STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	**Inquest into the death of "S"** [redacted]
Hearing dates:	4 and 5 May 2021
Date of findings:	7 May 2021
Place of findings:	Ballina Local Court
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – suicide by a police officer – death a result of police operations – adequacy of risk assessment
File number:	2018/114791
Representation:	***(1) Counsel Assisting*** Mr Jake Harris of counsel, instructed by Ms Amber Doyle of the NSW Crown Solicitor's Office ***(2) NSW Commissioner of Police*** Ms Christine Melis of counsel, instructed by Ms Alaana Wooldridge of the Office of General Counsel, NSW Police Force ***(3) Leon Bayley*** Mr Don Cameron, solicitor of Don Cameron & Associates

Non-publication order:	***Order made on 7 May 2021*** 1. Pursuant to s. 75(5) of the *Coroners Act 2009,* a) the information contained in these finding may be published, and b) there shall be no publication of any other part of the proceedings. ***Order made on 26 April 2021*** 1. Pursuant to s. 74 of the Coroners Act 2009, there shall be no publication of the name [redacted] ***Order made on 26 April 2021*** 1. Pursuant to ss. 65 and 74 of the *Coroners Act 2009,* and/or the Court's implied or incidental powers, in relation to the documents listed in Schedule A and the information contained in those documents: a. There shall be no publication of those parts of the documents listed in the second column of Schedule A; b. Un-redacted versions of the documents listed in the first column of Schedule A may be disclosed to the State Coroner, those assisting the State Coroner, the Officer in Charge of the coronial investigation, and the legal representatives of the interested parties to the inquest; c. The documents may be disclosed beyond the State Coroner, those assisting the State Coroner, the Officer in Charge of the coronial investigation and the legal representatives of the interested parties to the inquest, provided that the documents have first been redacted to remove the information identified in the second column of Schedule A; and d. The interested parties may inspect, but not uplift or copy, un-redacted copies of the documents listed in the first column of Schedule A; i. In the case where the interested party is legally represented, in the presence

	of his or her legal representatives; or ii. In the case where the interested party is not represented, in the presence of those assisting the Coroner 2. Pursuant to ss. 65 and 74 of the *Coroners Act 2009,* and/or the Court's implied or incidental powers, in relation to the documents listed in Schedule B and the information contained in those documents: a. There shall be no publication of those parts of the documents listed in the second column of Schedule B; b. Un-redacted versions of the documents listed in the first column of Schedule A may be disclosed to the State Coroner, those assisting the State Coroner, the Officer in Charge of the coronial investigation, and the legal representatives of the interested parties to the inquest; c. The documents may be disclosed beyond the State Coroner, those assisting the State Coroner, the Officer in Charge of the coronial investigation and the legal representatives of the interested parties to the inquest, provided that the documents have first been redacted to remove the information identified in the second column of Schedule B; and d. The interested parties may inspect, but not uplift or copy, un-redacted copies of the documents listed in the first column of Schedule B; i. In the case where the interested party is legally represented, in the presence of his or her legal representatives; or ii. In the case where the interested party is not represented, in the presence of those assisting the Coroner 2A. Pursuant to s. 74 of the *Coroners Act 2009*, and/or the Court's implied or incidental powers, in relation to the first column of Schedule C, there shall be no publication of those parts of the documents listed in the second column of Schedule C.

3. Subject to orders 1, 2 and 2A, the unredacted documents listed in the first column of each of Schedules A, B and C are not to be supplied or copied to any person seeking access to the Coroner's file pursuant to s. 65 of the *Coroners Act 2009*.

4. The Commissioner of Police is to provide a copy of the documents in the first column of each of Schedules A and B, redacted in accordance with second column of each of Schedules A and B, to the solicitor assisting the State Coroner on or before 30 April 2021.

5. The Commissioner is to be provided with any findings pertaining to the Commissioner's application for non-publication orders and restricted access orders at least 24 hours prior to those findings being published in order to review those findings and notify the State Coroner of any application for information not to be published.

6. Within 14 days of the publication of the findings to the Commissioner's application, all copies of the unredacted documents listed in the first column of Schedules A and B that are held by the legal representatives of the interested parties are to be returned to the legal representatives of the Commissioner.

Schedule A

Document	*Information*
Statement of Detective Insp Tim Attwood (Tab 7)	[245]-[258]; [260]-[262]; [275]-[292]; [294]-[309]; [319]-[328]; [332]-[337]
Statement of Ch Insp Greg Lynch (Tab 47)	[27]-[38]; and Annexures 2, 3, 6
Statement of Ch Insp Adam Powderly (Tab 50)	[7]-[29]; all annexures except for pp. 901-902, 907-909
Transcript of directed Interview & annexures of Detective Sgt Lee (Tab 51)	All

	Statement of Sgt Kevin Hood	[6]-[10]
	Correspondence between S and PSC regarding misconduct investigation (Tab 90)	Entire document, except read receipts
	Notification, directions & Advice (Tab 91B)	Entire document but not enclosed support package
	Schedule B	
	Document	*Information*
	Statement of Bernard Joseph Sloane (Tab 31)	[5]-[11]
	Statement of Nick Jones dated 10 September 2018 (Tab 53)	[4]-[5]
	Statement of Nick Jones dated 11 February 2019 (Tab 54)	[5]-[6]
	Statement of Tim Attwood (Tab 7)	[149]-[153]; [155]-[156]
	Call Sign Log for STH278 (Tab 74)	entries commencing from 8:31am on 11 April 2018
	Schedule C	
	Document	*Information*
	Statement of Timothy Scott Briggs (Tab 11)	[20]-[21]
	Statement of Matthew Clayton (Tab 18)	entries shown in photograph 37
	S's Official Police Notebook No. F633749 (Tab 77)	entries in photograph on second page (p. 248)

	Crime Scene Photographs (Tab 93)	photographs (pp. 46 and 47)

Findings:	Pursuant to s. 81(1) of the *Coroners Act 2009,* the following findings are recorded: **The identity of the deceased** The person who died was [redacted] **Date of death** 11 April 2018 **Place of death** Collingullie, NSW **Cause of death** Gunshot wound to the head **Manner of death** Self-inflicted, with an intention to end his life
Recommendations:	Pursuant to s. 82 of the *Coroners Act 2009,* the following recommendation is made: ***To the NSW Commissioner of Police*** Review any relevant policies and procedures to clarify whether a police officer subject to a criminal complaint investigation should be given a direction that a subject officer should not disclose information about an investigation to a witness or involved person.

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Introduction

1. These are the findings of inquest into the death of [redacted] whom I shall refer to in these findings as "S".

2. S died on 11 April 2018 from a self-inflicted gunshot wound to the head. He was 42 years old and a Sergeant of the NSW Police Force. At the time of his death, S was alone on active duty as a Highway Patrol officer. He was positioned near the Berry Jerry rest area, on the Sturt Highway, about 30 kilometres from Wagga Wagga.

3. A week prior to his death, on 4 April 2018, S had been made aware that he was the subject of an investigation by the Professional Standards Command, including allegations of serious criminal conduct. That investigation was ongoing at the time of his death.

The nature of an inquest

4. An inquest was required to be held into this death because it appeared S died as a result of police operations (s. 27(1)(b) and 23(1)(c) of the *Coroners Act 2009*).

5. The primary function of an inquest is to identify the circumstances in which the death occurred. At the conclusion of an inquest, the role of a coroner, as set out in s. 81 of the *Coroners Act 2009*, is to make findings where possible as to:

   a. The identity of the deceased person;

   b. The date and place of the person's death; and

   c. The manner and cause of death.

6. A secondary purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves considering whether any lessons can be learned from the death, and whether anything should or could be done to prevent a death in similar circumstances in the future.

The facts

Background

7. S was born on 15 November 1975 and was therefore 42 years old at the time of his death. He grew up in the Lismore area with parents, sister and two brothers. S was in partnership in a business with one of his brothers, Ian. Together, they owned property and a cattle stud.

8. Their niece, Sarah, lived with her grandparents from when she was 14. She viewed S as a father figure, and he viewed her as a daughter. She was named as the sole beneficiary in his Will.

9. S joined the police and attested as a Probationary Constable in 1998. In 2016, he moved from Ballina to Wagga Wagga, to take up a promotion as Sergeant within the Traffic and Highway Patrol Command.

10. He was described by colleagues as an intelligent, professional, highly motivated and committed officer. He was considered to be borderline workaholic and something of a perfectionist. He was also a compassionate supervisor; he was selfless, and colleagues went to him for advice and support. As one colleague put it, "*everyone loved him*". He was also decorated, having achieved Police Medal, National Medal and National Police Service Medal.

11. S formed an intimate relationship with his partner, Leon, in 2006. They lived together between 2012 and 2016 in Ballina. When S relocated to Wagga Wagga in 2016, Leon remained in Ballina. Nonetheless, they remained in a long-distance relationship at the time of his death. S intended to serve out his tenure of 3 years and then return to the Lismore area.

12. S appears to have been reserved or guarded about his private life; some colleagues knew or suspected he was gay, but none of them knew about his relationship with Leon.

2013 investigation

13. As I have mentioned, at the time of his death, S was subject of an investigation in relation to allegations of misconduct. S's death occurred before any findings

were made about these allegations. It is beyond the scope of this inquest to reach a conclusion about the correctness of the allegations, but a short explanation is necessary to inform the events that led to S's death.

14. In March 2013, an acquaintance of S's, whom I shall refer to as "MR", was arrested at Ballina in relation to serious criminal conduct. In the course of investigating MR, his phone was seized and was found to contain text messages with S. Those messages suggested S knew about MR's alleged criminal activity. [redacted]

15. As a result, police commenced an investigation. The investigation identified further non-criminal misconduct, namely that S had accessed a COPS event involving MR and had also allowed MR to drive a highway patrol vehicle. Those non-criminal allegations were referred to the Traffic and Highway Patrol Command for investigation and were sustained, following S's admissions in interview.

16. S received a Commander's Warning Notice and was placed on a conduct management plan for six months. That disciplinary action had consequences for S's career. He was not eligible for promotion until May 2015. S was in dispute with his employer regarding this.

17. However, no further action was taken in relation to the criminal allegations against S at that time. There seems to have been due to a misunderstanding as to which police command was to investigate these matters. While regrettable, there is no basis to conclude that this had any contribution to the circumstances of S's death.

2018 investigation

18. Some 4 ½ years later, on 4 December 2017, MR attended the police station at Ballina and asked to speak with police. MR alleged that, in 2013, S had been involved in serious criminal conduct. MR identified an alleged victim, who was interviewed about the allegations.

19. [redacted]

[redacted]

20. [redacted].

21. [redacted]

22. [redacted].

23. On 6 February 2018, Strike Force Kurbnesh was established under Det Sgt Michael Lee. The terms of reference included both criminal allegations and non-criminal allegations against S. Det Sgt Lee commenced investigating, taking statements from witnesses. Neither Ch Insp Powderly nor Ch Insp Lynch were updated about the progress of Det Sgt Lee's investigation until early April.

24. In early March 2018, S travelled to Ballina to visit Leon for about 3 weeks. On 8 March 2018, while S was visiting his family's farm, Det Sgt Lee contacted Leon and asked him to attend Ballina police station, which he did.

25. Det Sgt Lee informed Leon that a witness had come forward in relation to S's involvement in drug supply five years ago. Det Sgt Lee did not reveal other, more serious allegations. Leon declined to give a statement about what he knew. At the end of this discussion, Det Sgt Lee told Leon that S was not aware of the allegation, and asked him not discuss the matter with S. Leon was also asked whether he had any concerns about S, which he denied.

26. [redacted].

27. [redacted].[1]

28. Following this call, Det Sgt Lee made a second call, wherein he informed S of a direction not to discuss the investigation with possible witnesses, including his partner, Leon. [redacted]

[redacted]

[1] See *Baff v New South Wales Commissioner of Police* [2013] NSWSC 1205 at [111] to [116] per Adamson J

29. This is a matter of some significance. Pursuant to cl. 8(1) of the *Police Regulation 2015,* S was obliged to promptly comply with all lawful orders from those in authority over him. [redacted] These directions were given formally in the complaint, which was signed by a senior officer, Det Insp Glen Browne, and were therefore made by a person in authority over S.

30. [redacted].

31. Those two calls were the only occasions when Det Sgt Lee had contact with S.

32. [redacted]

33. [redacted].

34. The following day, S sought advice regarding participation in an interview from a solicitor, Mr Ken Madden. Mr Madden later told police that he did recall speaking to S about the complaint, but he did not recall anything of concern about S's presentation.

35. On 9 April 2018, S emailed Det Sgt Lee, invoking his privilege against self-incrimination and declining to be interviewed. [redacted]

36. [redacted]

2015 motor vehicle fatality

37. On 18 December 2015, S attended the scene of a traumatic motor vehicle accident in Lismore area which involved the death of a four-year-old girl and the serious injury of her 2-year-old sister. The vehicle in which they were travelling had been severed in two. She was the daughter of a police officer.

38. S was affected significantly by this accident, and by the criminal proceeding that followed. The statement he prepared for those proceedings was within the brief, and it speaks to his level of shock at the time. Leon also described how S was "*not coping too well*" with the accident, and that S had said "*it will be good when* [the proceedings] *are over with*." They remained ongoing at the time of his death and were concluded in April 2019.

39. Following the incident, the local area command arranged for a trauma team to attend the police station. It does not appear that S took up this support. However, S was critical of the response by management and the lack of support he was subsequently given.

Financial position

40. At the time of his death, S was in a loan dispute with the National Australia Bank and in debt to a builder, Wayne Carter Homes, whom he had contracted to build a new house on a site in near Wagga Wagga.

41. S applied for a loan approval in early 2017, and subsequently signed a contract to purchase the land and build the house. However, it transpired that NAB had only approved a loan for around $100,000, whereas the total cost was about $470,000. Subsequent requests for review were declined, because of S's commitments on the farm properties.

42. On 7 November 2017, S made a complaint to the Financial Ombudsman Service. A conciliation meeting was held in January 2018, but NAB declined to change its position and the Ombudsman proceeded with a determination. This process was still outstanding at the time of S's death.

43. Construction of the home commenced in July 2017 and had progressed to the point where it was almost at lock up stage and there was nearly $150,000 outstanding to Wayne Carter Homes for construction costs.

44. While NAB's loan refusal appears to have caused S stress, there is a basis to conclude that it was not of high concern. For example, S's niece Sarah believed that he was not too distressed about the dispute. He had arranged for an alternative plan for financing the home through Leon. Leon thought S was "*more pissed off about the process he was put through with the bank as opposed to being financially stretched*."

Ineligibility for promotion

45. S was, as I have noted, a committed police officer and was ambitious to rise through the ranks. The background difficulties in relation to his career have been described. On 7 August 2017, a Senior Sergeant role, Cluster Senior Supervisor, was advertised within Traffic and Highway Patrol Command. However, S was ineligible for this role because it required that the applicant serve two years as a Sergeant first, and S had commenced his role in May 2016.

46. After it had been advertised, the role was put on hold for a period, due to a restructure. Nonetheless, S was given an opportunity to act in the role by his supervising officer, Ch Insp Lynch. S performed the role very well. He was committed and diligent, and he assisted with implementing changes in the Command brought about by the restructure. In total, he worked as the Cluster

Senior Supervisor for about 18 weeks, mainly during the period from 24 September 2017 to 27 January 2018.

47. In late 2017, the recruitment for the role was reactivated. However, Human Resources advised Ch Insp Lynch that the previous recruitment had not been finalised, and so the role should be filled without further re-advertisement, with the effect that only existing applicants would be considered. S was upset with this decision, and he informed several of his colleagues about his concern. However, given the timing of the recruitment, S was still not eligible to apply, even when re-advertised; he would not have attained 2 years' service as a Sergeant until May 2018.

48. On 6 April 2018, one of S's colleagues, Sgt Darryl Thomas, was informed he was the preferred candidate for the Senior Sergeant role, with an official announcement taking place after S's death. It appears that S came to be aware that Sgt Thomas had won the role prior to his death.

S's presentation

49. During the period prior to his death, none of S's family, or his partner, or colleagues recall anything which would have indicated that he was considering self-harm. This is consistent with S being guarded and reserved about his private life.

50. There was one conversation that, in retrospect, has significance. On about 3 March 2018, one of S's colleagues, Sen Cst Michael Hoogvelt, asked him how he was going. He was aware that there had been some stressors in S's life. S said, "*everything's fucked. I may as well shoot myself in the head*". Although Sen Cst Hoogvelt thought this was odd, he did not form the view that S was in need of support at that time. I note that this occurred at a time when S was apparently unaware of the complaint made against him.

Events prior to the death

51. On Monday 9 April 2018, S reported that he had been unwell. He had been due to attend an Internal Investigation Training course at Goulburn that day. As I have noted, Ch Insp Lych phoned S, having been made aware that he had

declined an interview. They discussed why S did not attend the course, and also welfare support. S remained adamant that he wanted to remain at work. He left the office that afternoon.

52. On Tuesday 10 April 2018, S sent instructions to his solicitor, regarding the distribution of his life insurance, which he and his brother Ian had taken out to meet any liabilities in relation to their joint business venture. He instructed his solicitor to distribute the payout between Ian, Sarah, and Leon, and to purchase livestock with the balance.

53. At 4.54pm that day, S sent a Leon a package containing: a letter, details about his superannuation policy, a ring, a photo of their cat (Kimba) and S's medals. S also sent letters to his family, including Sarah. That letter reminded her that he considered her to be his daughter. The letters each acknowledged that "*this is going to be hard for you".* The letters do not give any insight as to why he had made the decision to end his life.

54. S last spoke with Leon at 6.00pm on 10 April. According to Leon, S sounded chirpy and happy, and Leon did not detect that anything was wrong.

Events of 11 April 2018

55. On the day of his death, Wednesday 11 April 2018, S's behaviour at work was initially unremarkable. He attended Wagga Wagga police station at 5:51am, which was earlier than originally rostered. At 6.22am, he collected his appointments belt including his gun. He spoke with some of his colleagues and appeared to be cleaning out some paperwork.

56. At 8.12am, while at the station, he called his mother. There was nothing of significance in the phone call, although he usually called her on Fridays. He asked her to open some of his mail and read the contents.

57. At 8.39am, he left the police station in a fully marked highway patrol car, South 278. Later investigations show that he turned off the Police CAD system, which would normally display messages from the police dispatcher, and would also track the location of the vehicle. He also turned off the vehicle's Automatic Number Plate Recognition device.

58. During the late morning, a neighbour recalls seeing S leaving his driveway in a marked police car. The house, when later searched, was noted to be very clean and tidy, with electrical items unplugged and the fridge cleaned out and defrosted. Investigations also show that S backed up some files on his computer at home during this time, and sent an email to his accountant.

59. S returned to the police station at 11:22am. He left again at 11:48am in the same vehicle, South 278. The CAD system shows that he travelled to the Sturt Highway, towards the Berry Jerry rest stop, stopping in a road siding near that rest stop at 12.18pm.

60. [redacted]. That information was reported back via the police CAD system.

61. [redacted]

62. The CAD system records show that South 278 remained stationary between 12:18pm and 2:43pm. The Call Sign log shows that at 2.06pm, S logged out of the system, and then logged back in again. [redacted]

63. There is no evidence that the relevant police radio dispatcher, Nick Jones, performed any welfare check during this time.

64. Significantly, S wrote a note in his notebook, which he timed at 2.30pm, stating:

    [redacted]

65. During this time, it appears that S also wrote a "goodbye" note to colleagues in his police notebook, which was discovered after his death. In part, that message reads as follows:

    The staff at Wagga Wagg HWP. Thanks for the support you have all shown me. Can't believe it is nearly 2 years. As we all know this job can be stressful and it takes our toll on us. All I can ask is that if you need help,

please speak to someone don't bottle it up inside. Mr Lynch sir, thank you for letting me relieve in the CSS position. I totally enjoyed it.

66. Each of these notes show that S was mindful of his colleagues' welfare, even at a time when he appears to have arrived at a decision to end his own life. This speaks cogently to that aspect of his character.

The death

67. At 2.43pm, the CAD system shows that S drove the vehicle to an area near the Berry Jerry rest stop. The vehicle then slowed, appeared to perform a U-Turn, and returned to its previous location.

68. Sometime between 3.00pm and 3:30pm, a civilian witness, Troy Derrick, was at a property nearby. He observed a police car, facing west, towards Narrandera. As he and a colleague finished their work, he heard a sound similar to a gunshot. As they drove out onto the highway, he observed a male police officer, who is likely to have been S, picking up some small objects from the ground. The police officer got into the police vehicle and drove west along Sturt Highway. About 30 minutes later, Mr Derrick was driving past the same spot, and he observed a police car at the same location, but facing east towards Wagga Wagga.

69. [redacted] At 3:28pm, the dispatcher Nick Jones conducted a welfare check, [redacted]. There was no response. Mr Jones did not record the fact that he had performed a welfare check at the time.

70. Upon hearing the welfare check broadcast, one of S's colleagues, Sen Cst Lawson, also phoned S's mobile, with no answer.

71. S made a final notebook entry, which he timed at 3.34pm:

[redacted]

72. At about 4.15pm, traffic workers who were travelling along the highway noticed S lying motionless next to his police car on the side of the Sturt Highway. They stopped to check he was alright and saw that he had blood coming from his head. They called '000' at about 4.17pm.

73. NSW Ambulance paramedics arrived on the scene at 4:41pm. They noted a gunshot wound to the right temple and no signs of life.

74. Police then attended and established a crime scene. Three spent cartridges were found at the scene. S's firearm was examined, and it was discovered that three cartridges were missing, with 12 remaining. DNA linked S to the firearm and to one of the spent cartridges.

Autopsy

75. Dr Hannah Elstub performed an autopsy on 16 April 2018. Her report confirms that the cause of death was a gunshot wound of the head. There were no premorbid medical conditions nor other remarkable features noted. Toxicology was negative.

Issues

Was the death self-inflicted?

76. The investigation has carefully pieced together the events that occurred on 11 April 2018, including what is known about S's final movements. There are only two issues arising from those events.

77. The first is the reason why S remained at the location near the Berry Jerry rest stop for a period of over 3 ½ hours. While he wrote some short notes during that time, it is unclear what else he did. [redacted]. That did not occur until 3.28pm. This was only shortly prior to his death.

78. The second is the fact that S appears to have fired two other shots from his firearm. Police later searched the surrounding area, but were unable to locate the projectiles using metal detectors and a line search.

79. It would appear probable, from Mr Derrick's evidence and the records of the police CAD system, that S fired two shots, then left the scene, possibly having been disturbed by Mr Derrick and his colleague. Whether he did in fact pick up the spent cartridges as Mr Derrick suggests is unclear, given that they were later found at approximately the same location. He then drove off, and then performed a U-turn and returned to the same location, facing back towards Wagga Wagga. This was the location where he fired the fatal shot.

80. One might speculate that he fired those two shots to confirm that his firearm was in working order. Det Insp Attwood notes that, upon reviewing CCTV from the police station, it does not appear that S checked the function of his firearm when he collected it that morning.

81. Nonetheless, the evidence supporting a conclusion that S caused his own death, and that he intended to do so, is compelling. Five matters can be noted:

    a. *Firstly,* the investigation revealed no evidence of the involvement of any other person. Neither Mr Derrick and his colleague, nor the traffic workers, nor any witnesses on the highway saw any other person present at the location near to the time of S's death.

    b. *Second*, the firearms evidence shows that only S and his firearm were involved. The firearm belonged to S and had his DNA on it, and his DNA was detected on a spent cartridge. Three cartridges were missing from the magazine, and there were 3 spent cartridges at the scene. Ballistics evidence linked the spent cartridges to the firearm.

    c. *Third*, the nature of the injury, being a gunshot wound to the right temple, supports a conclusion that S intended to end his life. The autopsy demonstrates a contact entrance wound, caused by being fired from very close range.

    d. *Fourth,* the letters S had sent the previous day to his family. There is a clear inference that S had decided by 10 April 2018 to end his life, and intended do so imminently, prior to the time when those letters would be expected to be delivered.

e. *Fifth,* the note S wrote to his colleagues while he was in the vehicle shows he maintained that intention shortly prior to the time of his death.

82. I find that the death was self-inflicted, and that S had an intention to end his life.

S's state of mind at the time of his death

83. It is unnecessary, in reaching findings pursuant to s. 81 of the *Coroners Act 2009,* for me to determine the reasons that led S to end his life. However, those circumstances broadly come within the enquiry into the manner of death. In the circumstances of this case, it is not possible for me to make a finding about why S did so, in particular in the absence of any suicide note in which he stated a reason.

84. Nonetheless, I have described above the different stressors that existed in S's life. The traumatic vehicle accident, the dispute about the loan, and perhaps his disappointment regarding the promotion, were all matters that are likely to have been operating on S's mind in the period prior to his death to some extent.

85. The complaint about serious criminal allegations would no doubt have been stressful for S. In light of the proximity of the notification of the complaint to S's death, there is an available inference that it was a significant stressor for S, and that it was the dominant stressor operating on his mind at the time of his death.

The steps taken to assess and monitor S's welfare

86. The NSW Police Force's Interim Risk Management Guidelines provide a process to assist commanders effectively manage staff when a risk is identified. Taking steps to manage risk does not presume misconduct or impose a form of discipline, but is employed to manage an identified risk. Interim risk management is commonly used during complaints investigations, and is also explicitly referred to in the relevant policy, the Complaint Handling Guidelines.

87. A range of possible risks are identified in the policy, including the risk of self-harm. The process described is to consider a broad range of circumstances when assessing risk, including the seriousness of the allegations, possible impacts on the subject officer, any complainants and witnesses, and the wider community expectations. The first consideration is whether the officer can be

adequately managed in the workplace. One issue to be considered is any risk associated with the subject officer's access to a firearm.

88. A range of strategies can be developed, as part of an interim risk management plan. This could include working in a different location, with different duties, or with restrictions on access to weapons and appointments.

89. In some circumstances, risk management may comprise suspending an officer from duty. In that event, the Suspension Procedures are engaged. These commence with a suspension review and a questionnaire, and ultimately a decision whether or not to suspend is made by the Commander. The circumstances in which a Commander must give consideration to suspending an officer include where there is reasonable cause to believe the officer's conduct is such as to justify the institution of criminal proceedings.

90. However, the NSW Police Force's Policy Statement on Suspension of a Police Officer notes that it is an "*extreme measure and should only be exercised when no viable alternative is available*", which include those canvassed above.

91. [redacted]

92. [redacted]

93. [redacted] It was Ch Insp Lynch who was to perform the role of monitoring S's welfare, although both Ch Insp Powderly and Det Sgt Lee stated that, if they had become aware of anything concerning, they would have done something.

94. Ch Insp Lynch worked in Wollongong, while S was in Wagga Wagga. Although during January 2018 he was in regular contact with S by phone, he did not see him face-to-face. After that point, he did not have as regular contact. He relied to some extent on the lack of adverse reports from the command by way of monitoring.

95. However, I note also that it was unlikely that S could have become aware of the investigation at that early stage, and as he was physically distant from the informant and alleged victim, the risk was minimal. Accordingly, risk management strategies did not need to be employed.

96. The situation with regard to risk potentially changed when S became aware of the investigation. Two points in time need to be considered.

97. The first is 8 March 2018, when Det Sgt Lee met with Leon and advised him of a complaint against S. Despite his request that Leon not tell S about the complaint, there was some risk that S would learn about it.

98. Det Sgt Lee did not inform Ch Insp Lee or Ch Insp Powderly that he had contacted Leon. He told the Court he would not usually do so, and was not aware of any of his colleagues within Professional Standard Command updating other commands about an investigation. Some were performed covertly.

99. Det Sgt Lee accepted, in hindsight, that it would have been appropriate to have updated Ch Insp Lynch or Ch Insp Powderly about the fact that he had told Leon about a complaint. I agree that it would have been desirable for him to do so. However, the following matters are relevant:

    a. Det Sgt Lee only told Leon about the less serious aspect of the investigation, which carried with it a lesser risk.

    b. There is no evidence that S became aware of the investigation at that stage, although he may have learned about it prior to 4 April 2018; Leon denied he told S at any stage.

    c. Ch Insp Lynch was, in any event, [redacted] monitoring S's welfare at this stage, and received no reports of anything of concern.

100. The second point in time was 4 April 2018, when Det Sgt Lee informed S of the detail of the allegations. At that point there was clear a need to reassess risk. Although he attempted to contact the command on the day prior, Ch Insp Lynch and Ch Insp Powderly only learned about it after S had been informed. It would have been desirable for them to receive more notice, so that they could consider what action to take to support S.

101. Ch Insp Powderly and Ch Insp Lynch each gave evidence. They both impressed as thoughtful, concerned officers who addressed their mind to the need to monitor S's welfare. The obligation to consider S's welfare primarily rested on Ch Insp Lynch.

102. While no formal process was undertaken to re-assess risk at this point, none is in fact required by the policy. What was required was consideration of all the circumstances to identify any risk, and where risk is identified to develop a plan to meet that risk.

103. [redacted]. He had a good working relationship with S, if not a close personal one, and thought S would raise any concerns with him. To some extent, this is supported by the message S wrote to Ch Insp Lynch shortly prior to his death, thanking him for the opportunity to take on the Cluster Senior Supervisor role, which at the least shows gratitude and a lack of animosity. He believed S was being frank with him.

104. S did become upset about the issue of the direction not to discuss the matter with Leon. However, Ch Insp Lynch had experienced S becoming upset about his inability to apply for the promotion a few months prior. He used that as a "yardstick" against which to assess S's emotional state, and concluded that S was no more upset about the complaint. He said in evidence that S did not raise the issue of the direction regarding Leon with him again.

105. Ch Insp Lynch continued to monitor S's welfare over the coming days. He made further calls to S, during which he did not detect any change. He drew

comfort from the fact that there were no reports from officers at Wagga Wagga raising concern about S. He noted that at least 2 officers at Wagga Wagga, the Commander and the Crime Manager, were also aware of the complaint, and therefore would be expected to identify any concerning behaviour in that context.

106. The fact that Ch Insp Lynch was relying on the lack reports from others, rather than actively seeking feedback, was not a robust manner to monitor S's welfare. However, his own contact with S did not detect concern.

107. All of this needs to be considered in context. Importantly, S was guarded and private about his life generally, and there is no evidence that he displayed any open signs of distress to anyone during this time. Neither Leon, nor Sarah, nor any of S's colleagues at Wagga Wagga who have provided statements to this inquest, detected any adverse change in S's behaviour at any stage. He maintained the pretence of outward normality right up until the time of his death.

108. Mr Cameron submitted that a risk assessment ought to have been conducted not only on the basis of outward signs of distress, but on the simple fact that S faced serious allegations, the implication being that these brought a risk of self-harm that needed to be managed regardless of a person's presentation.

109. The seriousness of the allegations was one factor to be considered; it is explicitly identified in the policy, and was a matter clearly known to both Ch Insp Lynch and Ch Insp Powderly, albeit neither knew the details of the allegations.

110. Ch Insp Lynch did address his mind to risk management at the time. He stated that, had he known about the comments made by S to Sen Cst Hoogvelt, about "shooting himself in the head", he would have taken action. Mr Cameron also submits that I should make a recommendation, requiring such comments to be reported. While I understand the reason behind that submission, in my view there may be undesirable consequences of any policy that would require compulsory reporting in the manner suggested. It would alert subject officers to the consequences of doing so, and it may inhibit people from disclosing fears of self-harm. In my view, such a recommendation is not desirable.

111. Ch Insp Lynch also told the Court that the stage of the investigation was significant. If the case had come back from the DPP and criminal proceedings were to be commenced, he would have performed a suspension review. But the investigation was not at that stage.

112. If interim risk management strategies had been undertaken, these also brought risks. Almost any action would have alerted S's colleagues to the fact that he was facing a complaint investigation. Suspension, removal from the workplace or removal of a firearm would have had that effect. This may have caused S greater stress and isolation. Ch Insp Lynch endorsed the proposition that removing a person from the workplace can bring a greater risk than managing them within the workplace. In particular, it takes away a protective factor, namely a person's work colleagues and routine.

113. Ch Insp Lynch was evidently focussed on S's welfare during this time. He told the Court he genuinely did not believe there was a risk to manage, in light of the way S presented. He also stated that, had he identified a need, he would not have hesitated to remove S's firearm.

114. In all the circumstances, I accept that the steps taken to assess and monitor S's welfare were appropriate.

Support offered to S

115. Det Sgt Lee informed S that he should seek advice and support, and he provided details of support packages to S at the time he emailed the complaint. These are standard support packages provided to police officers facing a complaint, and copies are within the brief. They include the EAP and Police Association guidance, and a guide which describes the support and the process of a complaint investigation. S did not avail himself of support services at any stage.

116. In addition, Ch Insp Lynch reminded S that he could access support during their discussions on 5 and 9 April 2018. On 9 April, he asked S if there was anything he needed for support, and they discussed the EAP or contacting his doctor, which S declined. He also suggested S take some annual leave. S was adamant that he wanted to stay in work.

117. It is clear to me that, even apart from this contact, S would have known about support he could obtain. He may well have felt isolated by his predicament, but he knew services existed to help. Ch Insp Lynch described how S had been instrumental in setting up a program of support for the command, during his period as the Cluster Senior Supervisor. S also referred obliquely to the need to access support in the message he wrote to staff on 11 April 2018, when he said, "*All I can ask is that if you need help, please speak to someone don't bottle it up inside*."

118. Since the time of S's death, Ch Insp Lynch told the Court that the support available within the regional Traffic and Highway Patrol command has been improved. Psychologists attend the region three times per year to be available to staff who want to discuss issues, whether work-related or not. Ch Insp Lynch considers that the ready availability of this service has meant that officers now take it up, whereas before they would often decline assistance when it was offered. The program is intended to continue. This is a positive legacy.

The direction not to disclose information to S's partner

119. There was a need to protect the integrity of the investigation and to ensure than any potential witness would not be influenced. Leon had already stated that he did not want to give a statement, although the possibility that he might do so in the future was still in Det Sgt Lee's contemplation.

120. It was not in fact Det Sgt Lee who made a decision to give this direction, although he delivered it. The direction was one of a number that are given to police officers who face a complaint, as I have set out above. It is part of a "standard form" and Det Sgt Lee understood that it is (or was in 2018) provided to all police officers who are the subject of a complaint. He had been investigating complaints for about 2 years at the time of these events. He told the Court that he was aware of, but had not in fact read, the Complaint Handling Guidelines. He has since moved to a different role.

121. Det Insp Attwood formed the opinion that this was not a lawful direction, though he acknowledged it was his personal view. His rationale was that police

officers facing a criminal investigation should be placed in the same position as a member of the public facing a criminal investigation. A direction could not be given to a member of the public not to talk to a potential witness, at least not prior to the point of charge and when bail is determined. Det Sgt Lee endorsed this view. Each of them are experienced investigators.

122. The direction was given by an appropriately senior officer (Insp Browne) and on its face S was required to comply with it (cl. 8 of the *Police Regulation 2015*). Whether it was appropriate in the case of a criminal investigation is unclear.

123. The lawfulness of the direction is not strictly a matter within the scope of this inquest. I note that there are provisions which restrict information that may be disclosed by a police officer about a complaint, including a complaint about criminal conduct, but these relate to specific information, such as the identity of the complainant (see cl. 54(3) *Police Regulation 2015*). There are no provisions preventing disclosure of other information about an investigation.

124. I acknowledge, as Ms Melis has reminded me, that police officers are in some respects held to a higher standard than members of the public. There is a community expectation that this should be so. This is supported by the Code of Ethics and the unique framework for investigating complaints, under Part 8A of the *Police Act 1990.* There are also other instances where police are required not to disclose information. For example, in the case of critical incident investigations, involved officers are directed not to discuss an incident, a direction that would not (and could not) be given to witnesses in other incidents. Such incidents might later become criminal investigations.

125. The guidance relevant to this issue is the Complaint Handling Guidelines. The only relevant reference is at [9.3.3], which relates to a direction to be given "*at the conclusion of a departmental interview*", i.e. a non-criminal interview, which is in similar terms to the direction given to S, namely:

> *You are directed not to disclose any information in respect of this interview to any person including any person you have reasonable cause to believe could be a subject officer or witness or otherwise involved in this*

investigation without my authority or the authority of a member of the CMT. Do you understand that?

126. Similarly, the "*Support package for police officers interviewed in relation to a complaint",* which was provided to S, contains the same direction as above, but only under the heading "*Non criminal investigations".* It would appear the guidance available to the inquest does not advise such a direction be given in criminal investigations, or what to do in the situation where an investigation has both criminal and non-criminal elements.

127. The direction given to S might have contributed his feeling of isolation. It did not prevent him talking to Leon, but it meant he was not able to talk about the details of what was probably a very stressful event. As I have noted, S did have other support he could have accessed.

128. While the direction appears to be given as standard, I consider it to be unsupported by, if not at odds with, the guidance available to this inquest. I consider it desirable that the Commissioner clarify relevant guidance, to make clear whether a direction such as the one at issue should be given in the case of a criminal investigation. I will make a recommendation to that effect, below.

The adequacy of welfare checks performed on 11 April 2018

129. Sen Sgt Bernard Sloane, the State Co-ordinator of the Radio Operations Group, provided a statement regarding system for conducting welfare checks.

130. [redacted]

131. [redacted]

132. Dispatchers are trained in this process, to actively monitor the welfare prompt box and to be aware of the situation where officers are located. It is best practice to note when a welfare check has been conducted, either in the CAD log relating to a job the unit is attending, or in the Call Sign log.

133. The dispatcher, Nick Jones, gave evidence that he was aware of this process as at 2018. He was on duty from 7.30am to 7pm that day. He was working for the relevant radio channel where S was located. He would have taken breaks at different times, and would have spent some of the day dispatching, and some assisting.

134. The evidence supports a finding that the dispatcher was prompted to make a welfare check at [redacted], and that no welfare check was performed, in particular prior to 2.06pm, [redacted].

135. Mr Jones was unable to explain why. He may not have been working as dispatcher at that time, although the message would also have been displayed to the dispatch assist. He suggested that a message may have been broadcast, but did not get through to S. However, the note S wrote about the lack of a welfare check suggests one was not broadcast. In any event, there was evidently no follow-up.

136. When the later welfare check prompt was displayed [redacted], Mr Jones says he did make a broadcast, at 3.28pm. There was no response to this. S died shortly afterwards, with the 000 call being made at 4.17pm.

137. While Mr Jones did not record the fact that he performed this check at the time, this is because he was unaware he could do so, by making a note on the Call Sign log. He did make a retrospective entry in the CAD log relating to S's death, at 5.08pm.

138. Mr Jones, to his credit, has learned from the experience. He has been guided about his conduct. He now makes a point of recording welfare checks he performs on the Call Sign log, to ensure there is a record.

139. Since S's death, an education package has been prepared regarding the importance of welfare checks, and best practice when conducting these. It was required to be completed by all communications officers.

140. In the circumstances of this case, while it was regrettable that the earlier welfare check was not performed, it is unlikely to have had any impact on the circumstances of S's death. His death occurred soon after he knew the second check had been performed. As I have already noted, prior to that time, he had clearly made a decision to end his life.

Findings required by s. 81(1)

141. As a result of considering all of the documentary and oral evidence given at the inquest, I confirm that the death occurred, and I make the following findings.

The identity of the deceased

The person who died was [redacted]

Date of death

11 April 2018

Place of death

Collingullie, NSW

Cause of death

Gunshot wound to the head

Manner of death

Self-inflicted, with an intention to end his life

Recommendations

142. I make the following recommendation pursuant to s. 82 of the *Coroners Act 2009*.

To the NSW Commissioner of Police:

Review any relevant policies and procedures to clarify whether a police officer subject to a criminal complaint investigation should be given a direction that a

subject officer should not disclose information about an investigation to a witness or involved person.

Conclusion

143. This inquest concerned the tragic death of a valued and dedicated police officer. I acknowledge that the inquest has dwelled on aspects of his life which those who knew him would prefer not to recall. The material shows he was a compassionate person who often placed the interests of others above his own. He was meticulous in his life, and also in the steps he took preceding his death.

144. S's partner Leon, Leon's mother Jenny, and S's niece Sarah were present throughout the inquest. I thank them for their attendance, and for Leon's insightful words about S at the conclusion of proceedings. I hope that the inquest has been of benefit to them, and to the rest of the family, and that some of their questions about the circumstances surrounding the death have now been answered.

145. I again express my condolences for their loss.

146. I would like to thank Detective Inspector Tim Attwood for his outstanding work. His thorough investigation and thoughtful consideration of the wider circumstances of death has been of great assistance to me in determining the issues.

147. I also express my thanks to the assisting team: to Amber Doyle, of the Crown Solicitor's Office, and to Counsel Assisting, Jake Harris. Their hard work and sensitivity in preparing the matter for inquest has been invaluable to me.

148. I now close this inquest.

T M O'Sullivan
NSW State Coroner

7 May 2021