STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of MC
Hearing dates:	20-22 June 2017- evidence at Gosford Local Court, 13 July 2017 - submissions at Glebe Coroner's Court
Date of findings:	17 August 2017
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in a police operation, police shooting, self-inflicted death.
File numbers:	2015/64099
Representation:	Mr J Harris, counsel assisting the coroner, instructed by Ms J Wardle, solicitor, Crowns Solicitors Office Mr D Evenden, solicitor advocate, instructed by Ms H Cooper, solicitor, Legal Aid Commission of NSW for CB Mr P Madden of counsel, instructed by Walter Madden Jenkins for Senior Constable Vrana Mr R Hood, instructed by Mr S Robinson, solicitor, Office of General Counsel for the NSW Commissioner of Police and other involved officers

Findings:

Identity

The person who died was MC.

Date of death

The date of death was 1 March 2015.

Place of death

MC died at Ettalong Oval, NSW.

Cause of death

MC died of a gunshot wound to the chest.

Manner of death

MC was shot by a police officer, as he ran towards that officer with two kitchen knives. MC's death was self-inflicted in the sense that he engaged in a deliberate and conscious course of conduct with the intent of ending his own life.

Recommendations

To the NSW Commissioner of Police

That the NSW Police Force consider using the circumstances of the death of MC as a guide for future training to highlight the risks arising from a person who intends to use police to commit self-harm.

Non-Publication Orders

Pursuant to section 74, I order that there be no publication of various police policies contained at Volume 5, Exhibit 1. (See court file for full list of exclusions)

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

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

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This decision was written without the benefit of a transcript. Section 81(1) of the Coroners Act 2009 (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of MC.

Introduction

1. On 1 March 2015 MC was shot at close range by a policeman who was attending his home in response to a complaint of domestic violence. Immediately after the shot was fired, attending police commenced first aid. Unfortunately, although ambulance officers arrived and continued treatment, MC died prior to being transported by helicopter to hospital. MC's death is tragic and the loss and pain felt by his family is both significant and ongoing.

The role of the coroner and the scope of the inquest

2. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[2]

3. In this case there is no dispute in relation to the identity of MC, or to the date and place or medical cause of his death. For this reason the inquest focused on the manner or circumstances surrounding MC's death. In particular, the inquest examined the response of the New South Wales Police Force to the call which had been made earlier in the day and to police actions at the scene.

4. This is a mandatory inquest, because MC's death occurred "during the course" or "as a result" of a police operation. Parliament requires that inquests of this kind are conducted by a senior coroner.[3] This statutory position reflects the importance of independence and transparency when it comes to investigating deaths in this category. There is a significant public interest in understanding how it is that a person was shot and killed during what has been described as a routine arrest situation. The circumstances surrounding a death such as this should be carefully scrutinised and care must be taken to ensure that all relevant police policies and practices are most carefully reviewed. Any opportunities for improvement should be identified and explored, particularly if they have the capacity to save lives in the future.

5. At the same time it is important to remember that operational policing can be highly unpredictable and stressful. Police are often required to face great personal danger in the course of their work. One must always be careful when reviewing decisions made in the field from the relative comfort of the courtroom. The purpose of this inquest is not to lay blame on any individual, but rather to see if it is possible to identify opportunities to reduce the risk of tragedy in situations of this nature.

[1] Section 81 *Coroners Act* 2009 (NSW)
[2] Section 82 *Coroners Act* 2009 (NSW)
[3] See sections 23 and 27 *Coroners Act* NSW 2009

6. I am satisfied that, after the shooting, a proper investigation of the events surrounding MC's death took place pursuant to the relevant critical incident guidelines and that the necessary information was gathered by non-involved officers so that these matters can now be properly and fully reviewed.

7. The inquest explored the New South Wales Police Force's policies and procedures in relation to a number of matters relevant to the events in this case. A guiding list of identified issues was circulated prior to the inquest commencing. These issues included

    - Did MC receive adequate and appropriate medical treatment following the shooting?
    - What was the medical cause of death?
    - Did MC's psychiatric history have an impact on the actions he took on 1 March 2015?
    - Was MC's death self-inflicted?
    - What information regarding MC was known to the responding police officers?
    - What information did CB provide to the responding police officers?
    - What steps did police take to plan their approach to arrest MC?
    - Was an alternative approach to arresting MC available to police and warranted in the circumstances

    Following a brief outline of the chronological events, I intend to deal with each of these issues in turn.

The evidence

8. The court heard oral evidence over three days and received extensive documentary material including witness statements, expert reports, photographs and recordings. At the end of the evidence there was substantial agreement in relation to what had actually occurred. In setting out the brief chronology I intend to rely heavily on the summary of events reproduced in counsel assisting's opening remarks.[4]

Background

9. MC was born in Lismore to RH and PC. His parents separated when he was two years of age. His mother re-partnered with LH, who then adopted MC and his sister, AT. MC's mother had a third child with LH, JH. While the family was at times close, by the time of his death MC was sadly estranged from members of his family. Prior to the morning of his death, MC had not spoken to his mother for some years. He had last seen JH in 2010, and although he had seen his sister AT briefly in 2014, prior to that he had not seen her in many years. In the period just before his death, MC appears to have been somewhat socially isolated, with little meaningful contact with those outside his home. His mother and various other relatives apparently did not get on with CB and this may have exacerbated the family discord.

10. The records show that MC had a troubled childhood in many respects. There was some family violence and he reported having been sexually assaulted by a family member as a child. MC left school at 15 and commenced work as a painter, a trade he continued throughout his life.

[4] I thank those assisting me for their detailed and thorough summary of the background material.

11. Despite these difficulties, family members report that MC was often happy. He loved football, surfing and being in nature. He was warm and had a good sense of humour.

12. When MC was about 20 years of age he commenced a relationship with a girl he had known for some time, CB. They remained together for 25 years, apart from a few periods of separation and conflict. They had three children, a girl and two boys, who were aged 17, 15 and five at the time of MC's death.

13. There is no doubt that the family circumstances had been difficult for a number of years prior to MC's death. They had experienced homelessness and poverty. There were several documented reports made to the Department of Family and Community Services regarding domestic violence, drug use, mental health issues and neglect of the children.

14. In January 2012, the children were removed from their parents and placed in care. The C's daughter soon returned, but the two boys remained in out-of-home placements. The removal of the children was a source of continuing distress and enormous pain for MC and CB.

15. Despite the difficulties the family had suffered MC was focused on getting his family back together. Between around July 2012 and January 2014 the boys were placed in the care of MC's sister, AT, before being moved to other foster carers. Unfortunately this appears to have caused further animosity within the family.

16. Over the years MC had also suffered from a number of health problems. He had spondylolisthesis, which is an abnormality of the spine, and hyperthyroidism or Graves' disease. He also suffered various mental health problems throughout his life. He was apparently first involved with mental health services around the age of five, when he was diagnosed with a conduct disorder. While the early records are not available it seems that he was treated by a psychiatrist as a child and also spent time as an inpatient at Ryde Hospital. In his adolescence he was diagnosed with ADHD and then with symptoms of depression. A family member described how he attempted to hang himself at aged 15, tried to jump through a window at aged 16 and then how he jumped from the third storey of a building when he was about 20 years of age, causing a fracture to his spine. His mother also reports that MC threatened to throw himself off the cliffs at Curl Curl, although she and other family members were not sure whether he was "serious". Despite these reported issues, MC's mental health diagnosis appears to have been complex and somewhat unresolved.

17. In recent years the care MC received for his mental health issues was minimal and provided primarily by his GP, Dr Young. MC was prescribed antidepressants at various times, although Dr Young notes that MC was not always compliant with the regime. MC does not appear to have undertaken any long term counselling or behavioural therapy. While CB wanted him to engage in treatment, there was no way for her to force him to seek help.

18. MC's medical records include several references to self-harm and suicidal ideation. In January 1997, when MC was 27 years of age he was admitted to hospital following an attempted overdose. In February 2003, MC was found by police sleeping rough in bushland, and was taken to hospital for assessment. Records from that time state that he said he wanted someone to "finish him off". In October 2011, he again took an overdose of medication and was admitted to hospital. However, MC discharged himself, against medical advice a few days later and refused to engage with any follow-up from the local Community

Mental Health Team. It was shortly after this that his children were removed. Dr Young attempted to refer MC back to the Community Mental Health Team in 2012 and also to a psychiatrist, but these referrals do not appear to have been followed up.

19. CB reports that MC continued to be depressed. During 2014, she reports that MC told her that he was going to kill himself. In October 2014 he asked for her medication, which she understood was in order to commit suicide. Significantly, after this point, when he was distressed, MC began to make repeated threats that he would get police to shoot him. CB says that he told her this so many times that "she had lost count". CB says she spoke with Dr Young about MC's deteriorating mental state. Dr Young states that MC did not report any suicidal ideation to him.

20. In addition to his self-destructive tendencies, MC was also apparently increasingly aggressive to others. CB describes MC as being "often volatile", saying he could go from "crazy angry" to calm very quickly. His GP states that staff at the surgery reported that MC would become aggressive if he had to wait for an appointment. His Aikido instructor also recalls that MC failed the test to achieve his black belt due to his lack of control and aggression. CB reports that after failing his test MC made a decision to immediately quit studying Aikido, even though he had been very happy there and the structure it offered had been helpful to the whole family.

21. MC was also violent towards CB. At times police were called and several apprehended violence orders were taken out to protect CB. MC was charged with breaching these orders on three occasions. In August 2003, MC assaulted his partner by kicking her and was convicted of assault occasioning actual bodily harm. In June 2005, MC is alleged to have again assaulted CB. He was also given a suspended sentence around this time for damaging her car. Just prior to Christmas 2012, CB made an allegation that MC had sexually assaulted her. Charges were never brought because CB did not continue to cooperate with the investigation.

22. MC's criminal record is not lengthy but it includes various offences of violence and offensive behaviour and convictions for resisting arrest. A few of the interactions with police are of significance because they resulted in warnings about MC being placed on the police COPS system. In June 1993, MC was arrested for offensive behaviour and on that occasion he resisted arrest. As a result, a warning was placed on the COPS system stating that MC "may assault police".

23. In November 2013, MC was involved in a "road rage" incident. MC lost his temper at the conduct of another driver and proceeded to intentionally ram another vehicle. Police were called. When they arrived it appears that MC admitted his conduct. Senior Constable Kirk, one of the police officers who attended MC's home on the day of his death, recalls having dealt with MC during this earlier incident. As a result of the incident a further warning was added to the COPS system, stating MC "can be extremely aggressive."

24. MC failed to appear at court in relation to that matter. He was convicted in his absence and a warrant was issued. In January 2014, police attended MC's home to arrest him on this outstanding warrant. They found him near the garage holding a sharp metal spatula which they asked him to put down. He complied. However, he then moved towards police officers aggressively and proceeded to violently resist arrest. Further police had to be called and in

the course of the eventual arrest MC was sprayed twice with capsicum spray. This was the last encounter he had with police, prior to his death. An additional warning was added to the COPS system at that time which stated "has LoR [level of resistance]; unarmed; resisted control: wrestle."

The days leading up to MC's death

25. It is clear that in the weeks prior to his death, MC was in a distressed and depressed state. His mental health was deteriorating. It is not known whether he was taking his antidepressant medication. CB describes MC as being suicidal for most of 2015. She was worried about MC and spoke with friends in relation to her concerns. The couple were also becoming increasingly concerned about their eldest son whom they had not been able to see for a period of time. They were worried about his state of mind and were concerned that people were trying to turn him against them.

26. On 27 February 2015 a meeting was held between the Department of Family and Community Services, the agency managing the children and MC, CB and their daughter. MC and CB were understandably emotional during the meeting and MC became so upset and angry that he walked out before the meeting had finished. He was reportedly distressed and felt that his concerns had not been adequately listened to or resolved.

27. According to CB, despite her efforts to calm the situation, MC remained angry and upset the following day. He was "raging around the house". He worked on his car for a while and later they watched a movie together. During the day he received an offer of work for the coming days, which he apparently accepted. That night CB says that MC was acting in a bizarre manner, rummaging around his room and turning all the lights on in the house, but not responding to her when she spoke to him.

The events of 1 March 2015

28. On Sunday 1 March 2015, MC and CB woke around 8 am. MC was intending to go to work. However, a short time later MC discovered that some of his clothes had fallen down behind the washing machine and had been ruined. He became immediately angry and accused CB of "sabotaging" his clothes, and deliberately trying to ruin them. When CB tried to calm him he told her that he "hated her guts" and said that he was going to let the house and everything "go down the tubes". He broke a coffee cup and smashed his mobile phone.

29. MC then assaulted CB. He grabbed her by the hair and punched her, grinding his fist into her face. The noise of the argument apparently woke their daughter KC, and she heard a sound "like someone getting punched".

30. MC then went to the kitchen and rummaged through a drawer, apparently looking for knives. CB screamed at her daughter to get out and later they both left the house. It was CB's evidence that as she left the house MC called out "you call the cops and I'll make sure I'll cause a scene and get them to shoot me. All I need to do is get a knife. It doesn't take much to get them to shoot me" or words to that effect. It was CB's evidence that she had previously heard threats such as this repeated on other occasions.

31. CB and her daughter ran to a house three doors along, which was a group home operated by Catholic Care. Two staff members Mr Hoad and Ms D'Adam answered the door. They took the pair inside and at 8.22 am Mr Hoad called Triple 0 from the internal office.

32. The police VKG operator broadcast a "priority two" message about a minute later. The message identified MC and stated that he had a knife and had gone "crazy".

33. The broadcast was acknowledged at 8.25 am by Senior Constable Rhys Kirk and Constable Michael Bridgeman. They were at Woy Woy Police Station and immediately proceeded with lights and sirens to the location. A minute or so later a third police officer, Constable John Vrana, who was then at Gosford Police Station, also acknowledged the job and proceeded to the Ettalong Beach area.

34. While the police were *en route*, the VKG operator checked the relevant information held on the NSW Police system. The operator informed the responding police that there were three warnings in relation to MC, namely that MC had a "level of resistance - unarmed, resist control, wrestle", "can be extremely aggressive", and "may assault police".

35. Officers Kirk and Bridgeman arrived at the location shortly after 8.30 am. Senior Constable Kirk entered the Catholic Care home and spoke with CB while Constable Bridgeman mostly spoke with her daughter outside. Constable Vrana arrived about five minutes later. He did not speak to either witness.

36. After speaking with the witnesses a decision was made to arrest MC as it appeared the offences of intimidation and assault had been committed. Senior Constable Kirk initially stated that Constable Vrana should take CB and her daughter back to the police station to obtain full statements. However, Constable Vrana said that as he was already there he should help with the arrest. Constable Vrana was aware that there were warnings about MC and he suggested that he should therefore help with the arrest in case MC made any trouble. There appears to have been no discussion about the role each officer would take during the arrest. There does not appear to have been any discussion about whether MC was known to have weapons on the premises.

37. About 15 minutes after their arrival, Senior Constable Kirk radioed VKG and informed the operator that no weapons had been produced, "it seems to be a case of intimidation and common assault". He said they were going to "pop over and arrest MC". The officers then proceeded to the family's home. Senior Constable Kirk drove his caged vehicle, parking on the verge outside so that it was conveniently placed for the arrest which was about to take place. The other two officers walked the short distance and entered the boundary of the property first.

38. Unbeknownst to police, MC was inside the premises preparing for their arrival. He seems to have taken out his Aikido weapons, which had been stored in the bedroom. Police later found a wooden staff called a Jo stick and a wooden sword called a Bokken positioned near the front door. A Samurai sword was also found under the blanket on the bed. Police also found that on a computer near the kitchen, MC had apparently typed a message in the search bar of the web browser which read "im dead hope your happy".

39. Perhaps, most significantly, while police had been talking to CB and her daughter, MC had made a phone call to his mother, RH. It had been 3 years since MC had spoken to his mother and she was surprised to hear from him. He told her that he was held up in the house, surrounded by police and that he was about to die. He said "I've got a Samurai sword in my hand, and when the police come to the door, I'm going to attack them, and they're going to shoot me, dead".[5] While RH tried to reason with her son, he ended the call. It is unclear exactly how seriously she took the threat.

40. The three officers approached the front door of the family home. They were walking in a V formation with Constable Vrana on the left, in front, Constable Bridgeman slightly behind him to the right, and Senior Constable Kirk at the rear. Senior Constable Kirk was the only officer who possessed a Taser. As Constable Bridgeman was approaching the steps leading to the front door, he turned and apparently asked Senior Constable Kirk if CB had mentioned any weapons. Immediately after this, as Constable Vrana drew level with the front porch, MC burst out of the door.

41. The evidence in my view clearly establishes that MC was brandishing two large kitchen knives. He ran straight at Constable Vrana, who backed away slightly towards the rear of the house. As he did so, Constable Vrana drew his firearm. It is likely that he shouted or told MC to drop the knives. MC continued towards him. Constable Vrana shot MC once in the right chest area and he fell to the ground. Ballistic evidence establishes that MC was between 90 cm and 130 cm from the muzzle of the gun at the time it was fired.

42. Emergency services were called and first aid was immediately commenced. Tragically MC did not survive his injury.

Identified issues

Did MC receive adequate and appropriate medical treatment following the shooting?

43. I am satisfied that MC received appropriate and adequate care after the shooting. Unfortunately in the circumstances he could not be saved. I am satisfied that Senior Constable Kirk promptly radioed for an ambulance and that each of the officers assisted, as best they could, by providing first aid equipment or applying pressure to MC's wound.

44. The ambulance arrived within about eight minutes and a Careflight helicopter was summoned. MC was taken by ambulance to Ettalong Oval to meet the helicopter, but unfortunately went into cardiac arrest before he could be airlifted.

45. I have had the medical and ambulance records reviewed by an independent expert[6] and I accept his opinion that given the substantial loss of blood, where access to a trauma centre was not immediate, MC's death is likely to have been the inevitable result of his injuries.

What was the medical cause of MC's death?

46. MC died of a gunshot wound to the chest.

[5] The whole transcript of this important conversation is at Exhibit 1, Volume 3, Tab 107
[6] Report of Dr Vinen, Exhibit 1, Tab 213 A

Did MC's psychiatric history have an impact on the actions he took on 1 March 2015?

47. There is little doubt that MC was suffering from a deteriorating mental state from at least October 2014. He had been making frequent references to ending his own life and to getting police to shoot him. He was under enormous pressure and felt hopeless and angry about losing his children. There is evidence that he was increasingly unable to control his mood and temper. He had been medicated for depression but it is likely that he was non-compliant with his medication. There is however no evidence of a prior firm diagnosis of psychosis or schizophrenic illness.

48. MC's medical records were reviewed by a consultant psychiatrist, Dr Diamond.[7] He found no evidence of schizophrenic illness and thought MC was more accurately described as someone who was suffering from a "persistent disabling personality disorder". He based this opinion on reviewing past medical records and on descriptions of MC's behaviour at various times. He was of the view that MC's depressive symptoms were not an underlying cause for psychiatric disturbance, but "secondary to his dysfunctional lifestyle resulting from his personality disorder".

49. Dr Diamond was of the view that MC was struggling with longstanding features of a serious personality disorder. He had a limited coping repertoire and had developed a range of dysfunctional mechanisms for dealing with his considerable stress. His personality vulnerabilities could produce enormous rage, aggression and constant feelings of being overwhelmed. However, he was not in a state where he had completely "lost touch with reality" nor had he entered a recognised psychotic state on the morning of his death. I accept this opinion on the evidence before me.

50. MC was under enormous pressure at the time of his death. He had never engaged with long term professional help, aside from the intermittent use of anti-depressants. He lacked coping skills and the ability to control the rage he felt. He had developed a range of completely dysfunctional coping mechanisms which culminated in the plan he hatched on the morning of 1 March 2015.

Was MC's death self-inflicted?

51. A finding that a death is intentionally self-inflicted should not be made lightly .The evidence should be extremely clear and cogent in relation to intention. In my view the weight of authority suggests that the proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard.[8]

52. There is overwhelming evidence that MC intended to die that morning, not all of which was available to the attending officers, prior to their approach. There is, in my view, sufficient evidence to establish that MC engaged in a deliberate and conscious course of conduct which he intended, as he embarked upon it, would have the result of ending his own life. The evidence includes,

[7] See Report of Dr Diamond, Exhibit 1, Tab 213 B

[8] *Briginshaw* v *Briginshaw* 60 CLR 336. For a thorough and useful discussion of the law in this area see Her Honour Judge Jennifer Coate's findings in the *Inquest into the death of Tyler Jordan Cassidy* (November 23 2011) Coroners Court of Victoria

- MC had committed self-harm and threatened suicide on previous occasions.
- MC had apparently repeatedly told CB that he would make a fuss and cause police to shoot him over the past few years.
- MC had seen a news report of a police shooting in 2015 and commented that he could get police to shoot him. He communicated this fact to CB.
- When CB left home on the morning of MC's death, he said "If you call the police I will make sure that I make such a scene that they will kill me".
- MC called his mother by telephone at 8.39 am on 1 March 2015, only 9 minutes before he was shot, saying "I've got a samurai sword in my hand and when the police come to the door, I'm going to attack them, and they're going to shoot me, dead". He had not contacted her in some time.
- At some stage, just prior to his death, MC left an improvised suicide message on the search bar of the computer in his home. The message read "im dead hope your happy".
- MC made preparations to ambush police by placing weapons near the door and getting his samurai sword out of its usual storage place. This suggests that he planned to make a significant scene, if necessary.
- MC ran towards Constable Vrana brandishing two knives. He is likely to have felt confident that this would provoke a lethal response. He did not stop or drop his weapons when commanded to do so.
- After he had been shot and was lying on the ground, he spoke to police, saying "why didn't you shoot me in the head?" and "I want to die". He did not remonstrate with police about what had happened or appear to blame them for shooting him.
- Although distressed and angry, it does not appear that MC was suffering from psychosis at the time of his death. He appears to have understood what was happening.
- Toxicological results do not indicate that his reasoning is likely to have been greatly affected by drugs or alcohol.

53. I have carefully considered whether or not it is possible that MC just wanted to "cause a scene", rather than die, but the weight of the evidence suggests otherwise. I have also considered whether he was so overwhelmed by anger and distress that he cannot be said to have been acting in a voluntary manner. However, the evidence is that he planned the placement of weapons and rang his mother to announce his intention just minutes before rushing at Constable Vrana. In reviewing the available evidence I have come to the view that he appears to have been acting on a plan that he had already carefully formulated. I am of the view that as MC ran at Constable Vrana, he intended and planned to die. His death was self-inflicted in the limited sense that he intentionally carried out an action that he believed would provoke a lethal response. I note that CB's legal representative did not appear to reject this view in his submissions.

54. Dr Diamond described what had occurred as a classic "suicide by cop". While I accept that it is a term widely understood in the public arena, it is in my view a most unfortunate term that tends to have the effect of trivialising or even glamourizing the tragedy of the situation. Nevertheless, I accept that it appears to have been a concept that MC was aware of and had discussed with his partner in the months before his death. In my view it is not particularly useful or appropriate to state that MC "committed suicide" in the way the term has been used in the criminal law for many years. However, I am satisfied that pursuant to the *Coroners Act*

2009 (NSW) the circumstances of his death are sufficient for it to be classed as "self-inflicted" and thereby attract the protections provided by section 75."[9]

What information regarding MC was known to the responding police officers?

55. Each of the officers attended the job, knowing what had been broadcast, namely that MC had gone "crazy" and had hit CB. They knew that they were going to a potentially dangerous domestic incident. All three officers heard the warnings that had been broadcast on VKG, but none of them considered these to be particularly unusual or noteworthy. Constable Vrana stated that he would pay attention to warnings that suggested a specific threat, but otherwise accepted that given the common nature of the warnings, he had a degree of complacency about them. Senior Constable Kirk explained that he always "expected that a person could be dangerous" when going to a job such as this. He recognised the name of MC, but only remembered his previous dealings with MC as he approached the house just prior to the shooting, so that prior contact offered him little extra information in weighing up the risk police faced that morning.

56. I accept that there was nothing about the warnings given which would have made them stand out. It is important to stress that police did not know that while they were on the scene, MC was calling his mother to convey his specific plan. Police did not become aware of that until well after MC's death.

What information did CB provide to the responding police officers?

57. On arrival, Senior Constable Kirk had a brief discussion with CB in the office of the Catholic Care home. Constable Bridgeman and Ms D'Adam were also present for a short time. According to KC, during this discussion CB said that MC "might have a knife", but KC contradicted her, saying that she had not seen her father with a knife and she had remained in the house longer than her mother and had actually seen him last. CB denied this conversation took place, but Senior Constable Kirk recalled it. After this point, the witnesses were separated and Constable Bridgeman took KC outside.

58. Senior Constable Kirk then obtained further information from CB about MC. CB said, in her original statement, that she had told Senior Constable Kirk that MC had a mental illness, and she had asked police to Taser MC rather than to shoot him. Senior Constable Kirk acknowledged in evidence that she had said each of these things, although he had not recalled this information during his directed interview. In retrospect he agreed that it was an unusual and memorable request. CB also said that she had clearly warned Senior Constable Kirk that MC would make a scene and encourage police to shoot him. She stated that she knew he would cause a scene and she hoped police would "just" Taser him, rather than have to kill him. I accept her evidence on this issue.

59. During the inquest CB gave emphatic evidence that she had seen MC holding two knives and advancing towards her in the kitchen, before she fled the home. She told the court that

[9] While others have suggested the term "self-inflicted" in the *Coroners Act* 2009 (NSW) is merely a euphemism for "suicide", (See discussion of this point in Waller's Coronial Law and Practice in NSW, (Fourth Edition) 75.1)
I am not so sure. In my view it may be that "self-inflicted" deaths form a slightly broader category than would traditionally be encompassed by the term suicide. It is unnecessary in the context of these findings to state a final view on this issue.

she had told Senior Constable Kirk of this at the time. Senior Constable Kirk denied that CB had told him about two knives. He stated that she had told him that she had seen MC rummaging in the drawer and that she believed he was going to get a knife. As a result, Senior Constable Kirk later informed VKG radio "no weapon produced".

60. In my view the totality of the evidence does not support the conclusion that Senior Constable Kirk was told in clear terms that MC had armed himself with two knives whilst in the house. There are a number of factors which suggest the evidence was more confused than that. Certainly KC had contradicted her mother about MC having a knife when she last saw him. Ms D'Adam remembered a suggestion that "obviously" there were knives in the house, but not a specific report of MC holding knives in a threatening manner. Mr Hoad can be heard on the Triple 0 recording finding it difficult to obtain from CB a clear answer to questions about this issue. I have no doubt CB was extremely distressed and fearful, this may have affected her subsequent recollection about what had occurred and exactly what information she had imparted at the time. In any event, I am not satisfied that I can rely on her later confidence that she saw MC holding two knives whilst still in the house, in the manner she described in court, or that she clearly conveyed this to Senior Constable Kirk at the time they spoke in the Catholic Care house.

61. On the other hand, I am well satisfied that CB did tell Senior Constable Kirk that MC had made a threat that he would cause a scene and get police to shoot him. Both KC and Ms D'Adam support the fact that this was said, and this much was accepted by Senior Constable Kirk himself. However, Senior Constable Kirk appears to have believed that this was unlikely to happen or that these words were some kind of empty threat.

62. While CB denied using the words "usual mantra" she accepted that she probably told Senior Constable Kirk that MC "usually" made the threat when they argued. This appears to have had a diluting effect on the information in Senior Constable Kirk's mind. Senior Constable Kirk told the inquest that he believed that if the threat had been repeated it was "less likely" to happen. Accordingly, he discounted its significance and appears to have regarded it as an "empty threat". In my view, Senior Constable Kirk wrongly discounted what CB was saying in relation to this issue. It is a real skill to obtain and evaluate information from a distressed person and in this case it may have needed more time that Senior Constable Kirk gave the task. With hindsight it is clear that he put little value on her warning. Discounting the importance of this information was an error of judgement on his part.

63. After speaking with CB, Senior Constable Kirk made a decision to arrest MC. He was of the view that a domestic violence offence had been committed. He decided that CB appeared to be in need of protection. In his view it was New South Wales Police Force policy to support a proactive approach to investigating a situation like this and arresting a perpetrator if appropriate.

64. Senior Constable Bridgeman and Constable Vrana did not have any significant discussion with CB that morning and they therefore relied on Senior Constable Kirk to inform them about what CB had said. It appears that Senior Constable Kirk did not discuss with his police colleagues the view that he had formed that MC did not have a knife. This is apparent from the fact that Constable Vrana still believed MC had produced knives, relying on what had been said in the original broadcast.

65. The more significant issue is whether he shared the report that MC intended the police to shoot him that morning. In evidence Senior Constable Kirk stated that he believed he had told his colleagues about the threat MC had made to cause a scene and "get police to shoot him". However in cross examination he accepted that it was possible that he had not told his colleagues about the threat, stating that while he still believed he did, "he had been wrong before".

66. In evaluating all the evidence on this issue it is extremely significant that Senior Constable Kirk did not mention telling his colleagues about this threat during his directed interview, which occurred so soon after the events themselves. I also note that Constable Bridgeman and Constable Vrana did not mention the threat in their directed interviews. It is particularly striking that neither Constable Bridgeman nor Constable Vrana recalled hearing about the threat, given that the threat accurately described what MC went on to do. When questioned before this court both Constable Bridgeman and Constable Vrana did not recall hearing about the threat at any stage prior to the shooting or even immediately afterwards. The weight of the evidence supports the fact that Senior Constable Kirk did not pass on this threat to his colleagues. I am of the view that this is because he simply failed to understand its importance.

67. Senior Constable Kirk was the senior officer present, he was the one who had spoken with CB, and it was incumbent upon him to inform the other officers about what she had said. The threat was, on any view, highly relevant to the assessment of the risk at hand. It was information which should have been assessed prior to arresting MC. It was important for Senior Constable Kirk to pass on this information on to his colleagues, even if he had already discounted it himself. Failing to do so deprived them of vital information which could have informed their own assessments of the risks they were about to face.

68. As a result, the two more junior officers did not turn their minds to the possibility that MC might try to provoke a lethal response from police. They were missing an important piece of information, as they approached a dangerous and difficult situation.

What steps did police take to plan their approach to arrest MC?

69. The three officers undertook minimal planning about how the arrest would be affected. Their evidence suggested that they approached the arrest in a routine way. The extent of their planning comprised of two steps. Firstly, Constable Vrana said that he should accompany the others because he was already there and because the warnings suggested that MC might "bung it on". It was his view that three officers would be better than two. Secondly, Senior Constable Kirk said that he would drive the caged vehicle across to MC's house, so that if they had to wrestle MC into the vehicle they would not have far to go.

70. Other strategies they adopted were not discussed. Senior Constable Kirk informed his supervisor via VKG that they were going to arrest MC. Constable Vrana saw his role as providing backup. The officers adopted a V formation on approach to the house. This formation prevented them blocking each other's line of sight.

71. Senior Sergeant Davis, the Police and Training Coordinator attached to Weapons and Tactics Policy and Review (WTPR) in the NSW Police Force gave evidence in relation to this issue. He stated that it was indeed important that officers plan their approach and that the

NSW Police Force already has extensive training to assist officers in doing just this. He said that planning need not involve a long discussion or be documented or elaborate in detail. However in this factual scenario, he would have expected the officers to discuss what each witness had said and to discuss any risks or safety concerns they had identified before agreeing on a course of action.

72. It appears clear that further planning was called for in the circumstances of this case. Given that both CB and KC were safe, and that there were no other known potential victims or people at immediate risk, there was time to share information before approaching the house. While it is impossible to say whether or not this would have changed the ultimate outcome, it was certainly a missed opportunity.

Was an alternative approach to arresting MC available to police and was it warranted in the circumstances?

73. It is always important to guard against a hindsight bias when reviewing action taken in the field. However, it can be useful to consider what other options may have been available to the path taken.

74. A number of more cautious approaches were potentially available to the officers involved in the arrest of MC. However, given that the officers did not appreciate the risk that MC intended to cause police to shoot him, it is not surprising a more cautious approach was not considered at the time.

75. Nevertheless, a number of alternative approaches were canvassed during the inquest. Firstly, the officers could have attempted to contact MC by telephone. Dr Diamond said that he had experience of this technique being used with success, in the context of high risk negotiation situations, where specially trained police were involved. However, this is a different situation to the one faced by these officers on 1 March 2015. It is the kind of approach used by trained police negotiators when they are present on the scene and where the scene has already been effectively contained. In contrast, Senior Sergeant Davis conceded that whilst this approach was a possibility, it would reveal to the person inside the premises that the police were present and that could then increase the risk of the suspect fleeing the scene or could potentially expose police to an ambush situation. We will never know for sure if MC would have responded favourably, had he been telephoned in this particular situation, although it is probably unlikely.

76. Secondly, it was canvassed in evidence that police could have remained at a distance from the house and shouted or used a loudhailer in an attempt to contact MC. This may have had the possible advantage of allowing officers a greater “reactionary gap” when and if MC emerged. It is clear that Constable Vrana only discharged his firearm because he believed his life was in immediate danger. A greater reactionary gap may have allowed more time for the possibility of placating or subduing MC. However, it is certainly not clear that using this strategy would have led to any different outcome, given MC’s stated intention to get police to shoot him.

77. Thirdly, police could have called for backup, either from other general duties officers or from tactical or specialist police prior to making contact. However, Senior Sergeant Davis stated that the first responding police would firstly need to establish that MC was actually inside the house. Tactical police would not respond until the general duties officers had confirmed that

MC was present and that they had commenced to "triage" the situation. The same may be said of other personnel such as mental health specialists.

78. A further option canvassed in evidence was whether the police officers present could have anticipated using a Taser as a tactical option or planned their approach accordingly. Senior Constable Kirk was the only officer present with a Taser. As the officers approached the house he was at the rear, too far from the property to use his Taser effectively, particularly given the two other officers were standing between him and MC. Greater planning would have made it possible for Senior Constable Kirk to position himself where he could have used his Taser against MC more easily, had it been necessary.

79. The court considered whether it was open for Senior Constable Kirk to use the "draw and cover" technique with his Taser. The Taser policy describes this technique as being where a Taser is withdrawn from the holster and pointed at the suspect so that it can be deployed quickly. However, it is worth noting that Senior Sergeant Davis, who performs a role in reviewing the use of Tasers, did not believe that the Taser policy requirements for "draw and cover" were actually made out in the circumstances of this case.

80. Given the way MC emerged from the house, it is far from clear that the "draw and cover" technique would have resulted in a different outcome. While the Taser may have been deployed, it may not have connected with or indeed stopped MC. It is worth noting that each of the officers present was adamant that upon seeing MC running towards Constable Vrana with knives drawn, their only thought was to use a firearm. Each officer believed that attempting to use a baton, Taser or OC spray in these circumstances would have been too dangerous as the time taken to try these less lethal options would have meant the opportunity to use a firearm, if necessary, was lost. Each officer was of the view that in the circumstances as they presented, Constable Vrana had time for a single approach.

81. The court accepts that when MC emerged from the house and ran towards Constable Vrana brandishing two knives, Constable Vrana was in a very vulnerable position, effectively hemmed in on three sides by the fence, wall and rubbish bins. Once MC charged at Constable Vrana, the officer had no chance to use conflict resolution skills or negotiate. It was too quick and too dangerous. It is likely that all Constable Vrana had time to shout was something like "drop the knives". The whole interaction was over in a number of seconds.

82. Senior Sergeant Davis did not consider that the other tactical options available to police officers such as a baton, OC spray or Taser would have been appropriate options to use in these circumstances, given the effective limitations of the range and reliability of those weapons. He also stated that he would have been very concerned if either Senior Constable Kirk or Constable Bridgeman had discharged their firearms because they would have been firing directly towards Constable Vrana. I accept that even if Constable Vrana had a Taser it would have been a risky weapon to choose in the circumstances. Equally, OC spray does not appear to have been a viable option. Its use may have disabled the officer himself and may not have had the necessary coverage to be effective against MC. It is also well known that many offenders will continue to attack, while feeling the first effects of the spray, sometimes with added aggression.

83. I note that it was Senior Sergeant Davis's evidence that Constable Vrana's action in discharging his firearm was legally justified in the circumstances, particularly, in light of his

obligations pursuant to section 230 of the *Law Enforcement (Powers and Responsibilities) Act* (2002). My own task is not to involve myself in tests appropriate to civil or criminal law, however, I accept that at the time Constable Vrana shot MC he genuinely believed that he was acting to save his own life and possibly the lives of his colleagues. I accept that he was faced with a frightening and dangerous situation and needed to make an urgent decision. I accept, without reservation that Constable Vrana was faced with a man rushing towards him with two large kitchen knives. I commend each officer present for immediately attending to first aid after experiencing the shock of such a frightening situation.

84. When one carefully examines what occurred in this tragic situation, the opportunities for learning and improvement are not found in the split second that MC took to run at Constable Vrana, but occur in the period before police attended the house. The opportunities to learn from these tragic events will be found in revisiting police training with regard to information gathering and in adequate planning for arrest. In my view there is great merit in developing targeted training so that police will be more aware of the possibility that a distressed person may be acting to provoke a lethal response. Any warnings received with regard to this particular kind of threat need to be taken extremely seriously.

85. Senior Sergeant Davis, the Police and Training Coordinator attached to the Weapons and Tactics Policy and Review (WTPR) in the NSW Police Force accepted that the tragic circumstances of MC's death may be a useful case study for his unit to consider in planning this kind of future training. I intend to formalise this suggestion as a recommendation.[10]

Conclusion

86. MC told his mother that police would shoot him on 1 March 2015, minutes before they did. His psychological distress had been continually escalating for months. His partner knew best how precarious his grip on life had become. She warned police that MC would create a scene and provoke police to kill him. Unfortunately, that warning was not taken seriously enough. Police approached the arrest as a "routine" domestic violence job, with little information sharing or planning by the senior officer involved. Unfortunately, once MC charged from the house, it is understandable that Constable Vrana acted swiftly to protect himself. The ultimate result had been tragically foreshadowed by CB in her warning to Senior Constable Kirk only minutes before.

87. MC's suffering at the end of his life is a tragedy. Unfortunately, there is no simple solution to prevent the despair MC felt as he ran at Constable Vrana. This pain and anger had been brewing for many years. CB had urged MC to seek further help and support on countless occasions, but he would not.

88. Equally, there is no simple remedy for correcting any errors of judgement or planning made by police that morning. It is easy to be critical from the safety of a courtroom, but I recognise the situation was extremely dangerous and that there would have been substantial risks involved, even if Senior Constable Kirk had taken more time to consider the importance of the warning he had received. I hope a close analysis of the circumstances of police

[10] Since the evidence in this inquest has concluded it has come to my attention that the Victorian Police have developed a specific training package designed to assist police in identifying and diffusing situations of potential "suicide by cop". That material was not before me and forms no part of the evidence in this matter. However, I urge the relevant NSW Police to follow up and review this material to judge its usefulness in the NSW context.

involvement in this death, by those who conduct police training, will provide learning opportunities for other police officers who find themselves in similar dangerous situations in the future.

89. Finally, I once again offer my sincere condolences to MC's partner, children and extended family. Although divided, I see the pain they all share and acknowledge their great loss. I strongly urge that any published report of this death include reference to suicide prevention and mental health treatment contact points. I thank the involved officers for their open cooperation with these proceedings.

Findings

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

Identity
The person who died was MC.

Date of death
The date of death was 1 March 2015.

Place of death
MC died at Ettalong Oval, NSW.

Cause of death
MC died of a gunshot wound to the chest.

Manner of death
MC was shot by a police officer, as he ran towards that officer with two kitchen knives. MC's death was self-inflicted in the sense that he engaged in a deliberate and conscious course of conduct with the intent of ending his own life.

Recommendations

91. Pursuant to section 82 of the *Coroners Act* 2009 (NSW) I make the following recommendation to the NSW Commissioner of Police.

92. That the NSW Police Force consider using the circumstances of the death of MC as a guide for future training to highlight the risks arising from a person who intends to use police to commit self-harm.

93. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
17 August 2017
NSW State Coroner's Court, Glebe