CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of SB
Hearing dates:	16-20 October, 2023
Date of findings:	17 November, 2023
Place of findings:	Coroners Court of New South Wales
Findings of:	Magistrate DB O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW— mental health issues, police operation, siege, negotiations
File number:	2022/00075390
Representation:	Mr Jake Harris, Counsel Assisting instructed by Ms Ellyse McGee and Ms Hannah Place (Crown Solicitor's Office)
	Ms T Vakauta for SB's mother, (Legal Aid)
	Mr D Jordan for the Commissioner of Police, instructed by Stuart Robinson (Office of the General Counsel NSW Police)
	Mr A Deards Solicitor of Makinson D'Apice Lawyers for the Commissioner of Police in relation to Protective Orders

Findings:

I make the following findings in relation to the death of SB, pursuant to s 81 of the *Coroners Act 2009* (NSW):

Identity:

The person who died was SB.

Date of death:

SB died on 14 March 2022.

Place of death:

Bathurst, NSW

Cause of death:

SB died from stab wounds to the chest.

Manner of death:

Self-inflicted during a mental health episode in the context of a police siege

Non- disclosure orders and non-publication orders prohibiting publication of certain evidence pursuant to section 74(1)(b) of the Coroners Act 2009 have been made in this inquest. A copy of these orders, and corresponding orders pursuant to section 65(4) of the Act, can be found on the Registry file.

Introduction

1. SB died on 14 March 2022 at Bathurst. He was 51. On 13 March 2022, he was at a house in Bathurst, in breach of an Apprehended Domestic Violence Order ("**ADVO**") and bail conditions. Police attended the home, and SB barricaded himself in a bedroom with a knife, threatening to kill himself if police entered. Police engaged in protracted negotiations with SB over several hours. At about 3.55am on 14 March 2022, SB opened the blinds to the room, lay on the bed, and began to stab himself in the chest. Police broke into the room, discharged a Taser so as to stop SB stabbing himself and commenced first aid. SB died at the scene. The cause of death was given as "stab wounds to the chest".

Inquest

2. The inquest took place on 16-20 October 2023.

3. The inquest was a mandatory inquest pursuant to section 23 of the Coroners Act (NSW).

4. An inquest is a public examination of the circumstances of a death. It provides an opportunity to closely consider what led to the death. It is not the primary purpose of an inquest to blame or punish anyone for the death. The process of holding an inquest does not imply that anyone is guilty of wrongdoing. Despite this, there may nevertheless be factual findings which necessitate an adverse comment or criticism to be made.

5. The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the *Coroners Act 2009* (NSW) ("the Act"); namely:

    - the person's identity;
    - the date and place of the person's death; and
    - the manner and cause of death.

6. Another 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 identifying any lessons that can be learned from the death and considering whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

Coronial Investigation

7. Prior to holding the inquest, a detailed coronial investigation was undertaken. Investigating police compiled an initial brief of evidence. The brief included the statement of the officer in charge of the investigation ("**OIC**") Detective Inspector Andrew Barnes in addition to statements from police officers at the scene, statements relating to the examination of the scene, statements from some civilians including members of SB's family, statements from health professionals and medical records.

8. The following agencies and individuals were identified as having a sufficient interest in the proceedings and received notification:

    1. SB's mother
    2. New South Wales Commissioner of Police

9. All the material obtained during the coronial investigation formed part of the six-volume brief of evidence that was tendered at the commencement of the inquest. Material was also received and tendered throughout the inquest. All of that material, and the oral evidence at the inquest, has been considered in making the findings detailed below.

Witnesses

10. The following witnesses gave oral evidence in the inquest:

    1. Detective Inspector Andrew Barnes
    2. Inspector Adam Beard
    3. Sophie Matthews
    4. Dr [redacted]
    5. Police negotiators
    6. Police tactical team members

Issues considered in the Inquest

11. An issues list was circulated to the interested parties, which described the broad areas of focus for the inquest as follows:

    i. What were the nature of SB's mental health issues?

ii. Was the decision to deploy tactical police appropriate in the circumstances?

iii. Were the tactical plans adequate and appropriate?

iv. Why was information obtained from the mental health line not communicated to other negotiators and to Dr [redacted]?

v. Would that information have made any material difference to the advice given to, or actions taken by, the negotiators?

vi. Did police correctly understand the advice given by Dr [redacted]?

vii. Were the methods employed during the negotiation appropriate, in particular in the final bracket of conversation prior to SB's death?

viii. Was the execution of the [redacted] plan adequate in the circumstances?

ix. Was the death intentionally self-inflicted?

Background

12. SB's family at the time of his death were his mother and sister. His father died in the early 1990s, when SB was in his 20s. The family lived in Bathurst from when SB was 4 years old.

13. SB had a normal upbringing. He did not have any major health issues as a child. He was a smart student at school, in particular at maths.

14. After leaving school, SB obtained work in a printing firm in Bathurst, and then as a computer programmer in Sydney. After a couple of years, he returned to Bathurst, and later opened a painting and decorating business. He had not worked for several years prior to his death.

15. After SB returned to Bathurst, his father died unexpectedly.

16. In 2005, SB was charged with Centrelink fraud. He was convicted and (after a successful severity appeal) sentenced to 9 months' periodic detention and ordered to pay $10,000

reparation. In the year or so prior to his death, SB began to ruminate on this conviction, and wrote to the Attorney General and other agencies about it.

Drugs and alcohol

17. SB began consuming alcohol to excess in his 20s. This got worse after the death of his father. In about 2017, SB was diagnosed with cirrhosis of the liver. SB ceased drinking for a period , however, he continued to smoke cannabis.

Mental health

18. SB's mental health deteriorated towards the end of his life. He became more intolerant and fixated on things, including his Centrelink fraud conviction. He formed some delusional ideas about his sister and complained of police corruption.

19. SB suffered at least two significant head injuries. In 2002, he was seriously assaulted in a park in Bathurst. He was taken to hospital but discharged himself against advice. SB suffered another brain injury in March 2010. He climbed a telegraph pole for a dare, while drunk, and fell sustaining serious injuries. He spent 3 days in Westmead Hospital in a brain injury unit. A CT brain scan revealed a subdural haematoma, with associated changes, and an un-displaced skull fracture.

20. SB's mother believes his personality changed after the 2010 accident.

Contact with mental health team

21. On 17 May 2021, SB was assessed by a nurse at home. He referred to an incident involving a train, and he also made an apparently delusional reference to a missing person.

22. On 19 May 2021, SB was assessed by a psychiatrist, Dr Greg Hugh. Dr Hugh believed SB had hypomania, with a differential diagnosis of drug induced psychosis with elevated mood. He prescribed an antipsychotic, olanzapine, but SB refused to take it.

23. On 21 May 2021, SB was reviewed by at the community mental health team. SB was laughing inappropriately and declining to take medication. A schedule was completed, and SB was taken to Bloomfield Hospital, where he was admitted as an involuntary patient.

24. He remained in hospital for 2 weeks and was discharged to a friend's home on 3 June 2021. He remained delusional, with grandiose ideas. He incorporated the psychiatrist, Dr Hugh, into his delusions. He was prescribed antipsychotics, but later refused to take them. It was not thought that SB was having therapeutic benefit from the admission, so he was discharged for community follow up. SB blamed his sister for his admission to hospital.

25. Over the latter part of 2021, SB was reviewed sporadically by the community team. He appeared to present with transient delusional beliefs, when either stressed or using cannabis. However, SB declined assistance.

26. A second opinion was sought from a psychiatrist, Dr Patfield. His view was that, although SB did not need case management at that time, he may well relapse, and accordingly there was a need to be alert to any concerns raised by the family or police.

27. An incident occurred in July 2022 in which SB swore at his mother and stood over his sister, making a stabbing motion. Police were called, and SB was charged with stalk/intimidate and assault. Those charges were listed to be heard on 12 August 2022.

28. Police obtained Provisional ADVOs to protect SB's mother and sister. Those orders prevented SB from approaching either of them or from attending the family home.

29. After this, SB left the home and did not speak with his mother or sister directly for several months. In September or October 2021, he began living in the home of a friend.

30. Although SB did not see his family, he continued to write letters. He wrote to his sister on 31 August 2021 and 2 September 2021. He was arrested and charged with contravening the ADVO. Those matters were listed for hearing on 4 July 2022.

31. On 25 November 2021, SB sent emails to about 300 people, including his sister's associates and media outlets, copying the letter to Paul Toole MP, and including photos of his sister and her children sleeping. SB was again charged with contravening the ADVO, and those charges were scheduled for hearing on 12 August 2022.

32. In December 2021, SB wrote again to his siter and Paul Toole MP. He was charged with contravening the ADVO, and on 2 March 2022 he was convicted and fined $600.

33. In early March 2022, SB's mother saw SB's car parked on her street, for the first time in many months. She tried to contact him and also made contact with the community mental health team.

34. On 3 March 2022, SB had been due to attend the District Court in relation to an AVO he had tried to take out against his sister. He did not attend court.

35. Around that time SB's mother discovered where SB was living. A few days later she went to see him, and he appeared well, and she gave him some of his mail. SB told his mother he had been stabbed a few days earlier, and he showed her injuries on his torso.

36. In the evening of 9 March 2022, SB's mother arrived home to find tarot cards arranged on her table in the form of a cross, with "Death" written at the top. There was a note stating, "you are a terrible person. Your daughter won the battle, you lost a son (on your hands) I will not give [my sister] the psychological gratification of turning me into a vegetable this is only the beginning of your pain rot in hell."

37. At about 9.30pm, SB called his mother, and she went to see him. He was upset about missing the Court appearance on 3 March 2022. He threatened to harm himself. SB's mother left and called police, but they could not locate him.

38. The next day, SB's mother reported the tarot card incident to police.

39. On 11 March 2022, SB attended a friend's home. He was going to sell his car to her son. During the evening, SB became enraged when talking about his court cases, and he produced a large knife. He wanted to stay at the friend's house, but she declined.

40. During the day on 12 March 2022, SB attended the home where he had been staying and left a note and a USB containing legal and medical documents. In the note, he asked his friend to arrange for another friend to pay for a motel room.

41. On the same day, A/Sgt Darren Carter of Bathurst police reviewed the reports about SB's threats of self-harm and possible breach of an ADVO. He attended various houses but SB was not located.

13 and 14 March 2022

42. During the morning of 13 March 2022, SB attended his mother's house. He told his mother he was sorry for what he had been doing to his sister and promised he would not do it again. His mother felt happy about this. She then left, returning about 2.45pm. At that point, SB was watching TV.

43. At about 3.30pm, A/Sgt Carter and colleagues decided to look for SB at his mother's house.

44. At 4.15pm, A/Sgt Carter attended SB's mother's house, in company with Leading Senior Constable (LSC) Ward, Constable Radice and Probationary Constable Green.

45. LSC Ward asked SB's mother if SB was home, and she said, "no, is he in big trouble?" When police asked to come inside, she admitted SB was in the house, that he had a big knife and that he had told her if she let the police in, he would kill himself. She asked police to "just go and let me handle this myself".

46. A/Sgt Carter asked SB's mother to leave the house, which she did. She also gave police a key to the back bedroom, where SB was located. She went to her neighbour's house and remained on the street with SB's sister until about 2.15am the following morning.

47. A/Sgt Carter asked for other units to attend, and at 4.27pm spoke with Inspector Adam Beard, the duty officer. Inspector Beard noted that the incident was high risk, and police should set up a perimeter and not enter the home. He then made his way to the scene and assumed the role of Police Forward Commander, in overall command of the operation.

48. Police did not enter the home, but instead took up positions around the outside. They obtained protective equipment, including helmets and shields.

49. A/Sgt Carter tried to call SB by phone, and then approached the rear of the property and spoke with SB via a window. SB was inside the bedroom, with the wooden venetian blinds closed. He expressed anger at his family, in particular his sister. He produced a knife and said if police entered, he would put the knife through his heart. He said he was concerned he would be taken back to Bloomfield Hospital.

50. Inspector Beard made arrangements for more police to attend, including police negotiators and tactical police. Inspector Beard also went to the rear of the house to have a discussion with SB.

51. Formally, the incident was identified as a “high risk incident” in that there was a risk of injury to SB himself, or others, including police.

52. At inquest there was an issue as to whether SB threatened police at any stage. There is an entry in the police CAD system that SB threatened to harm police. The information was said to have come from car 15. Outside of that entry, which was picked up in some later broadcasts of information, there is nothing to suggest that SB issued any threat to police at any stage.

53. In particular the negotiators, who spoke to SB for several hours, made no mention of any threats to any other person. During their dealings with him, SB regularly referred to self-harm but did not threaten to harm anyone else.

54. That is not to say there was no risk to police. They were dealing with a very un-well person who was armed with a knife. The situation was appropriately deemed to be a ‘high risk incident’.

55. In such incidents, police operate under a very clear hierarchy. Inspector Beard was the Forward Commander, and he was integral to all operational decisions at the scene. He worked closely with the negotiation team leader and tactical operations unit team leader. Where it was necessary, he sought approval from police officers, not at the scene, who were higher up the police chain of command.

Attendance of negotiators

56. The primary negotiator arrived at about 6:00pm. He had 14 years’ experience as a negotiator.

57. On arrival, he received a briefing from Inspector Beard and SC Gava. He then had a short conversation with SB’s mother. This appears to have been the only time after the arrival of negotiators that SB’s mother was spoken to, although she had spoken to other police earlier. SB’s mother confirmed that there was no-one else in the house and that there were no firearms. She described the knife and the threats SB had made to kill himself. She said SB had been in a mental health unit the year before.

58. The primary negotiator discussed a plan with the other police. At about 6.25pm, he went to the rear of the house to take over the negotiations. SB in fact recognised him, from a

previous interaction. After a short while SB said, “we’ll talk again in two hours”, saying he wanted to have a rest.

59. Other negotiators then arrived. A secondary negotiator arrived at about 6.30pm. His role was to provide assistance and to keep a log. The negotiation team leader arrived at about 8pm. His role was to coordinate the team and communicate with tactical police. A fourth negotiator arrived at about 11.45pm. He made some enquiries at the scene. The negotiation co-ordinator also provided assistance by phone, including by making enquiries on police systems.

Attendance of tactical police

60. Following Inspector Beard’s request for tactical police to attend, permission was given for Tactical Operations Regional Support ("**TORS**”) to attend the incident from their commands. Six officers attended.

61. At about 8:00pm, the region commander, Assistant Commissioner Greentree, gave permission for the use of special weapons and tactics.

62. Operator 111, a Tactical Commander from the Tactical Operations Unit (“**TOU**”) at Sydney, was monitoring the incident. He sought permission for the TOU to attend, which was approved. He then made his way to the incident, together with six TOU operatives. They arrived at about 11.30pm.

63. After the arrival of TOU officers, two units were formed. “A” unit (comprising TOU officers) initially took up a position outside the rear of the house, by the rear sliding doors. “B” unit (comprising Operator 187 and the TORS operatives) took up a position to the left side of the house. Other police units were at the front.

64. Operator 111, acting as Tactical Commander, remained at the command post with the Forward Commander, Inspector Beard and the negotiation team leader.

65. The TOU officers had some special equipment with them. A tactical police dog handler also attended, although the dog was never deployed during the incident.

66. At inquest it was made clear by SB’s family that they had been surprised by the size of the police presence and the need, for example, for the road to be blocked off. After hearing

the evidence, the family indicated that they had had come to a better understanding of the role played by the various police officers who were present at the scene.

The course of the negotiations

67. At about 7:00pm the primary negotiator had taken up a position at the rear window. He could see into the room, through gaps in the blinds, and could see SB's knife. He saw that SB had begun to barricade the door.

68. At about 8:00pm, the negotiation team leader asked police to obtain information from Bathurst Hospital. At 8.24pm, A/Sgt Carter made contact with Sophie Matthews, a worker from the mental health line in Orange.

69. Ms Matthews provided some details about SB's interaction with the mental health services including an admission to hospital the previous year and noted that his engagement was sporadic, and he mistrusted mental health staff. According to her note, she advised that no-one from the mental health team was able to attend the scene, as it was after hours, but would be available by video link if needed.

70. The secondary negotiator was present and heard at least part of this conversation, as well as a summary from A/Sgt Carter. There is no dispute that the information provided by Ms Matthews was not passed on to Inspector Beard, despite the second negotiator indicating that he asked A/Sgt Carter to pass the information on. This also means that the information was not relayed to the psychiatrist, Dr [redacted], who later provided advice to police.

71. The negotiations with SB were protracted. SB would engage and then disengage and turn up his radio. Communication was difficult, due to the negotiators being outside the house and the window of the room SB was in, being shut. The negotiators swapped roles at times, with the secondary negotiator taking over for a period from about 9.40pm and the fourth negotiator also commencing a period at about 1.50am.

72. During negotiations the conversation with SB revolved around similar themes. SB stated he was going to stab himself if police entered. He knew there would be an inquest. He said he had supplies and a makeshift toilet and was willing to remain inside for a long period. He talked about conspiracy theories, corruption and his delusion regarding his sister. He demanded his sister be charged. He wanted to speak to senior officers, and to his friend Jim Warry. He was worried about being re-admitted to Bloomfield Hospital.

73. A surrender plan was communicated to SB on multiple occasions, for him to come out through the rear door, with hands in the air with no weapons, and to follow instructions. It was promised that police would investigate all the issues SB wanted investigated. At one stage, SB suggested the negotiators should come into the house to speak to him through the door to his room.

74. At about 11.37pm, a decision was made to move the negotiators closer to SB, outside the bedroom door, as SB had suggested. Appropriate approval was sought from the Regional Commander and approval was granted at 11.43pm.

75. At about 12.01am on 14 March 2022, "A" unit entered the premises and moved to a position outside SB's door. They were able to confirm that SB had barricaded the door.

76. At 12.28am, negotiators moved to that position, and negotiations resumed.

Consultation with Dr [redacted]

77. At 2.28am on 14 March 2022, the primary negotiator and team leader made phone contact with Dr [redacted]. Dr [redacted] is a forensic psychiatrist who was available to assist police.

78. Dr [redacted] was informed about the circumstances and the known background. He was not provided with any medical notes, or the information obtained from Orange mental health line.

79. Dr [redacted] considered SB 's most likely psychiatric diagnosis was [redacted].

80. Dr [redacted] recommended that police [redacted].

81. Dr [redacted] said he was available to advise further if there were any changes in presentation or information.

Third party intermediaries

82. At several points in the evening, negotiators discussed the possibility of involving a third party in the negotiations.

83. Two possible options were considered. One was SB's friend, Jim Warry, whom SB had asked to attend. The fourth negotiator spoke to Mr Warry, but formed the view that Mr Warry was somewhat confused and erratic, and did not have a close relationship with SB. Consideration was also given to involving SB's mother as a third party, but that was also ruled out.

84. Dr [redacted].

85. Additionally, there was clear evidence at inquest that involving third parties involves complex considerations including whether the third-party can fit in with the plan that has been developed by police as informed by any expert psychiatric advice.

Circumstances of SB's Death

86. After talking with Dr [redacted], the primary negotiator resumed talking with SB at 3.26am There was no obvious change in SB's presentation in the period prior to his death. He was no more elevated than he had been at other times that evening. The primary negotiator had been continuing to engage SB, and SB was freely conversing with him. The primary negotiator was of the view that progress was being made. The events that transpired were therefore a shock.

87. In the final bracket of conversation, SB talked about his legal issues. The primary negotiator told SB he had a "strong sense of social justice" and said, "we need people like [you] to stand up … and make your voice heard".

88. SB reportedly said he was going to "make a martyr of himself …". He had made similar comments before. At about 3.40am, SB said words to the effect of, "it's too late now, you guys have done this to me, corruption … you're taking me to the morgue". Shortly after, he stopped talking.

89. Police could hear furniture being moved around, which they believed may have been SB removing the barricades and were hopeful he may come out of the room.

90. At about 3.55am, SB drew the blinds to his bedroom window. They had been closed for the last 4 hours. The "B" unit approached the window. Two tactical officers, TR1 and TR2 ascended ladders, to see what was happening. They both saw SB lying down on his back with his arms raised in the air. TR1 gave evidence that SB as was on the ground/ floor, however TR2's evidence was that SB was on the bed in the room. They both believed SB may have been surrendering.

91. SB then commenced stabbing himself in the chest.

92. "B" unit communicated what they had seen and the [redacted].

93. "A" unit forced entry via the bedroom door, whilst "B" unit smashed the bedroom window.

94. On entry into the room, the "A" unit officers saw that SB had a knife in his chest, with his hands still on the knife and he was attempting to stab himself repeatedly. Operator 217 was one of the "A" unit officers who entered the room and described seeing SB lying on the bed.

95. Operator 217 determined it was necessary to discharge a Taser prevent SB from further harming himself. The Taser struck SB and caused him to release the knife.

96. SB was then moved to the hall and first aid was commenced.

97. Paramedics, who had been present at the scene for some hours were called from their location and attended to SB.

98. Tragically, at 4.09am, SB was declared deceased.

99. The evidence established that each officer knew their role once the plan was put into action. Each officer was assigned a role and knew from training and experience what they were to do. There is no evidence that any officer did anything wrong or inappropriate during the execution of the plan.

100. At inquest, SB's mother raised concern that one police officer indicated SB was lying on the floor and others indicated he was lying on a bed. I have closely considered exhibit 4 which is a photo of the room SB was in during the entire negotiations right up until the time of his death. The photo shows a bed which is very low set. It appears to be one mattress (or perhaps more very thin mattresses) either resting on the floor or, if they are on legs or a base, the legs or base do not extend far from the ground. Additionally, the police officer who described SB as being on the floor was looking down from an elevated position on a ladder, and the room was in darkness at that point. In those circumstances I do not have any concern arising from the varying descriptions and conclude it is most likely, as recalled by TR2 and Operator 217 that SB was on the bed at the relevant time.

Autopsy

101. An autopsy by way of external examination and CT scan, was performed on 18 March 2022 by Dr Allan Carla at Newcastle. Dr Carla determined the cause of death to be "stab wounds to the chest." Multiple recent penetrating chest wounds were observed. There was also evidence of healing superficial penetrating wounds to the chest and abdomen.

102. Toxicology showed no alcohol, and low levels of cannabis and propranolol (a medication which slows the heart rate).

Resolution of the identified issues and whether any recommendations should be made

103. In relation to SB's mental illness, as indicated above there was a diagnosis of SB in 2021 and a preliminary analysis by Dr [redacted] based on what he was told over the phone during negotiations in March 2022.

104. The 2021 diagnosis was of hypomania with a differential diagnosis of drug induced psychosis. Dr [redacted] was of the view SB suffered from [redacted].

105. I am satisfied that as at 13 and 14 March 2022 SB was suffering from psychosis and paranoia.

106. In relation to the police and their tactics, I am satisfied that both the engagement of tactical police and the plans developed by the police were appropriate in the circumstances of this “high risk incident”.

107. In addition, the evidence indicates that all steps were taken with appropriate approval after careful consideration

108. Before dealing with the remaining issues, I will deal with a separate mater raised by Counsel for the Commissioner of Police.

109. Counsel submitted that the terminology ‘missed opportunity’ was suggestive that some outcome which could have been achieved was not achieved because of what was not done. Counsel developed the submission by suggesting that more appropriate terminology would be ‘room for improvement’. Whilst I understand the point made and can see some content within the various components of the submission, I am of the view that ‘missed opportunity’ is such a commonly used expression in the jurisdiction that it is preferable to continue to use the expression and to make clear, where appropriate, whether it is thought that a different outcome would have been achieved if a different approach was taken.

110. In relation to the failure to pass on the information provided by Ms Matthews to the negotiation team or Dr [redacted], there is no evidence to indicate that this missed opportunity would have made any difference to the ultimate outcome. The primary purpose of the information was to assist in assessing SB. As it turned out Dr [redacted] assessment of SB was relevantly similar to the diagnosis made during 2021 and in my view accurate. Additionally, it was clear on the evidence that the primary negotiator identified that SB was psychotic, and the secondary negotiator identified aspects of paranoia.

111. Somewhat ironically, there was only a short period of negotiation following the engagement of Dr [redacted] prior to SB taking his own life. Negotiators had been involved with SB from 6:00pm on 13 March until 3:30 am on 14 March prior to Dr [redacted] advice being put into effect by the primary negotiator.

112. There is no suggestion at all that Dr [redacted] advice was inappropriate or wrong in any way. Rather the advice tended to confirm that the negotiators had been on the right track and negotiating appropriately in the preceding period. It is relevant to note that the primary negotiator was very experienced, and that it was obvious throughout his evidence at inquest how dedicated he was, how significant his expertise are and how focused he was

upon achieving an outcome which involved, as a priority, SB being alive. There is no evidence to suggest that the failure to pass on the information from Ms Matthews in any way detracted from the work done by the negotiators.

113. The one question that did arise from the advice of Dr [redacted] was why it took so long to seek advice from him. The evidence indicated that whether to engage expert psychiatric advice is always a judgement call based upon the circumstances. Often negotiators can resolve situations without having to contact the on-call psychiatrist. On the evidence, there is no basis to criticise the timing of the call to Dr [redacted]

114. The failure to pass on the information did reveal an opportunity for improvement in ensuring all information in a high-risk incident is shared appropriately. In high-risk incidents there are a number of officers gathering information from a number of sources, and a number of decisions to be made.

115. In the incident involving SB the primary means of communication was through radio. The evidence revealed that iPads containing an iSurv App have been provided to all negotiators and all TOU members in NSW. In addition, the iPads are being gradually rolled out to be available to the regional TORS members. [redacted]

116. In relation to the issue as to whether police correctly understood the advice provided by Dr [redacted], I am satisfied they did. There were some differences within the brief of evidence between the language of Dr [redacted] and the language of police. Dr [redacted] I am satisfied that police did understand the advice provided by Dr [redacted].

117. Overall, I am well satisfied that the negotiation methods were appropriate including in the final bracket of conversation with SB.

118. The final issue on the issues list relates to the question as to whether SB's death was intentionally self-inflicted. On the evidence it is clearly the case that it was.

119. Some ancillary issues arose during the inquest, and I will now address those.

120. SB's mother and sister were, and remain, distressed that they were unable to communicate at all with SB from the time police became involved. Not only did they have no opportunity to try to talk SB into surrendering, but they also had no opportunity to talk to SB before his passing. This is understandably incredibly painful for SB's mother and sister

121. In my view no criticism can be levelled at the police for not allowing SB's mother and sister to communicate directly with him in circumstances where there were ADVOs in place prohibiting such contact.

122. SB's mother's concern, however, went further and related to the fact that the ADVO prohibiting her from talking to SB from on or about 12 July 2021. From her point of view, as SB's mother she had dealt with his mental health issues over many years. She had no concerns for her own safety and yet the ADVO remained in place. SB's mother was unaware of how she could seek to have the order rescinded or varied. SB's circumstance is a stark reminder of the difficulties confronted by police and judicial officers in the complex area of domestic violence orders.

123. It is worth noting that all who work in the field of domestic violence should make sure so far as practicably possible that the protected persons have a thorough understanding of their rights in relation to orders. This ensures that, if a protected person seeks a variation to existing orders, they can pursue an application and that application can be considered on its merits by a judicial officer.

124. Whilst I accept the decision of the police not to involve SB's family members as third-party intermediaries, police should have made more substantial efforts to have SB's mother and sister provide them with information about SB.

125. Police negotiators, including their commander, gave evidence that the more information they have on the person they are negotiating with, the better. Further, in evidence it was accepted that no-one knows the person being negotiated with, better than

their family. In that context, the failure to talk more to SB's mother and to talk at all with SB's sister was a missed opportunity.

126. SB's family expressed concern at inquest that the negotiators did not know of SB's allegation that he had been attacked in the period leading up to the 13th of March. SB told his mother of this and showed her some injuries. The matter, whilst known to SB's mother was never formally reported to police by SB and even after consideration during the investigation phase police were unable to establish that an assault had occurred. The other possibility was that SB had self-harmed and police were aware during negotiations of SB's regular threats to self-harm.

127. Whilst the police missed the opportunity to get further information from the family of SB, including for example SB's report to his mother, of the assault referred to immediately above, it is not possible to say that if that opportunity were taken any different outcome would have been achieved.

128. The evidence revealed that police have taken steps to address the broad issue as to how they liaise with families during, and in relation to negotiations during incidents in which negotiators are involved. [redacted]

129. In relation to SB's request that Jim Warry attend the scene with various items, it is clear police made appropriate enquiries of Mr Warry and made a determination that it would not be appropriate to have him attend and be involved in the negotiations. There is no evidence to suggest that this decision was wrong. However, it was acknowledged in the evidence that consideration could have been given to asking Mr Warry for the documents which SB had indicated were in his possession.

130. Once again, it's uncertain where any enquiry about this would have led. It's not known what Mr Warry's response would have been and, as was pointed out, there may have been some difficulty in providing any document to SB given his reluctance to leave the room. Nevertheless, police accepted that it is an area that could have been pursued and is

another learning towards potential improvement. It is an issue which, at least to some extent, will be addressed by the provision of iPads facilitating fuller communication.

131. The final issue I want to comment upon is the issue of police having to deal with people suffering mental illness. As can be readily acknowledged, people in poor mental health can be a threat to themselves and or others. Police are required to be first responders and face the very difficult issue of dealing with mentally ill persons.

132. A/Sgt Carter had some training in relation to dealing with people suffering mental health issues at the police academy (more than 10 years prior) and had done a 4-day course in 2021. He considered the training helped him in some regards in dealing with SB. In particular, he had learnt to slow everything down and keep it as calm as possible.

133. In the circumstances with which he was confronted A/Sgt Carter did an admirable job and showed himself to be a caring and dedicated officer.

134. The evidence was that the negotiators had far more extensive training as part of the negotiators course, including lectures from Dr [redacted] and other psychiatrists and they also had refresher training in this area.

135. It is well known that police continue to grapple with this difficult issue. Currently there is a PACER trial in parts of NSW. The acronym stands for Police, Ambulance, Clinician, Early Response. The basic principle is that police are assisted by medical clinicians in responding to incidents involving someone suffering from mental health conditions.

136. This inquest did not examine PACER, but rather SB's family want their tragedy to shine a light on the pressing need for Government to address this issue as comprehensively and as quickly as possible.

137. It emerges from the above discussion that there is no need for any recommendations to be made. The overall approach of the police was commendable and the areas in which there was a missed opportunity or room for improvement either have already been, or are in the process of, being addressed.

138. Having considered all the evidence, the findings I make under section 81(1) of the Coroners Act 2009 (NSW) are:

Identity

The person who died was SB

Date of death

SB died on 14 March 2022.

Place of death

Bathurst, NSW

Cause of death

Stab wounds to the chest

Manner of death

SB's death was self-inflicted during a mental health episode in the context of a police siege.

Conclusion

139. On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the family, extended family, friends, and associates of SB.

140. I thank the OIC for his work in investigating the matter and preparing the brief of evidence.

141. I thank the assisting team for their invaluable assistance.

142. I thank the other parties and their representatives for the diligent, efficient and respectful way in which the inquest was conducted.

143. I close this inquest.

Magistrate DB O'Neil

Deputy State Coroner

Coroner's Court of New South Wales

17 November 2023