CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of SP
Hearing dates:	14 to 18 December 2020; 14 December 2021
Date of findings:	18 February 2022
Place of findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – missing or absconded patient, searches by NSW Ambulance and the NSW Police Force, cancellation of search, no need to attend, ProQA script, telephony standard operating procedures, reason for requesting police attendance, communication between emergency response agencies
File number:	2018/213031
Representation:	Ms E Raper SC, Senior Counsel Assisting, instructed by Ms A Doyle (Crown Solicitor's Office) Mr B Bradley for New South Wales Ambulance, instructed by Hicksons Lawyers Mr S De Brennan for the Commissioner of the New South Wales Police Force, instructed by the Office of the General Counsel, New South Wales Police Force Mr M Pont (Cardillo Gray Partners) for Ms R Logozzo
Findings:	SP died on 10 July 2018 at Blacktown NSW 2148. The cause of Mr SP's death was hanging. Mr SP died as a result of actions taken by him with the intention of ending his life. Mr SP's death was therefore intentionally self-inflicted.

Recommendation: I recommend to the Commissioner of the New South Wales Police Force (**NSWPF**) that training be provided to NSWPF Communications Officers as to: (a) how to decipher the ProQA script and understand its purpose for NSW Ambulance (**NSWA**); (b) the extent to which it may or may not be relied upon by the NSWPF when responding to an incident; and (c) to be alert to the fact that NSWA are required to include in "free text" communications the reasons for requesting the attendance of the NSWPF.

Non-publication orders: Pursuant to section 75(b) of the Coroners Act 2009, there is to be no publication of the names and any information likely to identify the following persons:

1. SP
2. NH
3. JP
4. Any other relatives of SP

Table of Contents

1. Introduction

1.1 At around 7:30pm on 10 July 2018 SP left his home in Blacktown on foot. Mr SP had been restless and not his usual self earlier in the afternoon. Ms NH, Mr SP's partner, attempted to follow Mr SP after he left home, but soon lost sight of him. Approximately 30 minutes later, after looking for Mr SP in the surrounding area, Ms NH called Triple Zero to seek assistance from emergency services.

1.2 NSW Ambulance paramedics arrived at Mr SP's home at 8:09pm. Mr SP had not returned by this time and the paramedics were unable to locate him. The paramedics left Mr SP's home a short time later and the emergency services response was later cancelled.

1.3 At around 10:30pm Mr SP was found by a member of the public to be suspended from a ligature that had been tied around his neck and attached to a tree branch outside a residential property in the Blacktown area. Emergency services were again called but Mr SP could not be revived and was, sadly, pronounced life extinct at the scene.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and the cause and the manner of that person's death.

2.2 Certain deaths are reportable to a Coroner. Some examples of reportable deaths are where the cause of a person's death is not due to natural causes, or where the cause or manner of person's death may not immediately be known. In Mr SP's case, the coronial investigation focused on the response by New South Wales Ambulance (**NSWA**) and the New South Wales Police Force (**NSWPF**) to the Triple Zero call made by Ms NH, communication between these two agencies, and attempts to locate Mr SP. For all of these reasons, an inquest was required to be held.

2.3 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

2.4 It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

2.5 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made to organisations and individuals in order to draw attention to systemic issues that are identified during a coronial investigation, and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable. Where an inquest is able to identify issues that may potentially adversely impact upon the safety and well-being of the wider community, recommendations are made in the hope that, if implemented after careful consideration, they will reduce the likelihood of other adverse or life-threatening outcomes.

3. Recognition of Mr SP's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Mr SP's life in a brief, but hopefully meaningful, way.

3.3 Mr SP was born at Blacktown Hospital on 11 February 1982 to his parents, JP and MP. He was the youngest of four siblings and by all accounts Mr SP had a happy and healthy childhood.

3.4 Mr SP previously worked as a forklift driver and labourer for a company in the Riverstone area. However, at the time of his death, Mr SP was not employed.

3.5 Mr SP resided at an address in Blacktown (**the Blacktown Residence**) with his long-term defacto partner of 20 years, Ms NH. They had a daughter together.

3.6 Regrettably, little else is known about Mr SP's personal background. However, two things are clear: first, a coronial inquest cannot hope to meaningfully portray the life of a person or accurately describe the importance and value of their life; second, it is evident that Mr SP's loss continues to be most deeply felt by those who loved and cherished him the most.

4. The events of 10 July 2018[1]

Attendance at court

4.1 On 10 July 2018, Mr SP appeared before Blacktown Local Court in relation to a number of relatively minor criminal charges. Mr SP's father and Ms NH accompanied him to court on the day. Mr SP's matters were finalised and orders were made for him to pay an amount in fines. Mr SP was reportedly "*restless and agitated*" during the day.

4.2 After leaving court, Mr SP went to his father's home at 38 Richardson Crescent, Hebersham, arriving shortly before 3:00pm. Mr SP and his father later walked a short distance to a medical practice at Blackett so that Mr SP could attend an appointment with Dr Andrew Ng.

Attendance at medical appointment

4.3 Dr Ng noted that Mr SP did not seem acutely unwell, and was not violent or agitated. Further, Dr Ng noted that it did not appear that Mr SP was a threat to himself or others at the time. Dr Ng also noted that Ms NH had reported that Mr SP had been "*behaving in a bizarre way*" and had been "*having mood swings*", resulting in their attendance at Blacktown Hospital a day earlier, but leaving before Mr SP was seen.

4.4 Ms NH reportedly made a request for Mr SP to be admitted to hospital and prescribed risperidone, however Dr Ng explained that as he had not seen Mr SP for four years, further assessment and observation was required, and that any treatment should be initiated by a psychiatrist. Dr Ng concluded that Mr SP should attend Blacktown Hospital for a psychiatric assessment and wrote a referral letter for him. Dr Ng also wrote a prescription for risperidone, which was later collected by Mr SP's father, who intended to fill it and provided it to Mr SP the following day.

Observations of Mr SP during the afternoon

4.5 After leaving Dr Ng's practice, Mr SP returned home to the Blacktown Residence. Dr Ng called Ms NH to emphasise the need for Mr SP to go to hospital and that if there was a need for "*further assistance, she should contact police or an ambulance*".

4.6 It appears that during the rest of the afternoon and early evening, Mr SP's behaviour was noted to be, restless, agitated and that he was acting bizarrely. Mr SP made repeated references to needing to go for a walk, stating, "I need to get out of here".

4.7 At around 7:30pm, Mr SP left the Blacktown Residence on foot, wearing a black short-sleeved polo shirt, grey tracksuit pants and white joggers. Concerned about Mr SP's behaviour, Ms NH attempted to follow him, but lost sight of him in the darkness after about 100 to 200 metres. Ms NH last saw Mr SP alive as he walked north along Heliotrope Crescent, and continued to search for him in nearby parks.

[1] This factual background has been drawn from the helpful opening submissions of Counsel Assisting.

4.8 At around 7:32pm an incident was broadcast by NSWPF dispatchers in the Blacktown area. At around 7:44pm further information was broadcast identifying the incident as relating to the alleged stabbing of a person by a person of interest (**the Stabbing Incident**). Over the course of the evening on 10 July 2018 a significant amount of NSWPF resources from Blacktown Police Area Command (**PAC**) were dispatched in response to the Stabbing Incident.

Call to Triple Zero

4.9 After about 30 minutes, Ms NH returned to the Blacktown Residence and contacted Triple Zero, in order to seek assistance from NSWA.

4.10 Ms NH's call was answered at 7:57pm by Lachlan House, a NSWA Control Centre Assistant. Some relevant portions of this call are extracted below:

Ms NH:	I've got a bit of a situation with a mental health person […] The thing is he's taken off from me maybe I should have gone through to the police and let them know or…?
Operator:	That's okay we can notify them as well.
[…]	
Operator:	Is this a suicide attempt?
Ms NH:	no. Although he keeps complaining you know his life is fucked, he keeps repeating […]
Operator:	[…] Is he thinking about committing suicide? He said anything to you or did or said anything that sounded suspicious to you?
Ms NH:	Um. Not along the lines of suicide but he's been very aggressive like out in public, we were – yeah, he wanted to attack someone today just for looking at him the wrong way, so, yeah.
[…]	
Operator:	In which direction was he last seen heading?
Ms NH:	I chased him up the Street and then he was on… But I think he'd turned right from there. If he's going anywhere he normally walks straight up Flushcombe Road to Blacktown.
[…]	
Operator:	When he goes to Blacktown, does he do anything in particular or does he go anywhere?
Ms NH:	There's always a group of people that hang around out the front of the 7-Eleven just at the bottom of the station escalator.
Operator:	Okay.
Ms NH:	Near the taxi rank, sorry. And when he'd taken off, he was there the other day.
Operator:	Okay.
Ms NH:	Hanging around, yeah.
Operator:	Sometimes loiters around 7-Eleven, you said at the bottom of the railway station at Blacktown.
Ms NH:	Yes.

Dispatch of NSW Ambulance resources

4.11 At 8:02pm, Rochelle Logozzo, a NSWA control centre operator, requested the attendance of the NSWPF using the Inter-CAD Electronic Messaging System (**ICEMS**). The NSWA Incident Detail Report recorded the following comments in relation to this request:

> [ProQA Script] Dispatch code: 25D01V You are responding to a patient who has abnormal or suicidal behaviour. The patient is a 35-year-old male, who is consciousness and breathing is unknown. Not alert (Violent). Psychiatric/Abnormal Behaviour/Suicide Attempt. Caller Statement: ACTING STRANGELY. 1. It's not known but possible that he is violent. 2. He does not have a

> weapon. 3. The patient is gone, location unknown. 4. This is not a suicide attempt. 5. It's not known if he is thinking about committing suicide. 6. He is not completely alert (not responding appropriately).

4.12 The above message was received by Donna Kennedy, a NSWPF dispatcher working at the Penrith Radio Operations Centre. As the request from NSWA was sent as non-urgent, the incident was automatically identified as "Priority 3" by the NSWPF Computer Aided Dispatch (**CAD**) system. According to the relevant NSWPF PoliceLink/ROG Telephony/Dispatch Standard Operating Procedures (**the Telephony SOP**), Priority 3 is described as follows:

> **Priority 3 – Non Urgent Response**
> Respond as soon as possible when there is not Priority 1 or 2 matter outstanding. Incidents that Police are required to attend, that generally involve a member of the public requiring police to attend as soon as possible. For example, break and enter, noise complaints, motor vehicle accidents, non violent domestics, animal complaints, shoplifters, etc.

4.13 At 8:02pm, Ms Logozzo assigned NSWA car crew 1970 to the incident.

4.14 At 8:03pm, NSWA sent an incident update to the NSWPF, and at 8:04pm Ms Logozzo updated the ICEMS with additional information that had been entered into the incident by Mr House:

> PT [SP] DOB 2/11/1982 PT HAS BEEN RAMBLING ACTING STRANGELY POSSIBLY AGGRESSIVE CANT REMEMBER HIS OWN ACTIONS OR BEHAVIOUR PT HAS LEFT AA WEARING ARK GREY TRACK PANTS BLACK POLO SHIRT GREY NIKE SHOES BROWN HAIR APPROX 160CM LAST SEEN TURNING ONTO HELIOTROPE CR KNOWN TO WALK UP FLUSHCOMBE RD TO BLACKTOWN.

4.15 At 8:05pm, the NSWA Incident Detail Report recorded the following entry, which does not appear to have been passed on to the NSWPF.

> SOMETIMES LOITERS AS 7/11 AT BOTTOM OF BLACKTOWN RAILWAY STATION

4.16 At 8:06pm, Alison Dangerfield changed the incident status to "*Concern for Welfare (017)*". A short time later, Ms Dangerfield added the following to the PoliceCAD incident log: "*Incident Type Status Keep Lookout 4*".

4.17 Also at 8:06pm, Ms Kennedy broadcast the PoliceCAD incident for a Blacktown crew to attend the Blacktown Residence.

Arrival of paramedics at the Blacktown Residence

4.18 NSWA Paramedics Michael Wood and David Lloyd attended the Blacktown Residence at around 8:09pm. Whilst en route to the address, Paramedics Wood and Lloyd performed a patrol of the area looking for a person matching Mr SP's description, without success. Upon arriving at the Blacktown Residence, Ms NH informed the paramedics that Mr SP was not at the location, having walked off in the general direction towards Blacktown CBD. The paramedics informed Ms NH to contact NSWA if Mr SP returned. After approximately three or four minutes, the paramedics departed the

Blacktown Residence. One of the paramedics contacted Sydney Control Centre by radio, which was answered by Ms Logozzo, to advise the following:

> 1970 Sydney… (indecipherable) verification left the address given prior to our arrival. Will just do a quick whip around the block to see if he is still in the vicinity. If not, then we'll have to mark it as unable to locate.

4.19 Paramedics Wood and Lloyd drove through sections of Heliotrope Crescent, Clare Street and Flushcombe Road, looking for any person matching Mr SP's description. At 8:16pm, Paramedic Wood marked Mr SP as "*Unable to Locate*" in the ambulance mobile data terminal. At the same time, the NSWA Unit Activity Log records the activity "*Cancel Activity*" with the following comment: "*Cancellation Reason: Unable to locate patient*".

Cancellation of the emergency services response

4.20 Also at 8:16pm, an incident status update was sent by NSWA to the NSWPF via ICEMS indicating that the incident status was closed. As a result, the PoliceCAD incident was updated to record that NSWA had removed itself from the ICEMS link to the PoliceCAD incident.

4.21 At 8:17pm, Ms Logozzo called Melissa Manning, a NSWPF communications officer working at Penrith Radio Operations Centre, with the following exchange taking place:

> […]
> Ms Logozzo: […] Um, just got a job in Blacktown –
> Ms Manning: Right.
> Ms Logozzo: - that we attached you guys to for a psychotic patient. Um, we've had a look around the area can't locate him so we've um called ourselves off a job, just to let you know.
> Ms Manning: What as the address sorry?
> Ms Logozzo: [the Blacktown Residence] in Blacktown.
> Ms Manning: Okay so you couldn't find anything?
> Ms Logozzo: Yeah couldn't find anything so – um –
> Ms Manning: *Cancel it?/Cancelled it?*
> Ms Logozzo: *Yeah, have to cancel it/Yeah, we've had to cancel it.*
> Ms Manning: Okay.
> Ms Logozzo: Thank you.
> Ms Manning: Thanks, bye bye.

4.22 Whilst the precise words used by Ms Logozzo and Ms Manning regarding the issue of cancellation is difficult to discern from the call, the conversation resulted in Ms Manning updating the PoliceCAD incident log at 8:19pm with the following notation:

> FROM AMBOS THEY HAVE ATTENDED WITH NIL FIND NO FURTHER ACTION.

4.23 At 8:30pm, as a result of the above notation, Ms Kennedy attached a "cancelled status" to the incident, and also attached a "Finished" status.

4.24 At 9:30pm, the notation was changed to "Incident Closed".

Discovery of Mr SP

4.25 At around 9:30pm, Paul Reid left his home at Bungarribee Road, Blacktown to take his dog for a walk. After crossing the road, Mr Reid entered a pedestrian thoroughfare leading into the cul-de-sac end of Killarney Avenue. As Mr Reid walked down the centre of the road past 118 Killarney Avenue, Blacktown he saw a person who appeared to be standing under a tree on the nature strip, partially covered in shadow. Due to there being limited street lighting at the time, Mr Reid was unable to see the person clearly and continued on his walk.

4.26 At around 10:30pm, Mr Reid walked past the same location on his return trip and observed the same person to still be in the same spot. As Mr Reid approached he saw that the person had a "*string around his neck*". Mr Reid contacted Triple Zero and reported that he had found a person hanging, with no signs of life. This resulted in a broadcast over police radio, which was acknowledged by Leading Senior Constable (**LSC**) Ashley Huie and Probationary Constable (**PC**) Michael Kerr. At the time, both police officers were performing first response general duties in the area.

4.27 At around 10:35pm, LSC Huie and PC Kerr will arrived at 118 Killarney Avenue and found Mr SP hanging from a bottlebrush tree, slightly knelt over and leaning forward, with his weight being held up by a piece of drawstring that had been attached to a tree branch. Mr SP was wearing a black short-sleeved polo shirt, grey tracksuit pants and white running shoes, with the drawstring appearing to have come from his pants. LSC Huie attempted to locate a pulse, but was unable to do so.

4.28 NSWA paramedics arrived on the scene a short time later and cut the ligature, allowing Mr SP to be brought down and laid on the nature strip. The paramedics attached an electrocardiography machine, which showed no signs of life. As a result, Mr SP was, tragically, pronounced life extinct at 10:36pm.

4.29 Attending police officers made a number of enquiries with the residents of 118 Killarney Avenue. These enquiries revealed that the household recycle bin had been placed on the street kerb at approximately 9:00pm. No person was seen in the vicinity at the time. Approximately 15 to 30 minutes later, one of the residents heard what was assumed to be a neighbour placing their bin at the kerb.

4.30 Following Mr SP's discovery, the bin from 118 Killarney Avenue was found to have been moved approximately 5 metres from where it had been originally placed, and tipped over. Mr Reid confirmed to police that when he first walked past 118 Killarney Avenue he did not recall seeing any bin tipped over.

5. The postmortem examination

5.1 Mr SP was later taken to the Department of Forensic Medicine in Sydney where a postmortem examination was performed by Dr Jennifer Pokorny, forensic pathologist. A ligature mark was found around Mr SP's neck, which rose towards the right side of the neck in keeping with a right-sided suspension point. A length of grey braided drawstring-type cord was found to be loosely

covering the ligature mark. Postmortem imaging revealed fractures of the right superior horn of the hyoid bone and of the left superior horn of the thyroid cartilage.

5.2 Ultimately, in the autopsy report, Dr Pokorny opined that hanging was the direct cause of Mr SP's death.

6. What issues did the inquest examine?

6.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues:

(1) Whether Mr SP's death was intentionally self-inflicted and/or was precipitated by a mental illness episode.

(2) Whether the absence of further NSW Ambulance and/or NSW Police searches could be said to be a contributory factor to the manner of Mr SP's death.

(3) The adequacy of the information provided by NSW Ambulance to and the actions of NSW Ambulance paramedics in searching for Mr SP and communicating with Police, having regard to whether their action or inaction were consistent with applicable procedures and policies.

(4) The adequacy of the actions of the telecommunications staff at NSW Police having regard to applicable procedures and policies, including:

(a) whether no further action by NSWPF was necessary;

(b) the change in job status to "Cancelled" and "Finished".

(5) The adequacy of:

(a) any joint protocols between the two agencies regarding the management of these kinds of incidents;

(b) applicable standard operating procedures and policies of each agency; and

(c) the training of agency personnel in relation to applicable protocols or procedures.

6.2 Each of the above issues is discussed in further detail below, and it will be convenient to consider some of the issues together.

7. Was Mr SP's death intentionally self-inflicted?

7.1 During his consultation with Dr Ng on the afternoon of 10 July 2018, Mr SP did not disclose any suicidal ideation or suicidal intent. Whilst it was noted that Mr SP had previously experienced psychosis, Dr Ng formed the view that Mr SP was not, at that time, psychotic or acutely unwell. Rather, although Mr SP described his mood as being "*stressed*", Dr Ng noted that Mr SP was polite and not aggressive. Relevantly, Dr Ng noted that Mr SP "*did not appear to be a threat to himself or others at the time*".

7.2 Later that evening, during her call to Triple Zero, Ms NH described the reason for her call as not relating to a suicide attempt. She did not convey any information that Mr SP had been contemplating self-harm. However, Ms NH reported that Mr SP "*keeps complaining yet his life is fucked, he keeps repeating*". Further, Ms NH described Mr SP as having been "*a little bit aggressive*", that he was "*acting very bizarre*", and that he was not aware of his actions.

7.3 There is no evidence that Mr SP had previously voiced suicidal ideation or intent to Dr Ng or to those closest to him, such as Ms NH and his father, JP. There is also no evidence that Mr SP had previously attempted self-harm.

7.4 However, the factual circumstances leading up to Mr SP's departure from the Blacktown Residence on the evening of 10 July 2018 indicate that he was troubled and not his usual self, sufficiently so for Ms NH to be concerned and to follow and look for Mr SP after he left home. It is most likely that the circumstances in which Mr SP left home influenced his actions later that evening.

7.5 **Conclusion:** A consideration of the circumstances in which Mr SP was found, the observations of Mr SP's mood and behaviour in the hours preceding his departure from the Blacktown Residence, and the absence of any suspicious circumstances associated with Mr SP's death, leads to the conclusion that Mr SP died as a result of actions taken by him with the intention of ending his life. Further, there is also no evidence to conclude that Mr SP lacked capacity to form intention to take his own life. Therefore, Mr SP's death was intentionally self-inflicted.

8. Searches conducted by NSW Ambulance and the New South Wales Police Force

What searches were conducted by NSW Ambulance, and were they adequate?

8.1 Paramedics Wood and Lloyd conducted a limited search for Mr SP on their way to and from the Blacktown Residence as follows:

(a) Having been provided with information as to what Mr SP was wearing, the paramedics drove slowly along Flushcombe Road and Azalea Street on their way to the Blacktown Residence, checking both sides of the street and looking down side streets for any person matching Mr SP's description;

(b) After speaking with Ms NH, the paramedics drove along Flushcombe Road in the direction of Blacktown Station (described by the paramedics as a "*quick whip around the block*") to see whether Mr SP was still in the vicinity;

(c) The paramedics did not attend Blacktown CBD or the 7-Eleven at Blacktown Station to look for Mr SP. Paramedic Lloyd described this as a "*massive search area*", and that paramedics would not normally travel that distance to look for someone. Further, Paramedic Wood noted that the information he and Paramedic Lloyd had been provided with was unconfirmed, that Mr SP was on foot and that the area was a 10 to 15 minute drive away. When asked about his perception of the role of NSWA had information been provided that Mr SP was known to frequent the 7-Eleven, Paramedic Lloyd explained:

> It would very much depend on how much you knew about the individual, whether you could identify them readily and the distance to that location. If we're talking about the shop or the house next door or in the street, you may go there. If we're talking about across town somewhere, then no you wouldn't and there's every perceivable possibility in between.

(d) After leaving the Blacktown Residence, the paramedics were allocated to the Stabbing Incident at 8:22pm.

8.2 Paramedic Lloyd gave evidence that:

(a) his role was to attend the scene and "*treat whatever medical issues [were] found there*";

(b) it was not his role to search beyond the immediate vicinity of the scene, or to look for a patient at another location;

(c) paramedics are not provided with any training in relation to searching for a patient.

8.3 Paramedic Lloyd further clarified:

> I don't understand that we have a technical search role, obviously we have - I suppose what I would describe as a non-technical look around as opposed to being a dedicated search role as in a rescue role.

8.4 When asked whether this view would be different if he was aware that the NSWPF were not providing any assistance in a searching capacity, Paramedic Lloyd explained that any search beyond the immediate vicinity of a scene would only occur with a new instruction from NSWA to do so:

> At the distance that we're talking about away, I would expect that our control centre would decide whether we proceeded to another location. Of what I would - for no reason other than just the way I view the world, but I would view as being almost a different second job.

8.5 Paramedic Wood explained his similar understanding of the role of a paramedic in circumstances where a patient is not at the nominated address for an incident:

> […] as far as I'm aware there's no New South Wales Ambulance instruction about searching for people. It's more so going off what the person at the address has told you this is where - you know

> this is where I am, they sometimes go next door or my dad lives across the road, they might be there, but outside of looking in the immediate vicinity, we don't search for people outside of that.

8.6 Assistant Commissioner Peter Elliott, Acting Director Control Centres, confirmed the evidence given by Paramedics Wood and Lloyd and further clarified in the respective roles of NSWA and the NSWPF in searching for a patient:

> Based on the information provided by a caller and any updated information, NSWA will make reasonable attempts to locate a patient or incident. It is not the role of NSWA to conduct a search for a patient that has left the location and cannot be located after a reasonable attempt has been made to find them. The role of searching for a patient is considered to be within the remit of the NSW Police Force.

8.7 As to the meaning of "*reasonable attempt(s)*", Assistant Commissioner Elliot further explained

> […] I mean that NSW Ambulance will respond to the address provided or the patient and/or incident and conduct a drive by search of the immediate area based on the information provided regarding Mr SP's direction of travel.
>
> Paramedics are not required to conduct a detailed geographic search beyond the surrounding area of Mr SP's home or the direction they were informed he was last seen heading in. In the event that a patient cannot be located, the incident will be marked as "unable to locate" and closed.

8.8 **Conclusion:** Where NSWA paramedics are dispatched to an incident location, and a patient cannot be found at that location, there is no obligation on the attending paramedics to search for the patient. In this regard, the primary role of NSWA is to provide medical treatment to patients and transport patients as required. The role of searching for a patient falls within the remit of the NSWPF. However, in some instances reasonable attempts may be made by attending paramedics to locate a patient in the immediate vicinity of an incident location.

8.9 Therefore, it cannot be said that NSWA conducted an inadequate search for Mr SP on the evening of 10 July 2018. Further, there is no evidence to suggest that the non-performance of a search other than in the vicinity of the Blacktown Residence, and searching whilst en route to and from that location, contributed to Mr SP's death in any way. There is no evidence that Mr SP did in fact travel to the 7-Eleven at Blacktown Station or to Blacktown CBD. In addition, there is no evidence that Mr SP intended to travel to the vicinity of 118 Killarney Road, which is located some distance from the Blacktown Residence and also from the other potential locations which the available information indicated that he may possibly have travel to.

What searches were conducted by the NSWPF, and were they adequate?

8.10 At the outset it should be noted that the NSWPF did not conduct any searches for Mr SP. At the time that the concern was raised for Mr SP's whereabouts, a number of police officers within Blacktown PAC were responding to the Stabbing Incident. This resulted in a number of police patrolling Blacktown CBD between about 8:00pm and 8:30pm to look for a person of interest.

8.11 When a person of interest is not at a fixed location and a sufficient description of the person is available, as in Mr SP's case, the Telephony SOP requires a new KLO4 incident to be created with the relevant details, and the available information to be circulated to appropriate channels. However, Ms Kennedy did not create a new KLO4 incident.

8.12 Acting Inspector Lauren Martin, a Duty Officer at Blacktown PAC, gave evidence that whilst police officers were patrolling the Blacktown area to look for the person of interest in relation to the Stabbing Incident it would not be "*abnormal to be looking for multiple people at the same time*". This then means that if a KLO4 incident had been created, and Mr SP's description broadcasted, police officers could have been looking for him concurrently.

8.13 Further, to the extent that it may be considered that available NSWPF resources were occupied with the Stabbing Incident, the evidence establishes that additional assistance could have been sought from outside the PAC. However, it should be noted that the decision for making such a request rested with a Duty Officer, and not a dispatcher like Ms Kennedy. In addition, it was not usual to make such a request for a Priority 3 incident.

8.14 Notwithstanding, if Mr SP's incident had not been cancelled, the evidence establishes that greater police resources were available after 8:30pm:

(a) High visibility policing units were patrolling the area in and around Blacktown CBD and could have kept a lookout for Mr SP if they had the capacity and time to do so;

(b) One unit (BN17) was available to attend Mr SP's incident after 9:00pm. Records indicate that BN17 attended another incident between 9:30pm and 10:00pm, which was of a lower priority than a concern for welfare;

(c) Two other units, BN16 and BN16, were able to attend Mr SP's incident after 9:40pm and 9:47pm, respectively.

8.15 It is clear then that any search by the NSWPF for Mr SP on 10 July 2018 depended on a number of factors: the NSWPF incident remaining open, a new KLO4 incident being broadcast, available resources being assigned to the incident, and standard search procedures being followed. However, even if these factors allowed for a search to be conducted by the NSWPF, it is not possible to reach a conclusion that Mr SP likely would have been found for the following reasons:

(a) LSC Huie gave evidence that she would not have searched the area where Mr SP was eventually found. Rather, LSC Huie would have treated the incident as a missing person case. That is, she would have sought further information from Ms NH regarding where Mr SP liked to go, whether he had any family and friends in the area, and the events prior to his departure, together with a description and photo of Mr SP. LSC Huie explained that any searches conducted by police would be limited to "*active areas*" such as Blacktown CBD and its surrounds, together with locations which Mr SP was known to frequent. The location at 118 Killarney Avenue did not fall within any of these potential search areas.

(b) There is no evidence that Mr SP was on Flushcombe Road, within the Blacktown CBD or at the 7-Eleven at Blacktown station.

8.16 **Conclusion:** As the NSWPF did not conduct any searches for Mr SP, the issue is not so much a question of adequacy, but rather, whether there was any opportunity to conduct a search. The evidence establishes that no KLO4 incident was created, contrary to the requirements of the Telephony SOP. Had such an incident been created, an opportunity existed, albeit with limited available NSWPF resources prior to around 8:30pm on 10 July 2018, for police officers to keep a concurrent lookout for Mr SP. Had Mr SP's incident not been cancelled, there was an increased availability of NSWPF resources after around 8:30pm.

8.17 Although a KLO4 incident ought to have been created, a conclusion cannot be reached that any search or lookout for Mr SP would have resulted in him being found. This is because, much like the actual search conducted by NSWA, there is no evidence to suggest that either Mr SP had made his way to one of the potential destinations which the available information suggested that he was heading, or to the location at 118 Killarney Avenue.

Communication to Ms NH regarding cancellation of the search

8.18 During her call to Triple Zero, Ms NH was informed that "*the ambulance and the police have been organised*", and that she should stay at home in case Mr SP returned. Later, Ms NH was not told by either NSWA or the NSWPF that Mr SP's incident had been cancelled or "called off". Paramedic Wood gave evidence that it is not usual practice for a paramedic to advise an informant like Ms NH that a person had not been found and that NSWA were calling off the job. As noted above, such a task falls outside the role and function of NSWA, as the NSWPF is the primary search agency.

8.19 In December 2021, NSWA issued a new Work Instruction *Concern for Welfare, Missing or Absconded Patient and Misdirected Calls* (**Concern for Welfare Work Instruction**), developed in consultation with the NSWPF to ensure best possible outcomes for patients who are lost or absconded or require locating due to concerns for their welfare. The Concern for Welfare Work Instruction provides that in a concern for welfare or a missing/absconded patient situation, once it is established that a patient's location is unknown a call taker is to "advise the caller that the incident will be referred to the Police who will assist with locating the patient". The call taker is also required to take procedural steps to communicate pertinent caller information, and introduce the caller, to the NSWPF.

8.20 Evidence received from the NSWPF indicates the following:

> For any incident where the informant requests to see police, police should speak with informant.
>
> Where police acknowledged a concern for welfare job where the informant wishes to see police, the informant should be spoken to, informed of actions taken and any future action to be taken until such time as the matter is resolved.

8.21 **Conclusion:** Regrettably, despite being informed that her Triple Zero had resulted in a response from both NSWA and the NSWPF, Ms NH was not informed that the incident created for Mr SP had been cancelled. No doubt, this uncertainty would have only added to the obvious concern that Ms NH had at the time for Mr SP. Since the events of 2018, NSWA had introduced a new work instruction which appropriately provides for a caller like Ms NH to be transferred to the NSWPF. Further, according to NSWPF practices, a caller will be kept informed of any actions taken, and to be taken, until an incident is resolved.

9. Adequacy of information provided by NSW Ambulance to the NSW Police Force

Communication of information regarding Mr SP and the 7-Eleven at Blacktown

9.1 During her call to Triple Zero, Ms NH provided information that Mr SP sometimes loitered outside of the 7-Eleven near Blacktown station (**the 7-Eleven Information**). This information was entered into the NSWA Incident Detail Report by Mr House at 8:05pm.

9.2 The Joint Communications Protocol between the Ambulance Service of NSW and NSW Police Force (**the Joint Protocol**) was developed to ensure timely and accurate exchange of information between the two agencies in respect of responding to incidents. The Joint Protocol relevantly provides that NSWA is to:

> Relay any further information relevant to the NSWPF as obtained to ensure NSWPF can revise their response as required.

9.3 Further, the Joint Protocol also notes the following in relation to sharing of information:

> Where information is received that will aid in the response and recovery to any incident, in particular search and rescue operations, each organisation will ensure this information is conveyed to other [Emergency Service Officers].

9.4 Ms Kennedy gave evidence that if she had received the 7-Eleven Information it would have been broadcast by radio. Further, LSC Huie gave evidence as to how provision of the 7-Eleven Information would have affected what she did on 10 July 2018:

> Had we been made aware on the night, then I'm sure someone would've gone to look at this particular area and canvassed whether or not he was there.
> […]
> […] well, for instance, getting out and actually physically walking the area or speaking with the attendant at 7-Eleven to see if they recognised the description of the person or, or - for, like, this particular 7-Eleven, it's quite close to a, a taxi rank. Like, we probably would've spoken with some of the taxi drivers that were there to see if they recalled seeing anyone.

9.5 Notwithstanding that the 7-Eleven information was information that:

(a) became available following the initial notification;

(b) was relevant to the conduct of any searches for Mr SP; and

(c) might have aided in the response to the incident;

Ms Logozzo did not provide it to the NSWPF.

9.6 It appears that a number of factors contributed to this omission:

(a) Ms Logozzo described the evening of 10 July 2018 as being a busy night, and that she was the sole dispatcher for the Sydney Operations West area;

(b) Mr House did not use a function to notify Ms Logozzo of the 7-Elven Information. This function allows a NSWA call taker to provide responding paramedics (via a Mobile Data Terminal) and a dispatcher (in a window on the dispatcher screen) with certain information. However, Mr House considered that the 7-Eleven Information was speculative (there was no confirmation that Mr SP was at that location) and provision of this information was not required by a relevant NSWA Work Instruction as it did not relate to a change of Mr SP's location. Mr House was also concerned that if the notify function was utilised, only the area around the 7-Eleven would be searched, rather than the area where Mr SP was last known to be;

(c) Even without a notification by a NSWA call taker, information such as the 7-Elven Information remains in the notes for a job and is therefore accessible to a dispatcher like Ms Logozzo. However, Ms Logozzo gave evidence that due to the volume of jobs, it is difficult to know whether a new note has been attached to a job. Notwithstanding, Ms Logozzo explained that if she had seen the comment, she would have passed it on to the NSWPF.

(d) Ms Logozzo described her experiences with "*glitches*" in the NSWA system that caused difficulties in sending messages via ICEMS. This was supported by the evidence of David Branson, a NSW Wales eHealth support analyst, who indicated that such glitches occurred during the selection of messages to be sent. The evidence established that these errors should be addressed in a new NSWA CAD platform which commenced operation in 2021.

9.7 Assistant Commissioner Steven Norris gave evidence that the current NSWA *Work Instruction – Notify Function* is adequate and that it would not be appropriate to require a call taker to notify a dispatcher of information that is relevant for transmission to another responding agency. This is because such a requirement would "*require NSWA call takers to be familiarised with current practices and procedures of another agency*", which is beyond the scope of NSWA call taking practice. In addition, Assistant Commissioner Norris explained that "*it would result in a disproportionate disruption to dispatcher and supervisor CAD functions*" and "*has the potential to dilute the meaningfulness of notified information over time*".

9.8 Since 2018, Assistant Commissioner Norris stated that two relevant improvements have been made by NSWA:

(a) The new Concern for Welfare Work Instruction will result in incidents like Mr SP's being transferred to the NSWPF so as to "*greatly reduce*" the risk of information such as the 7-Eleven Information "*not being provided to the NSWPF in circumstances where NSWPF will have direct access to the informant*"; and

(b) A review of the NSWA dispatch model aimed at reducing pressure on individual dispatchers during periods of high workloads is currently ongoing, and likely to result in a new model which will result in an increase from one to three dispatchers per board.

9.9 **Conclusion:** The 7-Eleven Information ought to have been communicated by NSWA to the NSWPF in accordance with Joint Protocol. There were a number of legitimate factors such as workload and technical "*glitches*" which operated against provision of the 7-Eleven Information. Had this information been communicated it would have resulted in a canvass by police of the area around the 7-Eleven at Blacktown and caused LSC Huie to approach matters differently. However, as there is no evidence that Mr SP attended the 7-Eleven, it cannot be said that provision of the 7-Eleven information to the NSWPF would likely have resulted in Mr SP being found.

Communication of the reason(s) for attaching the NSWPF to an incident

9.10 At the time of the incident, NSWA and NSWPF personnel had a differing understandings as to why the NSWPF was attached to the incident:

(a) Ms Kennedy understood that NSWA were seeking assistance with a person who may be aggressive. She did not have an understanding that NSWA were also requesting assistance from the NSWPF to locate Mr SP.

(b) Ms Manning understood that the NSWPF were required to assist and protect NSWA personnel, as it was possible that Mr SP was violent. She explained that the reference to a person "*acting strangely*" would not necessarily require police assistance, and that she did not understand that the NSWPF were being asked to search for Mr SP.

(c) Ms Logozzo, gave evidence that she attached the NSWPF to the incident because there was a concern for welfare and Mr SP was possibly violent. Further, Ms Logozzo considered that the NSWPF would create their own incident, assist with paramedic safety, attend the address and conduct a search.

(d) Paramedic Wood expected that the NSWPF were attached to the job, and would search for Mr SP if NSWA could not find him.

(e) Mr House informed Ms NH that ambulance and police had been organised, and that it was his understanding that the role of the NSWPF was to ensure the safety of both Mr SP and the paramedics.

(f) Senior Sergeant Bernard Sloane, the State Coordinator for the Radio Operations Group at the relevant time, considered that, due to the possibility of violence, there was a concern for the safety of NSWA paramedics, and that the NSWPF were not being asked to assist in the search

for Mr SP. If such a search request had been made, Senior Sergeant Sloane would have expected this to be more direct terms.

(g) Sergeant Tracey Freeman, Acting State Coordinator for the Radio Operations Group in June/July 2020, considered that the two factors that needed to be taken into account were Mr SP's immediate health and welfare, and his whereabouts.

(h) LSC Huie understood that the NSWPF were to attend alongside NSWA and if the latter were unable to attend, the NSWPF would still attempt to provide assistance.

9.11 Both Senior Sergeant Sloane and Sergeant Freeman gave evidence that if the reason for requesting the attendance of the NSWPF is not clear, then NSWPF dispatchers will contact NSWA, by phone or via ICEMS, to determine what is required. However, no such request was made regarding Mr SP's incident. Sergeant Freeman explained:

> So I would suggest that improved communications between the ambulance and the police and, you know, even [NSW Fire & Rescue] or SES who are also on that system would make things a lot easier. If we got a free-text through straight away before we got all the other information, it probably would've been a lot easier to ascertain what was actually required from police.

9.12 Senior Sergeant Sloane and Sergeant Freeman had differing views regarding the ability of Ms Logozzo to send a free text message to the NSWPF which stated the reasons for attaching the NSWPF to the incident. Whilst Sergeant Freeman considered that the provision of free text reasons would be very useful, Senior Sergeant Sloane considered that the information might be missed.

9.13 Assistant Commissioner Norris stated that the reason for the NSWPF being attached to Mr SP's incident was communicated in accordance with NSWA policies and procedures. In this respect, Assistant Commissioner Norris expressed the view that Ms Logozzo was compliant with the two applicable policies: the Joint Protocol and the NSWA *Work Instruction – Clinical Operations – Control Centres Dispatching – DISP 2.05 – Requesting Police Attendance* (Police Attendance Work Instruction). The Police Attendance Work Instruction provides that an incident is to be transferred to the NSWPF via ICEMS inclusive of all relevant information, the ProQA script and any scene safety information. The Police Attendance Work Instruction also directs attention to the Joint Protocol for further information. Relevantly, the Joint Protocol identifies circumstances in which the NSWPF are to be notified and provides that an incident is to be transferred to the NSWPF, "*ensuring details of why the police are required*".

9.14 Presently, there is no facility within ICEMS to require that a NSWA dispatcher provide reasons for attaching the NSWPF to an incident. Such a change would require agreement of all ICEMS connected agencies and software programming changes.

ProQA Script

9.15 Ms Logozzo sent the NSWA ProQA information to the NSWPF, together with additional free text information, in accordance with Police Attendance Work Instruction. No specific reasons were set out in the information provided by Ms Logozzo. Instead, it appears that there was a view at NSWA

that the information provided in the ProQA script would convey the reason for the request, and was the most appropriate way of doing so.

9.16 Notwithstanding, the evidence given by a number of NSWPF personnel indicates that the ProQA information is considered to be generic and, at times, confusing. Instead, it appears that particular attention is paid to free text information provided by NSWA which is regarded as being specific to an incident:

(a) Ms Kennedy described the ProQA script as being "*cumbersome*", and that she would generally use the free form text as it provided more detail and was easier to understand.

(b) Ms Manning described the ProQA information as being "*very generic*" and phrases such as "*not completely alert (not responding properly)*" is a standard phrase in incident headers.

(c) LSC Huie gave evidence that the messages were generic, and that she would filter down to understand the reason why the NSWPF were being called to attend, and to review information that was specific to the job.

(d) Senior Sergeant Sloane gave evidence, that in his experience, the primary focus when reading the ProQA information is determining whether there was an element of violence, or possible violence, associated with an incident. Further, Senior Sergeant Sloane considered that the NSWPF Radio Operations Group considered the free text field to be more useful, as it contained details regarding the incident.

(e) Sergeant Freeman gave evidence that the ProQA script needs to be "*deciphered*" in order to determine the reason for police attendance. She described the information received via ICEMS to be "*extremely confusing*" and "*contradictory*".

(f) Ms Manning gave evidence that communications officers were trained to read through the information to identify the reason for the request for police attendance.

9.17 Further investigation as part of the coronial investigation identified the following:

(a) Kristy Walters, Director of the NSWPF PoliceLink Command, expressed the view that no specific training should be provided to NSWPF personnel, as the ProQA script is specific to NSWA and used to triage a call. Ms Walters considered that NSWPF officers only require an awareness of ProQA and its function. In this regard, Ms Walters gave the following evidence:

> My belief is that the, the responses that ProQA could produce would be many and varied and I'm not, I'm not comfortable, whether that be the word that, that a dispatcher would be able to take in, as I said the width and breadth of learning an additional system in addition to their own requirements and retain and interpret that information. Particularly when the free-text field provides us that capability to, to clearly define why we are required and being invited into the job.

(b) The NSWPF consider that the ProQA script alone is not an appropriate means of communication information and reason(s) for the attendance of the NSWPF on every occasion.

(c) Further, the NSWA *Work Instruction – NSW Police Force* (**NSWPF Work Instruction**) has been updated to provide that when requesting NSWPF attendance a NSWA dispatcher is to ensure that "*concise details of why Police are required (including if it is for paramedic safety) is to be included*", together with the ProQA script and scene safety information.

9.18 It was submitted on behalf of the NSWPF that communications officers require no further training regarding ProQA given that:

(a) these officers already undertake a 16 week training course to become, after a period of consolidation, competent dispatchers;

(b) ProQA already forms a part of this training;

(c) emphasis should be placed on the use of free text that is clear and concise and builds upon clues and indicators from ProQA; and

(d) Assistant Commissioner Norris gave evidence that in 2020 there were in excess of approximately 167,000 ICEMS between NSWA and the NSWPF, indicating that the two agencies communicate successfully operationally.

9.19 **Conclusion:** The evidence establishes that the NSWA were of the view on 10 July 2018 that information contained within the ProQA script would adequately explain the reason for the request for the attendance of the NSWPF. However, the evidence given by a number of NSWPF witnesses at hearing establishes that this view did not accurately translate into practice. Instead, a number of witnesses gave evidence as to confusion regarding the ProQA scripts when responding to incidents, and instead placing reliance upon the use of free text. Further, some of the evidence suggests that the contents of a ProQA script is not comprehensive reviewed, and is only reviewed for the possibility of there being an element of violence associated with an incident.

9.20 It is accepted that NSWPF communications officers already undergo a substantial training program in order to develop and establish competency, and that the use of ICEMS is a well-used tool to facilitate communication between NSWA and the NSWPF. However, the evidence establishes that there is a need for NSWPF personnel to better understand the purpose of a ProQA script, and the extent to which it should be relied upon as regards the reason for a request for police attendance. Therefore, it is desirable to make the following recommendation.

9.21 **Recommendation:** I recommend to the Commissioner of the New South Wales Police Force that training be provided to NSWPF Communications Officers as to: (a) how to decipher the ProQA script and understand its purpose for NSW Ambulance; (b) the extent to which it may or may not be relied upon by the NSWPF when responding to an incident; and (c) to be alert to the fact that NSWA are required to include in "free text" communications the reasons for requesting the attendance of the NSWPF.

Reasons for cancellation of an incident

9.22 At 8:16pm, ICEMS recorded NSWA as having been removed from the incident noting the following "*Cancellation reason: unable to locate patient*". As there was no facility which allowed NSWA to send an ICEMS message to the NSWPF to convey the reason for removal, Ms Logozzo called Ms Manning. There are a number of differences as to what was discussed during this call:

(a) Ms Logozzo's understanding was that she informed Ms Manning that NSWA had cancelled the incident, but did not intend to communicate that there was no need for police attendance. With hindsight, Ms Logozzo indicated that she would have clarified that the cancellation only related to NSWA cancelling its response, with this having no bearing upon any response by the NSWPF.

(b) Ms Manning's understanding was that Ms Logozzo was providing confirmation that the NSWPF could cancel the incident, as there was no need to protect NSWA personnel from a possible threat of violence. For this type of call, it was standard practice for dispatch assist to review the type of incident and incident header. However, it was not standard practice for telephonists in telephony call centres to do so.

(c) The audio recording of the call does not assist in resolving these differences, but rather, highlights the fact that the communication was unclear.

9.23 Relevantly, the Joint Protocol does not provide for cancellation of incidents by one agency, and the reason for cancellation is limited to a telephone call, unless the incident is reopened.

9.24 The Concern for Welfare Work Instruction applies "*in situations where it is determined that the patient location is unknown due to the call relating to a mental health concern for welfare, or in a missing/absconded patient situation*". Further, the Concern for Welfare Work Instruction states that the NSWPF is the primary agency for searches, and that NSWA will provide medical assistance once the person's location has been determined. In addition, where an incident is marked "*Patient Location Unknown*", the Concern for Welfare Work Instruction provides a procedure for the call to be transferred to the NSWPF and for a supervisor to review all such incidents and contact the NSWPF.

9.25 The NSWPF Work Instruction is also relevant to Mr SP's case in a number of respects:

(a) It ensures that NSWPF is joined to an incident when there is a "*concern for welfare*", and expressly states that this includes "*calls where the patient's location is unknown due to the call relating to a mental health concern for welfare, or a missing/absconded patient situation*".

(b) It requires that "*concise details of why police are required*" are provided when police attendance is requested, with NSWA dispatchers to refer to an agreed list of 20 or more circumstances ;

(c) Where NSWA will not be attending the incident, this information is required to be communicated by "*free text*" and the incident is referred to a supervisor who will perform a

"*follow-up*" call. Reference is made to the Concern for Welfare Work Instruction regarding details of this process.

(d) If the attendance of the NSWPF is no longer required, a reason for cancellation must be provided to the NSWPF via ICEMS, and if it cannot be provided (or the circumstances require clarification or discussion), the incident is referred to a supervisor who must verbally communicate the reason via telephone.

9.26 Assistant Commissioner Norris gave evidence that the NSWPF Work Instruction was operationalised on 10 December 2021, meaning that:

> […] it has been both published on [the NSWA] intranet system for all of the relevant control centre staff to access and that publication also includes what we call an operational alert. So it draws to the attention of the relevant staff the publication. It also creates responsibility on the staff member to both read it and then acknowledge that they understand it as part of that process. There is also the option for staff to seek any further assistance, should they have any other questions or be unsure about elements of the published work instruction.

9.27 It should also be noted that, following the conclusion of the evidence in the inquest, information was provided by NSWA indicating that the Concern for Welfare Work Instruction was operationalised in the same manner on 17 December 2021.

9.28 **Conclusion:** The difference in understanding between Ms Logozzo and Ms Manning highlights the absence of clarity regarding the reason for cancellation of the incident at the time, and emphasises the need for clearer communication between the respective agencies. The NSWPF Work Instruction has appropriately addressed these deficiencies by requiring that a reason for cancellation is provided to the NSWPF, with appropriate follow-up at a supervisor level to mitigate against the possibility of any miscommunication.

10. The adequacy of actions of NSWPF telecommunication staff

Cancellation of the incident by the NSWPF

10.1 In evidence, Ms Kennedy accepted that she did not take a number of steps that were required by the relevant protocols in operation at the time:

(a) The Telephony SOP requires that all reasonable effort and attempts should be made to broadcast Priority 3 incidents every five minutes if possible. The incident should continue to be broadcast until it is acknowledged, so far as possible, even if the incident occurs during times of high demand. Although some latitude regarding the five minute timeframe is allowed during busy periods, it is expected that dispatchers will continue to broadcast the incident, and that an incident will attract a higher priority if not broadcast for some time. Instead, there was one broadcast at 8:06 PM and no further broadcasts until 8:30 PM when the incident was closed.

(b) The Telephony SOP also requires dispatchers, upon receiving a memo for cars to "*Keep a Lookout for*" within a certain area, to broadcast to the area the KLO4 information. The

available evidence indicates that once the incident was amended to KLO4 it is unlikely that Ms Kennedy broadcasted any additional information, as this is absent from the incident log.

(c) The Telephony SOP requires that when a person of interest is not at a fixed location and a sufficient description is available, the available information is to be circulated to appropriate channels by creating a new incident with the relevant details. However, Ms Kennedy did not create a new KLO4 incident. If one had been created, it would not have been cancelled automatically when the original incident was cancelled, and it would have been re-broadcast at reasonable intervals.

(d) Finally, the Telephony SOP requires that if a call is received advising that there is no longer a need for police attendance, the "*Property/Company Name or Misc text*" field should commence with "*NNTA*" (no need to attend).

10.2 **Conclusion:** It is evident that there was non-compliance with the Telephony SOP on 10 July in a number of key respects. Perhaps most importantly, a new KLO4 incident was not created, meaning that an opportunity was missed for information to be broadcast that would have potentially assisted in locating Mr SP. Again, it should be noted that the evidence does not establish a likelihood that Mr SP would have been located using such information.

10.3 A number of factors bore upon the omissions by Ms Kennedy. Relevantly, she was the dispatcher for the Stabbing Incident which required significant attention and the dispatching of a large number of police resources. Ms Kennedy also indicated that the channel was constant in its level of activity at the time, which may also have affected her capacity.

The response by the NSWPF once the NSWA response was cancelled

10.4 After Ms Manning recorded the following information – *FROM AMBOS THEY HAVE ATTENDED WITH NIL FIND AND NO FURTHER ACTION* – Ms Kennedy attached a cancelled and a finished status to the NSWPF incident, consistent with NSWPF procedures and protocols which existed at the time. However, the system allowed Ms Kennedy to leave the NSWPF incident open.

10.5 The evidence given by various NSWPF witnesses was that NSWA had cancelled the attendance of the NSWPF so as to inform the NSWPF that they were no longer required:

(a) Ms Kennedy's understanding was that NSWA had advised the NSWPF that their attendance was no longer required because NSWA had been unable to locate Mr SP "*with nil further action*". However, this did not address the concern that had been raised for Mr SP's welfare. Ms Kennedy considered that the information recorded by Ms Manning meant that the NSWPF "*were not required to attend and no further action was necessary*".

(b) Ms Manning considered that there was no need for police to attend because the role of police was limited to protecting NSWA paramedics who had already attended the location, and were cancelling the job.

(c) Senior Sergeant Sloane considered that NSWA did not require assistance from the NSWPF and therefore cancelled the request, and that any concern for Mr SP's health, was a matter for NSWA given that they had cancelled the attendance of the NSWPF.

10.6 In contrast, Ms Logozzo gave evidence that her understanding was that NSWA had no authority to direct the NSWPF to cancel their incidents, although NSWA dispatchers would advise the NSWPF that they were no longer required in some circumstances, for example when paramedics had no concerns for a patient's safety. However, Ms Logozzo did not intend to convey that the NSWPF were not required for Mr SP's incident.

10.7 Sergeant Freeman gave evidence as to the reliance placed on NSWA by NSWPF communications officers:

> If they have an original informant who's contacted them and it's New South Wales Ambulance, which is someone that we consider a trusted person to give advice, ambulance and [NSW Fire & Rescue] are the only people that are non-police resource that we will actually trust to call off a specific incident. Things like persons trapped incidents, for example, they're the only source of truth that we rely on.

10.8 Similarly, Senior Sergeant Sloane stated that in relation to NSWA cancelling the request for NSWPF assistance, the NSWPF "*relied on the advice, guidance and expertise of Ambulance personnel at the scene*".

10.9 However, Senior Sergeant Sloane and Sergeant Freeman had different views regarding what will should have been done with the information from Mr SP's incident:

(a) Senior Sergeant Sloane considered that the concern for Mr SP's welfare was primarily a health concern that fell within the responsibility of NSWA. Therefore, it was open to NSWA to cancel the incident. Senior Sergeant Sloane considered that the NSWPF had been attached to the incident due to possible concerns for the safety of attending paramedics, and not to search for Mr SP. Further, Senior Sergeant Sloane considered that whether the NSWPF have an independent obligation to assess whether a response is appropriate (notwithstanding that NSWA may cancel an incident) is to be determined on a case-by-case basis. In Mr SP's case, Senior Sergeant Sloane observed that NSWA had initially requested the attendance of the NSWPF, and then subsequently indicated that such attendance was not required.

(b) Sergeant Freeman considered that once NSWA had attended the location and been unable to locate Mr SP to assess his health and welfare, the incident should have remained with the NSWPF so that Mr SP could be located in order for medical assessments to be performed. Therefore, although Sergeant Freeman considered that the dispatchers were correct to close the incident (having regard to the relevant procedures at the time, and the information that police assistance was not required), she expressed the view that the incident should have been left open.

10.10 The differences in views described above raises a question as to whether the Joint Protocol should be amended to provide for the respective role of each agency when they are joined to incidents:

(a) The view of NSWA is that these respective roles are well understood and that changes have been made since Mr SP's incident to reinforce the delineation between the two roles, including transferring misdirected calls and where, in similar circumstances, NSWA will not attend until a patient is located.

(b) The view of the NSWPF is that the agencies are committed to replacing the Joint Protocol with a memorandum of understanding that will "*set out an agreement between the agencies to share any interrelated work instructions, SOPs, policies or procedures and consult on any changes which have the potential to impact on the other agency*". This will purportedly include what an agency should do when removing themselves from a job or cancelling their attendance, and associated notifications. Assistant Commissioner Norris explained:

> […] what we're trying to achieve is two things. One is to avoid what is potentially the duplication of work instructions or in the case of New South Wales Police, their Standard Operating Procedures in a, in a separate document. But also to create an onus on both agencies to come together and regularise I guess, the review of the Standard Operating Procedures and work instructed or work instructions respectively, to identify for example, any lessons learnt or any, any opportunities for continuous improvement as, as a, a regular and ongoing commitment.

10.11 **Conclusion:** There may be circumstances where it is appropriate for the NSWPF to accept the advice of NSWA that the attendance of police is no longer required. For example, where NSWA have requested the attendance of police solely to protect NSWA personnel. However, this cannot apply to every incident, in particular where the incident relates to a concern for the welfare of a person who cannot be located.

Amendment to the No Need to Attend protocol

10.12 In August 2020 all NSWPF Radio Operations Group staff were advised of an amendment to the NSWPF *NNTA – Dispatch Standard Operating Procedure* (**NNTA SOP**). The amendment provides that if an external agency (such as NSWA) advises that there is no need to attend, a relevant supervisor is to assess whether the incident should be closed, or whether it still requires police resources and is to remain open to be acknowledged. In practice, if the reason for cancellation is considered to be insufficient, the supervisor is to make further enquiries, and either authorise a dispatcher to close the job or to call for the attendance of an available police resources. However, these provisions are not contained within the NNTA SOP.

10.13 Sergeant Freeman gave evidence that pursuant to the NNTA SOP, if she had been a supervisor, a simple no need to attend would not constitute sufficient information to make an assessment required by the NNTA SOP to cancel an incident. Instead, Sergeant Freeman would have sought further information and, in Mr SP's case, indicated that a decision would have been made by radio operations to dispatch the job and have police attend.

10.14 In contrast, Senior Sergeant Sloane indicated that the message received from NSWA was sufficiently clear, namely that the attendance of police was not required. Having regard to the information that Ms Kennedy received from Ms Manning, Senior Sergeant Sloane would have

advised Ms Kennedy to cancel the incident. This suggests that if Senior Sergeant Sloane had conducted an assessment, the outcome would have remained the same, that is, the NSWPF would not have responded.

10.15 As to the issue of whether the NNTA SOP addresses the matters described above:

(a) The NSWPF considers that "*removal of an agency from an ICEMS should not automatically result in all other agencies removing themselves from the job. Each agency should determine their need for attendance in line with the agency's own requirements*". Relevantly, the Telephony SOP has since been amended to provide for the following:

> NOTE: when ambulance has requested police attendance but then cancels the job, they will provide full details why they are no longer attending. It is the responsibility of the dispatcher to apply NSW Police protocols to determine whether Police still need to attend.

(b) Further, the Telephony SOP now provides that where a NNTA is indicated via ICEMS or telephone from a non-NSW Police emergency resource, the operator is to add a message on to the police CAD incident and make a supervisor a recipient. The supervisor will then assess the incident and make a recommendation as to the whether the incident will be finished.

Responsibility for incidents

10.16 During her Triple Zero call, Ms NH indicated that she perhaps should have been put through to the NSWPF. Had this occurred, or if the NSWPF had been the first responder at the location, the response of the NSWPF would have been different. The NSWPF would have created a job and added NSWA to assist with a medical assessment. Sergeant Freeman gave evidence that if the NSWPF had attended the location and been unable to find Mr SP, NSWA assistance would have been called off, but the incident would not have been closed. Further, Sergeant Freeman believed that the incident would have been "*handled as a concern for welfare where the focus was to locate Mr SP and then see to his medical welfare*". Instead, as the Triple Zero call went through to NSWA, the incident was regarded more as a "*medical*" incident.

10.17 It is clear then that the response of the NSWPF to an incident such as Mr SP's should not depend on which agency a Triple Zero call goes through to. Rather, the response should be determined by the information provided during the call.

10.18 The Concern for Welfare Work Instruction will result in similar incidents being transferred to the NSWPF immediately, so as to avoid any differences in response where the NSWPF is not the first responder.

10.19 The Joint Protocol does not designate one agency or the other as being the lead agency for a particular incident. Further, it does not describe the respective roles of each agency when both are joined to the same incident. There are particular difficulties with regarding one agency as the "*leader*" or "*primary response agency*". For example, the attending agencies do not always immediately know the complete nature of an incident, each agency assumes responsibility for its own functions at law, each agency requests assistance where required and for large-scale incidents

certain relevant legislation (for example, the *State Emergency and Rescue Management Act 1989*) identifies a single lead agency in specific situations.

Concern for Welfare incidents

10.20 At 8:06pm, the NSWPF incident status was changed from ICEMS (084) to "*Concern 4 Welfare (017)*" by Ms Dangerfield.

10.21 Senior Sergeant Sloane stated that there is no official policy or procedure in relation to concern for welfare incidents, which encapsulates many possible scenarios. Whether police are required to attend such incidents is assessed on a case-by-case basis. The evidence established different views regarding the nature of the concern for welfare in Mr SP's case:

(a) Ms Manning gave evidence that she did not understand from the incident header that there was a concern for Mr SP's welfare;

(b) Ms Kennedy gave evidence that she understood that there was a concern for Mr SP's welfare, that the NSWPF were notified because of a concern for the welfare of a person who was threatening self-harm, and that the NSWPF were only attending to assist NSWA;

(c) LSC Huie gave evidence that she understood a concern for welfare to mean that there was a concern for a person's welfare and the person should be located;

(d) Ms Logozzo gave evidence that there was a concern for both the welfare of Mr SP and a concern for the paramedics, given the possibility that Mr SP might be violent.

10.22 At no stage did Paramedics Wood and Lloyd inform the NSWA Control Centre that the concern for Mr SP's welfare was no longer an issue. Rather, as no paramedic had made any assessment of Mr SP, the concern for his welfare remained. However, both Ms Kennedy and Senior Sergeant Sloane were of the view that as NSWA had advised the NSWPF that they were no longer required, the NSWPF no longer had any obligations in relation to Mr SP's welfare. In particular, Senior Sergeant Sloane gave evidence that NSWA needed to advise the NSWPF if any further concerns existed.

10.23 The Telephony SOP requires that it be made clear whose welfare a concern for welfare incident relates to, and whether the location of the person who is the subject of the concern is known. In addition, as already noted, Police Attendance Work Instruction requires that a concise reason be given for attendance. In addition, a concern for welfare incident should remain open until confirmation is received (whether from NSWA or the original informant) that the concern is no longer present.

10.24 Following the initial hearing of the inquest, an enquiry was made by the Assisting Team of both NSWA and the NSWPF as to whether further training should be provided to respective dispatchers from each agency regarding their roles in relation to concern for welfare incidents. NSWA responded with an indication that a level of face-to-face training/instruction for control centre staff regarding the new Concern for Welfare Work Instruction will be provided. As noted above, this work instruction was operationalised on 17 December 2021.

10.25 In their response, the NSWPF indicated that there are "*opportunities*" to discuss the respective role of each agency when responding to generic incidents during training, but provided no commitment to undertake the same nor suggest that such training is necessary.

10.26 Ms Walters gave evidence that training PoliceLink Command staff in relation to concern for welfare incidents, as to whose concern is being raised, is not required because in Mr SP's case there was no clear articulation from NSWA. Ms Walters went on to note:

> Training is ongoing for us, but I just wanted to clarify that the, the, the concern for welfare could come into a number of avenues and we applied the concern for welfare telephony SOP when the call comes in to triple-0. If it comes to us via ICEMS, we apply the ICEMS protocol and business rules, so that's what we would train to. So I'm not suggesting that we won't continue to educate and train our people around concern for welfare telephony and ICEMS. It's just I wanted to, to I guess clarify for you just the, the various ways that the call can come in and how we would apply those SOPs.

10.27 Ms Walters also gave the following evidence in relation to a proposed recommendation that the Telephony SOP make it clear that the Telephonist and Dispatcher ensure in all communications that the identity the person(s) of concern is listed and the need to ensure that a concern for welfare incident remains open until confirmation that the concern has abated:

> So in terms of the telephony SOP, that does talk to, including the details of the, the person of interest and, and I do. I think it's important to say as well that our SOPs are a, a, a document that we continually review and, and enhance if we need to. So there will always be opportunities for us to, to review those. But the SOP does indicate that we need to talk and we need to include details about who the concern for welfare is for.

10.28 **Conclusion:** In Mr SP's case, independent consideration should have been given by the NSWPF to whether the there was a need for police to attend, and for the incident to remain open. The information that was available on 10 July 2018 indicated that there was a concern for Mr SP's welfare, without any information being available that the concern had abated. Therefore, it could not be said that the communication from NSWA to the NSWPF obviated the need for the latter to independently assess whether the concern remained.

10.29 Having regard to the evidence given by Ms Walters it is neither necessary nor desirable to make any recommendation regarding training in relation to concern for welfare incidents, and any amendment of the Telephony SOP.

Missing Persons

10.30 The NSWPF 2013 Missing Person Standard Operating Procedures (**Missing Person SOP**) defines a missing person to be "*anyone who is reported missing to police, whose whereabouts are unknown, and there are fears for the safety or concern for welfare of that person*". The Telephony SOP provides that an incident can be identified as a missing person incident, meaning that "*a person has gone missing and there are concerns for their safety and/or wellbeing*".

10.31 However, it is evident that the NSWPF Communications officers did not consider it to be part of their role to designate an incident as a missing person incident:

(a) Ms Kennedy gave evidence that missing person reports are taken by police officers, not by a dispatcher or telephonist. Further, Ms Kennedy indicated that the Missing Person SOP only applies in relation to persons reported as missing to a police officer, and not a dispatcher. Further, Ms Kennedy considered that Mr SP had not been reported missing, and said that it was her understanding that a missing person was someone who had not been seen for an extended period of time. Therefore, Mr SP's incident was not regarded as a missing person incident.

(b) Ms Manning gave evidence that a missing person incident typically involved the attendance of police and an actual report being received about a missing person. Ms Manning indicated that she might classify a job as a missing person incident if a call maker had already made a report to police, and the person had been established as a missing person.

(c) Senior Sergeant Sloan gave evidence that a person in radio command cannot take a report of a missing person over the phone. Instead, the details of the reported missing person would be taken, and police officers would be sent to the address of the reporter, or the reporter would be asked to attend a local police station.

10.32 Neither Senior Sergeant Sloane nor Sergeant Freeman considered that Mr SP's incident should have been regarded as a missing person incident. Senior Sergeant Sloane noted that Mr SP had just left his home and had not been officially reported as missing, and therefore the incident was appropriately regarded as a concern for welfare. Similarly, Sergeant Freeman noted that information provided to the NSWPF indicated that Mr SP was "*acting strangely*", not that he was missing.

10.33 LSC Huie gave evidence that she would have treated a concern for welfare incident in the same way as a missing person incident where a person was not at the location identified. However, before regarding the person as a missing person, LSC Huie explained that greater specificity was required, such as an informant wanting a person reported and recorded as a missing person.

10.34 **Conclusion:** The evidence established that the whereabouts of a person being unknown does not automatically equate to them being a missing person. Further, no person made a report to the NSWPF that Mr SP was missing. In addition, it was noted by Ms Walters that "*[t]he Concern for Welfare incident type can be applied across a number of scenarios where both the location of the person is known and in circumstances where the location is unknown*". In this regard, it is the person who receives the request for assistance that selects the incident type. Further, in the case of a request for assistance from another agency, it is the dispatcher who selects the incident type.

11. Findings pursuant to section 81 of the *Coroners Act 2009*

11.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Elizabeth Raper SC, Senior Counsel Assisting, and her instructing solicitor, Ms Amber Doyle from the Crown Solicitor's Office. The Assisting Team has provided outstanding assistance during the conduct of the coronial investigation and throughout the course of the inquest. I am also extremely grateful for the sensitivity and empathy that they have shown throughout the course of this distressing matter.

11.2 I also thank Leading Senior Constable Ashley Huie for conducting a comprehensive investigation and compiling the initial brief of evidence.

11.3 The findings I make under section 81(1) of the Act are:

Identity

The person who died was SP.

Date of death

Mr SP died on 10 July 2018.

Place of death

Mr SP died at Blacktown NSW 2148.

Cause of death

The cause of Mr SP's death was hanging.

Manner of death

Mr SP died as a result of actions taken by him with the intention of ending his life. Mr SP's death was therefore intentionally self-inflicted.

12. Epilogue

12.1 On behalf of the Coroner's Court of New South Wales and the Assisting Team, I offer my deepest sympathies, and most sincere and respectful condolences to Mr SP's father and Ms NH, as well as Mr SP's friends and loved ones, for their most painful and devastating loss.

12.2 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
18 February 2022
Coroner's Court of New South Wales