CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of A
Hearing dates:	20 July 2020 – 24 July 2020.
Date of findings:	11 August 2020
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of a man in police operation – deceased shot himself – two responding police officers also injured – was risk assessment and tactical planning appropriate?
File number:	2019/20200
Representation:	Counsel Assisting the Inquest: J Downing of Counsel i/b NSW Crown Solicitors Office. The NSW Police Force and NSW Commissioner of Police: K Burke of Counsel i/b Office of General Counsel, NSW Police. Former officer H McMurtrie: B Haverfield of Counsel i/b Greg Willis. A's spouse B: D Evenden, Legal Aid Commission. Sgt M Johnston and Constable S Petty: P Madden of Counsel i/b Walter Madden Jenkins.

Findings:	**Identity** The person who died is A. **Date of death** A died on 18 January 2019. **Place of death** A died at Glen Innes NSW 2370. **Cause of death** A died of a gunshot wound to his head. **Manner of death** A died when he shot himself to the head while a police operation was underway.

Non-Publication Orders pursuant to section 74 of the Coroners Act 2009

Orders made pursuant to section 75 and 65 of the Coroners Act 2009

On 20 July 2020 Deputy State Coroner Ryan made orders pursuant to sections 74, 75 and 65 of the *Coroners Act 2009*, prohibiting publication and access to certain evidence in this inquest. The orders are located on the Registry file.

The orders include an order of non-publication of evidence that identifies:

- the deceased person (anonymised in these findings as 'A')
- the deceased person's spouse ('B'), sister-in-law ('C') step daughter ('D') and two children ('L' and 'M').

Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to the date and place of the death, and its cause and manner.

These are the findings of an inquest into the death of A.

Introduction

1. A aged 74 years died on the night of 18 January 2019, at his home in Glen Innes in northern NSW. Police officers had been called to the home by A's wife B. Soon after they arrived A, who was armed with a rifle, fired a shot which injured two of the responding police officers. A then fired a round into his own head. He suffered unsurvivable injuries and died immediately.

2. This is a mandatory inquest pursuant to sections 23(1)(c) and 27(1)(b) of the Act. An inquest is mandated when it appears that a person has died '*as a result of police operations*'. The purpose is to ensure there is an independent and transparent investigation of the circumstances of the death, and the conduct of any involved police officers.

3. Detective Sergeant Jason Ronczka was appointed to lead the subsequent Critical Incident investigation and to prepare the coronial brief of evidence.

The issues examined at the inquest

4. The issues examined at the inquest were:

    - what risk assessment did the responding police officers make prior to proceeding to A's house on 18 January 2019? Did it sufficiently take account of information that A was armed with a firearm?

    - when the police officers attended A's house were their actions adequate and appropriate?

    - was the incident a high risk situation? If so what should have been done as a consequence?

    - had the police officers received adequate training regarding high risk situations?

A's life

5. A was born on 1 October 1944. As an adult he lived in Wollongong and worked as a plastics fabricator. He married and had two children, L and M, who are now adults. After about fifteen years the marriage came to an end. Sometime afterwards A married B, whom he had known for many years.

6. When A retired thirteen years ago he and his wife moved to the town of Glen Innes with her adult daughter D. Their house at 54 Church Street was a two level building with a long balcony on the upper floor which faced the street. At the rear of the house was a detached granny flat which D lived in. Church Street is the main thoroughfare running north to south through Glen Innes.

7. At the time of A's death his wife was working in her career as a nursing home carer. She and A shared a love of camping and hunting, and between them they owned thirteen registered firearms. These were stored in three gun safes on the ground floor of their home. Ammunition was separately stored. One of the firearms, belonging to B, was a Winchester Marlin Model .30-30 rifle. It was fitted with a magazine capable of holding seven cartridges. This was the gun which A used on the night of 18 January 2019.

8. A's death has had a devastating effect on many people. At the close of the evidence the court heard a tribute from his two children, who spoke of a generous and hardworking man whom they loved whole-heartedly. Following this, Mr Evenden read to the court a loving statement prepared by B. She spoke of her heartache at losing her husband and her bewilderment as to why he had taken his life that night. She remembered him as a man who loved her and her family '*beyond measure'*. She misses him deeply.

9. It is not only A's family who continue to suffer the effects of his death. Three police officers attended A's house on the night of 18 January 2019: Sergeant Mark Johnston, former Leading Senior Constable Helen McMurtrie, and Probationary Constable Samantha Petty. Officers Johnston and McMurtrie received gunshot wounds that night which required hospitalisation. Because of her injuries, Ms McMurtrie found herself unable to resume her career as a police officer and she retired from the service this year. While their physical wounds have healed, it is clear that she and Sgt Johnston suffer profound distress at the memory of that night. The third police officer, PC Petty, was but four weeks out of the police academy when she attended the Newman home with her fellow officers. She remains a police officer but undoubtedly will never forget these events.

The lead up to the police operation on 18 January 2019

10. At the inquest the court heard that the relationship between A and B was volatile at times. In 2010 B left her husband and moved to Queensland following an incident in which he had assaulted her. A undertook anger management counselling, and after about a year B returned to live with him. She told her family that his behaviour had become less aggressive. In her statement to police following A's death she denied that he had ever assaulted her after she returned to live with him.

11. However B's sister C presented a different picture of this aspect of their domestic life. C lived near A and B in Glen Innes and she saw her sister most days. In her statement to police she said that although she herself never saw A being violent towards her sister, on several occasions she had observed bruising on B's upper arms. B had reported to her that there was *'a lot of*

yelling and arguing and lots of verbal abuse', and that she had thoughts of leaving him again.

12. On 27 May 2018 an ambulance was called to A's home when he fell down the stairs after drinking whiskey. He was initially aggressive to the ambulance officers and punched a hole in the wall, prompting the arrival of police.

13. On the night of A's death the couple was at home together. An argument broke out between them about domestic chores. At about 9.40pm B went upstairs. A followed her, grabbed her arm, and put his arm around her neck in a choke hold. After that he released her and went to another part of the house.

14. Fearing for her safety, B ran to the granny flat to get help from her daughter D, and they made a call to '000'. The operator said they would send an ambulance and police officers. B then rang her sister, who got in her car and collected B and D from outside their home. She drove them down the road a short distance and parked outside 39 Church St. It was here that the responding ambulance and police crew met them.

15. The responding officers were:

    - Kerry Trow, paramedic officer with NSW Ambulance
    - Peter Adams, paramedic officer with NSW Ambulance
    - Sergeant Mark Johnston
    - Leading Senior Constable Helen McMurtrie
    - Probationary Constable Samantha Petty.

16. On the evening of 18 January 2019 these three police officers were the only ones rostered on duty at Glen Innes Police Station. PC Petty was in the very early stages of her probation as a police officer, and LSC McMurtrie was her Field Training Officer. At that stage of her training PC Petty was required to work with two other officers at all times, which is why all three officers attended the Newman home that night in response to the triple zero call.

What risk assessment did the responding police officers make prior to proceeding to A's house on 18 January 2019? Did it sufficiently take account of information that A was armed with a firearm?

17. As will be seen, senior officers Johnston and McMurtrie did perform an informal risk assessment that night. This involved gathering information about what had happened and assessing what risks they faced in attempting to resolve it. A critical question is whether during this process they placed sufficient credence on information that A was physically in possession of a firearm.

18. NSW police officers receive training about how to respond to the wide range of incidents to which they are called. In addition to being trained in the tactical options at their disposal, police officers are taught to apply situational awareness in determining their appropriate response.

19. The court was assisted with an expert report and evidence from Detective Inspector Justin Waters. DI Waters had been asked to provide his opinion on the actions of the three involved officers that night in respect of planning, coordination and tactics.

20. DI Waters is a police instructor of more than 22 years' standing. Prior to that he had many years' operational experience as a general duties and plain clothes police officer. At the time he prepared his report he was a Senior Operations Safety Instructor with NSW Police Force's Weapons and Tactics Policy Review Unit.

21. In his report Detective Acting Inspector Waters described the aim of situation awareness training as to reinforce '*the dynamic nature of the decision-making process'.* [par 38]. Key elements are the gathering of all situational information, then identifying a plan and a tactical option which will best resolve the incident. Police training emphasises the need to continually monitor the effectiveness of the plan during and after implementation. Thus:
'Officers are taught to conduct a risk assessment of the situation confronting them. This risk assessment must also be reassessed on an ongoing basis to minimise the risk of danger to all involved.'(par 43).

22. Of direct relevance to the issues in this inquest is the feature of officer safety. The significance of officer safety was emphasised by DI Waters:

    '…operational safety instructors continually reinforce with participants during training sessions the importance of maintaining their own personal safety first. In fact, it is considered paramount. If a police officer is seriously injured or killed, they are of no use to themselves or other officers present, or to those innocent bystanders whom they serve to protect.' (par 15.)

23. I now describe the information which the officers sought and obtained prior to their approach to A's house that night.

The Computer Aided Dispatch report.

24. The police radio message to which the three officers responded was one of a number of information sources to which they had access in forming their risk assessment and plan. The Computer Aided Dispatch (CAD) radio message, broadcast at 9.48pm, advised there had been an assault by a man on his wife who had suffered injury to her neck and hand. The message went on to advise that at the premises there were thirteen firearms which were '*in safe store'*, but that there were no weapons in play nor any current Apprehended Violence Orders.

25. B's call to triple zero was clearly the source of some of this information. The transcript of her call shows that she informed the operator of her injuries and told him their thirteen guns were locked up. In the call she made no mention of A having taken possession of one of the guns. Other evidence heard at the inquest suggests that B's information in this regard was accurate at the time

of her call. At this time she was most likely inside her daughter's flat, unaware that her husband was in the process of going to the gun safe and removing her Winchester rifle. As will be seen, it is likely that by the time the police officers arrived at the scene, B had become aware of the likelihood that A was in fact armed.

The conversations outside 39 Church Street

26. When the ambulance and police officers arrived outside 39 Church Street at just after 10.00pm, officers Johnston and McMurtrie set about gathering information from B and her sister. Paramedic officers Adams and Trow also participated. While there are common elements to the information imparted in these conversations, it is fair to say that there were areas of inconsistency. One of the issues explored at inquest was whether the police officers placed too much weight on these, to arrive at a conclusion that the information they received about A's possession of a gun was not fully reliable.

27. In his statement and evidence to the inquest, paramedic Adams said he observed that B and C were unsteady on their feet. He heard B tell paramedic Trow she had had four to six wines that night. He also heard B say that her husband had told her he was '*going to get*' the 30.30 rifle from the gun safe. Mr Adams observed that B had injuries: red marks on her neck, a bruise on her left upper arm, and a haematoma on her thumb.

28. The above conversations were not captured by audio or video. However once the three police officers arrived, much of the subsequent conversations were. Officers Johnston and McMurtrie each wore police-issue body-worn video cameras which they activated upon their arrival. The resulting recordings [the BWVs] reveal that while C was in the presence of officers McMurtrie and Johnston, she reported that her sister had told her the following:
    - that she and her husband had both been drinking that night
    - A had grabbed her by the wrist and had tried to strangle her
    - A had pulled out a gun and threatened to kill her.

29. When asked by officer McMurtrie to confirm that this is what B had told her, C repeated that B had said that A had tried to kill her, he had broken her wrist, he was going to murder her, and that *'he's got his gun'*. C also volunteered that A had previously *'pistol-whipped'* B but she hadn't reported it, and that the couple were hunters with a safe full of guns and ammunition.

30. Officer McMurtrie then turned her attention to B for her account of what had happened. B was very distressed and her sister made an attempt to speak on her behalf. Officer McMurtrie rightly discouraged C from interrupting and returned her attention to B. At the inquest B told the court she had felt somewhat annoyed by this and had concluded the police did not want her help.

31. In the presence of Sgt Johnston, B told officer McMurtrie the following:
    - she'd had '*a couple of wines'* and A had got '*a little bottle of Scotch'*

- A had put his hands around her neck and she couldn't breathe, she'd thought she was going to die
- A had mentioned a 30-30 and had said to her something like '*Oh you'll get what you want'*
- she and her daughter had hidden outside the house and she had seen A sitting on the balcony. It '*looked like'* he had her gun. She thought he was going to shoot himself.

32. It is to be noted that there is a discrepancy between the accounts to the police given respectively by the two sisters. According to C, B had told her that her husband had '*pulled out a gun and threatened to kill her'*. In contrast, B described A uttering an ambiguous threat while assaulting her, and that she subsequently saw him on the verandah holding what looked like a gun. It is presumably for this reason that in her evidence, officer McMurtrie expressed the view that B had not '*backed up'* C's version, and that there was reason to regard as inconsistent their accounts of the relevant circumstances.

C's visit to the house

33. There was a further piece of information relevant to the officers' assessment of the risks involved that night. While officer Ms McMurtrie was speaking with B, C decided to walk to A's house to see if she could find out what was happening. She ignored calls from B and the police officers to return to the group. C explained in her evidence that she had known A for many years and had always had a good relationship with him. She thought she might be able to help resolve the situation.

34. To the court she described going into the front yard and seeing A sitting on a bench at the northern end of the upstairs balcony. She called out to him, asking if she could come up and talk to him, but he told her to *'fuck off'*. This startled C as, she said, he had never spoken to her like that before. She saw A was holding something on his lap which was shaped like a pipe, which she assumed was a gun. Now fearful for her own safety, she returned to where the group was still gathered down the road.

35. There is conflicting evidence as to whether on her return C told police about her visit, and in particular about seeing A holding an object which she assumed was a gun. In her evidence to the inquest C said she definitely told her sister about it, and also that A had looked '*so angry'*. She thought that while she was saying this the police officers were standing nearby. She was clear that she did not specifically speak to the police because she was still annoyed that they had, from her point of view, ignored her earlier attempts to assist them.

36. Neither officers Johnston nor McMurtrie recalled hearing from C that she'd just seen A with an object that looked like a gun. On the contrary, they believed she had said that although A was upset, he was *'fine'* and she was sure he would speak to them. In her evidence however PC Petty said she *did* hear C saying A was holding an object that looked like a gun.

37. It is to be noted that in her evidence C denied saying to the police officers that she was sure A would talk to them. Nor is this information captured on the BWV recordings. Of itself this does not mean the words were not said: it is apparent from the recording that at times conversations were proceeding simultaneously, and that some of the participants were out of audio range. Nevertheless given C's evidence that after her encounter with A she was left feeling scared for her life, it seems unlikely she would have told the police officers that he was '*fine*' and that she was sure he would speak to them.

38. It appears that following these conversations, officers McMurtrie and Johnston had an informal discussion and decided on a plan to go up to the house and attempt to engage A. One of their purposes was to ascertain if he did in fact have a gun in his possession.

<u>Why did officers Johnston and McMurtrie not believe there was sufficient evidence that A was physically armed?</u>

39. In their interviews and their evidence at inquest, officers Johnston and McMurtrie were clear that when they began their approach to the house they knew A had *access* to numerous firearms. However they said they were uncertain if he was actually *in possession* of one of them. It was, they said, a possibility but they could not be sure. This state of mind influenced not only their assessment of the risks involved in the situation, but also the plan they formed and implemented, of approaching the house to see whether he did in fact have a gun and to find out what his intentions were.

40. Officers Johnston and McMurtrie were questioned as to why they were uncertain whether A had a gun in hand, given the information imparted by B and C (described above at paragraphs 28 and 31). Both replied that they considered B's reliability was compromised because of her level of intoxication. Commenting that B appeared extremely distressed (an observation with which I agree, having viewed the BWV footage), Sgt Johnston also questioned her reliability on this account. As noted, both officers were also under the impression that upon her return from the house, C had reported that although A was upset he was fine and she was sure he would talk to the police.

41. In addition when asked about her assessment of the risk, officer McMurtrie cited what she described as confusing and '*contradictory'* information about whether A was in fact in possession of a gun. As well as the discrepancy she perceived to exist between B and C's accounts, referred to at paragraph 32 above, she cited the contents of the CAD report. This had advised that the household's guns were all stored, clearly inconsistent with B's subsequent information that she had seen A with what looked like a gun in his hand. Officer McMurtrie did not agree that this information, being later in time to the CAD report, may have accurately reflected subsequent events.

42. There was a further factor which Sgt Johnston said had affected his state of mind about whether A was in physical possession of a gun. During his directed interview he was played a recording of the BWV conversations. After

listening to this he told the interviewing officers that he now realised he had failed to absorb a critical part of the conversation while it was taking place. This was the part where B had said that while hiding in the garden with her daughter she had seen A on the balcony holding what looked like her gun. Sgt Johnston told the interviewing officers: '*I can see I missed something very important – that she explains she thought he had the firearm already.'*

43. Had he picked up this information, he said, he would have been '*reasonably satisfied'* that A did have a gun. He went on to explain that the omission had reduced his perception of the risk level. On arrival he had been under the impression from C that A had actually produced a firearm when he had assaulted B in their home. He had found that this was not reflected in B's account of the events at the scene, according to which A had *threatened* to get a firearm when he assaulted her. Sgt Johnston told the court that had he appreciated what B had said about later seeing A on the balcony with what looked like a gun, this would have heightened his assessment of the risk level to that of 'high risk'.

44. Having carefully considered the evidence, the conclusion I reach is that there was sufficient information available to officers Johnston and McMurtrie to conclude that it was probable A was in physical possession of a gun. I accept the closing submission of Counsel Assisting, that although the accounts provided to the police officers were not without inconsistencies, and factors were present which potentially affected their reliability, there was credible evidence that A was probably in possession of a gun. Viewed objectively and admittedly in hindsight, there was no real basis for officers Johnston and McMurtrie to be uncertain about this to the degree they apparently were. The very unfortunate consequence was that each underestimated the degree of risk to themselves in approaching A as they did.

Were the actions of the police officers adequate and appropriate?

45. The evidence enables me to establish that after forming this plan, the police officers acted as follows:

- Officer McMurtrie informed B that they would go to the house, arrest A and seize all the firearms. She instructed B and C to leave the area and not to drive past the house

- The officers moved their police car to a position closer to number 54. On the way officier McMurtrie attempted on two occasions to speak to A on his mobile phone. This was to try to ascertain from a safe distance where he was and what his intentions were. He did not answer.

- Unbeknownst to officers McMurtrie and Johnston, C did not drive her sister and niece to her home as directed. Instead she drove around the block, then parked her car at a point diagonally opposite number 54. Soon afterwards C commenced filming the events across the road on her mobile phone.

- The three officers, led by officer McMurtrie, approached the front gate of number 54 on foot. Taking on the role of the 'cover' officer, Sgt Johnston shone his torch at the verandah and the officers were able to see A sitting there. They could not see if he was holding a gun.

- Adopting the role of the 'contact' officer, officer McMurtrie called out to A, introducing herself and her colleagues and telling him they needed to talk to him. She asked him to raise his hands to where she could see them. He made no response.

- The three officers then entered the front yard, with officer McMurtrie at the fore and the other two officers on either side of her but remaining closer to the front fence. Officer McMurtrie continued to call out to A to raise his hands as '*we have been advised you have a firearm'*. By this time she was standing very close to the area beneath the verandah. Sgt Johnston can be heard urging her to '*come back, come back'*.

- The three officers then saw A stand up, walk to the southern end of the verandah, bend down and pick up a firearm. He yelled out something, which Sgt Johnston thought was something like: '*See what you've gone and done now'.* It is not possible to determine whom A was addressing, but a plausible theory is that he had just spotted C's car and its passengers across the road.

- All three officers drew their service pistols, shouting to A '*Put it down now!*' Sgt Johnston saw A load the rifle. He shouted to his colleagues to back out of the property. As they did so officer McMurtrie noticed C's car across the road and yelled at her to '*Get in the car and drive away now!'*

- At that point A discharged a round from the rifle. The bullet hit the gravel driveway and ricocheted, striking Sgt Johnston in the face and officer McMurtrie in the neck. Both fell to the ground. A second shot can faintly be heard. It was not apparent to anyone at this stage that A had fired this round to his own head.

- Although injured Sgt Johnston managed to get to his feet and with PC Petty, he dragged officer McMurtrie out of the front yard and into the driveway of the neighbouring house. PC Petty called for an ambulance, while Sgt Johnston retrieved a first aid kit from the police car and radioed for police assistance. PC Petty commenced giving first aid to officer McMurtrie, with the courageous help of two occupants of 50 Church Street.

46. Very soon afterwards the three officers were joined by an off duty police officer, Constable Jack Chapman-Burgess. He was PC Petty's boyfriend and had learnt of the shooting via police radio. He parked his own vehicle, a ute, in front of number 54 to give some protection to the group on the ground administering first aid to officer McMurtrie.

47. Uncertain whether A had been shot, Sgt Johnston and Constable Chapman-Burgess put on the police car's only two ballistic vests. Edging closer to the house they were able to see A slumped over on the verandah. He was not moving and the gun was positioned between his legs.

48. When an ambulance arrived and collected officers McMurtrie and Petty, Sgt Johnston refused to go to hospital until reinforcing police officers were on the scene. These arrived shortly afterwards and he briefed them, before being taken to hospital in the returning ambulance.

49. The newly arrived police officers cautiously entered the house and found A on the upstairs verandah, deceased. He had a large gunshot wound to his head.

The injuries to the involved officers

50. Officer McMurtrie received serious injuries from the shrapnel which entered her neck. She was placed in an induced coma in Gold Coast Hospital's Intensive Care Unit, then onto a ward. Remaining in her neck are pieces of shrapnel which cannot be removed without unacceptable risk. The consequence is that a knock to her neck would pose a serious risk of injury to her spine, meaning that she is unable to perform police operational duties. She was medically discharged from the NSW Police Force this year.

51. A large bullet fragment entered Sgt Johnston's left cheek and struck his jawbone. He underwent surgery and remained off work for twelve weeks. A scar of approximately ten centimetres is visible on his cheek.

52. PC Petty received a graze to her head from one of the bullet fragments, and required four weeks off work.

53. At the inquest, reliving the experience of being shot that night was very painful for these three people. At the close of the evidence their ordeal was acknowledged by A's children and by B who each expressed their regret at what the police officers had endured. I join them in expressing the hope that in time they will be able to put behind them the harm that they suffered.

The cause of A's death

54. The cause of A's death is clear on the evidence. The autopsy report of forensic pathologist Dr Allan Cala found A had died as a result of a perforating high velocity gunshot wound to the head. Dr Cala reported that the single round had entered A's head in the area under his chin, and that it had caused severe destruction to his face, skull and brain. In his opinion, the anatomical site of the entry wound was indicative of a self-inflicted wound.

55. Testing of A's post mortem blood samples showed a high level of alcohol, at 0.164g/100mL. Dr Cala opined that based on the blood alcohol level recorded, it was likely A's judgement, co-ordination, reflexes and cognition were '*significantly impaired'*.

56. I turn now to consider the remaining issues for examination at this inquest.

Was the incident a high risk situation? If so what was required?

57. In his expert report DI Waters identified errors, these primarily arising from the two senior officers' underestimation of the danger signs inherent in the information provided to them, in particular about A being in possession of a gun. I have addressed this issue above. DI Waters also opined that as the senior officer, Sgt Johnston ought to have identified the incident as 'high risk', and requested specialist resources such as police negotiators or Tactical Operations police. At the least he ought to have contacted the duty officer or DOI on duty that night.

58. A 'high risk' situation is defined in the NSW Police Force's Operations Manual as one where the essential judgment is:
'whether the real or impending violence or threat to be countered is such that the degree of force that could be applied by the police is fully justified'.
The Manual advises that one or more of the following criteria may be used to define a situation as 'high risk':
    - the seriousness of the offence committed by the person
    - an expressed intention by the person to use lethal force
    - reasonable grounds to believe that the person:
        - may use lethal force
        - has or may cause injury or death
        - has issued threats to kill or injure any persons
    - the person has a prior history of violence, or is currently exhibiting violence
    - there is involvement of participants such as hostages or bystanders.

59. In his report DI Waters commented that on the information provided to the involved officers, a number of these features were present. B and C had advised of a serious assault committed that night by A and of threats by him to use lethal force. In addition there was credible information that he was currently armed with a firearm.

60. Before giving his evidence at the inquest DI Waters had the benefit of hearing the witness evidence, including that of the senior officers McMurtrie and Johnston. This included their evidence as to what matters they took into account when assessing the risk level of the situation. Although in some respects this caused DI Waters to moderate the opinions he had expressed in his report, he maintained the view that this incident was a 'high risk' situation which required more extensive consultation between the two senior police officers and at the least, justified a consultation with the duty officer or Duty Operations Inspector.

61. DI Waters noted Sgt Johnston's evidence that he had missed a very important piece of information imparted by B. He noted further that although officer McMurtrie *had* absorbed this information, nevertheless she had only assessed the risk level as 'medium', whereas according to Sgt Johnston's evidence,

with the benefit of this information he would more accurately have considered it to be ‘high’. For her part it appears that unlike her fellow officers, PC Petty had picked up from C that A was in fact up on the balcony holding what C had assumed to be a gun. For these reasons, in DI Waters’ opinion it would have been very important for the officers to have consulted together after speaking to B and C. The purpose would have been to ensure that they had assimilated all the available information relevant to risk.

62. DI Waters considered there were other points at which the two senior officers might appropriately have consulted about the risk level. These were when A did not answer officer McMurtrie’s calls to his phone, and a little afterwards when he made no response to her attempts to engage him personally. In this regard it is interesting to note in Sgt Johnston’s directed interview how he described his own reaction to A’s non-responsiveness:
‘..there was nothing from him [A] to us at all at that stage. There was no acknowledgement that we were even talking to him …at that point you realise that…the hairs on the back of your head stand up because obviously something’s not quite, he’s not interacting with us at all.’

63. According to DI Waters, by that stage at least the situation was of sufficient gravity that the senior officers ought to have strongly considered withdrawing and contacting the duty officer or the DOI to discuss their tactical options. This discussion could have included whether specialist police resources should be called to help resolve the situation, such as police negotiators or members of the regional Tactical Operations Service.

64. Regarding the feasibility of deploying specialist resources to this incident, the court heard evidence from Detective Senior Sergeant Nathaniel Luck. He is the coordinator for the Western Region Scarce Resources Unit. In this role he arranges for the deployment of specialist officers to specific incidents if that action has been approved by the duty officer. DS Luck acknowledged the Western Region covers a vast area, which usually means there will be a time lag before specialist officers can arrive at a scene. Nevertheless he maintained that police negotiators and tactical operations police would be made available if requested.

65. When asked why he had not considered the option of canvassing specialist assistance, Sgt Johnston emphasised that he had felt a strong duty to engage with A, due to the imminent risk that he would carry out an act of self harm or suicide. Sgt Johnston was concerned that if he sought specialist assistance there would be delays which would compromise A’s safety. It is very much to his credit that Sgt Johnston takes with great seriousness his professional duty to try to avert such tragedies. But as DI Waters emphasised in his report and evidence, notwithstanding the risk to A the safety of the attending police officers had to remain the paramount consideration in the police response that night. In his view this factor had not been given sufficient weight.

66. The evidence supports DI Waters’ opinion that the situation facing the officers that night met the description of ‘high risk’. It followed that the interests of officer safety required that there be a careful process of planning the steps to

resolve the situation. The two senior officers missed opportunities to ensure they were in possession of all relevant information, by means of a more effective consultation with each other after their conversations with B and C, and following A's lack of response to their attempt to contact him and to engage him. On the basis of Sgt Johnston's evidence, it is likely that had they done so the attendant risks to themselves would have been assessed at a higher level. This may have led them to consider whether officer safety justified at the least a consultation with a superior officer as to their tactical options.

67. DI Waters was at pains to acknowledge that had consultation with a more senior officer taken place, this would not necessarily have altered the tragic outcome. I accept this assessment.

68. In his report and evidence DI Waters also commented on the extreme vulnerability of the three officers as they tried to engage A in his front yard. None was wearing a ballistic vest. They had no cover or concealment by way of buildings, vegetation or parked cars. In addition A was in an elevated position with a weapon of much greater range and accuracy than their service pistols.

69. The court heard that the three police officers were not wearing ballistic vests because their police car was equipped with only two. As DI Waters acknowledged, had ballistic vests been worn on this night they would not have prevented the face and neck injuries which M and J received. Nevertheless it was reassuring to hear at the inquest that since this incident, the NSW Police Force has purchased sufficient ballistic vests to ensure that Probationary Constables are able to be issued with them.

70. Regarding the absence of cover and concealment, DI Waters acknowledged that the environment afforded the officers almost no options to remedy this. However one option they might have considered prior to entering the front yard was to direct PC Petty to move their police car to a position directly outside A's driveway. From this position the officers could have attempted to engage A with the benefit of at least some protection.

71. I accept that there were flaws in the risk assessment and in aspects of the plan which the officers attempted to execute that night. This led to the implementation of a plan which underestimated the risks confronting the officers as they approached A and tried to engage him. There is however no evidence that had they taken a different approach this would have prevented A's death.

72. I want to endorse two further points made by DI Waters in his evidence. The first is that the situation facing the police officers that night was volatile with high potential to escalate in unpredictable ways. An element of hindsight bias inevitably comes into play when such situations are later analysed. This reality must temper any criticism of shortcomings in the planning that took place that night.

73. The second point is that the three officers and in particular Sgt Johnston acted with great courage and professionalism in the terrible aftermath of the shooting. Sgt Johnston and PC Petty returned to their fellow officer and dragged her to a safer place, in circumstances where they were completely without cover and knew A was still armed. Still not knowing whether A remained an active shooter, they ensured officer McMurtrie received first aid and called for reinforcements. Until these arrived Sgt Johnston refused to leave the scene until he had briefed the new officers and ascertained with some degree of certainty that A was no longer a threat. I sincerely hope that Sgt Johnston drew comfort from hearing DI Waters commend him highly for his bravery.

Had the police officers received adequate training regarding high risk situations?

74. The training records of officers Johnston and McMurtrie were tendered at the inquest. These recorded that Sgt Johston had completed online training modules in Policing High Risk Situations, but officer McMurtrie had not, although she had received training in a number of related areas. As noted however she is no longer a serving police officer due to her injuries, and there is therefore no recommendation to be made in this regard.

The question of recommendations

75. I accept the closing submission of Counsel Assisting, that the shortcomings in the police officers' risk assessment cannot be attributed to deficiencies in the materials used to train officers in high risk situations. I accept that the definition of a 'high risk situation' in the NSW Police Force Operational Manual cannot be prescriptive, given the wide range of incidents which police face on any given day. The Operational Manual adopts the pragmatic approach of providing a non-exhaustive list of factors which may characterise a situation as high risk, followed by explanations of what practical action is required. This instruction is augmented by face to face and online training in high risk scenarios.

76. On behalf of B, it was submitted by Mr Evenden that the Commissioner could consider amending the existing definition of a high risk situation, which appears at paragraph 60 above. Mr Evenden's proposal was that it be amended, such that a situation be considered high risk where the real or impending violence or threat to be countered *'is such that a degree of lethal force would be justified'*.

77. However in my view this proposal would unduly restrict the circumstances in which a situation can be considered 'high risk'. As argued in the submissions made on behalf of the Commissioner, there may be high risk situations where the threat to be countered requires a lesser option than that of lethal force. This should not preclude the situation from receiving a 'high risk' classification and the practical responses that are appropriate to it.

78. I have concluded that there is no basis to make any recommendations arising out of the tragic circumstances of A's death.

Conclusion

In closing and on behalf of all at the Coroners Court, I offer sincere sympathy to B, to A's children and to C for the loss of a much-loved husband, father and brother-in-law.

I express to officers McMurtrie, Johnston and Petty my sincere hope that in time they too will recover from the traumatic events of that night.

I thank Counsel Assisting and Ms Healey-Nash for their outstanding assistance throughout the inquest, and to the other counsel and solicitors for their helpful and cooperative approach. I thank also Detective Sergeant Ronczka for his preparation of a comprehensive coronial brief and his support in the conduct of the inquest.

Findings required pursuant to section 81(1) of the Act

Identity
The person who died is A.

Date of death
A died on 18 January 2019.

Place of death
A died at Glen Innes NSW 2370.

Cause of death
A died of a gunshot wound to his head.

Manner of death
A died when he shot himself to the head while a police operation was underway.

I close this inquest.

Deputy State Coroner Elizabeth Ryan

11 August 2020