CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of D B
Hearing dates:	1 – 3 September 2020
Date of findings:	16th November 2020
Place of findings:	Lismore
Findings of:	**Deputy State Coroner Magistrate Linden**
Catchwords:	CORONIAL LAW – Cause and manner of death
File number:	2018/00001444
Representation:	Climo – Counsel assisting the Coroner Curry – for the Police Simpson – for the Family
Non-publication and non-access orders:	1. Pursuant to s. 75(1) and (2) of the Coroners Act 2009, there be no publication of any matter (including the publication of any photograph or other pictorial representation) that identifies: the deceased D B 2. Pursuant to s. 75(4) of the Coroners Act 2009, order (1) continues to have effect after the delivery of findings.

Findings:	**Identity of deceased:** The deceased person was DB, born *redacted*/1978 **Date of death**: He died on 28 December 2017 **Place of death**: *Redacted* **Cause of death:** The cause of his death was self-inflicted death by hanging **Manner of death:** The manner of death is as follows. DB died as a result of a self-inflicted death.
Recommendations:	**To the Commissioner of Police** 1) The development of procedures and policies for ready access to operational and responding police to medical records of persons of interest relating to previous scheduling in a mental health facility or previous hospital presentations in relation to mental health. 2) The mandatory mental health training provided to the New South Wales Police Force (NSWPF) be revised to include the following: a) Risk assessment based on practical scenarios which encompass a range of factors including mixed events including domestic violence and mental health presentations that are not deemed to be 'high risk'; b) The inclusion of a practically focused 'How to Guide' on conducting a risk assessment regarding imminent or probable risk of harm in accordance with the section 22 criteria Mental Health Act 2007; and c) The expansion of training to include practical scenarios in the area of alternative options to the use of section 22 of the Mental Health Act 2007 d) The implementation of a mandatory face to face mental health 'refresher course' for NSWPF.

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The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of D B

Background:

History prior to 28 December 2017

The deceased was first treated by Dr Harry Freeman in 1997 when he was admitted to Lismore Base Hospital under an involuntary schedule. He was diagnosed with and suffered from Bipolar Disorder. As a result, there were many admissions for this disorder in NSW and QLD. Specifically, there was a mental health schedule dated 24 June 2017 noting that the deceased had presented to the hospital with “suicidal ideation jump in front of truck or hang self. Heavily in debt recent gambling no money left depressed, hopeless, worthless. Risk to reputation”. The risk assessment noted a history of suicidal ideation and attempts, Bipolar Affective Disorder, alcohol consumption. The hospital noted that he had minimised the events of the previous night and indicated that everything was fine. The deceased stated he had been depressed for months often feels hopeless and has nothing worth living for. He denied needing help and requested discharge but was admitted and transferred to Tweed Heads inpatient unit.

In Dr Freeman's dealings with the deceased there was constant talk about his suicidal impulses. In particular, the deceased told Dr Freeman on many occasions that he had imagined hanging himself from one of the roof struts in his father's shed. The deceased told Dr Freeman that there were many occasions when he had thrown a rope over the structure but had not gone ahead and done it. This ideation was coupled with his expression to Dr Freeman of a real dislike of his father. This information was not available to the family and consequently to the police officers who attended the premises on 28th December 2017.

Dr Freeman's opinion was that the deceased had a lifelong struggle with Bipolar disease and he often had suicidal ideation. Dr Freeman was further of the view that the combination of alcohol consumption, the failed marriage and lack of money contributed to the final decision to commit suicide.

An important aspect of Dr Freeman's evidence was that the deceased was capable of sounding very plausible and this in turn is mentioned in the events of the 28th December 2017.

The Fatal Incident:

Events of 28th December 2017.

During the course of the day the deceased's mood became more and more worrisome. There were more and more arguments. The deceased called his mother an old bitch and his sister a barren bitch. He continually told them that they were interfering with his disciplining of his children. At one stage the deceased threw a glass he was holding out the sliding door of the house and shortly thereafter threw an ice tray around the kitchen and in addition was banging cupboards and doors. The deceased returned to the living room and continued to yell and verbally abuse his mother and sister. According to his mother the yelling just kept escalating and escalating.

The deceased's mother decided to call 000 and just prior to that the deceased said, "I am going to nut myself".

During the course of the afternoon the deceased had a text conversation with his estranged wife as follows:
The deceased: "Can I please have my wife back now?"
The Wife: "No Ben, we are finished".
The Deceased: "Sorry just wanted to try 1 last time before I die goodbye …… look after yourself and our children."

The deceased's mother called 000 and the following is relevant:
000 operator: "All right so tell me what's happening he's causing problems for you is he?"
Deceased's mother: Um yeah he's been screaming at his sister and he's been drinking all afternoon and his children are here it's a separated situation."
000 operator: "Ok has this happened in the past?"
Deceased's mother: "Yes. He's got mental health, um Bipolar".
000 operator: "Any other mental health conditions?"
Deceased's Mother: "Yeah. No that's it just BipPolar."

The 000 call formed part of the message received by the attending police officers. In particular the Bipolar aspect.

Arrival of Police

Senior Constable's Laura Keogh and Grant Burns arrived at the premises at about 6.45pm.
Senior Constable Burns asked "What's happened?"

The deceased's mother said “He's been arguing with his sister” and shortly there after said “can't you just take him away, lock him up for the night”
Senior Constable Keogh said “ We can't just lock him up for no reason.”
To which the deceased's mother said “Well take him away for mental health or something”.
Senior Constable Keogh said “It's not that simple but we will talk to him”.
Constable Burns said “Is there anywhere else he can go?”
The Deceased's mother said “He's just moved back from Rockhampton, apparently he's living here but he hasn't talked to me about it”.
At this point both police officers went to the back yard where the deceased was located.
Senior Constable Keogh said “Your mum told us you had an argument with your sister.”
The deceased replied “Yeah we had an argument”.
Senior Constable Keogh then asked “What was the argument about?”
He said “Just and mum and my sister trying to butt in and tell me how to raise my children”.
The deceased then moved across the back yard and the conversation with police continued.
Senior Constable Keogh said “Is there anywhere else we can take you?”
He said “No”.
Senior Constable Keogh said “What about a motel?”
He replied “If my mother gives me money for a motel I'll go there”.
Some short time later senior Constable Keogh said to the deceased's mother “DB said he'd go to a motel but does not have any money to pay.”
His mother stated “That's not unusual” and further “well if he's got to stay here he'll just have to stay here”.
His mother then said “He said he was going to top himself can't you take him away for that?”
Senior Constable Keogh said “When did he say that?”.
His mother replied “while they were arguing”.
Senior Constable Keogh said “I will ask DB about that and if he says anything that concerns me I will call an ambulance and they can do an assessment”.
As a result of that conversation Senior Constable Keogh spoke to the deceased asking “Your mum just told me you made threats to kill yourself”.
The deceased said “Yeah I said that in the heat of the moment but I was just venting”.
Senior Constable Keogh said “How do you feel now?”
He replied “Fine”.
Senior Constable Keogh then asked “Do you feel like killing yourself?”
He replied “No”.
Senior Constable Keogh then said “Have you had a few to drink today DB?”.
He said “Yeah I've had a few”.

Senior Constable Keogh said “Your mum mentioned you suffer from Bi Polar, are you taking medication for that?”
He replied “Yeah I take my medication every day”.
Shortly after Senior Constable Burns returned from being in the house and said “Righto DB we're going to head off. I'll be making a record of what's gone on but there won't be any charges against you. Maybe just try and give each other space for the rest of the night.
The deceased said “Yeah I'll just sit out here for a while.”
The attendance of police lasted approximately 15 minutes and history shows that the deceased fatally self-harmed within minutes of the police departure.

Adequacy of the Police assessment of the deceased.

An expert report was obtained from Dr Kerri Eagle and she gave evidence at the inquest. Her view was expressed in her report as follows:

“Overall and with the benefit of hindsight I am of the view that the police assessment of DB was inadequate in the circumstances. The assessment was complicated by DB's minimisation of the situation to officers Keogh and Burns. None the less there appeared to be sufficient indicators to warrant closer scrutiny of the situation and further assessment of DB particularly the specific concerns raised by his family. Officers Keogh and Burns should have sought further information from DB's family regarding their concerns and his mental health history, or alternatively and in any event sought further mental health assessment advice and or support.” Dr Eagle was of the view that this further assessment may have been achieved by transporting DB to hospital under section 22 of the Mental Health Act 2007 or alternatively by calling the mental health hotline or the ambulance service.

I bear particularly in mind the evidence of Dr Freeman as to;

1. The deceased's ability to be plausible
2. The deceased's many references to self-harm in the manner finally undertaken. This information was unknown to the family and the police officers.

Accordingly, with the benefit of hindsight, I am satisfied more inquiry should have been undertaken by the officers in all the circumstances.

Adequacy of police training for Mental Health and future proposals.

There are currently two mental health workshops namely the One Day Mental Health Awareness Program that is delivered as a core curriculum for all recruits at the Goulburn Police Academy and a four day workshop mentioned below. This one day workshop is a scaled down intensive course. Dr Eagle's view was that this

mandatory training could be improved by providing more scenario based learning involving common but more complex police interactions with persons who may be at risk of suicide and incorporating a broader more problem solving approach. She was of the view to optimise the chance for internalisation and embedding of the training in the workplace, refreshes and workplace reinforcement of training by policies and the regular involvement of contact with police officers who have specialised mental health training with front line officers would be of benefit. She noted that any training programs be systematically reviewed for their effectiveness over time.

The 4 day workshop is a registered and accredited course of the NSW Police force. It is facilitated once a month for 10 months of the year for approximately 30 officers each time. At the conclusion of the program successful participants are given an MHIT metal pin to be worn on their uniform distinguishing them as being trained in Mental Health intervention. To the end of April 2019, 2,420 officers had completed the program. My only comment about this course is that it is a shame all officers are not able to attend the training program.

Redacted

The information contained regarding ….. is confidential and subject to a non-publication order

Chief Inspector Hanlon gave evidence of a revised training package called Enhanced Policing Practice Model (EPPM). This package is said to contain several new clinically approved sessions and areas of recent improvement include the STOPAR de-escalation package which trains officers in the principles of de-escalation. Also there is a revised critical incident package that explores critical decision making, the physiological responses occurring to officers in high risk situations and how those effects can lead to impaired decision making. The Mental Health Awareness component of the workshop is delivered by a mental health clinician and seeks to educate attendees in the signs and symptoms of major mental illnesses and the treatment and care of persons living with a mental illness.

This revised training package is awaiting NSW Police Force academic board accreditation, and this should be encouraged.

<u>The PACER Program</u>

PACER stands for Police Ambulance Clinicians Early Response. This approach places two specialist mental health clinicians in police area commands and police districts to work closely with first responders. Their role is to attend mental health incidents when requested by police and work with Police to conduct assessments under the Mental Health Act. The program currently is available across 12 police

area commands and districts. It is part of a wider effort to adapt the program to work effectively in the diverse regional and rural areas across the state. This may include not only clinicians on the scene but also virtual Mental Health Services.
This is to be encouraged.

Findings required by s81(1)

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

The identity of the deceased

The deceased person was DB, born 6/11/1978

Date of death

He died on 28 December 2017

Place of death

Redacted

Cause of death

The death was caused by was self-inflicted death by hanging

Manner of death

DB died as a result of a self-inflicted death.

This was on a background of a diagnosis of bi-polar 1 disorder and a recent deterioration in his mental health and hospital admissions. DB died as a result of hanging, resulting in a single asymmetric ligature abrasion mark around his neck.

Recommendations pursuant to section 82 of the Coroners Act 2009.

Counsel assisting drafted proposed recommendations. I have considered those recommendations and believe they are appropriate, and they are as follows:

3) The development of procedures and policies for ready access to operational and responding police to medical records of persons of interest relating to previous scheduling in a mental health facility or previous hospital presentations in relation to mental health.

4) The mandatory mental health training provided to the New South Wales Police Force (NSWPF) be revised to include the following:
   e) Risk assessment based on practical scenarios which encompass a range of factors including mixed events including domestic violence and mental health presentations that are not deemed to be 'high risk';
   f) The inclusion of a practically focused 'How to Guide' on conducting a risk assessment regarding imminent or probable risk of harm in accordance with the section 22 criteria Mental Health Act 2007; and
   g) The expansion of training to include practical scenarios in the area of alternative options to the use of section 22 of the Mental Health Act 2007
   h) The implementation of a mandatory face to face mental health 'refresher course' for NSWPF.

At this point I express my condolences to the family of the deceased.

I again wish to thank assisting counsel and the representative of the Crown Solicitors Office for their extraordinary assistance in the preparation and presentation of this inquest and in addition my sincere thanks to the legal representatives of the police and the family for assisting in the manner in which the inquest was run.

I close this inquest.

Magistrate
Deputy State Coroner

Date