from the police,"* who was obviously, Mr Drylie, telephoned her from *VKG* to reassure her *"We have word that a group of people have lifted a woman off the roof of her car."* Mrs. Rapley is *"pretty sure"* although not certain that the caller specified Main Arm. The lights on the car in the creek continued to burn until about 2.15am but Mrs. Rapley saw nobody there and, on the strength of the phone conversation with Mr. Drylie, she thought everything was *OK* and went to bed.

At about 12.59am, Mr. Drylie opened yet another job, # 031558, on the *CAD* system to properly record Mrs. Rapley's involvement and to note that "*Informant's husband has checked the car – and there was no one inside but they are concerned now that they may be in the water*." This updated information was promptly broadcast to *MUL20* but, at 1.04am, the job was *"linked as child of # 031483*."

The practical effect of this confusion was as follows. Firstly, job # 030858 had been opened at 11.42pm as a result of urgent information supplied by Ms. Rasmussen and Mr. Grenby but by 12.06am, 24 minutes later, much of the urgency had gone out of it because the *CAD* system was showing that the lady we now know to have been Cristy Moffitt, had been rescued. Secondly, by 12.55am on 5 January 2005, job # *031483,* opened only six minutes earlier, had been characterised as the same job so that no further rescue effort was required. Thirdly, by 1.04am, job # 031558, opened at 1.01am, had been linked to the earlier incidents. Thus, for most of the night, there was confusion on the *CAD* system as to whether Cristy Moffitt remained at risk or was in need of rescue.

It is important, however, to recognise that any confusion appearing on the *CAD* system played no part in the sad loss of Cristy Moffitt. Indeed, the *SES* team knew nothing of any confusion and was entirely unaffected by it until next morning, long after the flood waters at Blindmouth Creek had abated and, obviously, long after Ms. Moffitt had perished. The evidence is that Cristy Moffitt's difficulties were first notified to police at about 11.42pm when job # *030858* was opened and it is clear that neither police nor *SES* were able to reach the Main Arm Crossing from at least the time when Mr. McAviney and his team were stopped at *Leesons,* until about 7 next morning. Indeed, Mrs. Rapley's evidence is that the road was impassable from about 9 or 9.30pm. From the time Cristy's difficulties became known to the authorities, the evidence shows strenuous efforts of both *SES* and police to reach the Main Arm crossing whether by way of Main Arm Road or north through Billinudgel and it appears that flying conditions were such that helicopter assistance subsequently provided by the Rural Fire Service was not viable. It is not clear that any confusion appearing on the *CAD* system played any part at all in reducing the efforts of police and, certainly, it played no part in reducing the efforts of the *SES* to come to Ms. Moffitt's aid.

The *SES* team had enjoyed only about two hours break when, at about 6am on 5 January, Mr. McAviney put a team of nine together to search the Main Arm area and, by that stage, the flood waters had receded considerably as he had predicted they would and the *SES* team was able to reach the Main Arm Causeway at about 7am. There was still about 8" of water flowing across it but cars were passing over it, albeit with caution. Mr. McAviney saw what turned out to be Cristy Moffitt's motor vehicle *"about ten metres*

from the causeway in an upright position and facing west. It appeared as though water had gone right through it." There was no sign of Cristy.

At about 7.15am *SES* officers came to Mrs Rapley's house and she told them everything that had happened the night before including details of the message she had received from Mr. Drylie. The *SES* officers said *"That's good because we have got an open case here with the car in the creek and nobody's heard about the person who was in the car."* In his statement, Mr. McAviney says that, by that stage, *"We were hearing rumours from different sources that the persons had got out of the vehicle."*

Sometime later, Mr. McAviney met police officers near the crossing and Sgt. Steward told him that *"he believed she had got out of the vehicle."* Accordingly, the search was called off at about 10.34am. This was the first time that Mr. McAviney had received confirmation from police that Cristy Moffitt (whom he did not yet recognise by name) had been saved and, up until that time, he had proceeded on the basis that she was in danger and urgently required rescue or, perhaps, that she had already been lost.

In the sadly unsuccessful attempts to assist Cristy Moffitt, the work of the *SES* was particularly impressive. Most of the *SES* officers, including Mr. McAviney, are volunteers who make themselves available at all hours of the day or night and often put themselves at risk to assist fellow members of the community who are in trouble.

Their unselfish service to the community, the effort which they put into locating Cristy Moffitt and coming to her aid, though unsuccessful, and the extent of their local knowledge were remarkable.

Mr. Harvey of Counsel for the NSW State Emergency Service submitted that there should be a coronial recommendation regarding the operation of the *CAD* system and the procedure for the recording of information on that system by various police officers. He is concerned that the insertion of the update of 12.06am into job # *030858* might in other circumstances have had disastrous consequences. While I think the matter is of concern and merits the consideration of senior police, I think that this inquest is not the appropriate vehicle for such a coronial recommendation. Mr Clarke reminded me that this was a rare and uncommon situation of two very similar and simultaneous incidents in neighbouring areas. It is clear that any confusion, which may have arisen, played no part in Cristy Moffitt's death and the evidence does not allow me to say how mistake arose. Furthermore, in the absence of more detailed technical evidence and advice regarding the complexities of *CAD* system, I am ill equipped to trespass there.

Mr. Harvey made a further submission that I should recommend more and/or better public education programmes regarding the risks posed by flash floods with particular emphasis on risks not just to property but also to human life. I have considered that submission in the context that, on the evidence before me, there was no other loss of human life as a result of the wide spread flooding in northern New South Wales in the December, 2007/January, 2008 period and in light of the *2008 NSW Drowning Report* of *Royal Life Saving NSW* which encouragingly demonstrated that, in the 12 months ending on 30 June, 2008, 97 persons in this state lost their lives as a result of drowning – a 12% reduction in the previous year's figure and 7% below the 5 year average. Of those fatalities, drowning due to driving during floods represented only a tiny proportion of the fatalities. I am unable to say that there is inadequate public education in this area or that fatalities would be further reduced if public education were to be increased.

On Wednesday 9 January 2008 Sgt. Bradley James Stewart was in charge of the recovery of the white Toyota *Camry* motor vehicle *264BZH* (QLD) from Main Arm Creek. Obviously the car had been seen by a large number of people, beginning with Mr. and Mrs. Rapley and their visitor, Shaun, in the early hours of 5 January.

Wayne Gordon Hyland, a local resident, noticed the car on Sunday 6 January when he was driving across the Main Arm Causeway. He recognised the car as belonging to Cristy Moffitt who was an acquaintance of his. Mr. Hyland got out of his own car to have a look and observed the motor vehicle *"resting against the river bank, on its wheels, with the front of the car almost facing the Pocket Road."*

He could not see the number plate but he could see house cleaning equipment carried in the back of the vehicle (Cristy Moffitt was a cleaner) and he saw a large black wallet which he recognised as belonging to Cristy sitting on the driver's seat.

Subsequently, he handed that wallet to Police and it was found to contain a driver's licence in the name of *Cristy Joanne Moffitt (dob 14 Feb., 1971).*

Sometime later Sgt. Stewart commanded a search for the body of Cristy Moffitt. In this regard he had the assistance of various police officers, *SES* officers co-ordinated by Mr. McAviney, the Rural Fire Service and others. At about 11.20am the *RFS* helicopter crew located a body face down over a semi-submerged wooden stump within Main Arm Creek about 20 metres south of the Williams Bridge. Sgt. Steward inspected the body and noticed that the body was wearing a gold coloured bracelet bearing the word *"Cristy"* and saw that the body fitted the physical description of Cristy Moffitt as it had been given to him. The body was placed in a body bag by Senior Sergeant Paine and members of the Brunswick Valley Rescue Association and Mr. Stewart tagged the body bag # *00049315*. The body was then conveyed to the mortuary at Lismore Base Hospital and subsequently to Newcastle.

David Charles Wright, dental practitioner, examined the body at the Department of Forensic Medicine of John Hunter Hospital, compared his findings with dental records of Cristy Moffitt and, as his certificate of 14 January, 2008 indicates, noted that *"there are identical dental markers in all dental quadrants …"* which he concluded furnished significant evidence indicating that the body he examined was that of Cristy Moffitt.

As to cause of death, an autopsy was conducted by Dr. Kevin Andrew Patrick Lee, Senior Specialist Forensic Pathologist at the Department of Forensic Medicine, Newcastle on 11 January 2008. Dr. Lee's report is contained in the brief. He found her cause of death to be *"consistent with drowning."* Dr. Lee found tablet granules in the airways, the stomach and the first part of the small bowel which he saw as *"consistent with a capsule containing these granules having been swallowed a short time before death."* He went on to explain that *"material of this nature is usually only present in the stomach for an hour or two after consumption, except in the instance of a significant meal having been consumed, of which there was no evidence."*

The Certificate of Analysis of the Division of Analytical Laboratories dated 20 March 2008 shows stomach contents of *Codeine*, 0.1mg/kg and *Morphine* 0.6mg/kg. *Diazepam, Ibuprofen, Sertraline* and *Vanlafaxine* were all detected.

It is clear, thought, that, sometime shortly before her death and while she had been drinking or was still affected by alcohol, Cristy Moffitt ingested a quantity of medication, some prescribed and some, perhaps, not.

The origin of Sertraline is not clear. According to his report, Sertraline is not one of the medications prescribed by Dr. Devine. Dr. Perl suggested that perhaps Cristy Moffitt's medication had recently been changed and that *Sertraline* was in the course of being replaced by *Effexor*. If that were the case, Dr. Perl speculated that Ms. Moffitt might have been maintained on *Sertraline* until the therapeutic effect of *Effexor* asserted itself.

We simply do not know how long she had been on the regime of medication described by Dr. Devine. Perhaps she had saved up some *Sertraline* or perhaps somebody had given her some.

Dr. Perl noted that no blood tests had been possible but her view is that, although they were probably taken in low doses, both *MS Contin* and *Valium* can impair ability to drive and both will interact with alcohol to heighten that effect.

Formal Finding

That CRISTY JOANNE MOFFITT who was born on 14 February 1971, drowned very late on 4th or in the early hours of 5th January 2008 in Blindmouth Creek near Mullumbimby, NSW when the creek was in flood and the motor vehicle she was driving was washed off the Main Arm Causeway.

6. 418 of 2008 Name suppressed non-publication order

Inquest into the death AA at St Leonards on the 12th March 2008. Finding handed down by Deputy State Coroner MacMahon on the 18th October 2010

Order made pursuant to Section 75(6), Coroners Act 2009:

A report of the proceedings and Findings may be published however the publication of the name of the deceased and of any evidence that could identify him or any member of his family is prohibited.

Introduction:

AA lived and undertook his schooling in the northern suburbs of Sydney. AA was one of three children in the family. His family was a close one and he was loved and supported by his mother and father.

When he was in his final year of primary school AA was diagnosed as suffering from epilepsy. He was treated with medication and although he suffered a number of fits the condition appears to have been well managed.

AA did not enjoy school or academic work and, in the early part of his year 10 studies, left school. At about the same time he, and a number of his school friends, began

experimenting with the use of cannabis.

Following him leaving school AA undertook a number of casual jobs and also commenced a course at TAFE. The jobs AA undertook did not last for very long and eventually he also withdrew from the TAFE course.

Although as a young boy he had been close to his siblings, as he grew older he grew apart from them. Eventually they left home and established their own lives. AA however continued to reside with his parents but over time reduced his had interaction with them eventually placing a lock on his bedroom door to prevent them accessing his room. At times he also left his room through the window.

By 2007 AA parents had became concerned about his introversion and considered seeking professional mental health assistance for him. They thought his behaviour might have required treatment. After some discussion they however decided not take any action. They did not think AA would accept any assistance and they considered that it was better for him to be at home, where they could remain in contact and keep an eye on him, than for them to do anything that might have resulted in him leaving home.

On 10 March 2008, at about midmorning, AA came out of his room, had a short conversation with his mother and then left the house.

At about 12.30pm Mr Michael Hanna observed a person in an ally-way next to Eastwood Mall. Mr Hanna became suspicious. The person was unusually dressed for a hot day and appeared to have a *"hard implement under his jacket"* The person was also very close to a number of banks. Mr Hanna tried to alert staff at the Westpac Bank but was unsuccessful so he rode his bicycle to the Eastwood Police Station and reported his suspicions to the counter officer, Constable Lewis. Constable Lewis subsequently asked Sergeants' Glen Stirton and Peter Stenz, who were leaving Eastwood Police Station at the time to get their lunch, to investigate.

At about the same time Scene of Crime Officer (SOCO) Powell was in the Eastwood Mall. She observed a person she considered was acting suspiciously. She also phoned the Eastwood Police Station to report her concerns.

On arriving at the Eastwood Mall and undertaking an initial search Officers Stirton and Stenz could not locate the person described by Mr Hanna and SOCO Powell. They then purchased their lunch.

Whilst returning to the police station however they observed a person who matched the description that they had been given. That person was subsequently identified as being AA.

AA made eye contact with the officers and then left the Eastwood Mall. Officers Stirton and Stenz followed him into Hillview Lane. AA was asked to stop. He, however, responded by drawing a pistol from his jumper and entered an area behind the Eastwood shops.

Subsequently both AA and the officers fired shots and AA sustained gunshot wounds. AA was taken by ambulance to Royal North Shore Hospital (RNS Hospital) where he

underwent emergency surgery under the care of Dr Timothy Siu, a Neurosurgeon. Unfortunately that surgery was not successful and AA died on 12 March 2008.

Jurisdiction and function of the Coroner

Section 81(1), Coroners Act 2009 (the Act) sets out the primary function of the Coroner. That section provides, in summary, that at the conclusion of an Inquest the Coroner is required to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

Section 82 of the Act provides that a Coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths. It is not the role of the Coroner to attribute blame.

In addition Section 27 (1) (b) provides that where a person dies *as a result of, or in the course of, a police operation* an inquest must be conducted while Sections 22 and 23 require that, in such cases, either the State Coroner, or a Deputy State Coroner, must conduct the inquest.

Section 75 is also relevant to these proceedings. Subsection 5 of that section provides that if a Finding is made at an inquest that the death of a person was self-inflicted a report of the proceedings (or any part of the proceedings) must not be published unless (and to the extent that) the coroner holding an inquest makes an order permitting the publication of the report. Subsection 6 of the same section allows a coroner to permit the publication of a report in such situations where the coroner is of the opinion that it is in the public interest to do so.

Coronial Issues.

The identity of AA, the date and place of his death and the direct cause thereof were never in any doubt. What needed to be explored, and if possible a determination made, if the evidence allowed, was what happened following him being challenged by Officers Stirton and Stenz, who fired the shot that resulted in his death, and what was AA's intention in being in Eastwood Mall on 10 March 2008? These matters also raised issues concerning compliance by the officers with the relevant NSW Police Force policies and procedures and the circumstances in which AA had possession of a pistol and the subsequent investigation of the death by police.

What happened on 10 March 2008?

As already noted Officers Stirton and Stenz had responded to the concerns reported by Mr Hanna and SOCO Powell. Having been initially unsuccessful in trying to locate the man described by Mr Hanna and SOCO Powell they then observed him as they were returning to the Police station having purchased their lunch. They followed AA into Hillview Lane, Eastwood and called on him to stop. AA did not do so.

He then began to run and drew a pistol from his clothing. The inquest had the benefit of viewing CCTV footage that recorded some of these events as well as being able to hear the police radio recordings.

Officer Stenz gave evidence that he observed the gun drawn by AA, warned Officer Stirton and then drew his own pistol. Both Officers Stenz and Stirton gave evidence, confirmed by the CCTV footage and the contemporaneous VKG recording that very soon after this AA commenced firing on both officers from the driveway that he had entered. Both officers returned fire. The VKG records have Officer Stirton directing AA put his gun down. He failed to do this.

Officer Stirton's evidence was that he then saw AA holding his pistol to the right hand side of his head and shortly thereafter heard a single shot. Officer Stirton is heard on police radio to say; *" he's shot himself in the head."*

The whole incident took very little time. The time from Officer Stirton's "urgent" call to VKG to the last recorded shot is estimated to be less than sixty seconds.

In addition to receiving the evidence of Mr Hanna, SOCO Powell, Officers Stenz and Stirton I also had the assistance of the evidence of Johnnie Eid and David Armstrong. These men were working in a fruit shop with two others when they heard loud bangs that were followed by projectiles coming through the roller doors that separated the shop from Hillview Lane. In addition Mr Eid, from his position, was also able to observe Officers Stenz and Stirton in the laneway.

Having regard to the available evidence including that of the officers involved, the CCTV and VKG recordings and that of the independent witnesses I am satisfied that Officers Stirton and Stenz were fired on by AA and that each officer returned fire in defence of himself and each other.

Was AA death self-inflicted?

Following the incident the location was declared a crime scene. Crime scene officers undertook an examination of the site and Mr Potegeiter, a ballistic expert, also undertook an examination of the available evidence and prepared a report. Following AA death a forensic pathologist Dr Szentemariay performed an autopsy. Mr Potegeiter and Dr Szentemariay each gave evidence at inquest.

Mr Potegeiter' evidence was that the ammunition fired from the pistols of the two police officers was what is known as *"hollow point ammunition."* That fired from the pistol in the possession of AA, as well as that subsequently found on his person and in his motor vehicle, was what is known as *"full metal jacketed ammunition."*

Dr Szentemariay's evidence was that AA died as a result of a gunshot wound to the head and that the wound characteristics he observed at autopsy were of a close contact wound. The entry wound was star shaped.

The shape of the exit wound, and the CT reconstruction, were such as to allow Dr Szentemariay to express the opinion that the gunshot wound to AA's head was consistent with an injury that would be inflicted by a *full metal jacketed bullet.*

Dr Szentemariay also gave evidence that during the course of his examination he found no other injuries or conditions other than the wound to his head that could have resulted in AA's death.

The evidence of Dr Szentemariay corroborates the evidence of Officer Stirton when he said that he observed AA putting his gun to his head and his subsequent report to VKG that *"he's shot himself."*

Having regard to the available evidence I am satisfied that AA died as a result of a gunshot wound to his head that was self-inflicted.

Did Officers Stirton and Stenz act appropriately?

Where a person dies in the course of a police operation it is mandatory for an inquest to be conducted. One of the matters to be examined during the course of the inquest is the conduct of the police involved. This is necessary in order to ensure that the public can have confidence in the actions of police and that the officers involved are not subjected allegations that are unfounded.

Police policy and procedures provide, in summary, that an officer is only to use a firearm when it is necessary for the purpose of protecting himself or herself, or a member of the public, from death or serious injury.

As I have already indicated the time during which the interaction between the police and AA occurred was very short. I am satisfied that the evidence establishes AA drew the pistol that he had been carrying and shortly thereafter fired towards Officers Stirton and Stenz. I am also satisfied that the officers' use of their firearm in the circumstances was appropriate. The circumstances faced by officers Stirton and Stenz was life threatening. In addition I am also satisfied that the evidence establishes that none of the shots fired by either officer contributed to the cause of AA's death.

What was AA's Intention on 10 March 2008?

This is, of course, a matter of some speculation. We do not have anything from AA as to his intentions. We may, however, be able to draw inferences from AA's actions.

Det Sgt Andrew Marks, a member of the Homicide Squad who was the officer in charge of the investigation into the shooting that resulted in AA's death, was of the opinion that:

"AA was loitering at the Eastwood Mall, gathering the courage to discharge the firearm at numerous persons, with the intention of killing those persons. I don't believe that AA had a specific target, and that any killing would have been random."

Detective Inspector Russell Oxford, who was the commissioned officer who reviewed the evidence, was of a similar view. He said that:
"There is no doubt that AA had specific intentions on Monday 10th March 2008 in the Eastwood Shopping Centre. I believe he intended to kill people that day and then to seek a confrontation with Police in which he intended to be involved in a fatal shooting."

Trying to determine what AA's intentions were on 10 March 2008, if possible, is important, as it will set the background to a later discussion in these findings that deal with the possession of a firearm by AA.

I have already mentioned that over time AA withdrew from his family and other work, education and other social environments. He became very isolated and secretive, as is evidenced by his locking of his room in order to prevent his parents from entering and then leaving his room through the window. It is hard not to conclude, as his parents did, that he was experiencing some form of mental health issues. When his actions are looked at in retrospect it would seem that these issues were becoming worse over time.

I have had the assistance of the evidence of Dr Neillsen's case studies of homicide, self-inflicted harm and the link with the onset or first episode of psychosis. It is well known that persons who suffer from schizophrenia, if not receiving treatment, suffer from a number of persistent symptoms including:

Confused thinking. When acutely ill, people with psychotic symptoms experience disordered thinking. The everyday thoughts that let us live our daily lives become confused and don't joint up properly.

Delusions. A delusion is a false belief held by a person that is not held by others of the same cultural background.

Hallucinations. A person sees, hears, smells or tastes something that is actually not there. The hallucination is often of disembodied voices that no one else can hear. Sometimes those voices are telling the individual that other people bear them ill will or are seeking to harm them.

Low motivation and changed feelings.

AA was a young man who had had no previous altercations with the law. He grew up in a loving and supportive family environment. There were no indications in his background that would suggest that, if he were mentally well, he would be likely to want to undertake a mass killing of innocent bystanders as was suggested by Det Sgt Marks and Inspector Oxford.

On 10 March 2008, however, AA attended Eastwood Mall with a firearm and large amount of ammunition. In the laneway he was in possession of 6 full magazines of ammunition (60 projectiles). In addition there was found in his car another 6 full magazines of ammunition (60 projectiles), a reloader and boxes full of ammunition. He had a veritable war chest. One can only imagine what was going through his mind when he assembled this collection.

Having regard to AA's history, his actions on the day as observed by Mr Hanna and SOCO Powell, the possession of firearms and ammunition and the research undertaken by Dr Neillsen I am satisfied that it is more likely than not AA, when he was in Eastwood Mall, was experiencing a psychotic episode and that he was acting out of a delusion or hallucination. What he could or would have done in Eastwood Mall is open to speculation however the situation was one of very great danger in which the lives of the many people present were at considerable risk.

That risk resulted from AA's ability to access firearms and ammunition. This raises the question of how he came to have such access.

How did AA have Access a Firearm?

All persons in New South Wales, who are considered to be fit and proper, are entitled to have access to and possession of a firearm. Such access to and possession of a firearm is regulated by the Firearms Act 1996. One of the underlying principles of that Act contained in Section 3 thereof is that:

" Firearm possession and use (is a) privilege that is conditional on the overriding need to ensure public safety."

The objects of the Act set out in the same Section include:

"To require each person who possesses or uses a firearm under the authority of a licence to prove genuine reasons for possession or using of firearms, and
To ensure that firearms are stored and conveyed in a safe and secure manner."

AA obtained the firearm that he used on 10 March 2008 in accordance with the procedures that are established by the Firearms Act 1996. The short history of him doing so is as follows.

On 8 August 2006 he applied for membership of the St Mary's Pistol Club as a trainee. His application required two referees. AA's mother and father were his referees. The referees were not required to answer any questions concerning the applicant. AA's father, in his evidence, said that although he was not personally happy about the use of firearms he supported AA's application because he was involving himself in a social activity that he thought must, of itself, be a good thing.

As part of his membership application AA was required to answer a number of questions. Relevantly in the answers to such questions he stated that "*he had not, in the last 10 years, been referred for or treated for a mental or nervous disorder and that he did not suffer from any mental disability that may affect him in the control of a firearm".* He also consented to the Club undertaking a police check.

The St Mary's Pistol Club operates out of a location at which members and other persons undertake shooting activities as a sport. Such activities include education, competition, sales and the storage of firearms. There are a number of entities involved. They include the Sporting Shooters Association of Australia (NSW) Sydney Branch Inc and the SSAA St Mary's Pistol Club. Notwithstanding there are a number of entities involved in these Findings I propose to refer to the various activities as being activities of "the Club" whether or not that be the case as a matter of law.

Following his joining the Club AA undertook pistol training on 2 and 3 September 2006 and was assessed as competent.

On 5 September 2006 he completed an application for a Personal Firearms Licence. In this application he was once again required to answer a number of questions including

"*whether or not he had, in the last 10 years, been referred for or treated for a mental or nervous disorder"* which, as previously, he denied. His application was witnesses by his mother.

On 14 October 2006 a probationary pistol licence was granted.

On 17 May 2007 AA hired a locker at the Club in which to store a firearm.

On 1 June 2007 AA completed an Application to Acquire a Handgun and nominated the Club as the place that the gun would be kept safe. The application was approved and a permit granted. It is of note that AA had previously spoken to his father about having a firearm stored at home and his father had refused.

On 26 July 2007 AA ordered a "Glock 34" handgun through Safari Firearms.

He took possession of the gun on 2 August 2007.

Between 11 August 2006 and 26 November 2007 AA engaged, on a regular basis, in various sports shooting activities at the Club.

The probationary pistol licence granted on 14 October 2006 was to expire on 7 December 2007.

On 29 October 2007 AA completed an Application for the renewal the Personal Firearms Licence. The Firearms Registry sent a photograph advice to AA on 15 December 2007. For him to have his licence renewed it was necessary for him to attend the RTA. AA did not do this in the prescribed time or indeed at all. His licence therefore expired on 7 December 2007.

AA was not authorised to have possession of a firearm on 10 March 2008. The "Glock 34" was, however, on that date registered to him. As far as the Firearms Registry was concerned the firearm was located in the lockers at the Club. The evidence at inquest was that no action had been taken by the Registry to ensure that AA surrendered the pistol prior to 10 March 2008.

The above history gave rise to a number of matters that were investigated at inquest.

Those matters were:

- Was the assessment process undertaken by the Firearms Registry prior to AA being granted a licence to purchase a firearm appropriate?

- When AA did not renew his licence why was no action taken to ensure that the firearm was surrendered prior to 10 March 2008?

- Where was the firearm located between 7 December 2007 and 10 March 2008?

As the Club's lockers was the official location of the firearm did the Club have an obligation to be aware of what firearms were stored on its premises and to take action to locate and arrange the surrender of the firearm once AA ceased to be licensed?

I have outlined above the assessment process that occurred prior to AA being granted a firearms licence. For the most part AA appears to have answered the questions asked of him truthfully as he understood them. He had not, in the previous 10 years, "*been referred for or treated for a mental or nervous disorder."* At that stage, however, he would probably not have understood that he may have been *"suffering from any mental disability that may affect him in the control of a firearm."* Many people who are suffering from a mental illness do not necessarily understand that they are and indeed that lack of understanding or denial of the illness can be a symptom of the mental illness.

In the circumstances of this case, having regard to AA's life situation and actions, as we now know them, it would be reasonable to conclude that his mental health was beginning to decompensate during 2007. Had he undergone a mental health assessment the difficulties that he was to later suffer may have been identified and he may have received appropriate treatment. The assessment process for the granting of a firearms licence was not designed to identify persons who have undiagnosed mental health issues that may, in future, affect their suitability for the holding of a firearms licence.

As previously indicated it is one of the objects of the Firearms Act 1996 that:
" Firearm possession and use (is a) privilege that is conditional on the overriding need to ensure public safety."

It is not in the interest of public safety that a person who has an undiagnosed mental health condition that may affect their suitability for the possession of a firearm be granted a licence to do so. The assessment process should, to the extent that it is possible, seek to ensure that such persons are identified.

Whilst it is noted that since these events the *"Application for a Personal Firearms Licence"* has been amended. The amendments do not, however, ask any questions that would put the Firearms Registry on notice as to any potential problems.

Having undertaken a number of inquests that have involved mental health issues I am able to take judicial notice of the fact that mental health is a growing issue in society, and that a great deal of general duties policing is occupied by incidents in which mental health is a factor.

The Parliament has stated that the ability to possess of a firearm is a privilege. Society, in such circumstances, has a right to expect that persons granted such a privilege are suitable. Ensuring that an applicant does not suffer from an undiagnosed mental health condition that might affect their suitability to possess a firearm is what the community would expect prior to the granting of a licence. I propose to make a recommendation to this effect in accordance with Section 82, Coroners Act 2009.

The Firearms Registry:

The evidence is that when AA did not renew his licence no action was taken to ensure that he surrendered the firearm that was registered to him. On 15 December 2007 the Firearms registry sent him a photograph advice. He was then required to attend the RTA to produce the appropriate documentation, establish his identity, pay the prescribe fee and receive his licence. He was required to do this by 23 February 2008. Had he done so he would have been licensed on 10 March 2008?

When he did not do so his license was revoked and the revocation was effective from 7 December 2007. The time that police had to seek to arrange the surrender of the firearm was thus some seventeen days. Although the evidence is that no action was taken in that time no criticism of the Firearms Registry is warranted having regard to the short period involved.

During the course of the inquest Det Sgt Peter Hill, Crime Co-ordinator St Mary's Police Station, who was responsible for the Licensing Section for Liquor and Firearms, gave evidence. Officer Hill's evidence dealt with the resources available to the St Mary's Police Station for the supervision of firearms licensing. Without going into the detail the effect of other policing demands at the relevant time was that very little resources were available and that even if the Firearms Registry had, after 23 February 2008, requested action by St Mary's Police to arrange the surrender of AA's firearm it would have been unlikely that the resources would have been available to take such action.

I do not, however, consider that the practices and procedures of the Firearms Registry in this regard contributed in any material way to the events on 8 March 2008 or that any recommendations in accordance with Section 82 are appropriate.

Likewise I do not consider that the lack of police resources at the St Mary's Police Station at the relevant time contributed to the circumstances of AA's death. That resource issue is therefore a matter for the Commissioner of Police to note and attend to. It is not a matter that should be the subject of a recommendation pursuant to Section 82.

Where was the "Glock 34"?

The location of AA's firearm at relevant times was one that was examined during the course of the inquest. Its official location was at the Club. The Firearms Act obligation to safely secure and store the firearm is one that rests on the registered holder of the firearm. It can be stored at any location that meets the requirements of the Act. The Club provides such a location. The Club does not, however, have access to the lockers once they have been rented to gun holders. It thus does not have any knowledge as to whether or not a firearm that is said to be located in its facilities is, in fact, located there.

In this case the evidence shows that AA did not engage in any activities at the Club after 26 November 2007. Sometime between then and 10 March 2008 he removed the firearm. There is no evidence available to determine when he did so. He may well have been carrying it with him, or storing it at this home without the knowledge of his parents, for some three months.

These circumstances gave rise to a large number of suggested recommendations by various witnesses. I do not propose to record, or respond, to each of the various suggestions. The power to make recommendations pursuant to Section 82 is one that is constrained by the need for the recommendation to be one that is "connected with the death" with which the inquest is dealing. In this case however the fact that there was no ability to confirm that the firearm registered to AA was in fact located in the place that it was meant to be is, in my opinion, one that is connected with the death.

It is recognised that the legislative obligation to safely store and secure a firearm rests on the licence holder. Where a location is, however, provided on a commercial basis for the

storing of firearms and that location is the registered address of the firearm it would not be unreasonable for the community to expect that the storage location would be aware what firearms were located on its premises.

It was suggested during the inquest that for such an obligation to be imposed would be inappropriate having regard to the legislative scheme. I disagree. The provision of storage lockers is a commercial activity. Knowledge of what is in the lockers does not take away from the obligation placed on the licence holder to safely secure and store the firearm.

I propose to recommend that organisations that provide storage for firearms maintain a register of what firearms are located on their premises and, if taken from the storage facility, the dates or removal and, where appropriate, return of the firearm. I propose, in addition, to recommend that the facility operator confirm, each time a firearm is removed from a storage facility, the currency of a firearms licence.

The Police Investigation!

Following a death in a police operation the circumstances in which the death occurs is examined closely. This is done under the direction of the Coroner and in accordance with the *"Guidelines for the Management and Investigation of Critical Incidents"* of the Commissioner of Police.

The objective of such an investigation is, among other things, to ensure that it is timely and that the best evidence as to the circumstances is gathered in a manner that ensures that such evidence is not contaminated by extraneous sources.

The Guidelines also have procedures that seek to ensure that relevant police protocols or procedures were followed by police officers involved in the incident. The officers who undertake such investigations must be officers from a Police Command other than that of the officers involved. The investigation is also to be reviewed by an independent commissioned officer.

I do not propose to examine each of the requirements of the Guidelines and relate them to the relevant parts of the investigation conducted in this case as, for the most part, I am satisfied that the Guidelines were complied with. There were, however, a number of matters relating to the investigation that were raised during the course of the inquest concerning compliance with the Guidelines that I do need to consider.

Those matters were:

- Mandatory testing of involved officers,
- Separation of officers and witnesses so as to ensure that evidence of such officers and witnesses is not contaminated either deliberately or by misadventure, and
- The decision not to undertake an electronically recorded interview of the involved officers.

With regard to the first two matters raised Counsel Assisting has suggested that possible non-compliance with the Guidelines occurred during the course of the investigation when:

Officers Stirton and Stenz, the involved officers, were questioned together at the scene,

A relevant Appointment Belt was taken to the Police Station in the same car as the involved officers,

The involved officers travelled to the police station in the same vehicle,

The involved officers were questioned together at the police station,

There was a delay in arranging mandatory drug and alcohol testing such delay raising the possibility of questions as to the integrity of the relevant samples.

As Counsel Assisting noted there is no evidence to suggest that the investigation into this critical incident was in any way compromised by any of these matters and there was also no doubt that the involved officers acted appropriately throughout the incident. The Guidelines are, however, designed to protect the interests of both the public and the involved officers and as such should be adhered to as closely as possible in order to endure that there is no doubt as to the integrity of the investigation.

The final aspect of the investigation that was raised by Counsel Assisting was the decision as to whether or not to take evidence from the involved officers by way of electronically recorded interview or by way of statement. It was acknowledged that there are competing arguments for each procedure and different views held by different senior police officers. How it is done in any particular incident is, in fact, left to the discretion of the officer in charge of the relevant critical incident team.

Whilst there was no suggestion that it occurred in this case it was suggested by Counsel Assisting that this discretion is a lack of clarity in the Guidelines that could result in favouritism and thus harm the integrity of the process of the investigation. Counsel Assisting suggested that a recommendation be made that the discretion be removed and all involved officers in the future should be interviewed electronically.

This is an issue of considerable complexity. In this particular case both Officers Stirton and Stenz made written statements that were available to the inquest and shortly thereafter participated in video recorded walkthroughs that were also available to the inquest. The video recorder walkthrough is in fact, in many ways, a very effective electronically recorded interview. However, as Counsel Assisting acknowledged, there was no suggestion that the taking of a statement in lieu of an electronically recorded interview resulted in of any lack of integrity in the investigation in this case.

Counsel Assisting may be correct when she suggests that the availability of discretion in this regard opens the process to favouritism. That did not however occur in this case. A problem not having arisen in this case I do not consider it is appropriate for me to recommend a change in the current procedure.

Retention of Evidence:

Dr Timothy Siu, the neurosurgeon who operated on AA at RNS Hospital, gave evidence that large bone flaps from AA's skull were discarded in the biological waste bin following that surgery. He said that he understood that disposal was the usual practice. Dr Istvan Szentmariay, the forensic pathologist who performed the autopsy on AA, gave evidence that the disposal of the bone flaps was highly unusual and that their availability would have been of assistance to him in the undertaking of his post mortem examination.

Neither the RNS Hospital nor the Northern Sydney and Central Coast Area Health Service (NSCCAHS), of which the Hospital forms part, were a party to the inquest. It is important that all relevant evidence relating to coronial matters be retained. I accept Dr Szentmariay's evidence that the retention of the bone flaps that were removed during surgery was important evidence and thus should be retained.

As neither RNSH nor NSCCAHS were parties to the inquest I do not consider it appropriate to make a recommendation in accordance with Section 82 relating to this matter. I do, however, propose to ask the Registrar of the State Coroners Court to write to the Chief Executive Officer, RNS Hospital to reinforce the need to ensure the retention and transfer, to the Department of Forensic Medicine, of all evidence, including biological material, that is relevant to coronial investigations.

Coroners Act 2009, Section 75.

As already indicated Section 75(5) prohibits the publication of a report of an inquest where a finding is made that a death was self-inflicted unless the Coroner makes an order allowing such publication. Such an order may be made if the Coroner is of the opinion that it is in the public interest to do so.

In this case AA's death was self-inflicted. It, however, occurred during the course of a police operation. There are thus the competing interests of the family's right of privacy in the tragedy that accompanies suicide and the communities right to be able to be satisfied that the actions of police are appropriate. Allowing the publication of a report but prohibiting the publication of AA's name and other evidence that would identify him or his family can in my opinion, meet these competing interests.

Formal Finding:

That AA (born 20 July 1985) died on 12 March 2008 at Royal North Shore Hospital, St Leonard's NSW. The cause of his death was a gunshot wound to the head which was self inflicted with the intention of taking his own life

Recommendations:

To: The Minister of Police:

1. That the procedure for the granting of a licence to possess firearms be reviewed so as to ensure that prior to the granting of such a licence, and at each renewal thereof, applicants undergo a mental health assessment by a general medical practitioner, or other appropriate professional, so as to ensure that they are not

suffering from any previously undiagnosed mental health condition that would render the applicant unsuitable for the holding of such a licence.

2. **That organisations that provide facilities for the secure storage of firearms maintain a register of all firearms that are located in such facilities and, if taken from the storage facility, the dates of removal and subsequent return of the firearm.**

3. **That each time a firearm is removed from a storage facility the currency of a firearms licence held by the person removing the firearm be confirmed by the facility operator.**

7. 2625 of 2009 Branko Lazarovski

Inquest into the death of Branko Lazarovski at Silverwater on the 26 May 2008. Finding handed down by Deputy State Coroner Mitchell at Parramatta on the 3 December 2010.

This is an inquest into the death of Branko Lazarovski who was born on 8 July 1952. Mr. Lazarovski died at 5.35pm on 23 May 2008 at Westmead Hospital. He was born in Macedonia in the former Republic of Yugoslavia and came to Australia as a young man. His widow is Jovanka Lazarovska of 50 O'Donnell Street, Port Kembla and they have one daughter, Valentina.

His inquest tool place at Glebe on 1 and 3 December 2010. Mr. Matthew Johnston of Counsel instructed by Mr. Bulbulia of the Crown Solicitor's Office appeared to assist the Coroner. The Officer-in- Charge of the investigation is Plain Clothes Constable Jenny Chrystal. Others appearing at the inquest were Mr. Walters for the Department of Corrective Services, Mr. Delmonte of Counsel for Mrs. Lazarovska and Mr. Rooney of Counsel for *Justice Health* and Westmead Hospital. The formal documents including the *P79A*, the *Identification Statement*, the *Report of Death to the Coroner* and the *Autopsy Reports* prepared by Dr. Dianne Little are **EXHIBIT 1.** The cause of death proposed by Dr. Little in her second autopsy report dated 26 August 2008 is *Multi system Organ Failure* and the antecedent causes cited by her are *Sepsis* and *Status Epilepticus*.

The Coronial Brief is **EXHIBIT 2** and contains statements of the Officer-in-Charge and of the widow, various medical and nursing records, a statement of *RN* Maria Swift of *Justice Health* and copy correspondence between the Department of Corrective Services and *Justice Health* together with two reports by Dr. James O'Driscoll, a Fellow of the College of Anesthetists in Ireland and an expert intensivist who, in May, 2008 was a senior Registrar at Westmead Hospital and is about to take up a post as a specialist anesthetist at a university-affiliated teaching hospital in Ireland. In addition, the brief contains the expert report of Professor Gordian Fulde of *St.Vincent's Hospital*, the *University of New South Wales* and *Notre Dame University.* Dr. O'Driscoll, Professor Fulde and Constable Chrystal were the only witnesses who appeared to give evidence.

EXHIBIT 3 is a folder of documents produced by *Westmead Hospital* and *Bayview Medical Centre* and **EXHIBIT 4** is a report of *Illawarra Area Health Service* dated 17 December

1987. **EXHIBIT 5** are copies of *Fact Sheets*, prepared by Police for *Wollongong Local Court,* one dated 14 September, 2006 relating to a charge of *Common Assault* and the other, on 7 April, 2007, relating to the charge of *Knowingly Contravene AVO*.

At the time of his two admissions to Westmead Hospital, Mr. Lazarovski was an inmate at the *Metropolitan Remand and Reception Centre* at Silverwater. His appeal against a conviction for assault in the Local Court had been dismissed at Wollongong District Court and he had been sentenced to a period of imprisonment of 9 months, with a non-parole period of 6 months, to commence on 6 December 2007. His earliest release date was 2 June 2008. On 16 May 2008, the *State Parole Authority* granted release on parole on compassionate grounds. Had it not been for this grant of parole, Mr. Lazarovski would have been serving his sentence at the time of his death.

On 1 May, Mr. Lazarovski was conveyed to Westmead Hospital from the *Metropolitan Remand and Reception Centre* at Silverwater and treated for acute abdominal pain. Both the report of the Illawarra Area Health Service of 17 December, 1987 (Ex. 4) and the fact sheets (Ex. 5) are indicative of long term, chronic alcohol abuse on Mr. Lazarovski's part and he presented at the time of his first admission to Westmead with a history of alcohol-related liver disease together with Type II *Diabetes Mellitus* and gall stones. Additionally, there had been a suggestion of *encephalopathy* raised in 2007 by Dr. Jenny McDonald of Wollongong which, Dr. O'Driscoll pointed out is, not uncommonly, a consequence of chronic liver disease. But the principal diagnosis at Westmead was *pneumonia, which* was treated, apparently successfully, with oral antibiotics. Mr. Laszarovski was discharged on 4 May 2008 with oral antibiotics prescribed on discharge and returned to the *MRRC* at Silverwater. Dr. O'Driscoll is convinced that, when he was discharged from Westmead on 4 May, Mr. Lazarovski's *pneumonia* infection had been cleared and he noted that subsequent blood tests during Mr. Lazarovski's second admission confirmed that to be the position.

Once back at Silverwater, Mr. Lazarovski received his prescribed antibiotics together with his routine medication including medication for his diabetes and blood pressure. If indeed he missed *an occasional dose* of the antibiotics, Professor Fulde would see that as *"not significant"* and Dr. O'Driscoll explained that the medication already consumed by the time Mr. Lazarovski left the hospital had most probably been effective in clearing the infection. The *Justice Health* notes on 4 May 2008 read *"patient returned from hospital. Treated for community-acquired pneumonia. Patient currently on anti-biotics. All observations within normal range. Patient to have follow up x-ray in 6 weeks."* Coincidentally, on 6 May, his eyes were checked and, allowing for his chronic conditions, he seemed generally to be in good health.

On 8 May, *RN* Maria Swift who was the Unit Nursing Manager at Silverwater saw Mr. Lazarovski at the request of fellow inmates who reported that he had not seemed himself following his return from Westmead and that, in particular, he seemed to have lost his interest in playing cards and seemed not to be taking his medication. His temperature, blood pressure, pulse and blood sugar readings were taken that day at 12.15pm and 2pm. On the first occasion, the readings were *normal* and, on the second, his temperature had risen slightly to 37 degrees and his pulse rate had risen from 82 to 112. *RN* Swift and Dr. Eu had a consultation with Mr. Lazarovski that day and, on 9 May, when *RN* Swift again saw him, his condition seemed to have deteriorated and he looked *unkempt, lethargic and unwell*. Although he knew his name and his whereabouts, he was unable to tell Ms.

Swift how many children he had, the date of his birth or the last time he had passed water or what medication he was on. His pulse was slightly quicker than normal. *RN* Swift recorded her observations and made a decision to send Mr. Lazarovski to Westmead Hospital and, within the hour, he was conveyed there by ambulance. It seems to me that there is no cause for criticism of Mr. Lazarovski's care by the Department of Corrective Services or *Justice Health*.

At 12.29 pm on 9 May, 2008, when Mr. Lazarovski was admitted to Westmead Hospital, the triage nurse noted *"Recent admission to WMH. PMHX CLD and CCF, Nurse from gaol reports decreased PO intake. NESB nil HX from PT. Feels hot, PT Tachycardic. Tongue moist, BLS 4.6MMOL, Staff report a change in behaviour. Appears to have flat affect."* Mr. Lazarovski was regarded as *"confused but otherwise afebrile and haemodynamically stable."* Cardiovascular and respiratory findings were noted as *unremarkable* and there was no neurological deficit present. His history of " *increasing confusion and loss of appetite… recent treatment for pneumonia and a background history of chronic liver failure secondary to alcohol, Type II Diabetes Melitus and cholecystectomy"* was noted. He was given a diagnosis of *decompensated liver disease*, admitted to a ward and placed under Dr. Kwan, gastroenterologist.

Late in the night of 9 May, Mr. Lazarovski developed, apparently for the first time, generalised seizures, which were managed, with apparent initial success, with *benzodiazepines.* A *CT* scan and lumber puncture revealed no relevant abnormality but when, despite therapy with *benzodiazepines*, the seizures persisted, Mr. Lazarovski was intubated and transferred to the *ICU* where he was placed in the care of a staff neurologist.

As his seizures intensified, Mr. Lazarovski received increased doses of medication and the notes indicate "*persistent status epilepticus despite being on maximal antiepileptic therapy."*

Despite what, in Dr. O'Driscoll's view, ultimately became *extremely high* though, no doubt, appropriate levels of medication directed to controlling his seizures, Mr. Lazarovski's condition worsened and he developed *Vancomycin resistant enteroccus* and multi-organ failure. He died at 5.35pm on 23 May, 2008.

Dr. O'Driscoll first met Mr. Lazarovski and took over his management on 16 May. His evidence is that the cause of death was *multi-organ failure, possibly due to sepsis, on a background of chronic liver disease with new onset seizures.* In that regard, Dr. O'Driscoll notes that Mr Lazarovski suffered a severe failure of the liver, kidneys, heart and central nervous system which he sees as associated with sepsis but he told the inquest that he is not able to say whether the various organ failures were a consequence of sepsis or whether the sepsis was a consequence of Mr. Lazarovski's chronic liver disease and diabetes. Nor was he able to describe with any certainty the link between the organ failure and the seizures but, given the absence of any other identifiable cause, it seems likely that the *status epilepticus* was secondary to Mr. Lazarovski's chronic liver failure.

According to Dr. O'Driscoll, it is not possible to say whether sepsis arose while Mr. Lazarovski was at the *MRRC* Silverwater or at Westmead Hospital to which he was admitted for the second time on 9 May. What he can say with some confidence is that Mr. Lazarovski was not carrying an infection when discharged on 4 May and almost certainly

probably was free of infection on 14 May when tests were undertaken and antibiotic medication ceased. This would seem to suggest that sepsis was acquired shortly after the tests on 15 May against a background of chronic liver disease and diabetes together with deep sedation required as a response to his seizures. All of these factors would have rendered Mr. Lazarovski vulnerable to infection and would have compromised his ability to survive.

Somewhat in contrast to Dr. O'Driscoll's view, Dr. Little's opinion is that the infection and the seizures caused the organ failure and she states *"as a result of the sepsis and the continuing status epilepticus, (Mr. Lazarovski) developed failure of multiple organs that was evident clinically and at autopsy. This condition directly caused his death."* Perhaps the best way to describe Mr. Lazarovski's sad plight in the closing stages of his life, however, is to adopt Professor Fulde's opinion that there is no clear separate causation separating the *status epilepticus*, the organ failure and the *sepsis*, each of which contributed to his vulnerability and ultimately to his inability to survive.

Just as it is not possible to say precisely when Mr. Lazarovski became infected with *VRC*, it is not possible to tell the source of infection.

Professor Fulde observed that Mr. Lazarovski's history of chronic liver failure, type II *diabetes*, alcohol issues and possible *hepatic encephalopathy* would *"bring with it significant risks to a patient's general health, ability to fight infections, disease and especially, as in this case, when chronic or long standing the predisposition to more severe illnesses and complications. This is even very much more so with the combination* (sic)*…"*

Further, Dr. O'Driscoll noted that, in order to control his *status epilepticus*, it proved necessary to sedate Mr. Lazarovski and to induce a deeper and deeper coma, an undesired consequence of which was a heightened vulnerability to infection. Further, Dr. O'Driscoll's opinion is that Mr. Lazarovski's underlying liver disease left him particularly vulnerable to infection.

No doubt it was for those reasons that antibiotic treatment was instituted at 4pm on 9 May, 2008, within about three hours of admission to hospital and continued until 14 May tests were undertaken and a judgment was made, subsequently supported by further tests on both 14 and 15 May, that "*sepsis was unlikely."* Nevertheless, it became necessary on 16 May to re-start Mr. Lazarovski on broad spectrum antibiotics and these continued until his death.

It seems to me that, at Westmead Hospital, medical and nursing staff took all appropriate steps in Mr. Lazarovski's care and treatment and I note Professor Fulde's evidence in that regard.

Formal Finding

I find that Branko Lazarovski, born 8 July, 1952, died at Westmead Hospital, Westmead NSW at 5.35pm on 23 May, 2008 of multi-organ failure, possibly due to sepsis, on a background of chronic liver disease with new onset seizures.

8. 1202 of 2008 Gordon John Moran

Inquest into the Gordon John Moran finding handed down at Glebe on the 11th May 2010 by State Coroner Jerram

This is a death in Custody under *Section 23 and 27 of the Coroners Act* into the death of Gordon John Moran who was an inmate at the Cessnock Correctional Facility and who died at the John Hunter Hospital in Newcastle on 23 July 2008.

Mr Moran was working in the industrial area of Cessnock on the 2nd June and was on a ladder fixing a screen to an air conditioning unit with a handheld cordless drill when unseen immediately by anybody he seems to have fallen backwards off the ladder.

Mr Moran was serving a sentence that amounted to something like 31 years and he had at this point something like 50 incidents of institutional misconduct almost entirely for drug use whilst in various correctional facilities. His most recent was on the 15th May two weeks before the fall and on that occasion cannabis was detected in the urine test.

When he was seen directly after the fall he was lying on his back attempting to get up and speak. He was taken to hospital where it was found he had a considerable head injury and haematoma, he underwent surgery and made slow progress and did appear to be recovering.

However in the week leading to his death he developed pneumonia and then suffered a cardio respiratory arrest, which was found to have caused hypoxic brain injury. Mr Moran died in hospital on the 23rd July 2008.

Workcover inspected the premises and issued two improvement notices and I am quite satisfied that these have been properly responded to by Corrective Services.

There is a possibility that Mr Moran had drugs or alcohol in his system at the time of the fall, however as there was no drug or alcohol testing on presentation to the hospital I am unable to confirm this.

I do have the evidence of an overseeing officer who was clear that there was nobody near the ladder at the time the deceased fell ruling out assault.

The post mortem suggests considerable cardiac disease that leads to another possibility which is that Mr Moran may have indeed had some sort of cardiac arrest which caused him to fall.

Formal Finding

That Gordon John Moran died on 23 July 2008 of complications of blunt head injury and coronary artery disease following a fall.

Recommendation:

To the Minister of NSW Health

That a toxicology screen including blood alcohol level be performed by hospital personal on all persons admitted to hospital either seriously injured or killed as a result of an accident in the workplace as a matter of routine.

9. 1435 of 2008 Paul Gregory Hogan

Inquest into the death of Paul Gregory Hogan at Goulburn on the 26th August 2008. Finding handed down by State Coroner Jerram at Goulburn on the 26 March 2010.

Paul Hogan was found dead, hanging in a cell at Goulburn Correctional Centre where he was an inmate, on 26 August 2008. His death was reportable to the Coroner under s 23 of the *Coroners Act of 2009* and an inquest mandatory because it was a death in custody.

THE INQUEST

From March 22 to March 26 2010 sitting as a Coroner's Court at Goulburn Local Court, I heard evidence relating to this death. I have been ably assisted by Ms Peggy Dwyer as Counsel Assisting, and Ms Clare Miller of the Crown Solicitors Office. Mr Hogan's former partner, Ms Kirwin, was represented by Ms Yehia of Senior Counsel, Justice Health by Mr Singh, and Corrective Services NSW by Ms Mahony of Counsel. Ms Dwyer and Ms Miller liaised closely with Mr Hogan's family, and put questions on their behalf when necessary.

A view was held at Goulburn Gaol a week before formal sittings commenced, attended by all legal representatives and me. We were shown the surrounds, the unit, and the cell, D7, in which Mr Hogan died. As usual, that view was of considerable help in understanding the circumstances of this death. Written submissions were received from all parties.

Section 81 of the Coroners Act requires that the Coroner determine the identity, date, place, cause and manner of death. It has been agreed by all parties that all but the last are not in issue, rather the investigation has concentrated on how it came about that, as the post mortem performed by forensic pathologist Dr Szentamariay clearly indicates, Mr Hogan came to hang himself, alone in a segregation cell.

THE FACTS

Mr Hogan had been partnered with Ms Amanda Kirwin for several years and they had two children together. Mr Hogan was also step-father to a child of Ms Kirwin's. He was a much loved son, brother and nephew.

Mr Hogan and Ms Kirwin had had a volatile relationship, and Mr Hogan was no stranger to prison, albeit generally for short terms. On 18 July 2008, he was arrested for allegedly breaching an apprehended violence order made against him on her behalf.

He was refused bail on 19 July, and admitted to Goulburn Gaol. During the screening process, which is standard for new inmates, he told both Justice Health nurse Lana Skelly, and Corrective Services officer Marion Cannon that he had previously suffered from depression and had recently been on an anti-depressants for approximately two years, although he had apparently stopped taking anti-depressants. He denied any current suicidal ideation. In April 2008 while under supervision from Probation and Parole Service, which is a sector of Corrective Services, a notification was made that he had been diagnosed with mild depression and medicated accordingly.

On July 23, Goulburn Local Court made an interim variation to the AVO already in place, adding the three children as persons in need of protection. Mr Hogan took part in these proceedings by video link from the Gaol.

On 19 August, after allegations by officers of aggressive and intimidating behaviour by Mr Hogan, the Immediate Action Team, known as the IAT, were called to detain him, and to transport him to a special cell to be charged with breach of discipline offences. Prison procedure required that their actions be videoed, involving as they did use of force. The court was shown that video, but it is notable that it was highly unsatisfactory in that at many points the filming is blocked by persons standing between the camera and the events. What is clear is the considerable aggression and humiliation inflicted by several officers upon one prisoner. However, no physical injuries were claimed or recorded. Mr Hogan was ordered to be punished by being taken off amenities for 42 days in total. He was then moved to segregation cell C7, apparently for a reason other than punishment.

On 25 August he was moved again to cell D7, another cell within the segregation unit (for practical rather than disciplinary purposes) by officers Maddock, Hollis and Neely. A Nurse Heath saw him half an hour after that move, and noted no issues re his mental health. Officer Maddock, who was probably the last person to see Mr Hogan alive, handed him in his last meal of the day at about 2.15pm. The segregation unit has a lock-down policy from 3pm to 8.30 am. During those hours, a prisoner will not be sighted or visited by any body, officer or otherwise, in normal circumstances.

Throughout the next hours, Mr Hogan spoke with the prisoner in the next door cell, Mr El Zayeat many times. He told El Zayeat at about 3 pm that he was ‘stressing out a bit’, that he was worried that the squad ‘would try and knock him,’ and that he was ‘very frightened of one particular officer’. At 4.15 pm Mr Hogan used the knock up button, an intercom used for medical emergencies, to ask the officer on duty to let him speak with another prisoner, Gardener. He was refused. He continued to talk to El Zayeat, who ultimately managed to pass him a cigarette, and he appeared to calm down. Around midnight, El Zayeat began to watch a late movie, and some time later, heard a bang.

At 8.30 am Mr Hogan was found hanging from the bars above the door to his cell by three officers delivering breakfast. There was an attempt at CPR but he was found to have been dead for some time. A note was found in the cell, reading ‘Sorry everyone, peoples’.

THE ISSUES

1. ***Was the intake screening and assessment process adequate?***
2. ***Was it reasonable to place an inmate with a documented history of mental illness in segregation without a psychological assessment?***

3. ***Were the segregation cells sufficiently free of hanging points, and if not, has enough been done since to rectify any problem?***
4. ***Why was there a failure to take in to account the alert on Hogan's file against his being imprisoned at Goulburn?***
5. ***Is there any evidence that Hogan had been threatened, assaulted or wrongfully treated by Corrective Services staff? Can the videoing system required of the IAT be improved?***
6. ***Was it reasonable for inmates in the segregation unit to be left unchecked and unmonitored for 17 hours as a standard practice? If not, has there been any change or improvement in the monitoring protocol?***
7. ***Was the knock up system functioning and properly responded to?***
8. ***Was the crime scene in the cell after Mr Hogan was found dead contaminated, and if so, do Corrective Service Officers need fuller training in procedures?***
9. ***Should any recommendations be made by me under s 82 of the Coroners Act as a result of findings on these issues?***

THE EVIDENCE

The Screening Process

Nurse Lana Skelly of Justice Health assessed Mr Hogan on reception, but said that she did not review Mr Hogan's Justice Health files. She was not aware that he had been on medication for depression recently. She did not obtain a detailed history of his alcohol or drug use. She agreed that had she known that a few weeks after this assessment he was behaving aggressively and threateningly to staff, she would have been concerned that such a change in behaviour might be an indication of a deterioration in his mental health and that it would have been appropriate for him at that time to have been re-assessed.

Ms Cannon, a welfare officer, also had limited access to Mr Hogan's medical history when she interviewed him two days after reception. Despite standard protocol requiring that she have access to an inmate's previous discharge summary, including any medical and welfare issues, she stated that she had not seen Mr Hogan's discharge summary, and rarely saw that of any inmate. His most recent discharge summary from May 2006 in fact recorded that he had 'serious mental health issues: depression and AOD issues'.

Neither Nurse Skelly nor Ms Cannon had ever seen the material subpoenaed from Corrective Service's Probation and Parole noting that he had some mental health issues in April 2008.

I heard evidence from Mr Breckenridge, who was the General Manager of the gaol at the time, that welfare officers rarely have access to the discharge summaries because they are stored elsewhere and take time to be sent to the gaol. He was unable to explain why the use of technology could not overcome this failure in the Services own protocol.

Segregation of Mr Hogan

The decision to segregate Mr Hogan after his increase in aggressive behaviour by 19 August was made by Mr Breckenridge, on advice from Mr Webb, his Assistant Superintendent. He did not concede that both being off amenities, and in segregation, created an extremely stressful environment, although Nurse Skelly, a psychiatric registered nurse, accepted that stress levels would be higher. He was confined to a cell for at least 22 hours daily. He saw no other human between at least 4 pm when shift staff

left, until 8.30am when breakfast was brought by officers of the morning shift. Because he was off amenities, he had no visits, no phone calls, no television and no buy ups. Although not refused tobacco, he was unable to procure any because he was prohibited from buy ups.

He was not given any further psychological assessment at the time of his move to segregation, despite the obvious changes in his behaviour, and not assessed generally other than by a cursory daily visit of a few moments from a Justice Health staff member. There was no Case Management Plan for Mr Hogan, despite the requirement of the gaol's own Policy and Procedure that an inmate placed in segregation must be immediately referred to the case management team (Goulburn Correctional Complex Standard Operating Procedures, Sector 4 – MPU at 5.7.2).

Senior Assistant Superintendent West's duties as sector manager of the MPU, according to his oral evidence, were set out in standard operating procedures which include, inter alia, to ensure that inmates in segregation are seen daily and their wellbeing checked and addressed. It had been on the recommendation of Mr West that Mr Hogan was taken off amenities. He confirmed that no officer is housed during the night shift in the MPU, but that four staff (for the whole complex) is on duty to visit the facility. There are up to 340 inmates in the main gaol and another 50 or more in the MPU, so that overnight, four officers staff 400 or more prisoners. They have no role in checking on welfare unless they receive a knock up call.

As for the role of Justice health, Mr West told the court that a nurse comes into the segregation area at least twice daily to dispense medications, and to attend to any health issues, accompanied by a correctional officer.

Prisoners are generally allowed access to their personal day yard for two hours daily, but from about 3 pm all inmates are locked in to their cells after their final meal of the day is served at about 2.30. On 25 August, there was a lockdown in the area for the whole day, because it was a staff training day.

Mr West was asked to read the Services Protocols and Standard Operating Procedures (SOPs), which set out the obligations of his role as sector manager. He expressed surprise that 5.7.2. states 'Immediate referral of inmates placed into segregated custody to the case management team for a focused case management plan', saying that that was not the practice at the time, and was not activated for Mr Hogan. Mr West was unaware that Mr Hogan had suffered from depression.

Unfortunately, it became increasingly apparent that it was the norm for Mr West and other officers to be unaware in fact of the specifics of the SOPs, with the result that many of them were not being met. Further, it was at Mr West's request that Officer Poulsen entered the cell to take photographs, and that Mr Coleman debriefed the three staff together, against all SOP directions re deaths in custody.

The decision to put Mr Hogan in segregation was made by the then General Manager, Mr Breckenridge on the advice of Mr Webb, the Assistant Superintendent.

Emphasis was put by all officers on the fact that segregation is not used as or for punishment but for security and safety reasons set out in s 10 of the *Crimes*

(Administration of Sentences) Act 1999. Mr Breckenridge did not agree that to be subject to the punishment of being off amenities while in segregation had the effect of a double penalty, or was more onerous or stressful than either situation per se. As noted above, Nurse Skelly accepted that it was. (It has been clearly established for the court that it is not unlawful to segregate a prisoner who is currently on punishment of deprivation of rights and privileges).

Hanging Points

Evidence was given (and confirmed by the view of the cells) that both Cell C7 and D7 at the time had obvious hanging points: bars on the windows, shower rails and bunk railings. Mr Breckenridge confirmed that despite the recommendations of the 2005 Hanging Point Committee (quite apart, may I note, from numerous coronial recommendations), nothing had been done, and no capital expenditure outlaid, from 2006 until June 2009 during his term as General Manager. I accept his comment that it is virtually impossible to eliminate all hanging points, but note that his solution was adequately to monitor welfare. There was no evidence that there was any increase in adequate monitoring of welfare and, as noted above, there was evidence that there was none at all between the periods of 4 pm to 8 am. It was also observed during the view of the cells that currently, barred areas over doors and windows were in the process of being meshed as a further attempt to eliminate hanging points.

Alerts

The statement of Corrective Services Officer Mark McInnes was tendered regarding the alert on Mr Hogan's file that he not be placed at Goulburn. Apparently, Officer McInnes is a uncle of Ms Kirwin's.

Because of the history of domestic trouble between Ms Kirwin and Mr Hogan and the latter's previous periods in custody following troubles between them, Officer McInnes, himself had asked that, for ethical reasons, Hogan not be placed in the institution at which he was employed. By the time of Mr Hogan's last incarceration Officer McInnes had only very limited contact with Mr Hogan and wasn't aware that the alert was still in force. I do not consider that this issue has any bearing on Mr Hogan's death.

Treatment by Corrective Services officers

There is varying evidence about treatment of Mr Hogan by the Corrective Services officers. The poor visibility of the video of his being moved by the IAT has already been commented upon.

El Zayeat gave evidence confirming a statement he made to police on 26 November 2008 (i.e. 3 months after Mr Hogan's death) that he had been told by Officer Maddock, just prior to Mr Hogan's being placed in the neighbouring segregation cell, that Mr Hogan was in for a 'putrid crime' (explained as meaning paedophilia or rape), and exhorted to 'give him heaps'. He did not tell the police of this when interviewed originally on the day of Mr Hogan's death but when this was put to him, offered the explanation, which had considerable credibility, that Corrective Services Officer West was part of the original interviewing team, and that with other officers about, he, El Zayeat, was fearful of making complaints and feared reprisal. In his evidence, Officer Maddock denied that he ever

said any words to any such effect. (Their conflicting evidence is complicated by the fact that on 27 November, the day after El Zayeat's second statement, Officer Maddock and El Zayeat each allege that he was assaulted by the other. Officer Maddock alleged a long history of tension between himself and El Zayeat, stating that there would be Case Notes to that effect. None were found, and the Unit Manager, Officer West, said that he was unaware of any problem between them).

El Zayeat said that later in the day, during their between-cell conversations, Mr Hogan spoke somewhat wildly, suggesting that he believed the Squad (the IAT) or an Officer was likely to kill him, and that he was 'not gunna let them…., I'll knock myself and not give them the satisfaction.' El Zayeat concluded at that point that Mr Hogan had psychological issues.

The Knock Up call

Officer Ruddy was the gate control officer on the afternoon watch (4pm till midnight) on 25 August. He explained the duties of that role, which is swapped with one other officer on the gate, as being primarily to ensure security from the control room, including answering any knock up calls. Only one officer is at each of the two posts, for the whole gaol throughout the afternoon watch. He described receiving Mr Hogan's call asking to speak to another prisoner, Gardener, early on his watch, and dismissing it as not a medical emergency. He clearly considered it a nuisance call. Obviously the knock up button was functioning. That was confirmed too by the officers who found Mr Hogan hanging in the morning and tested the button and by Senior Assistant Superintendent West.

'Crime scene' procedure

Assistant Superintendent Coleman had had 18 years experience with Corrective Services at this time. His then duties were to take responsibility for staff training and welfare. He described taking a call, possibly from Mr West, the area manager of the unit, that there was a serious incident in the segregation wing, and attending, with the Deputy, at Cell D7. He was satisfied that the matter was being well managed, and thus removed the officers who had found Mr Hogan, Maddock, McLachlan and Hollis to the officers mess. They discussed together what had occurred. He did not think to separate them, as he should have done according to the Corrective Services operation procedures manual, because his prime concern was for their welfare. He told the court that he had not thought that those procedures were the responsibility of the staff officer on the day, but were the responsibility of the area manager, who was in fact Mr West, but agreed that he had never read them.

Coleman then attended the cell with Officer Poulsen, in order for the latter to take photographs of the scene as instructed by Mr West. Police had apparently not arrived by that point.

The principal investigator for Corrective Services, Peter Wallace, in his report which formed part of the Brief, wrote that 'Crime Scene Preservation was compromised on this occasion when SCO Poulsen and Staff Officer Karl Coleman entered Inmate Hogan's cell and took photographs of the scene, after efforts to revive Inmate Hogan had been abandoned. This appears to be a local practice and on this occasion was done at the

request of SAS West, Manager of the MPU'.

CONCLUSIONS

Mr Hogan's mental health was not considered as a factor in his custodial management or treatment, as it ought to have been. His prior depression was documented and should have been an alert to those responsible for his initial assessment, and for his welfare from the time his behaviour changed and he was segregated. Mr Singh, for Justice Health, submits that this information was known to staff and that all relevant alerts are already listed on Justice Health's Patient Assessment System (PAS). This contradicts the evidence of all those who gave evidence, and if it were so, only further highlights the necessity of an inmate's previous mental health history being given greater attention.

While it is accepted that Mr Hogan was not demonstrating any obvious mental health issues at the time of reception or initial assessment, his mood obviously deteriorated while in prison, and became problematic after he was moved to D7. Neither Corrective Services nor Justice Health staff seem to have noticed or taken account of this change. I do not accept the submission on behalf of either Corrective Services or Justice Health that Mr Hogan did not have a serious mental health condition. That submission ignores the reality that depression is a psychiatric condition.

Mr Hogan had been diagnosed as depressive as early as 2004 and had been on anti-depressant medication. That should have established that he was an inmate in need of monitoring.

I have already stated that I am satisfied that the determination to deprive Mr Hogan of privileges was lawfully made, as was the order to transfer him to segregation (see ss. 10 and 12 of the *Crimes (Administration of Sentences) Act 1999*). I also accept that a decision to segregate is made for the general security and safety of the prison and its other inmates, rather than as a punishment. It must also be noted that Mr Hogan was no angel, and that he had demonstrated behaviour both over the years and in the day before he was segregated, which was anti social, and he was seen as a potential threat to prison discipline.

Despite the legislative power, on any humanitarian view, to be segregated at the same time as being deprived of virtually everything other than food, must impose a terrible and double burden on any person, particularly one with a prior record of depression, and who was, whether rightly or not, fearful of some of those in authority over him. Again, the history of mental health should be relevant to any decision to place an inmate in segregation in the first place, for how long, and in what conditions, with access to what privileges and welfare services. Any decision maker should have as a minimum, access to essential information from Justice Health relating to the inmate's health overall. That could be obtained by conferencing with Justice Health staff or reviewing the Justice Health intake assessment documents.

I am conscious of the fact that there are constraints on the disclosure of health information set out in the *Health Records and Information Privacy Act 2002* and in the *Crimes (Administration of Sentences) Regulation 2008.* While I do not intend to conduct an exhaustive review of that legislation, it is clear that privacy concerns should take second place to the overall duty of care owed by Corrective Services to an inmate. In my view

the exceptions in the *Health Records and Information Privacy Act* that allow for health information to be disclosed would cover the release of information by Justice Health to Corrective Services in the circumstances that Mr Hogan was in. That would have allowed for two things that may have made a difference to safeguard Mr Hogan's mental health, first, an alert on the Patient Administration System indicating that Mr Hogan suffered from a serious mental health condition (i.e. history of depression) and second the transfer of further information about that serious mental health condition at the time Mr Hogan entered into segregation. I note that if it is possible to have an alert where someone has attempted self-harm or suicide, or has a peanut allergy, then it must be permissible to have an alert regarding a serious mental health condition.

Mr Hogan would be by no means the first person to have been driven, perhaps literally, mad by the isolation and boredom of absolutely nothing to do (no television, no visitors, no tobacco, no books) alone, for more than two thirds of every day. I am aware that it might raise further privacy issues to check on inmates or monitor them during sleeping hours.

However, there must be some regularised supervision at the very least for the first few hours and the last and, once again, surely welfare concerns must be paramount. It is also deplorable that no Case Management Plan was drawn up for Mr Hogan, in spite of requirements set out in the Standard Operating Procedure.

As Ms Yehia submitted, it is acknowledged that Corrective Service officers do a difficult job in difficult and sometimes dangerous circumstances, with a long term lack of resources. Nevertheless, as prison numbers rise, it is not sufficient for those who administer and fund the prison system to maintain some standards, which, frankly, would not have been out of place in the nineteenth century. Money is finally being spent on meshing certain cells to diminish, if not eliminate, hanging points. But to have merely four officers on duty with the care of 400 souls is ludicrous. So is to serve a final meal for the day at 2:30 pm. The regular appearance of a welfare or other officer at the door of each cell, at least before midnight, would have established some human contact otherwise denied. It also might have alerted a properly trained officer to the fact that Mr Hogan was struggling obviously on the night of August 25 with some serious despair. I place no blame on the officer's response to Mr Hogan's knock up call. It clearly fell outside the purposes of that emergency button.

Again, while every officer cannot be expected to read and know every word of the Standard Operating Procedures, it was of great concern to hear how few of those procedures were familiar to most staff, even those holding senior rank. There is clearly a strong need for more education and training of Corrective Services staff (and that of Justice Health) in their own roles and protocols. This is a serious and systemic failure. Further, one is forced to ask why the Corrective Services has its own investigators at all, when their reports on an incident such as Mr Hogan's death are not disseminated amongst those involved, so that neither criticisms nor recommendations hit their target, and nothing is learned. The report of Wallace could have been a very useful training tool for all.

Finally, it is necessary yet again to criticise the lack of co-operation and communication between Corrective Services and Justice Health. This has been ongoing problem virtually since the creation of Justice Health. It has been the subject of innumerable inquests and coronial comment. The importance of making accessible information contained in

discharge summaries was pointed out by the then Deputy State Coroner Pinch in the inquest in to the death of Scott Simpson in July 2006. I made comment upon it in 2009 in an inquest in to the death of Adam Shipley, and as a result of the inquest into the death of Gary Kelso presided over by DSC MacPherson, Justice Health and Correctives Services have commenced negotiating a Memorandum of Understanding. This is but one of several systemic failures by Corrective Services to act on coronial recommendations, others being the reduction of hanging points, the failure of staff to understand and learn Standing Operation manuals, and the failure of management to act upon internal reviews.

I note that Justice Health have amended their reception screening tool so that staff are required to tick a box to indicate that they have seen the inmates previous PAS history. This is encouraging. It is hoped that staff will use that document appropriately.

Formal Finding

That Paul Gregory Hogan died on 26 August 2008 at Goulburn Correctional Centre by hanging by himself with the intention of ending his own life.

RECOMMENDATIONS

To Justice Health

1. **When an inmate has a history of serious mental ill-health, eg depression, Justice Health place an alert on the PAS, that will be obvious to staff accessing the system.**

2. **That Justice Health provide mandatory annual training courses for nursing staff working within NSW Correctional Centres (other than those qualified in mental health) in the area of suicide risk assessment and mental health first aid.**

To Corrective Services NSW

3. **When an authorised officers makes a decision about whether an inmate should be placed in segregation pursuant to s. 10 of the *Crimes (Administration of Sentences) Act 1999*, the officer must have regard to an inmates history of mental illness by reference to OIMs, case management files and discharge summaries. They should also refer to Justice Health staff to obtain essential information relating to mental and physical health.**

4. **Wherever practicable, when an inmate is placed in segregation a welfare officer or senior correctional services officer should meet with the inmate within 24 hours of the order being made, so as to determine immediate welfare needs and to advise the inmate of their right to access relevant services and options, eg family visits, library services.**

5. **Corrective Services NSW should introduce a mandatory training programme that must be completed by all corrections officers as soon as practicable. Training should include:**

a. **Identifying mental health needs of inmates.**
b. **Appropriate responses to mental health needs of inmates.**
c. **First-aid.**
d. **Standard operating procedures relating to deaths in custody.**

6. **Where an internal investigation is carried out in relation to a death in custody, the General manager of the Correctional Centre must make arrangements to ensure all Corrective Services officers they are responsible for are familiar with any significant findings or recommendations made. (Note: this echo's a recommendation previously made in the inquest in to the death of Adam Shipley)**

Corrective Services NSW review the absence of inmate checks between 3 pm and 8 am and investigate the feasibility of adopting a procedure whereby inmates in segregation are checked at reasonable intervals during that period.

10. 1793 of 2008 Michael Vanquelef Capel

Inquest into the death of Michael Vanquelef Capel at Belmont on the 19th October 2008. Finding handed down by Deputy State Coroner MacMahon at Newcastle on the 8th September 2010

Schizophrenia

Schizophrenia is an illness, a medical condition. It affects the normal functioning of the brain, interfering with a person's ability to think, feel and act. Some recover completely, and with time, most find that their symptoms improve. However, for many, it is a prolonged illness that can involve years of distressing symptoms and disability.

If not receiving treatment, people with schizophrenia experience persistent symptoms of what is called psychosis.
These include:

- Confused thinking. When acutely ill, people with psychotic symptoms experience disordered thinking. The everyday thoughts that let us live our daily lives become confused and don't joint up properly.
- Delusions. A delusion is a false belief held by a person that is not held by others of the same cultural background.
- Hallucinations. A person sees, hears, smells or tastes something that is actually not there. The hallucination is often of disembodied voices that no one else can hear.
- Low motivation and changed feelings.

The causes of schizophrenia are not fully understood. They are likely to be a combination of hereditary and other factors. It is probable that some people are born with a predisposition to develop this kind of illness, and that certain things – for example, stress, the use of drugs such as marijuana, LSD or speed – can trigger the first episode.

About one in a hundred people will develop schizophrenia at some time in their lives.

Most of these will be first affected in their late teens or early twenties.

Treatment can do much to reduce and even eliminate the symptoms of schizophrenia. Treatment will generally include a combination of medication and community support. Both are usually essential for the best outcome.

An understanding of the illness of schizophrenia is an essential starting point for the investigation of the tragic death of Michael Capel on 10 October 2008.

Michael Capel

Michael Capel was born on 29 June 1965. In 2008 he was 43 years of age. He was a single man who resided at the Spinnakers Caravan Park at Belmont NSW. He had resided at the Caravan Park since 1997. He had a close and supportive relationship with his mother, brother and sister and their families. In these findings I will refer to Mr Capel as Michael.

In 1988, at the age of 23, Michael was diagnosed as suffering from schizophrenia. Michael was admitted to the James Fletcher Hospital at Newcastle as an inpatient in 1988 and 1989. James Fletcher Hospital is a specialist psychiatric hospital. Following his discharge Michael began having monthly injections of antipsychotic medicine due to his unreliability in the taking of oral medication.

In 1991 the Lake Macquarie Mental Health team referred Michael to Dr Denis Gordon a General Practitioner at Belmont, to receive his injections.

Whilst on medication Michael lived independently.

In May 1992 Michael made the decision to cease receiving his monthly injections. After a period he became ill and as a result was readmitted to the James Fletcher Hospital in November 1992 with a two-week history of *"voices commanding him to kill himself and paranoid delusions that people were against him."*

Following his discharge from hospital Michael recommenced receiving monthly injections of antipsychotic medication. Michael thereafter received 150mg of Haldol administered by injection each month. This was changed to 100mg in 2000 but later increased to 150mg in January 2002.

In 2004 Michael's doctor decided to gradually reintroduce Michael to oral medication. By this time there had been significant advances in antipsychotic medication and it was hoped that the use of the more modern medication Olanzapine would have less chance of adverse side affects.

By October 2004 Mrs Heath became concerned that Michael was not taking his medication. She approached his doctor and expressed her concern. Michael was seen by either Dr Gordon or another doctor in the practice and was not observed to be exhibiting any psychotic symptoms.
Shortly thereafter however Michael was reported to be hallucinating, saying that people were talking about him, he was not eating and he took his phone off the hook. In January 2005 Michael's brother advised the Lake Macquarie Mental Health Team (the MHT) that

Michael had stopped taking his medication. Michael's sister also phoned Dr Gordon and informed him that Michael had ceased taking his medication.

As a result of the actions taken by Michael's family the MHT undertook a home visit on 6 January 2005. Michael was found by the team members to be guarded, he denied that he is mentally unwell and he did not allow the team members to enter his home. Dr Gordon was informed of the outcome of the visit.

Over the next few days Mrs Heath became more concerned. On 14 January 2005 she advised a psychologist attached to the MHT that Michael's concentration was poor, that his home was in a mess and that he was hostile towards her.

On 18 January 2005 two staff from the MHT attend Michael's home in the company of Mrs Heath. Michael was guarded and irritable. He was reported as voicing paranoid ideas and as talking to himself. After discussion Michael agreed to attend his general practitioner and following that Michael resumed the receipt of antipsychotic medication (150mg of Haldol) by way of monthly injection.

From February 2005 to August 2008 Michael's medical history was uneventful. Indeed his schizophrenia appeared to be managed; he maintained regular contact with his mother and other family members and later that year expressed an interest in finding work or becoming involved in activities during the day. He was discharged from the Mental Health Service and returned to the care of Dr Gordon receiving his medication by monthly injection.

On 5 August 2008 Michael received his medication by way of injection. He was due for a further injection on 5 September 2008 however he missed that injection. On 5 October 2008 Ms Heath spoke to Michael and found him to be *"quite pleasant."* They discussed the forthcoming birthday party of her grandson, which they intended to attend together.

On 8 October 2008 Mrs Heath contacted Michael again and thought that he appeared to be *"in an abnormal state."* Ms Heath was concerned so she tried to contact Michael again the next day but was unsuccessful. Mrs Heath suspected that Michael might not have been taking his antipsychotic medication. She phoned Dr Gordon's practice on 10 October 2008 and was able to confirm her suspicions. Mrs Heath decided that she would convince Michael to come in to the practice so that he might receive the injection. She then went to the Caravan Park to see Michael, arriving at about 10am.

The above history shows that although Michael suffered from schizophrenia he was able to live an independent life and support himself so long as he continued his medication.

The history shows that when he ceased his medication he began to experience psychotic symptoms. Because he was close to his family and in regular contact with them they were able to identify when those symptoms reoccurred and were then able to ensure that he received appropriate care and treatment.

Of significance is the fact that this history shows that Michael had a very close relationship with his mother and there had been no history of violence by him towards her.

Jurisdiction and function of the Coroner

Section 81(1) of the *Coroners Act 2009* (the Act) sets out the primary function of the Coroner. That section provides, in summary, that at the conclusion of an Inquest the Coroner is required to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

Section 82 of the Act provides that a Coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. Making recommendations is discretionary. They relate usually, but not always, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths. It is the role of the coroner to discover, if possible, what happened and why. It is not the function of the coroner to attribute blame.

In addition Section 27 (1) (b) provides that where a person dies *as a result of, or in the course of, a police operation* an inquest is mandatory and that Sections 22 and 23 require that either the State Coroner or a Deputy State Coroner conduct such inquest.

Date Place Cause and Manner of Death.

The evidence establishes that Michael died on 10 October 2008 at the Spinnakers Caravan Park, Belmont. The evidence also establishes that the direct cause of his death was gunshot wounds that he received when shot by a police officer. Michael thus died *as a result of, or in the course of, a police operation.* As such an inquest into the death of Michael is mandatory and the provisions of Section 23 apply.

10 October 2008.

As indicated above Mrs Heath was concerned about Michael and went to the Spinnakers Caravan Park to see him. Her evidence was that she went to his home and entered through the front door. She approached him in order to kiss him as she had done many times before. He stepped back and then struck her with his left arm. He pushed her backwards forcing her to the ground.

He then kicked her in the area of her hip. She was of course in shock. She had never seen her son behave like this before. He had never been violent towards her.

About that time Mr Ayaha, an employee of the Caravan Park, came to Mrs Heath's assistance. Mr Capel punched Mr Ahaya whilst he was trying to help Mrs Heath. They were able to leave the area and Mrs Heath then went to the reception area of the caravan park where she phoned the MHT. Because of the violence Mrs Heath was informed that she should phone the police and that the police could phone the MHT after they arrived if that was appropriate. Mrs Heath phoned the police. This call was recorded as having occurred at 11.17am.

Police did not arrive at the caravan park until shortly before 5pm. The reasons for the delay I will examine later in these findings. The responding officers were Senior Constables

Sally Hogg and Jason Battle who had commenced duty at 3pm that day. By that time Greg Capel, Michael's brother, had also arrived at the caravan park.

On arrival at the caravan park Officers Hogg and Battle spoke to Mrs Heath and Greg Capel, received a history of the events of the morning and Michael's general medical history then went to see Michael. What happened next was the subject of close examination during the inquest.

Officer Hogg gave oral evidence at the inquest and a DVD recording of a walkthrough in which she had participated was shown. A similar DVD walk through by Officer Battle was also shown. Civilian witnesses, Sheldon and Ruth Byrne who saw much of the tragedy unfold also gave evidence. Three other persons who also saw part of the events also gave evidence. They were Michael's near neighbours, Darren Fursey, Ron McGregor and Ray Noble. In addition Mrs Heath, Greg Capel and Hosain Ayaha also gave evidence as to the events that preceded Officer Hogg and Battle approaching Michael's home.

On the basis of the evidence available I am satisfied that Officer Hogg approached the front door of Michael's van followed by Officer Battle, knocked on the side of the van, announced that she was a police officer and asked Michael to open the front sliding door. Michael refused.

Officer Hogg then slid the partially open front door to the side and observed that Michael had something behind his back. Officer Hogg then stepped back and asked Michael what he had behind his back. Michael said that; *"he had something"*. Hogg and Battle then began shouting at Michael demanding that he show what he had behind his back.

Very shortly after this Michael began walking towards Officers Hogg and Battle with a large knife. The knife was produced at the inquest. The handle was 10.5 cm in length with a 28cm blade.
Officers Hogg and Battle retreated down the stairs to Michael's door. Officer Hogg tripped at the bottom of the stairs. Officer Hogg gave evidence that she sprayed capsicum spray at Michael three times as she retreated in an attempt to disable him.

This was unsuccessful.

The first two sprays appear to have reached Michael but landed on his clothes and chest but did not deter him. The third attempt did not reach Michael with the spray blowing back into the face of Officer Hogg temporarily blinding her. Officer Hogg was thereafter unable to assist in what occurred subsequently. Indeed being blinded the danger that she faced in the circumstances was considerable.

After officer Hogg was incapacitated she tried to get water in order to wash out her eyes. Battle continued to walk backwards with Michael advancing towards him. Sheldon Byrne, a neighbour of Michael's who was with his wife, who had just returned to the caravan park, and was parking his car called out to Michael. Michael then appears to have turned towards Mr Byrne.

At about this stage Officer Battle discharged his firearm at Michael a number of times in rapid succession. Michael then fell to the ground. There is a difference of recollection between Mr Byrne and Battle as to what occurred at this time. Mr Byrne's recollection

was that Michael was advancing towards him and then turned towards Battle who then discharged his firearm. Battle's evidence was that Michael was advancing towards Mr Byrne at the time he discharged the firearm. Ruth Byrne, who had a more restricted view of the events, gave another slightly different account of Michael's movements. Either way all witnesses agreed that the time involved was very short, indeed a matter of a few seconds. The different perspective of the various witnesses might explain the different recollections. In any event all witnesses' recollections of the events testify to the serious danger the circumstances posed to those involved.

Following Michael being shot officer Battle sought help for him by applying first aid and calling for ambulance assistance. Unfortunately such assistance was not able to save Michael's life.

Why did Michael act as he did on 10 October 2008?

It is hard to understand Michael's actions on 10 October 2008 without understanding his illness. Michael, as I have already mentioned, was 43 years of age, lived independently and had a close relationship with his mother and other family members. He had no history of violence. His assault on his mother, and Mr Ahaya, that morning was completely unexpected and completely out of character. Indeed it must have been a most distressing, if not terrifying, experience for Ms Heath given the relationship she had with Michael.

The explanation for these events can be found in the schizophrenia that Michael suffered. The inquest was helped by the analysis undertaken, and evidence given, by Dr Yvonne Skinner a consultant psychiatrist. Dr Skinner concluded that:

> *"Michael Capel had a past history of psychotic symptoms with paranoid delusions when he had not been taking medications. He had also expressed suicidal thoughts in the past, with command hallucinations, voices ordering him to kill himself when suffering from psychosis. The descriptions given of his behaviour on 10 October 2008 are consistent with behaviour of a person affected by paranoid delusions. It is probable that he had been affected by delusions, had become increasingly psychotic and on the day had acted on his delusional beliefs by assaulting his mother and another person who came to her assistance, and later by threatening police with a weapon."*

Of importance Dr Skinner noted that:

> *"Persons suffering from mental illness sometimes act on their delusions, are at risk of suicide and sometimes persons affected by severe mental illness severely injure or even kill other persons when acting on their delusional beliefs."*

I accept Dr Skinner's analysis and opinion. I am satisfied that at the time of the incident Michael was suffering from an acute psychotic episode and was more likely than not responding to delusional beliefs or command hallucinations that resulted in him fearing for his safety. The psychosis that he was suffering probably meant that he did not recognise Ms Heath as being his mother but as being a person who posed a threat towards him. Likewise when the police came to his home he probably believed that they were a threat towards him and his actions were, as part of his delusional beliefs, understood by him to be an attempt at self-protection.

The Police.

Michael's death occurred during the course of a police operation and as such it is important that the police response to the situation at an organisational level and the actions of the individual officers involved be reviewed. This is, in part, why an inquest is mandatory in such situations. It is in the interest of the public, the family of the deceased and the officers involved that such events be examined so that where lessons might be learned from the events that can occur.

The actions of the police can be divided into three time periods, each of which I will examine. Those periods are:

- The response to Mrs Heath's request seeking assistance,
- The actions of the police after Michael had been shot, and
- The actions of Senior Constables Hogg and Battle.

On 10 October 2008 at 11.17am Katrena Cox, an employee of Spinnakers Caravan Park phoned Belmont Police Station on behalf of Mrs Heath and sought police assistance. The job was broadcast on police radio at 11.26am. As previously mentioned officers Hogg and Battle did not arrive at the caravan park until just before 5pm. There was thus a delay in responding of a little over five and a half hours. The questions that must be asked are why it took the police so long to respond and did the delay contribute to Michael's death.

The actions of the police on the day were examined in detail. As indicated the job was broadcast on police radio at 11.26am. The evidence was that the Sen Constables McArthur and Mignanelli who were in LM 23 at 12.05pm accepted the job.

At 12.40pm Mrs Katrena Cox once again called the Belmont Police station to find out how long it would be before police arrived at the caravan park. She was assured that police were expected to arrive shortly. Unfortunately at 12.45pm LM23 responded to another job that was considered to be more urgent than the one at Spinnakers.

The reason the new matter was given greater priority was examined at inquest. It was, in fact, very similar to that involving Michael. It involved a person who also suffered from schizophrenia. The difference was that at the time the call was made to the police in that case the patient was still destroying property and attacking his mother and was thus an ongoing threat. It was considered that it had priority over Michael's case as Mrs Heath was safe and there was no current violence by Michael towards any third party. It was also the case that there were no other vehicles available to assist. I am satisfied that in the circumstances, and having regard to the availability of police resources at the time, the decision made was an appropriate one.

When police had not arrived at Spinnakers after 2pm Katrena Cox once again made a call to Belmont Police Station. This call is recorded as having occurred at 2.25pm. Mrs Cox spoke to Senior Constable Brady. Officer Brady made telephone contact with Officer McArthur and as a result it was decided that the job should be allocated to officers who commenced duty at 3pm. As a result of this Officer Brady spoke to Officer Hogg shortly before she commenced duty. The matter was to be the first matter that was to be undertaken by Officers Hogg and Battle.

Once again circumstances intervened to delay the officers attending to the matter.

Unbeknown to officer Hogg at the time she spoke to Officer Brady, Officer Battle had been directed to serve certain documents on the office of the Director of Public Prosecutions and the solicitor for a party in a forthcoming trial. Officer Hogg was required to do so before the conclusion of the day. This required Officers Hogg and Battle to travel to Newcastle and back. This resulted in them not arriving at Spinnakers until just before 5pm as previously mentioned. In the meantime Ms Heath and Greg Capel had, at about 4.20pm, gone to the trouble of attending the Belmont Police Station in person to inquire as to when police would arrive at the caravan park.

The further delay in attending to a request for assistance that was made at 11.17am was most unfortunate. One would hope that in ordinary circumstances where a person has been assaulted by a loved one suffering from mental illness and seeks help the police would be able to respond to such a request in substantially less than five and a half hours.

At the same time the police on duty have to respond to the demands placed on them within the constraints of the resources provided to them. I accept that it was necessary for Officer Battle to comply with the court direction that required him to travel to Newcastle and that he and Officer Hogg were the appropriate officers to be allocated to respond to Mrs Heath's request for assistance. Indeed, on the evidence available, it is likely that they were the only officers that were available.

The delay in responding to Mrs Heath's request for assistance has been explained. I accept that having regard to the resources available the delay, although disappointing, could not be avoided on the day. The question that I must try and answer, if possible, is whether or not the delay contributed in a material way to the events that were to occur when officers Hogg and Battle arrived at Michael's home. I accept that the best assistance available in answering this question is the opinion of Dr Skinner who thought:

> *" Police officers who attended the caravan park were faced with an emergency situation. At the time it would have been difficult to prevent a dangerous confrontation with Mr Capel. Even if they had arrived hours earlier, the situation would have been as problematic, as Mr Capel had been violent towards his mother and another person. Prevention of the acute psychotic episode might have been addressed at an earlier stage, weeks or days earlier, when Mr Capel might have been accepting of assistance from the general practitioner or the mental health team."*

Having regard to the evidence available I am satisfied that it is more likely than not that the delay in responding by the police did not aggravate the situation and as such the delay was not a significant contribution factor to the events that led to Michael's death.

Officers Hogg and Battle arrived at the caravan park just before 5pm. After speaking to Mrs Heath and Greg Capel for a short time they drove to Michael's home and parked in a position below his lounge room window. They then went to the front porch of the home and knocked on the door.

As I have already indicated during the inquest what followed was examined in detail. After the initial exchange between Michael and the officers they backed away from him and he followed with the knife in a threatening pose. Capsicum spray was used on

three occasions apparently having no effect on Michael but ultimately, due to the wind, disabling Officer Hogg.

As previously mentioned I am satisfied that during the confrontation with the police Michael, as was the case in the confrontation with his mother and Mr Ahaya, was suffering from an acute psychotic event.

He was either responding to delusions that Officers Hogg and Battle were threatening him or suffering from hallucinations involving auditory commands requiring him to act to protect himself. I am satisfied that his actions in threatening Officers Hogg and Battle, as well as Mr and Mrs Byrne, were thus a symptom of his illness.

Notwithstanding this the danger posed by Michael to Officers Hogg and Battle and Mr and Mrs Byrne was no less serious. At first glance many questions could be asked, and were, about the response of Officers Hogg and Battle to the situation. Such questions would include matters relating to where the police vehicle was located, how they approached the front door of Michael's home, the decision of Officer Hogg to slide the front door open, the use of capsicum spray by Officer Hogg, the manner in which they backed away from Michael as he advanced towards them, the manner in which they shouted their commands to him and finally the timing of the decision of Officer Battle to use his firearm. The asking of such questions is legitimate. The death of an individual resulting from the actions of a police officer must be examined in detail.

Having regard to the evidence available I am satisfied that each of the officers acted reasonably in the circumstances and that no criticism of their actions is warranted. I am satisfied that when Senior Constable Battle discharged his firearm he did so in response to a threat to life.

NSW Police guidelines with regard to the use of firearms states that:

> *"You are only justified in discharging your firearm when there is an immediate risk to your life or to the life of someone else, or there is an immediate risk of serious injury to you or someone else and there is no other way of preventing the risk."*

I am satisfied that at the time Officer Battle discharged his firearm he was confronted with Michael who, because of his actions, posed an immediate risk of death or serious injury to either himself or the other people in the vicinity. I am satisfied that Officer Battle acted in accordance with the above guideline.

The actions of Officers Hogg and Battle were reviewed by a number of parties including senior police officers. Each reached a similar conclusion. Of considerable assistance was the review undertaken by Dr Skinner. Dr Skinner reached a similar conclusion to that which I have reached in respect of the actions of the officers.

Of significance, however, Dr Skinner expressed the opinion that Offers Hogg and Battle may have underestimated the threat posed in attending Michael's home. Dr Skinner said:

> *"Police attending the situation appear to have underestimated the possibility of a crisis, they were told that Mr Capel had no record of violence and would be likely to go along with police.*

They anticipated that they would be able to speak with him, arrange a schedule and transport him to hospital, apparently without considering the possibility of a dangerous situation developing."

The officers had assisted persons suffering from mental health issues on many occasions before. They no doubt had a good police understanding of how to respond in situations. Unfortunately this expectation was not a valid one in this case. As Dr Skinner pointed out:

"The fact that he had assaulted his mother and another person, acts that were out of character, and then remained in his caravan without attempting to check on his mother were indications that he was in an acutely psychotic state and might have presented a danger to police and others."

This observation of Dr Skinner, with which I agree, is not made by way of criticism of Officers Hogg and Battle but simply to highlight that dealing with persons suffering from mental health issues is a complex matter and officers doing so need specific training and assistance in order to ensure that they can respond in the best possible way when faced with situations such as that which occurred on 10 October 2008. Indeed Dr Skinner recommends that such training occur. I shall return to this matter later in these findings.

One issue that must be dealt with is the number of wounds that Michael suffered. We were assisted in this matter by the evidence of forensic pathologist, Dr Nadesan, and ballistics expert, Senior Constable Schey.

The evidence, which I accept, is that Michael suffered eleven gunshot wounds. There were at least five identifiable entry wounds. The experts were not able to determine the order in which the wounds were suffered. They were, however, able to identify two wounds that would have been fatal.

Officer Battle's firearm was seized after the event and examined. Eight rounds were found to be missing from the firearm. Two bullet holes were located in a caravan wall and its vicinity. The evidence substantially accounted for all shots fired by Officer Battle.

Those who heard the firing gave slightly different evidence as to the number of shots fired and the manner in which the shots were fired. Those differences can probably be accounted for by the different circumstances of the various witnesses. The one common aspect of the evidence was that the time during which shots were fired was very short.

Police training requires that the use of a firearm should be no more than what is necessary to ensure that the danger is contained. I accept that once Michael fell to the ground no more shots were fired. I accept that shortly after that occurred Mr Byrne approached Michael and removed the knife that he had been carrying.

One might wonder whether the number of wounds suffered by Michael was excessive in the circumstances. The evidence was, however, that not all wounds Michael suffered were disabling. According to Dr Nadesan, two of the shots would have been fatal. Only one of those would have made Michael fall immediately to the ground. That meant that Michael could have continued to move forward, even after he had been shot several times. I am satisfied, having regard to the evidence considered as a whole; there is no basis to suggest that the number of shots fired by Officer Battle was excessive. I accept

the evidence that once Michael fell to the ground Officer Battle ceased firing.

Greg Capel made a statement to the police on 10 October 2008 and then participated in a video walk-through on 20 October 2008. When describing the events of 10 October 2008 during the walk-through Greg Capel suggested that whilst Michael was laying on the ground a police officer:

"Just kicked him over with his boot and that was it, as I stood there_"

Describing the event further Greg Capel said:

"And then they've just gone and shoved him over with the steel-capped boot, whatever they wear."

Greg Capel when further questioned on this topic said that the person, who acted in the way described was standing behind Michael and *"kicked him forward."*

Greg Capel was unable to describe the officer he said acted in that way and was unsure as to precisely when the incident happened.

It would be most inappropriate for a police officer to kick a person in the back that was on the ground having been shot. Such action would need to be the subject of criticism and the officer involved disciplined. I have examined the evidence available on this matter. Officer Battle denies that he acted as suggested. Mr and Mrs Byrne did not see such an event. Other officers who gave evidence denied moving Michael with their feet and stated that they did not see Officer Battle do so. None of the other persons present can assist directly.

The evidence is however that immediately after Michael fell to the ground Officer Battle sought to assist him. Towels were sought and Michael was rolled onto his side. At about the same time Mr Byrne approached Michael and removed the knife. There was a lot of activity going on at the time Greg Capel arrived. Perhaps Greg Capel misinterpreted what was occurring. There is no doubt that it would have been an extremely stressful, distressing and probably confusing time for him. Ultimately the evidence available does not support the suggestion that Michael was kicked. I am satisfied that Greg Capel was mistaken in this matter.

Michael's Medical Treatment Before 10 October 2008.

Michael was at various times under the care of his local general practitioner, Dr Gordon, and the Mental Health Team (the MHT) of the Hunter and New England Area Health Service (the AHS). There is no evidence to suggest that the care that Michael received was inappropriate.

All evidence available confirms that, when Michael was supported by the medication prescribed for him, he was able to live an independent life and was not a threat to either himself or any other person. However when he was not receiving his prescribed medication the symptoms of his illness began to manifest themselves and, as the events of 1992 and 2005 show, a crisis quickly developed.

Michael was receiving his monthly injection from his general practitioner Dr Gordon. He received his last injection on 5 August 2008. He was thus due for a further injection on or about 5 September 2008. He missed that injection. When Ms Heath spoke to him by phone on 8 October 2008 she thought that Michael *"seemed in an abnormal state."*

When Mrs Heath could not make contact with Michael on 9 October 2008 she became concerned. She suspected that he might not have received his medication and, the next day, contacted Dr Gordon's practice where her suspicions were confirmed. Unfortunately when Michael missed his injection on 5 September 2008, and again on 5 October 2008, he had not been followed up by anyone to ensure that he received the medication.

As I have already indicated I am satisfied that at the relevant times Michael was experiencing an acute psychotic event. The evidence would suggest that such events would be unlikely to occur if Michael were to receive his monthly injection of antipsychotic medication. In the circumstances I am satisfied that a contributing factor to Michael's death was the fact that he did not receive his medication when it was due.

At the relevant time Michael was not under any legal obligation to take his medication. He did so voluntarily. It would seem, however, that a symptom of the illness that he suffered could be the delusional belief that he did not suffer from an illness and thus did not need to take medication. That is why the legislation provides for the making of a Community Treatment Order (CTO) in an appropriate case so as to ensure that the individual receives the medication needed to maintain their wellbeing.

In this case Michael had been cooperating in his medication regime for a number of years and the making of a CTO would not have been appropriate. However it is unfortunate that when he did not attend to receive his injection he was not followed up. As Michael was a voluntary patient, Dr Gordon did not have any power to require him to receive his medication. However if Dr Gordon had had a system of following up patients who had not attended to receive the injection Michael might have been contacted at a time when he was willing to comply with the recommendations of his treating doctor.

By saying what I have said above I am not intending to criticise Dr Gordon in any way. He did not have a legal obligation to follow up Michael when he did not attend to receive his prescribed antipsychotic medication. The role of the Coroner is, however, to seek to learn from the circumstances of a death so as to, if possible, develop systems that will avoid such circumstances in the future.

Dr Gordon gave evidence at the inquest. He acknowledged the importance of following up patients such as Michael who have not attended to receive their prescribed medication. He gave evidence that since Michael's death his practice has introduced a system of following up such patients. This is a very positive response to the tragedy that led to Michael's death. I propose to make a recommendation in accordance with Section 82 that hopefully will ensure that all general practitioners who are assisting patients such as Michael have such a follow up system.

As indicated above Michael had also been a patient of the MHT of the Hunter and New England Area Health Service. He had been an in-patient at the James Fletcher Hospital in 1988 and 1992. The MHT had been his primary mental health carer between 1988 and 1991 and had also become involved with his care in 2003 and 2005.

It is not in dispute that Michael's last involvement with the MHT was more that three years prior to the events of October 2008. None the less on 10 October 2008 in her efforts to assist her son Ms Heath phoned the team at Charlestown. She was advised to phone the police. Having regard to Michael's violence towards Ms Heath the advice given was appropriate as police are the lead service provider in such situations.

Although there was no doubt that the advice that Mrs Heath received on this occasion was appropriate a question was raised as to whether or not such advice should have been given to Ms Heath by an employee who was not clinically trained. The evidence was that Mr Gavin Rook, an experienced administrative officer of the MHT, gave the advice to Mrs Heath. The fact that Mr Rook gave the advice did not give rise to any coronial issues in the inquest as the advice was appropriate and did not contribute to Michael's death.

Nevertheless evidence given at the inquest was that since Michael's death action has been taken by the Area Health Service to ensure that in such situations an employee with clinical qualifications and experience will give such advice. The giving of advice in such situations will on many occasions require the exercise of clinical judgement. It is appropriate that a person who is able to exercise clinical judgement respond to requests. The action of the Area Health Service is to be commended.

The MHT does, however, have a role to play in situations such as that which involved Michael. In a situation where a patient decides to cease taking medication and the treating general practitioner is unable to get him to do so it may be that members of the mental health team will be called upon to assist.

Such assistance may involve undertaking an assessment of the patient's mental state and instituting action to ensure appropriate treatment in accordance with the relevant mental health legislation.

In Michael's case because he had been discharged into the care of Dr Gordon his file had been closed. Had the members of the mental health team been required to assist they would not have had easy access to their file information relating to Michael's condition.

One would expect that the officers involved would have sought to obtain up to date information as to Michael's situation at the time they became involved. However it might also be the case that the MHT files could contain useful information.

During the course of the inquest it was suggested that I might make a recommendation in accordance with Section 82 that the files of patients' who have been discharged by the MHT be maintained, that there should be regular reviews of the patient's mental health status and that where an event occurs that requires access to such information the file would then be readily available.

The Area Health Service (the AHS) resisted such a recommendation. It was argued by them that the demand on the MHT was such that once a patient was discharged into the care of a general practitioner the resources available did not allow the conduct of regular reviews. The AHS was also of the view that it was for the general practitioner, who had responsibility for the care of the patient, to determine when, and if, mental health reviews should be undertaken.

Dr Gordon in his evidence agreed that he would have had access to the assistance of the MHT if he had needed it. He also agreed that it would be helpful if there were closer involvement between the general practitioner and the MHT in the care of a patient.

Resource availability for the care of persons with mental health difficulties is a major challenge for Australia. The AHS must, of course, use the resources it has available in the way it considers most appropriate. It is not for this court to make recommendations as to the distribution of funds between competing needs. I do not know what those competing needs are.

In any event the evidence available does not suggest that the lack of availability of the MHT file contributed to the circumstances of Michael's death and, in addition, I could not conclude that regular mental health assessments would have prevented the tragedy that occurred on 10 October 2008. In the circumstances I do not propose to make the suggested recommendation.

As I have already mentioned one of the reasons why coronial investigations are undertaken is to try and learn from the circumstances of a death. Michael's death was a tragedy for both his family and the wider society. Put in stark terms Michael lost his life when he became a danger to others due to an illness that he suffered.

From the evidence available when Michael was appropriately medicated he was not a threat to either himself or any one else. This changed when his medication ceased.

The MHT is the default primary carer for persons with mental illness. When diagnosed, and the patient is discharged from a hospital, the MHT will be the carer. I accept that in some, if not many cases, it is also appropriate for the patient to be discharged by the MHT to the care of a general practitioner once the acute stage of the illness has passed. The evidence suggests that the maintenance of regular medication is what is necessary to ensure that the illness will not once again become acute.

As has now occurred in Dr Gordon's practice there, needs to be a system in place so that when a patient ceases attending to receive medication they can be followed up and if necessary the assistance of the MHT can be sought. To ensure that this occurs the MHT should arrange that when a patient is discharged into the care of a general practitioner it ensure that such a system is already in place. I propose to make a recommendation in accordance with Section 82 to this effect.

Mental illness is a complex human condition. Its effect on a patient can be dynamic. Violence can be a characteristic of such illness when in an acute phase. In such situations the police will provide the primary response to the crisis. In this case, even though Officers Hogg and Battle had had previous experience in dealing with persons with mental illness it was Dr Skinner's assessment that they under- estimated the danger that they faced on 10 October 2008.

In dealing with such situations it is necessary to have regard to the wellbeing of not only the person suffering from the mental illness but also the police officers called upon to assist the patient. The officers thus need to be provided with as much training and information as possible concerning mental illness and how best to respond in situations such as occurred on 10 October 2008. Dr Skinner made a recommendation as to the

need for such training in her evidence.

Evidence was given to the inquest that the NSW Police Force had responded to such a need by the development of the Mental Health Intervention Team (MHIT) course. The MHIT course was developed because there was a recognition by police that:

> *"Front line police officers are often faced with mental health incidents that have the potential to impact on their own safety, and that of the community."*

As such the MHIT course aims to provide police with:

> *"The knowledge and skills to confidently interact with persons who are affected by mental health issues."*

The goals of the MHIT course are said to be to:

- Reduce the rate of injury to police and mental health consumers in interaction;
- Improve the awareness amongst frontline police of risks involved in mental health incidents;
- Improving collaboration with other government and non-government agencies in response to, and management of mental health crisis incidents; and
- Reducing the time taken by police in the handover of mental health consumers to the health care system.

In December 2009 the Final Evaluation report of the MHIT course, was released by the Charles Sturt University. That evaluation was positive and as a result the NSW Police Force is now arranging for officers to undertaking the course.

The NSW Police Force is to be commended for the development of the MHIT Course. It is clearly a very positive response to a significant need. The evidence before the inquest was that dealing with mental health incidents was an important, and growing, aspect of general duties policing.

The nature of the MHIT course is, however, resource intensive and costly. Only a small proportion of front line police officers will be able to undertake the MHIT course. No doubt for the officers that have the opportunity of undertaking the MHIT course the benefits will be considerable.

Dr Skinner in her review suggested that:

> *"It would be useful for police officers to have some training in dealing with mentally ill persons. This could be brief instruction of only one or two hours to give some insight into the problems that they might encounter."*

The MHIT course as described in the evidence before the inquest is a more substantial training activity than that suggested by Dr Skinner. The advantage of Dr Skinner's suggestion is that such training could be made available to a greater number of officers than the number it is anticipated will attend the MHIT course.

Balancing the resource demands for training is a difficult challenge for NSW Police management. The significance of the benefits that will flow to the community in general,

and front line police officers in particular, by the expansion of availability of the MHIT course would suggest that it should have priority over other training packages.

Notwithstanding this I propose to recommend that the Commissioner give consideration to the development of a training module as suggested by Dr Skinner and that such module form part of general duties officers mandatory annual training as soon as possible.

This proposed training should be in addition to the provision of the MHIT course. The involvement of front line police in incidents involving persons with mental health issues is significant and creates a current need. Basic training of the nature suggested by Dr Skinner would provide officers with training and support in the interim whilst the numbers of officers who are able to attend the MHIT course is expanded.

The Police Investigation

Michael's death occurred as a result of the action taken by police. It was a critical incident. The *Guidelines for the Management and Investigation of Critical Incidents* of the NSW Police Force applied to the subsequent police investigation. That investigation was the subject of review during the course of the inquest. Having regard to the evidence available I am satisfied that the police investigation was conducted in accordance with the Guidelines.

There is, however, one aspect of the investigation that I wish to comment on. In situations where a person dies during or as a result of a police operation there is sometimes a debate as to how the evidence of the involved officers should be taken.

In some instances such evidence is taken by way of electronic recording whilst at other times a statement is taken from the involved officers. It has been suggested that the taking of a statement is more appropriate as it treats the officers involved as witnesses where the taking of their account in an electronic form might be suggestive of wrongdoing or inappropriate action on their part.

In this case the use of the video recorded walkthrough by Officers Hogg and Battle shortly after the events was a very effective way of dealing with this issue. The evidence was taken whilst it was fresh in the minds of the officers concerned and in a manner that was non-threatening. Indeed it was so effective that at inquest none of the parties granted leave to appear required Officer Battle to be available to give oral evidence. The Officer in Charge, Detective Inspector Bryne Ruse, and the various other officers responsible for the police investigation are to be commended for the quality and effectiveness of the police investigation.

Conclusion

Michael's death was a tragedy. Looking at the circumstances of his death in retrospect it is apparent that it could have been prevented. If it had been realised that he had ceased receiving his prescribed antipsychotic medication and he had received assistance prior to him entering an acute psychotic state he may not have become a danger to both himself and others. Once that occurred, however, the situation became dynamic with an uncertain outcome. Hopefully the examination of those circumstances will help to lessen the possibility of a similar event occurring in the future.

Formal Finding:

Michael Capel (born 29 June 1965) died on 10 October 2008 at Belmont NSW. The cause of his death was multiple gunshot wounds received during the course of a police operation.

Recommendations :

To: The Commissioner of NSW Police.

That consideration is given to the development of a training module for general duties police officers to assist them in dealing with mentally ill persons.

That such training module, when developed, form part of the mandatory training obligations of general duties officers.

To: The Chief Executive, Hunter and New England Area Health Service.

That where a patient, who is receiving antipsychotic medicine by way of periodic injection, is discharged from the care of a mental health team (the MHT) to the care of a general practitioner the MHT ensure that the general practitioner has in place a system to identify and follow up such patients where they cease presenting themselves to receive the prescribed medication.

11. 1969/08 Wayne Sydney Thomas Pearsall

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Inquest into the death of Wayne Sydney Thomas Pearsall at Wagga Wagga Base Hospital on 28 October 2008. Findings handed down by Deputy State Coroner Brydon on 26 November 2010.

On 28 October 2008 Wayne Sydney Thomas Pearsall, aged 50 years, was serving a term of imprisonment for sexual offences at Junee Correctional Centre.

On the morning of the 28 October 2008 Wayne Pearsall was carrying out his function as a bin sweeper. This function involved sweeping and light rubbish removal. He was described as being in a good mood and had made no complaint about any health issues.

Following the completion of his duties he was observed a short time later seated at the front of the medical waiting room. He indicated that he did not feel well and complained of feeling hot. He was escorted into the waiting room where he appeared to lose his balance and commenced to suffer breathing difficulties.

Mr Pearsall was immediately seen by a nurse and he complained of crushing chest pain. An emergency code White was signalled. He was seen straight away by Dr Baguley and a resuscitation process was commenced. An ambulance was summoned. It arrived shortly thereafter and Mr Pearsall was transported to Wagga Wagga Base Hospital. On arrival, Mr Pearsall was described by the treating physician as, confused but talking, suffering severe respiratory distress with obvious evidence of heart failure. Mr Pearsall's

health continued to decline to the point of death, approximately one hour 46 minutes after his arrival at hospital.

Dr R. Van Vuuren undertook a post mortem examination. The cause of death was found to be Atherosclerotic Heart Disease

During the course of the inquest Dr Baguley gave evidence that that he conducted a medical examination upon Mr Pearsall on 1 May 2008. Whilst he noted that Mr Pearsall was a smoker and had some signs of alcoholic brain damage no other conditions were found that would have alerted Justice Health to a significant risk of heart disease. There was no evidence of any prior complaint of chest heaviness or heart disease by Mr Pearsall. No criticism was made by the Coroner of the medical treatment given to Mr Pearsall on the date of his death. It is clear on the evidence before the Inquest that Mr Pearsall died from natural causes.

Formal Finding:

Wayne Sydney Thomas Pearsall, aged 50 years, died on 28 August 2008 at Wagga Wagga Base Hospital as a result of Atherosclerotic Heath Disease consistent with a natural causes death.

12. 1647 of 2008 Glen Patrick McDonald

Inquest into the death of Glen Patrick McDonald at Quirindi on the 24 September 2008. Finding handed down by Deputy State Coroner Mitchell at Parramatta on 16 April 2010.

This is an inquest into the death of Glen Patrick McDonald who was born on 6 October 1967. Mr. Andrew Eckhold of the Crown Solicitor's Office, instructed by Ms. Bonner appeared as Counsel assisting the Coroner and Mr. Stuart Robinson, solicitor, appeared for the Commissioner for Police. Glen McDonald's parents attended the inquest but were not represented and Mr. Eckhold and Ms. Bonner conferenced with them and ensured that any matters, which they wished to have placed before the inquest, were properly aired.

This is a mandatory inquest because Glen McDonald's death occurred *"in the course of police operations,"* police having been called to his home at *"Karanilla,"* Lowes Creek Road off Borah Creek Road, Quirindi and, indeed, having arrived there immediately before his death. It is what is described as an *"OIC only"* inquest in that, because the investigations have been so thorough and the Coronial brief which constitutes the principal part of the evidence so comprehensive that it has been necessary to call only one witness, namely Detective Inspector R. Blackman who is the Officer in Charge of the investigation.

The Coronial brief contains not only Mr. Blackman's very lengthy and detailed statement but also statements of the other police officers that were involved in the matter, both

those who travelled to *"Karanilla"* in an unsuccessful attempt to render assistance to Glen McDonald and those who were otherwise engaged in the matter. In addition, there are police incident logs, sketches prepared by police officers and others and a Firearms Certificate under section 87 of the *Firearms Act.* In addition, the brief contains an interview with Glen McDonald's son, Robert, and with Michelle Linich, his friend and sometime companion, and statements of Mrs. Patricia McDonald, the mother of the deceased, Aaron Corbet, a family friend, Craig Southwell, a neighbour, and Robert's teacher at Quirindi High School, Jennifer Beresford. Medical and paramedical evidence contained in the brief includes statement of ambulance officer Beacroft, and a statement and attached reports and the records of Glen McDonald's treating *G.P.*, Dr. Guirguis Andrawes of Quirindi. The Autopsy Report was prepared on 24 November, 2008 by Dr. Allan David Cala, Senior Specialist Forensic Pathologist of the Newcastle Department of Forensic Medicine. Finally, there is a report of Lucas Cornelis van der Walt of the Police Forensic Ballistics Investigation Section.

The primary function of a Coroner at an inquest is to identify the deceased person and to establish the time, date and place and direct cause of death and, in this instance, because of the presence of police, that is relatively easy to do. Glen McDonald died at approximately 5.17pm on 23 September 2008 at Quirindi Hospital. The Autopsy Report pronounces *Gunshot Wound to Abdomen* as the cause of death and the evidence of police eyewitnesses is that the wound was self-inflicted. The certificate of Mr. van der Walt eliminates the possibility that ballistics found at the scene were police issue ballistics. At any event, police had only just arrived at the scene when Glen McDonald died and had managed to establish only the barest interaction with him.

Some time in the mid-afternoon of 23 September 2008, Glen McDonald called to see his son Robert at Quirindi High School. Robert was 15 years of age and lived with his father at *"Karanilla."* He was the only one of Glen McDonald's three children still living at home. Mr. McDonald said to his son *"Don't come home because it's going to be a mess"* and when Robert questioned him about what he meant, he added, *" Well, I'm going to shoot myself… …It's about Michelle; I've had enough of her. Um, me and her we just, I can't be with her if she leaves me you know. I can't handle it."*

In his statement, Robert McDonald, who I have never met but who I must say is a very brave young man, protested in vain and then reported the matter to the school authorities who informed police shortly after 3pm. Glen McDonald then returned home, hurriedly according to his neighbour, Aaron Corbett, and apparently remained there.

Police were not far behind. It had been raining very heavily and the creek between Quirindi and *"Karanilla"* was up, the road was unsealed and greasy and not very well marked and it took police about 40 minutes to make the trip. According to Senior Constable Lauren McNeice, four police officers arrived at the homestead in a caged truck, *""parked on the grass with the house in full view"* and watched as Glen McDonald came out of the front door on to the veranda, holding a rifle in his left hand, the muzzle pointed upwards. Constable Baker yelled out to him *"It doesn't have to be like this"* and Glen McDonald replied, *"I've had enough."* And then, as Senior Constable McNeice turned to don her protective vest, she heard a bang and saw Glen McDonald drop the rifle and fall to the ground. He was still alive and Ms. McNeice straightened him as he was lying, grabbed a towel and applied compression to his stomach. He started shaking and was *"quite pale"* and police covered him with a blanket. Constable Thompson fetched Mr. McDonald's

rifle, secured it in the police vehicle and then drove off to locate the ambulance, which had followed police but had failed to keep up with them as they sped towards *"Karanilla."*

In her statement, Ambulance Officer Nicole Beacroft describes the difficulty experienced in getting the ambulance to *"Karanilla"* particularly regarding the swollen creek. As she and her offsider, Tanya Pratt, approached the homestead, she saw the police vehicle approaching and heard the driver, who had come to look for her (I think was Constable Thompson) shout *"He shot himself in the stomach."* When Ms. Beacroft arrived, she approached Glen McDonald where he lay. He was conscious and police were applying compression to his stomach. She inspected the wound and noticed that his eyes were open but unresponsive. His respirations were good at first but were dropping off. He was cannulated, a Guedal airway was inserted to assist his breathing and other steps were taken but, according to Ms. Beacroft, *"the man was having what are called Chaynne-strokes breaths. We call them 'agonal resps.' So I was assisting him in his breathing. At this point in time we felt his pulse and noticed he did not have one. I formed an opinion that he had a non-sinus rhythm."* Compression was continued and Mr. McDonald was observed to have a strong carotid pulse but he was still not breathing effectively.

Another ambulance officer, Megan Ryder, and then two others, David McMillan and Derek Baker arrived at the scene and the highly experienced Officer McMillan took charge for the journey to Quirindi Hospital.

The Triage notes confirm Glen McDonald's arrival at hospital at 5.09pm and life was pronounced extinct by Dr. William Redmayne at the hospital at 5.17pm on 23 September 2008.

The death of Glen Patrick McDonald is a tragedy for his family and a matter of great sadness. I hope that, to some extent, they will be comforted by recalling the bravery with which he faced up to the terrible challenges, which his long illness imposed upon him. His parents will be comforted, too, by knowing that his youngest son, Robert, conducted himself so bravely during this ordeal and that he is now safe and well, living with his mother, in contact with his siblings and in constant and loving touch with his grandparents.

The latter part of Glen McDonald's life had been bedevilled by cancer which he appears to have fought bravely for a number of years. Most tragically, he had suffered from Bowen disease, which is defined as *"a form of intraepidemal carcinoma characterised by the development of slowly enlarging pinkish or brownish papules or eroded plaques covered with a thickened horny layer."* It can be a painful, unsightly, persistent and life threatening condition for which Mr. McDonald underwent surgery in 2005 and again in 2006. Notes of Dr. Singh dated 21 November 2007 record *"this 40y.o. man presented to E.D. with a large fungating SCC to his scalp.*

He had had numerous excisions and recurrences of SCCs in the same area over the past 6 years. His emergent presentation was due to a 4-week history of increasing headaches associated with photophobia. On examination, Mr. McDonald was seen to have a large fungating crater-like lesion on his right occipital/parietal scalp with a necrosed section in the centre." Dr. Andrawes' notes demonstrate Glen McDonald's continuing difficulties regarding long term and persistent infection of his wound and, by the end of 2007, he was complaining of increasing headaches and the wound had still not settled.

There was further surgery for a bone tumour in January, 2008 and Mr. McDonald experienced continuing headaches, pain to the shoulders and weakness. Despite radiotherapy in April, 2008, there was a lump at the base of his neck in May and, some time later, he was asked by his oncologist to undergo a bone scan because he might have bone metastasis.

For a long time, this brave man battled cancer with little complaint but, on 23 September, 2008, the day of his death, when he saw Dr. Andraewes, he mentioned to him for the first time *" that he had been suffering from depression since his surgery"* and Dr. Andrawes conducted a *K10* assessment of his mental health. In the course of that assessment, he told the doctor that he experienced depression, feelings of worthlessness and sadness. Mr. McDonald denied any suicidal ideation or suicidal intent and Dr. Andrawes, who saw him as *"withdrawn,"* prepared a mental health care plan for him.
I think, in fact, his continuing ill health and the worry, pain and depression it caused him were long-term burdens, which Glen McDonald carried. He had formed something of a romantic attachment rather than a domestic relationship with Michelle Linich which, in his mind, might not have been quite as casual as her statement to police would indicate and he seems to have been very sensitive to the continuing place of her estranged husband, Brian Linich, in her life and jealous of his recent reappearance.

Ms. Linich explained that *"He (Glen McDonald) was always saying that he loved me and I said that I didn't want to hear it and that the recent relationship was not going to go any further than a friendship. He used to always try and touch me in public places and used to push him away and sort of say, like, you know, it's not like that."* There had been some unpleasantness involving Glen McDonald, Ms. Linich and Brian Linich on 22 September, 2008 when Mr. McDonald had refused to accompany Ms. Linich to the local races if Mr. Linich was going to be there

Next day, the day of his death, he apologised to her for his behaviour but it is not clear that she had accepted his apology or that their relationship, such as it was, would continue.

Ms. Linich went on to tell police that Glen McDonald had sometimes threatened her that he would kill himself, telling her *"you don't know how often I've put a gun to my head."* Apparently he had acted towards her as though he was contemplating ending his own life. She seems to have thought that he was saying those things and acting in that way in order to elicit her sympathy and draw her to him. She also told police of an incident some weeks earlier when, after an argument, Mr. McDonald had fired a shot over her motorcar as she drove away.

There are a number of things to be said about Ms. Linich's evidence regarding Glen McDonald's erratic and unreasonable and perhaps manipulative behaviour towards her. Firstly, Glen McDonald has not been able to answer those allegations or put his own interpretation on what may have passed between them. Secondly, Ms. Linich did not appear at the inquest and was not cross-examined and, accordingly, her evidence was not tested. And thirdly, Glen McDonald's health problems were such that, to a large degree, a *"cry for help"* which, on one view of them, is what all of Ms. Linich's allegations might amount to, might be understandable in the circumstances even if unjustified. I think, as his note to his son Robert suggests, his disappointment that the relationship which he sought with Ms. Linich was not progressing as he had hoped may have added to Glen McDonald's other worries at the time of his death.

According to Ms. Linich, Glen McDonald had often threatened to kill himself. She told police *"there's incidents when we've had a falling out and he's texted me and said that he was going to shoot himself and I've got friends to go out there. We've searched all over the place and there's been Ratsak and bullets and the gun out on the bed and we've looked all around the house . And then, I've said that I've rang the cops and he's basically texted and said I'm sorry."*

Whether the events of 23 September leading up to his death were just other threats, other *"cries for help,"* I can't say but he certainly provided plenty of warning and plenty of time during which steps might be taken to come to his aid. As Detective Inspector Blackman pointed out, Mr. McDonald appears to have waited in his house for up to an hour after his return from Quirindi before shooting himself. His earlier mention of suicide had tended to refer to a discharge into his head and it seems to me such is a far more likely way of killing oneself that the painful, slow and quite uncertain method of a gunshot to the stomach. Had Mr. McDonald wanted to kill himself quickly and painlessly and without fear of botching the job, he might well have shot himself in the head. That he chooses not to do so, aiming instead for his stomach, raised a doubt in Mr. Blackman's mind as to whether he ultimately intended to take his own life.

Suicide is so grave and serious a matter that, for a long time, the law has insisted on a higher standard of proof than the mere balance of probabilities. At law, there is a presumption against suicide and, if it is to be found, it must be positively proven. A coroner must be *"comfortably satisfied"* before such a finding can be made. In the present case that degree of certainty is not available to me and I am unable to determine whether or not Glen McDonald ultimately intended to take his own life.

Formal Finding:

I find that Glen Patrick McDonald died at 5.17pm on 23 September, 2008 at Quirindi Hospital, Quirindi, and NSW. of a self-inflicted gunshot wound to the abdomen but whether he then intended to take his own life, I am unable to determine.

I direct that the non-publication order made in the course of the proceedings be dissolved.

13. 40 of 2009 Koan Heng

Inquest into the death of Koan Heng at Brooklyn on the 3rd January 2009. Finding handed down by State Coroner Jerram at Glebe on the 12 February 2010.

The Inquest before me concerned the death of *Koan Heng* (D.O.B. 26th April 1968) who, on the available evidence placed before the Inquest, died some time shortly after 9.30am on Wednesday 31st December 2008 of symptoms described in the post mortem report of Dr Orde as being not inconsistent with drowning (see post mortem report which forms part of exhibit "1")

BRIEF FACTUAL STATEMENT OF THE CIRCUMSTANCES OF DEATH

Just prior to 9.30am on Wednesday 31st December 2008 NSW Police, Leading Snr.

Const. Kevin Comber and Leading Snr. Const. Formston were driving in a NSW Police (4WD) vehicle (call sign *KU17*) north along the Newcastle Freeway (F3) at about 1.5kms south of the Hawkesbury River Bridge, when they came upon (by chance) a blue Toyota Camry (*Reg No. AD31DE*) that they observed being driven slowly at approximately 80kms to 90kms (in an 110kms per hour zone) on the F3 Freeway. Leading Snr. Const. Comber noticed the blue vehicle's right rear wheel was slightly wobbly and that this vehicle was moving in an erratic fashion from side to side in the lane. As the police vehicle was about 30 metres or so behind the blue vehicle and approaching the Hawkesbury River Bridge, Leading Snr. Const. Ronald Formston, having undertaken a transport check, noticed that the vehicle further slowed to a speed of approximately 50kms to 60kms per hour as it approached the middle of the bridge whereupon it then appeared to come to a complete stop. The blue Camry was at the time being driven by Koan Heng, and also contained his wife Ms Siv (Wendy) Ly, and their two (2) children Lynda (then aged 10) and their son Kim (then aged 8).

At this point Leading Snr. Const. Comber motioned the driver of the blue Camry vehicle to "*move on*" by way of moving his hands in the appropriate gesture. However he noticed the male driver open the driver's side door, climbed the bridge railing and has then been seen to jump from the bridge into the river below, a distance/drop of approximately 10 to 11 metres. The two (2) police officers then left their vehicle, and approached the blue coloured vehicle. While approaching the blue coloured vehicle the police officers then observed the (woman) passenger run to the same area of the bridge and climb over the railing. At that point both officers have told the lady "*do not jump and come back over the right side"*. As well at this point the two (2) children, who were in the vehicle, got out and also climbed onto the railing but were held back by police. Both police officers have then been able to bring Ms Ly back over the railing to a safe position.

At about the time that these events were taking place, two (2) RTA Traffic Controllers, James Geppert and John Kerslake, were also driving north bound on the Newcastle (F3) Freeway and while approaching the Hawkesbury River Bridge observed a police vehicle stopped in the middle of the bridge. At this point Officer Geppert states that he saw a woman on the "*ocean side*" of the handrail of the bridge with two (2) police officers attempting to take her back onto the roadway. He also noticed two (2) small children in close proximity.

The further evidence given at the Inquest as to the observations of both police officers and the two (2) RTA Officers was to the effect that the deceased was observed in the Hawkesbury River making what appeared to be one or two voluntary movements of his arms in the water but shortly thereafter he disappeared under the water surface. The two (2) NSW Police Officers (Comber and Formston) have proceeded to the northern side of the bridge where they gained access to a small boat and went in search of the body but without success.

Some days later, in the afternoon of 3rd January 2009, a resident of Mooney Mooney (Christine Checkley) noticed an object floating in Mooney Mooney Creek near where her residence is located and approximately 30 metres from the shore. This area is also known as Mooney Mooney Bay and forms part of the Hawkesbury River. It is within a few kilometres of the (F3) Hawkesbury River Bridge. With her husband, David Checkley, they went out in a boat to investigate and on getting closer to the object they realised that it was a body. The body was later identified as that of a male person noticed to have

short hair and at that of time there was a brown jacket around the top half of the torso. Subsequent identification reveals that it was in fact the body of the deceased Koan Heng.

A CRITICAL INCIDENT

In the circumstances of the two (2) police officers, being Leading Snr. Const. Comber and Leading Snr. Const. Formston, having (by chance) come across the vehicle being driven by the deceased when it was travelling in a northerly direction along the Newcastle (F3) Freeway, by "*waving on"* the deceased's vehicle that was slowing down on the Hawkesbury River Bridge, have commenced a "*technical"* police operation. Such was the determination at the time by NSW Police.

Accordingly the death of Koan Heng, having taking place during the course of a police operation within the meaning of the Police Safe Driving Policy, as operative at the applicable time, is to be treated as a death in custody. An Inquest is therefore mandatory by virtue of ***ss.23 & 27*** of the ***Coroners Act 2009***. Such an Inquest is to be heard either by me, as the State Coroner, or an appointed Deputy State Coroner.

ISSUES FOR CONSIDERATION

Issue – Manner and Cause of Death and the Evidence of Suicide

The cause of death, as already noted from the post mortem report of Dr Orde, was observed as being *not inconsistent with drowning*. It was further noted that there was no relevant reading obtained from the toxicology report.

As to the manner of death, in order for me to be satisfied that a finding of suicide can be made, the *Briginshaw Standard* needs to be established/satisfied (see ***Briginshaw v Briginshaw*** (1938) 60 CLR 336 at p.361).

I received evidence in ERISP form from the wife of the deceased, Ms Siv (Wendy) Ly (see again **[219]**). Ms Ly, having been admitted to the Psychiatric Emergency Care Centre, Hornsby Hospital, and under the care of the Director, Dr Peter Young, participated in an ERISP on the evening of 31st December 2008. It is plain that having lost her husband in tragic circumstances that very same day, Ms Ly was traumatized, worried and somewhat disoriented at the time of the ERISP.

This is to be compared with her evidence given before this court on 29th January last where, it is submitted, she has had time to reflect upon the answers to questions put whilst she was in the witness box. Indeed some of the evidence given was inconsistent to that recorded on the ERISP in December 2008 (e.g. talk of committing suicide together (Q/A. 152 at **[239]**)).

As to the ERISP interview, it seems to be reasonably clear that the reason for the Heng Family not proceeding to Brisbane on holidays was the advice/information that he had received from a NSW Police Officer Const. Gibson near Karuah on the morning of Wednesday 31st December to the effect that Brisbane was at least 8 to 9 hours and would take a whole day to drive there. That advice/information having been provided, it would appear that the Heng Family, and perhaps the deceased in particular decided to

come home (to Sydney) later that morning **[221]**.

It is also clear from the answers given at this segment of the ERISP that Ms Ly is making reference to the fact that the deceased was clearly distracted, indeed obsessed, by the fact that he felt he was being followed by, inter alia, police and other groups of cars and motor bikes who would "*stick their finger up"* as they drove by (again **[221]**). Ms Ly denied this evidence when she gave her evidence .Ms Ly then indicated (initially) that as the deceased approached the bridge, and without saying anything, has stopped their vehicle, opened the door and jumped into the river **[222]**.

Ms Ly indicated that prior to this tragic event her husband made comments that the police were following him this day (see **[226]**). She further indicated that he (the deceased) felt scared, frightened and that he said to her "I feel a little bit shakey"**[227]**.

Ms Ly then indicated as follows:-

> "*So there is no alarms, there is no signal. The police is driving behind, but when my husband goes fast, he's fast. When he's slow, the police slow and when he stop the police stop behind him. Then the police stop behind him and he just jumped, opened the door, run out and jump".*
>
> (See Q/A. 56 at **[229]**)

When this is added to other evidence that was heard concerning his attitude, as observed by his wife, over the previous few weeks of December 2008, including the rather stressful encounters with the Solicitor Andrew Lee, the spontaneous decision to drive "*north"* on a holiday without any specific plans and without apparently knowing how far it was to drive (to Brisbane), the turning around to come back to Sydney, the assertion of Ms Ly that she and her husband had spoken of "*all of them"* committing suicide together a few weeks beforehand, would tend to indicate that the deceased intended to take his own life when he alighted his vehicle and jumped into the Hawkesbury River. The river was observed by police and indeed RTA Officers to have a noticeable current flow at that point of time. As well the distance from the roadway level to the water was subsequently estimated to be within the range of 10 to 11 metres – not an insignificant distance.

Even for a good swimmer to enter the water from that height and in that location of the river, was inherently dangerous. ***On balance*** it may be that such actions were and are sufficient for a finding that the deceased intended to take his own life.

However there are other factors. If one accepts the evidence that Ms Ly provided in her ERISP, it would seem that, in large measure, the deceased was fixated upon the fact that police (and perhaps others) were following him during the course of the morning and were going to stop him at a time prior to him doing a u-turn and then proceeding again northwards along the F3 Freeway (see Q/A's.45 to 49 at **[227]** and **[228]**). It may well be, although no positive findings can be made, that the deceased was primarily concerned about the fact that he was being followed and that police he believed, may have wanted to take him into custody.

For whatever reason the deceased believed that he was to be returned to Cambodia. Again emphasising that whilst no positive findings can be made in this respect as to the attitude that the deceased may have had at the time, the above observations/actions of the deceased do suggest he <u>may</u> have intended to stop the car and then jump into the Hawkesbury River so as to escape "*detention"*.

The observations of police and RTA Officers indicate that he certainly survived the fall, and that he may have made some voluntary strokes whilst he was on the surface of the water but he has thereafter disappeared.

In the circumstances it leaves the evidence in such a state that it is difficult to be satisfied to the required standard that by entering the water in the location and manner he did that the deceased intended to take his own life.

THE POLICE RESPONSE

Leading Snr. Constables Formston and Comber had been driving in police 4WD vehicle, call sign KU17 at approximately 9.30am on 31st December 2008 when they noticed a slow moving vehicle travelling north in lane 1 at a slow speed and thereafter observed that vehicle slowing down even further as it approached the bridge.

This is taking place at a point of time and at a location where the speed limit is 110km per hour. That vehicle was the vehicle in which the deceased and his wife and two (2) children were travelling, being a blue Toyota Camry (Reg No. AD31DC). Both officers have given evidence of observing that vehicle come to a complete stop in the middle of the bridge with a male person alighting from the vehicle and then jumping from the bridge into the Hawkesbury River.

Importantly, both officers thereafter have immediately assisted the female (Ms Ly) who was on the "*waterside*" of the bridge railing to come back over and to safety. Both officers have then attended to the children who were proceeding to the edge of the railing themselves.

What thereafter occurred was that both officers sought the assistance of two (2) RTA Officers (Officers Geppert and Kerslake) to attend to the children and the Ms Ly while they proceeded with speed to attempt to rescue the deceased in the Hawkesbury River by obtaining access to a small vessel.

In my strong opinion, the actions of both officers deserves commendation. Their quick and timely response very likely saved the life of Ms Ly whose stated intention was to follow her husband by jumping into the river. They thereafter attended appropriately to the needs of the children whose lives they may also have saved .No criticism whatsoever should adhere to them.

While Mr Heng may have acted as he did because of their proximity, he was obviously in a delusional state, and their professional and proper actions in gesturing to him to move with the traffic were completely misinterpreted by him because of that. Indeed, these two officers probably also prevented a highly dangerous traffic situation involving many other vehicles.

OTHER ISSUES

The Hepatitis C treatment with Interferon and the deceased's mental state

It appears that the deceased was enrolled in the SEASON Study in approximately September 2006, he having contracted Hepatitis C at some point in the past. Evidence

has been given that this was not an uncommon occurrence for people living in Cambodia at the time of the Pol Pot Regime in its appalling inhumane conditions. That study was overseen by Professor M. C. Ngu, Clinical Associate Professor – Sydney University and Consultant Gastroenterologist.

The drug Interferon was utilised for the treatment of Hepatitis C for persons, such as the deceased, enrolled in that treatment program. Professor Ngu gave evidence in December 2009 – that evidence was helpful and credible. Professor Ngu, in speaking to his report of November 2009 (see addendum – at Tab 11 **[276]**), indicated that the deceased reported symptoms commonly encountered with such treatment such as aches and pains, headaches and fatigue. Significantly, although monitored, Professor Ngu stated there was no indication of depression.

The protocols for such monitoring for the side effect of depression were provided by Professor Ngu. When seen in August 2007 Professor Ngu again indicated, as was the case previously, that the deceased, like any patient in such a program, was assessed as to whether or not depression indicators were present.

Professor Ngu also indicated that, on the deceased's return in the second half of 2007 to determine whether or not he had still the Hepatitis C virus (the observation being made that the deceased had gone to another general practitioner), there was a negative test to the antibody of the Hepatitis C virus and he so informed the deceased.

Professor Ngu also indicated in his report of November 2009 that the deceased had mentioned to him (on 18th September 2007) that Dr Huynh had advised him to have a psychiatric assessment because he seemed to have trouble believing that he had experienced a good (positive) response to the treatment for Hepatitis C but that he was otherwise unduly anxious. His treatment on the SEASON Study thereupon was finalised (refer **[277]**).

However on 18th December 2007, the deceased again saw Professor Ngu and indicated that he felt better without the effects of medication. Very properly Professor Ngu then indicated that he should see him again in six (6) months for a repeat of the PCR testing (again refer **277]**). However there is no evidence of the deceased attending upon Professor Ngu, or anyone at Concord Hospital for that recommended six (6) month review.

There is also evidence that there was regular, indeed appropriate, contact between Professor Ngu and one of the deceased's general practitioners, Dr Huynh (Dr Huynh's case notes are in evidence in addendum to the brief – **[3]**). Indeed there are case notes of 1st February 2005, 17th January 2006, 26th July 2006, 11th October 2006, 20th April 2007 and 17th September 2007 that indicate a close consultation process between Professor Ngu and Dr Huynh as regards the deceased's treatment for Hepatitis C.

In all events, and whilst it is the case that the deceased consulted more than one (1) general practitioner, the submission is made that the mechanisms/protocols for testing and monitoring the potential "*side effects"* from Interferon (i.e. depression) followed and utilised by Professor Ngu and his team as well by Dr Huynh.

It also seems that the research on the topic suggests that the frequency of the onset of

depression, following the administration of Interferon for the treatment of Hepatitis C, is not a common occurrence. Further, there is evidence that suggests that Professor Ngu and his team at Concord Hospital and indeed the general practitioner Dr Huynh, were all well aware and indeed alert to such potential effect. But no such symptom was directly observed and arising from the deceased's treatment with Interferon for that ailment at least as at December 2007.

That said there does however seem to be a history of the deceased with some mental disorder. Dr Huynh had referred the deceased to a Psychiatrist, Dr S.K. Law, in mid 2002 (see report of 10th May 2002 of S.K. Law at addendum Tab [3] **– [190]**). The mental examination revealed that the deceased, at that point in time, probably suffered from Anxiety Disorder together with, inter alia, psychogenic headache. I also observe that on 13th December 2007, when the deceased apparently consulted Dr Huynh for insomnia, chest tightness and domestic stress, Dr Huynh made a provisional diagnosis of depression. At this point it is also observed that in March 2008 another general practitioner, Dr Malcolm La, was consulted by the deceased for depression. Dr La's case notes indicated that he prescribed *Lovan capsules 20mg 1 daily* for this ailment. After that consultation it is not indicated whether he received any further prescription for that anti-depressant.

Dr Huynh then seems to be last medical practitioner whom the deceased consulted. That consultation took place on 27th November 2008. There was no report of depression and "*nil distress"* being made, although the deceased felt tired. The case note goes on to indicate no remarkable observations were made (see addendum Tab 2 **[189]**). Dr Huynh, who gave helpful and credible evidence , indicated that his recollection of that (last) known consultation was that the deceased talked a lot, that he was quite cheerful, but that he also made mention that he would be going to Cambodia for a holiday.

In all the circumstances, it would appear that it might have been the case that in the early part of 2008 the deceased was depressed and was initially treated by administration of the prescription anti-depressant *Lovan*. Whether or not he continued with that prescription drug cannot be determined on the available evidence. He appears to have been a 'doctor-shopper' if I may use that crude expression, who constantly tested the opinion of one with another, and seldom accepted the advice of any. Added to that is the issue concerning domestic disharmony that resulted in the divorce application being filed or sought (called a "*joint application*") in October 2008. This leads to the submission to the effect that it is more likely than not that notwithstanding the observations of Dr Huynh, it is probable that the deceased was suffering anxiety and was stressed in the latter half of 2008. This would explain his actions leading up to, firstly, some confrontation with the Solicitor Andrew Lee as well as his actions as and from a point of time in or about Christmas 2008.

Dr Young, Director Mental Health Intensive Care Unit Hornsby Hospital took a detailed history concerning the Heng Family including Ms Ly and the deceased notwithstanding the fact that he (of course) never saw or consulted with the deceased. It is appropriate to note that Dr Young's opinion of the deceased was expressed in the following terms (see Tab 1 – at **[154]** of the addendum to the brief):-

> *" I am of the opinion that Mr Koan Heng at the time of his death was suffering from Major Depressive Disorder with psychosis. He had been depressed for*

more than one year and his illness may have or may have not been precipitated by Interferon treatment for Hepatitis C. ***Mr Heng's behaviour, including his suicide was a direct result of his untreated mental illness****"*.

(my emphasis)

It is also acknowledged that Dr Young has left open the possibility that the deceased's illness (depression) may have been precipitated by the Interferon treatment, but a possibility only. Based upon the evidence it would seem clear that there were sufficient safeguards, protocols and checks made of the deceased during his treatment regime whilst participating in the SEASON Study, and indeed thereafter, including a request for him to be reviewed in six (6) months (which apparently Mr Heng never arranged) to conclude that there was no indicator of depression present as at December 2007. That said it is otherwise the case Dr Young's view that the deceased was suffering from depression and, specifically, that his mental illness was apparently untreated (for some period of time).

This lends further support to the fact that certainly during the last month or so of his life the deceased was at least displaying significant symptoms of either anxiety disorder or indeed depression.

THE ACTIONS OF MS LY

There is certainly some evidence that suggests that Ms Ly, in giving her children tablets, did so with the intention to harm them (see Tab 1 at pps.111 to 112). This is of considerable concern. There is no question however that she too was under considerable stress at this time. She made clear that, at least prima facie, she wanted die with her husband and indeed her actions at the bridge on the day in question in proceeding to the *wrong* side of the railing is certainly supportive of that proposition. It follows that in the events immediately prior to going on to the bridge, that is to say including the time that she was giving the children the tablets which occurred during the morning of 31st December 2008, is all consistent with her distressed state of mind.

It is noted that Dr Young concluded as follows:-

> "*Ms Ly has continued to be observed and assessed throughout her admission to the Mental Health Intensive Care Unit [at Hornsby Hospital]. Her mental state ad (sic) behaviour has been consistent with a person suffering acute bereavement and loss. There has no evidence of any underlying mental illness. Ms Ly has consistently expressed concern for her children including the loss and trauma they have suffered and her desire to be with them again as soon as possible. She has consistently denied any thoughts of harm towards her children and has described as wanted to have a happy life together within the future".*

Further Dr Young then indicated of Ms Ly that:-

> "*… to an extent share the delusional beliefs of her husband but in her case these beliefs were held for reasons explicable by her background, education, cultural and social circumstances.* ***Her behaviour around the time of her husband's death was driven by these same factors****"*

Otherwise Dr Young makes clear that he had no difficulties, from a professional point of

view, and indeed otherwise held the strong view that, the best interests of the children, Linda and Kim, were that they should be in the custody of their mother Ms Ly.

I remain concerned about her actions and somewhat skeptical as to her inability to recall or to reconcile her oral evidence with her original interview with police. However, in all the circumstances and whilst noting that the evidence concerning Ms Ly's actions with respect to giving the children the tablets was the subject and indeed covered by a certificate issued under ***s.61*** of the ***Coroners Act 2009*** ("the Coroners Act"), I am satisfied that her actions on the day in question were caused by factors concerning her background, educational, cultural and social circumstances and her shared delusional beliefs sourced from her husband's own beliefs.

I therefore make the following formal finding:

Formal Finding

That Koan Heng died on 31 December 2008 by drowning after jumping from the Hawkesbury River Bridge at Brooklyn, NSW, but whether he was capable of forming the intention of ending his own life or not, the evidence does not allow me to say

14. 168 of 2009 Halmarko Quibulue

Inquest into the death of Halmarko Quibulue on the 16th January 2009. Finding handed down at Glebe on the 24th November 2009 by State Coroner Jerram

This is a death in a police operation within the meaning of *Section 23 the Coroners Act, 2009* concerning the death of Halmarko Quibulue.

Mr Quibulue was in a relationship with an Angeli Ongcal for some two to three years, they had a two-year-old son as a result of the union. There were instances of domestic violence between the couple and in fact an AVO had been taken out on Angela's behalf some seven or so months prior to Mr Quibulue's death.

In the months leading up to his death the evidence shows that Angela had commenced a close relationship with another man Louie Roble, neither Angela or Louie were prepared to tell Halmarko of the relationship and the extent of the relationship. Some two weeks before the death it would appear that Angela accepted a proposal of marriage from Louie.

On the night of Halmarko's death Angela returned home late to the premises she shared with Halmarko, she was out with her brother, Louie Robie was also present and it seems most likely that Halmarko was driven mad by jealousy and his rage at what he must have become aware was a continuing relationship between Angela and Louie.

The evidence shows that ultimately Halmarko stabbed Angela very seriously and as a result of that stabbing it is lucky she is alive today, I am told she very nearly did not survive the stabbing. Her brother came out of his room and saw her collapsed covered in blood and called 000. Halmarko had previously run off with what we believe were cuts on his hand as there was blood found directly outside the house.

A detailed search was conducted by police and Pol air, which was curiously hampered by numerous rabbits in the area, and it was not until the following day in the light of day that the body of Halmarko was located deceased in the Anita Cobby Park.

It was quite apparent to persons that found the body that he was deceased and in fact ambulance on attendance did not commence CPR.

I accept the evidence of Dr Orde (Forensic Pathologist) that Halmarko was at least dead by 7am that day and the cause of his death was a single stab wound directly through the heart.

I am satisfied that Louie Robie was not involved in any way with the stabbing of Halmarko.

I am satisfied that Halmarko appalled at what he had done and I bear I mind the evidence I have heard that once before after he had hurt Angela he had considered suicide, that in a frenzied state after what happened and probably thinking that he had in fact killed her he stabbed himself in the heart with the knife after making several vertical wounds on his right forearm.

Formal Finding

That Halmarko Quibulue died on 16 January 2009 sometime between 1.30am and probably 5am at Anita Cobby Reserve Blacktown as a result of a stab wound to his chest, which was self, inflicted.

15. 180 of 2009 name suppressed non-publication order.

Inquest into the death of AA on 19 January 2009 at Firetrail Rd., Castlereagh. Findings handed down by Deputy State Coroner Brydon on 20 August 2010

AA was a 41-year-old aboriginal man. At the time of his death he had been in a relationship for a number of years. They had four children as a result of their relationship. AA did not reside with his wife at her home at Cranebrook but would often visit. The relationship was described as “on and off” with his wife contributing the breakdown of their relationship to AA’s mental health and alcohol issues.

AA was diagnosed in 2003 whilst in custody as suffering from schizophrenia. On his release from prison he was provided with a letter indicating that his mental condition could be controlled with the use of the medication, Olanzapine Wafer, otherwise known as Zyprexa. AA approached Dr. Suresh Gupta to prescribe the medication. Dr. Gupta was aware that this medication was used in the treatment of schizophrenia although he was unaware of who made the formal diagnosis or when it was made.

In November 2007 AA suffered a significant episode of paranoia in which he believes that the police, biker groups and even his wife would try to kill him. On 22 November 2007 he voluntarily admitted himself to the Pialla Mental Health Unit of Penrith Hospital.

On 13 December 2007 AA was discharged from hospital on a community treatment order for a period of six months. During the course of the community treatment order AA

attended upon Dr Gupta for the administration of his drugs. It was during this period of medication that Dr Gupta described AA's mental state as at its best.

Following the expiration of the community treatment order in June 2008 it would appear that AA ceased taking his schizophrenia medication. Despite this there appears nothing from the medical records of Dr. Gupta that would suggest that further treatment was contemplated or he had treated AA for any psychotic episode. Police records suggest that AA came under notice on 13 August and 12 October 2008 however mental health issues did not appear to be the catalyst for their involvement.

On the morning of his death, AA attended the premises of his wife. He told her that he was going to stay at those premises and she refused. AA's wife contacted police. She raised her concerns about his mental health. A police car was dispatched to her address. Before it arrived his wife had notified the police that AA had left the premises and they were no longer required.

Despite this, two police officers attended within two minutes and spoke with the wife of AA. A search took place in the immediate area for AA however it failed to locate him. The police then left the premises.

AA had attended his wife's sister's address that was nearby.

AA and his wife arrived in the early afternoon at Dr Gupta's surgery, which operated on a first-come first-served basis. AA's wife persuaded Dr. Gupta to see AA straight away as she indicated to him her concerns about AA's mental health welfare.

On entry into the consultation room Dr Gupta was advised that AA was hearing voices, that he had punched a hole in a wall at another premises, and he had not taken his medication for some period of time. The issue of going back on to his medication was raised. During the course of the consultation AA did not speak much and was pacing about the room. Within a minute of two AA then left the surgery without any proper medical assessment or diagnosis having been made nor prescription being given.

AA returned to the premises of his wife's sister. He remained there during the course of the afternoon and exhibited increasing irrational behaviour both to her and at a later stage, to her husband. That irrational and paranoid behaviour included; randomly shouting towards neighbours; entering a Coles supermarket but leaving because he thought people were inside talking about him; frothing at the mouth; eyeballs protruding from his head and seeking to purchase black spray paint to paint his white shoes as he was worried about being seen the dark.

His wife's sister and her husband were very concerned about the deteriorating mental health of AA. The brother-in-law demanded AA to leave the premises after he smashed the side window with his fist on the four-wheel drive car AA had borrowed from his wife. AA drove off screaming and yelling within the car.

Within minutes of driving from the premises AA entered onto one of the main thoroughfares in Cranebrook. He drove up behind a RAV4 motor vehicle and rammed into the rear of that vehicle. He overtook that vehicle and a short distance further along collided again with the rear of another vehicle. The first vehicle that AA collided with continued to follow

him until the point where AA's vehicle stopped and reversed towards that vehicle on a number of occasions. The driver of the other vehicle was able to avoid contact. However, AA produced a metal pole and started waving it from the driver's side window, which caused the other driver to flee the location. Other drivers in the vicinity were also alarmed by the manner of driving by AA.

A number of calls were made to the '000' police telephone line from concerned drivers. Each of those calls was given a priority and police were dispatched to keep a lookout for the subject-offending vehicle driven by AA. It is clear from the evidence that the number of Police vehicles were involved in that search. Before Police located the vehicle a private citizen came across AA's car and observed the male occupant who appeared to have been shot. Police attended within minutes and observed AA's body slumped on the ground. Police Officers formed the view that AA was dead and this was confirmed shortly thereafter by ambulance staff.

Dr Duflou, Chief Forensic Pathologist, carried out a post mortem examination. The cause of death was blood loss as a result of incised wounds to his arms. The evidence was clear that AA had a knife and a blade from a disposable razor both, which were taken from his wife's sister's premises. It would appear that these items were used to inflict the injuries. The Inquest found that AA died as a result of the self-infliction of these injuries whilst suffering a psychotic episode associated with schizophrenia.

The Inquest considered the adequacy of the medical assessment and responsibility of Dr Gupta, as well as the role played by the police in attending upon the premises in the morning and later the adequacy of the police search for the vehicle driven by the deceased.

Dr Gupta's involvement on the date of the deceased death was very limited. The doctor attended to a request to see AA almost immediately. He gave priority to that consultation over other patients present. The consultation lasted only a minute or two before the deceased abruptly walked out. It was accepted that there was very little opportunity for any proper clinical assessment. Despite this, Dr Gupta properly concluded that the deceased appeared to suffering from an episode of schizophrenia for which he considered treatment with medication. Before any prescription could be raised the deceased left. The doctor was not informed by either by his wife or the deceased of any suggestion of self-harm or the possibly the harm to others.

The Inquest briefly considered the rights of doctors to have mentally ill persons detained under the Mental Health Act 2007. The Inquest concluded that no adverse finding should be made of Dr Gupta's treatment or conduct towards the deceased.

The Police involvement concerning the deceased on the date in question was twofold. Firstly, two Police Officers attended the home of AA's wife following a 'OOO' call expressing concerns about the deceased's attendance. Despite the fact that AA's wife rang back a short time later to say the deceased had left the premises, a car crew still attended and searched the immediate area for the deceased. The Inquest found that there were no serious concerns for welfare being raised by AA's wife at that time about the deceased, which required any further actions by the police. Thereafter, the Police were not contacted about the serious deterioration of AA's mental health.

The next involvement of the Police related to a series of complaints from members of the public about the erratic and dangerous driving of a four-wheel drive vehicle. The Police did not know the identity of the offending driver. The inquest reviewed the response of the police to the nature of the call received. The inquest found that despite the fact that a higher priority could have been given to the incidences as reported, there was a adequate Police response by the deployment of a number of car crews towards locating the offending vehicle, Sadly, this could not be done before AA had self inflicted the wounds that lead to his death. There were no matters that required the making of any recommendations under section 82 of the Coroners Act 2009.

Formal Finding

That AA died on 19 January 2009 at Firetrail Road, Castlereagh in the State of New South Wales, as a result of self inflicted incised wounds to his arms whilst suffering a psychotic episode associated with schizophrenia.

16. 744/09 Name suppressed due to non-publication order.

Inquest into the death of AA on 19 March 2009. Finding handed down by State Coroner Jerram on 13 May 2010 at Glebe.

NON PUBLICATION ORDER

This inquest relates to the death of a 34 year old aboriginal man and is reportable under Section 6 (1) of the Coroners Act and appears to be a death within a police operation.

The deceased was employed as a fulltime youth worker in Glebe, he lived alone at Erskineville and had no history of depression or mental illness he was homosexual and was not known adversely to police.

His employers described him as feeling persecuted and very emotional; he was difficult to work with and had recent financial issues, which involved the use of the corporation's credit card and company car. AA was counselled over his workplace problems, however he later complained in emails of bullying and harassment.

On the 18th March he was further counselled in relation to an outstanding debt following which he left packed his belongings and announced his resignation. It was later discovered that AA had transferred confidential information to his personal email in breach of the workplace confidentiality agreement.

AA was spoken to a number of times by his employers and informed of their knowledge of the breach, by this time it appears that AA had changed his mind about resigning and was asking for his job back. On the day of his death AA was advised that in view of the breach they could not offer him the position again, at the same time his employer advised him that all the outstanding debts he had would be wiped and that his entitlements would be paid to him.

It was during these conversations that he told his employers that he was going to kill

himself if he didn't get his job back. Triple 000 were called as a result and provided with the limited information that they knew concerning AA however the evidence is that his exact address was not known and could not be provided to the triple 000 operator.

VKG broadcast a general concern for welfare to all police.

Following this there was a series of communications between the employers of AA and VKG as well Police and it was not until 9.29am that police attended the correct address for AA in Erskineville following the initial phone call to triple 000 at 8.14am.

On attendance Police found AA hanging in the bathroom, he was cut down and found to be deceased. The time of death we know must have been between 7.43 and 9.29am. Whether AA was dead when the first call from VKG was acknowledged at 8.18am we cannot know.

The evidence makes it clear to me that there was a failure at Glebe Police Station on the 19th March 2009 to pick up jobs between 7.43am and 8.30am when there were 7 officers in that station or in a car which was merely on a high visibility patrol but not dealing with another job and two supervising sergeants. There was a failure that morning whether or not it contributed to Grants death.

Leading Senior Constable Barnes, I have to say, I did not find a very credible witness.

He clearly made errors of judgement and it would have been preferable had he acknowledged that; he did not.

Probationary Constable Beavis was very junior having only been in the police for three months. He was in no position to do anything other than follow the senior officers orders or suggestions he should be commended for his initial acknowledgement primary of the call and for his follow up.

I am very disappointed with the evidence of Sergeant Miller the external supervisor he did not appear helpful or frankly very open, Sergeant Miller bore all the responsibility for care crew allocations and at least half the responsibility for monitoring VKG calls and ensuring that they were followed up and yet he claimed in evidence to know nothing of the occurrences on the day. I have to conclude that he was simply unwilling to assist the court.

Formal Finding

That AA died between 7.43am and 9.29am on 19th March 2009 at Erskineville in the state of New South Wales as a result of hanging which was self-inflicted with the intent to end his own life

17. 777 of 2009 Lucas O'Connor

Inquest into the death Lucas O'Connor on 23 September 2009 at Warilla. Inquest suspended by State Coroner Jerram on the 6 November 2009.

The death of Lucas O'Connor was determined to be a death within a Police Operation. Following advice from investigating police that a known person was charged with an indictable offence arising from the death, the State Coroner in accordance with the Coroners Act suspended the inquest. No formal finding other than identity date and place of death was made.

18. 1196 of 2009 Bradley Clennett

Inquest into the death of Bradley Clennett on 3rd May 2009, at Harry Sawkins Park, Graham Street, and Nowra Findings handed down by Deputy State Coroner Brydon on 16 July 2010.

This was an inquest into the death of Bradley Clennett, aged 34 years, who passed away on 3rd May 2009. Bradley's body was discovered around 7.00am near Harry Sawkins Park, Graham Street, and Nowra. He had been sleeping in the park from about 3.00am having been conveyed there by Police in a Police vehicle.

Bradley had a significant drug use history including the use of heroin. He was known to the police for his drug use and associated behaviour. He also had a long history of mental health issues having scheduled hospital admissions for self-harm episodes in 2001 and 2003.

Between 17th April, 2009 and 1st May, 2009 Bradley Clennett had been residing in John Purcell House, Nowra, a government funded organisation that provided emergency accommodation for men. Whilst generally well regarded by the management of the accommodation facility unfortunately Bradley and his roommate were evicted on 1st May. 2009 for suspected substance use, a breach of the John Purcell House rules. Sadly, there was very little alternative emergency accommodation for homeless men in Nowra.

Around 10.50pm on the evening of 2nd May a number of security officers located Bradley sleeping on the stairs of the Best and Less store at the Nowra Shopping Centre. Those officers advised Bradley to move on for his own safety. He did not appear to the officers to be affected by drugs. Police were advised by the security officers about the presence of Bradley and they spoke with him at about 11.20pm. He told the Police that he had been evicted from John Purcell House and was intending on heading down to the Harry Sawkins Park. He did not appear to those Police to be affected by drugs or alcohol

At about midnight security and police officers again saw Bradley. He told them that he was going down to the park. On this occasion he appeared to be acting a bit differently and may have been affected by something. However the Police did not think that he was impaired to an extent that warranted their intervention. He was nonetheless cooperating well and speaking freely with them. He had sufficient clothing and bedding to spend the night outdoors.

Security guards again contacted the police at around 2.20am on 3 May 2009.to inform them of Bradley sleeping in front of the Firm Fitness Gymnasium in Kinghorne Street, Nowra. The attending Police woke and spoke with Bradley. His possessions were searched and a number of syringes were found but no drugs. Bradley did not appear to the police that to be under the influence of alcohol.

Bradley was told that he could not stay were he was and that he would be better off sleeping at Henry Sawkins Park. There was adequate light, toilet facilities and benches available in the Park. Bradley sought directions from the police and expressed a desire to go there Constables Ferraris and Easton gave evidence that they conveyed Bradley and his belongings to the Park in the rear of the police van. The evidence was clear that the conduct of the police officers was driven by a genuine desire to help Bradley. The police officers held concerns for Bradley's safety and welfare had he remained in Kinghorne Road due to his vulnerability from suspected intoxicated persons leaving a nearby nightclub at that time in the morning.

After conveying Bradley to the Park police made a number of vehicle patrols of the Park during the night. Bradley was observed to be lying under a park light

The following morning at about 6.50am, two council rangers observed Bradley to be lying on the footpath in Graham Street Nowra, adjacent to the park. There was no sign of life. A crime scene was established and Bradley's body was conveyed to Shoalhaven Hospital where life was pronounced extinct.

Certain drug paraphernalia consisting of a burnt metallic spoon with white powder residue was located. A recent injection mark was apparent in the crook of Bradley's right arm. Toxicological analysis revealed the presence of a high level of morphine in the blood (within the documented fatal range) .A post mortem report of Dr Matthew Orde indicated that the cause of death was consistent with morphine toxicity. There was evidence from a resident of John Purcell House that Bradley had been trying to source heroin in the days prior to his death.

Following the discovery of Bradley's body, and having regard to the earlier interaction with the Police, a "critical incident" was declared which involved an independent investigation being undertaken as well as a critical review of that investigation.

A consideration of the evidence relating to the death of Bradley Clennett showed no suspicious circumstances. There was also no suggestion that Bradley had any intention of taking his own life. The evidence was suggestive of an accidental drug overdose.

The Coroner was satisfied that there were no grounds for criticism of the conduct of the Police. It was apparent that at the times of the Police interventions neither mental health issues nor intoxication were evident to the extent that could have caused the police to invoke any arrest or detention powers.

During the course of the evidence Mr Steven Sweeney, the Manager of the John Purcell House, highlighted the severe shortage of accommodation for homeless men and women in the Nowra area. Sadly for Bradley Clennett he had been given such accommodation but was asked to leave for non-compliance with the strict restrictions against substance use.

There were no matters arising out of the Police conduct that in the Coroner's view called for the making of recommendations pursuant to section 82 of the Coroners Act, 2009

Formal Finding

Bradley Clennett died on 3 May, 2009 at Henry Sawkins Park, Graham Street, Nowra, from the effects of an overdose of a drug, consistent with morphine toxicity, in circumstances that do not suggest that he intended to take his own life.

19. 1519 of 2009 Elijah Holcombe

Inquest into the death of Elijah Holcombe on the 29 October 2010 at Armidale. Inquest suspended by State Coroner Jerram.

The death of Elijah Holcombe was deemed to be as a result of a death within a Police Operation. After hearing evidence the State Coroner suspended the inquest and referred the papers to the Director of Public Prosecutions. No formal finding other than identity, date and place of death was made.

20. 1961/2009 Robert Joseph Dunn

Inquest into the Robert Joseph Dunn finding handed down at Glebe on the 29th November 2010 by State Coroner Jerram

This is a mandatory inquest under *Section 23 of the Coroners Act 2009* into the death of a 69-year-old man Robert Joseph Dunn.

The deceased was serving a sentence of 20 years imprisonment for child sex offences. The deceased had suffered a number of medical conditions during his incarceration, which included the fitting of a pacemaker in 2004.

In 2009 the deceased was transferred to the Aged Care & Rehabilitation Unit within Long Bay Gaol.

The health of Mr Dunn continued to fail with ongoing renal and cardiac conditions requiring a wheelchair for mobility. During the night of 10th and 11th July the deceased was checked a number of times by nursing staff. At 5.00am the deceased was found unresponsive in his bed and declared deceased.

A post mortem conducted by Dr Van Vuuren determined the cause of death to be Ischaemic Heart Disease.

Having been satisfied that that it was a death entirely due to natural causes that the deceased was properly cared for medically and the death was inevitable given his condition the formal finding will be.

Formal Finding

Robert Joseph Dunn died at Long Bay Gaol on 11th July 2009 of Ischaemic Heart Disease, the manner of death being natural causes.

21. 2897 of 2009 name suppressed non-publication order

Inquest into the death of AA finding handed down at Bathurst on the 20th May 2010 by State Coroner Jerram.

This is a death within a police operation under Section 13A of the Coroners Act 1980.

- **Non-publication orders were made by the Coroner in relation to anything that identifies the deceased or any members of the deceased family including photographs.**

- **Non-publication order as to all evidence regarding police negotiation methodology, course documentation the covert identities, locations and resumes of the police negotiators and the tactical operations unit.**

The deceased was a 34-year-old man who was observed by police near the town of Lucknow on the 1st October 2009 at 10.17am. The vehicle was directed to stop by police, which he did however on police approaching the vehicle AA produced a shortened rifle and exited the vehicle. AA has then threatened self-harm.

A police officer commenced lengthy negotiation with AA until replaced by trained police negotiators some one and half hours later. AA continually made threats of self-harm.

Some 6 hours after the siege commenced AA was seen to enter his vehicle by police and then a single gunshot was heard. AA was found in the vehicle critically injured from a gunshot wound to the head. AA was conveyed to Orange Hospital where died at 2.35am the following morning.

The inquest heard evidence of a history of domestic violence issues culminating in apprehended domestic violence orders, allegations that he had breached those orders and even more serious charges of detaining his former partner against her will. AA had consistently claims that these allegations were not true and most strongly that he could not face gaol again if indeed he was found guilty of the charges.

On the 23rd September police found AA with a rope around his neck. He was taken to Walgett Hospital and provided mental health assessment via AVL. He was judged not to be a further threat to himself and had appeared to have calmed down and was no longer suicidal.

AA was assessed as not mentally ill under the Mental Health Act and after expressing a strong desire to leave the hospital was allowed to leave.

Indeed upon leaving he was arrested again by police for alleged breaches of bail. At a subsequent bail hearing it is unfortunate that none of the events of the previous night

were brought to the courts attention and AA was bailed to live with his aunty and not to return to Walgett. The mental health team were mistakenly informed that AA was in custody and I have found that this is the fault of no one but was an unfortunate error.

The evidence disclosed that AA has purchased a rifle on or around the 1st October and has driven out of Bathurst heading to Walgett. It was at this point that he was stopped by police at random breath test stop.

When I began this inquest I had fears that there may be exposed some bad flaws leading to AA's death, either by the police or the health system or individual health professionals. The evidence has clearly in my view shown otherwise. The Mental Health Team given the tyranny of distance operated extremely well. The thought that a highly experienced nurse could do a 3am assessment in a small town from far away and that AA was seen again at 7.30am by an experienced general practitioner is laudable.

The negotiators did a very good job, however it might have been from the outset that negotiations were doomed because AA by this time a desperate and unhappy man had reached the end of his tether in life, this is deeply sad for the family and I accept that it has deeply upset the police involved.

Formal Finding

AA died at Orange base Hospital at 2.35am on 2 October 2009. The direct cause of death being a gun shot wound to the head self inflicted at about 17.35 on 1 October 2009 at Beasley Rd, Lucknow, with the intent to end his life.

I also make two recommendations:

To the NSW Commissioner of Police

1. **That A/Sergeant Mark Hevers be recommended for his bravery, compassion and all actions on 1 October 2009**

2. **The that the commissioner give consideration to further training so that (a) police informants are aware of the desirability of providing information as to mental health and hospital admissions when known, in any antecedent section of any facts sheet which is to go before a court and (b) that any negotiating team give early priority to notification of next of kin in evolving high risk incidents and in particular before any relapse of information to the media.**

22. 3043 of 2009 Robert Charles Ballenden

Inquest into the death of Robert Charles Ballenden on 21 October 2009 at the Prince of Wales Hospital, Correctional Health Secure Unit. Findings handed down by Deputy State Coroner Brydon on 14 October 2010.

On 2 March 2002 Mr. Ballenden was sentenced to a full-time custodial sentence of eight

years with a non-parole period of five years.

On 12 August 2009 the deceased complained to prison staff of lower back pain. Justice Health officers identified a large abscess on the prisoner's left lower spine. The following day the deceased was transferred from Long Bay Hospital to the Prince of Wales Hospital, special Corrections Health annex. On 28 August 2009 Justice Health were advised by the hospital that the deceased had a large cell carcinoma in his right lung [lung cancer].

Despite the commencement of radiotherapy treatment, by 29 September 2009 the deceased infection was seen by treating doctors to be incurable. The deceased's health deteriorated significantly on 18 October 2009. He was seen to pass away at 12:03am on 21 October 2009. There were no suspicious circumstances relating to his death.

Dr. Irvine, forensic pathologist, carried out the post mortem examination on 23 October 2009. Dr. Irvine found the direct cause of death was complications of the metastatic non-small cell bronchogenic carcinoma.

Formal Finding:

Robert Charles Ballenden died on 21 October 2009 at the Correctional Health Secure Unit, Prince of Wales Hospital, Randwick, as a result of the complications of metastatic non-small cell bronchogenic carcinoma.

23. 3744 of 2009 Skye Sassine

Inquest into the death of Skye Sassine at Liverpool on the 31 December 2009. Inquest suspended by Deputy State Coroner MacMahon on the 23 July 2010.

The death of Skye Sassine was deemed to be a death resulting from a police operation. Following advice from investigating police that a known person was charged with an indictable offence arising from the death. The NSW deputy State Coroner in accordance with the Coroners Act suspended the inquest. No formal finding other than identity date and place of death was made.

24. 2493 of 2008 Joseph Cho

Inquest into the death of Joseph Cho on 25 December 2008 at Long Bay Correctional Facility Hospital. Finding handed down by Deputy State Coroner Brydon on 13 December 2010

Joseph Cho at the time of his death was in custody awaiting trial on a number of fraud related charges. On 9 November 2007, he had been extradited from Queensland in custody to stand trial in relation to the New South Wales charges. On 13 March 2008 Mr. Cho reported to the MRRC clinic with back pain for which he was given pain relief medication.

On 6 April 2008 he was unable to walk and was moved to the medical observation unit of the hospital. By the following day he had no movement in his legs and was incontinent. On 8 April 2008 Mr. Cho underwent invasive spinal surgery. It was discovered that he had

an adenocarcinoma of the lung was with several metastases on his spine. His condition was considered terminal. Over the following months Mr. Cho underwent intensive rehabilitation. There was a period of some stability until 2 September 2008 when his condition slowly deteriorated.

On 24 December Mr. Cho's condition rapidly deteriorated. Death appeared imminent. His wife and son were able to visit him. The following morning Dr. Stewart from Justice Health confirmed that the Mr. Cho had died at 5:22 am of natural causes namely the metastatic cancer.
Dr.Van Vuuren carried out a post mortem on 26 December 2010. Dr Van Vuuren found the direct cause of death was metastatic adenocarcinoma of the lungs and the consequences. According to the evidence it is clear that sadly this was a natural cause death with there being no suspicious circumstances.

Formal Finding:

Joseph Cho, aged 67 years, died on 25 December 2008 at Long Bay Hospital, Long Bay Correctional Facility of natural causes due to metastatic adenocarcinoma of the lungs and its consequences.

25. 429 of 2009 Name Suppressed

Inquest into the death of AA on 13 February 2009 in bushland at Kenthurst. Findings handed down by Deputy State Coroner Brydon on 26 October 2010.

(Non Publication order made as to the name of the deceased)

AA was aged 54 at time of her death on 13 February 2009. Sadly she had a long-running struggle with mental illness. She commenced receiving treatment from Dr. Pace, psychiatrist, at the Hills Clinic, Castle Hill in 2004, which continued until her death. Dr. Pace diagnosed her as suffering bipolar affective disorder, characterized by periods of recurrent severe depression with suicidal ideation and a borderline personality disorder. As a consequence of her illness she experienced chronic suicidal ideation.

AA had been admitted to a number of hospitals in the 18 months prior to her death following attempted suicides. She was admitted to Westmead Hospital in September 2007 after a drug overdose and later admitted to Blacktown Hospital in April 2008 following a further overdose of medication. On 1 May 2008 she took an overdose of medication and inflicted a large incision onto her arms. Her life was saved because of swift action of her daughter and police in finding her. She was admitted to Westmead Hospital and later the North Side West Clinic for treatment.

She had been receiving constant psychiatric supervision. On 3rd February 2009 her condition had reportedly improved and she was subsequently released from the North Side West Clinic. On 10 February 2009 she denied suicidal ideation to Dr Pace. It would appear that her mental health significantly deteriorated on 13 February 2009. She contacted her daughter on the morning of that date and informed her that she was going to take her own life. The last actual contact with AA by her daughter was at 12:50 pm. Police were contacted and informed of AA's suicidal intentions at 1:08 pm through the 'OOO' network.

About 1:15 pm a resident of Alicia Place Kenthurst, noticed a small white coloured car parked at the end of the cul-de-sac. At approximately 6:30 pm further residents of that street noticed the same motor vehicle and then discovered the body of AA lying on a white blanket in bushland a short distance from the road. The police were called. Police observed a severe cut on the left-hand side of the neck of the body, which was cold to touch. Rigor mortis has started to occur. It appeared to police that deceased had been dead for some period of time.

Close to AA's body was a mobile phone, her handbag, .a shopping bag containing one eagle utility knife and a retractable scraper that had its blade exposed. Also located was a receipt that indicated the razor blades had been purchased from a nearby Coles store at 12.09pm that day? The evidence suggested that there were no suspicious circumstances, with AA intending to take her own life.

There was no dispute on the evidence as to the date place cause and manner of AA's death. This inquest was a mandatory inquest pursuant to section 23 of the Coroners Act 2009 due to the involvement of the police in an operation seeking to find AAg once the police were notified by family members of their concern for her welfare.

From the Inquest two matters arose for consideration. The first issue related to the notification on the police systems of warnings of self-harm for individuals. The second issue concerned the knowledge and utilization by police of a triangulation procedure used in locating the whereabouts of mobile phones in possession of persons in life threatening situations.

Regarding the Police system of warnings being attached to a persons name from the CNI (Central Names Index) of COPS (Computerised Operational Policing System) the Inquest sought to determine whether any change should be made to the present system. In the case of AA, there was no actual warning attached to her name on COPS. However once AA's name was referenced the enquirer would have access to other events recorded on COPS that would provide an alert to the fact of previous self-harm attempts. The operational police seeking to locate AA were well aware of her history of these previous serious self-harm incidents. The Coroner was satisfied that there was an obligation on all police to initiate a warning on COPS in all circumstances where the failure to do so could jeopardize the safety of a Police Officer or another. This included the situation of noting that a person may have a mental illness (see Exhibit 7). There was no matter arising from the issue of warnings that required any appropriate recommendation.

The second issue considered in the Inquest was the use of mobile phone technology in the location of individuals in life threatening situations. Evidence was given that the police sought information from the telecommunication provider for AA's mobile phone in an effort to locate her whereabouts. The procedure involved contacting the Duty Operations Inspector, providing appropriate information as required under the Telecommunication Act, 1997 and then awaiting a response as to approximate location of a call made or received from a communication cell tower.

The Police received a response from the telephone communication provider that the mobile phone last cell detail suggested a location 2.7 to 3 kilometres east from a particular tower. The police were searching that general area when civilians found the body of AA. The location of the body was within the search area. Whilst the inquest found

that there was no ground for criticism of the subject police officer's use or deployment of this investigative tool, it nonetheless became apparent that there was a lack of general understanding of the precise nature of last cell details and use of the triangulation of calls by the mobile phone network providers. The inquest found that the police officers generally would benefit from further education about such technology and its implementation as an investigative tool. Accordingly the Coroner recommended pursuant to section 82 of the Coroners Act, 2009, a review of such education to officers.

Formal Finding:

AA died on 13 February 2009 in bushland near Alicia Place, Kenthurst, as a result of Exsanguination following the self-infliction of a wound with the intention of taking her own life.

Recommendation:

To the NSW Commissioner of Police

1. That the Commissioner of Police review the education of Police Officers in the field of tracing of telephone calls, in particular, the use of triangulation and last cell details, with respect to their use, interpretation and employment in the process of police investigations

Appendix 1:

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2010

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	2977/09	28/05/08	Westmead	23	In Custody
2	816/08	22/07/08	Silverwater	27	In Custody
3	2474/08	20/12/08	Penrith	25	In Custody
4	2523/08	27/12/08	Sydney	40	In Custody
5	174/09	18/01/09	Deepwater	21	Police Op
6	847/09	17/02/09	Yowie Bay	67	Custody home det
7	710/09	16/03/09	Silverwater	34	In Custody
8	725/09	17/03/09	Silverwater	24	In Custody
9	832/09	27/03/09	Malabar	26	Police Op
10	1221/09	30/04/09	Gilgandra	33	Police Op
11	1213/09	4/05/09	Penrith	32	In Custody
12	1330/09	17/05/09	Canberra	48	In Custody
13	1868/09	4/07/09	Malabar	76	In Custody
14	1949/09	10/07/09	Parklea	57	In Custody
15	2204/09	31/07/09	Katoomba	25	Police Op
16	2304/09	10/08/09	Willoughby	63	Police Op
17	2539/09	1/09/09	Canley Vale	18	Police Op
18	2648/09	11/09/09	Bathurst	42	In Custody
19	3333/09	18/11/09	Campsie	36	Police Op
20	3605/09	14/12/09	Lithgow	56	In Custody
21	3716/09	25/12/09	Lisarow	46	Police Op
22	485/10	25/02/10	Malabar	58	In Custody
23	520/10	28/02/10	Wollongong	39	Police Op
24	778/10	02/04/10	Campbelltown	40	Police Op
25	807/10	09/04/10	Concord	53	Police Op
26	835/10	13/04/10	Malabar	69	In Custody
27	914/10	21/04/10	Malabar	77	In Custody
28	959/10	23/04/10	Silverwater	18	In Custody
29	1107/10	20/03/10	Canberra	23	Police Op
30	1108/10	20/03/10	Canberra	33	Police Op
31	1109/10	20/03/10	Canberra	29	Police Op
32	1110/10	20/03/10	Canberra	3m	Police Op
33	1155/10	15/05/10	Randwick	44	In Custody
34	1305/10	01/06/10	Kogarah	18	Police Op
35	1322/10	02/06/10	Ivanhoe	36	In Custody
36	1369/10	08/06/10	Randwick	63	In Custody
37	1374/10	09/06/10	Bondi Junction	64	Police Op

No	File No.	Date of Death	Place of Death	Age	Circumstances
38	1378/10	09/06/10	St Marys	40	Police Op
39	1564/10	30/06/10	Parklea	47	In Custody
40	1576/10	14/06/10	Brisbane	53	In Custody
41	1753/10	17/07/10	Berkshire Park	23	In Custody
42	1809/10	23/07/10	Parklea	42	In Custody
43	1834/10	24/07/10	Shepparton	76	Police Op
44	1889/10	31/07/10	Berkshire Park	22	In Custody
45	1919/10	04/08/10	Randwick	55	In Custody
46	2076/10	21/08/10	Malabar	86	In Custody
47	2209/10	06/09/10	Randwick	86	In Custody
48	2222/10	09/09/10	Bankstown	26	Police Op
49	2325/10	20/09/10	Villawood detention	36	In Custody
50	2460/10	05/10/10	Liverpool	27	Police Op
51	2523/10	11/10/10	Randwick	49	In Custody
52	2547/10	04/10/10	Kogarah	35	Police Op
53	2794/10	11/11/10	Collarenabri	44	Police Op
54	2804/10	16/11/10	Liverpool	41	In Custody
55	2860/10	22/11/10	Bankstown	19	Police Op
56	2863/10	22/11/10	Parramatta	56	In Custody
57	2877/10	24/11/10	Silverwater	20	In Custody
58	2924/10	01/12/10	Parklea	35	In Custody
59	2980/10	08/12/10	Villawood detention	29	In Custody
60	3036/10	12/12/10	Terrigal	50	Police Op
61	3037/10	11/12/10	Lismore	47	In Custody
62	3159/10	25/12/10	Bathurst	80	Police Op

Report compiled by
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