CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Anzac Sullivan
Hearing dates:	14 December 2022 at Broken Hill
Date of Findings:	10 February 2023
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – cause and manner of death, underlying cardiac pathology, methamphetamine use, conduct of police officers, execution of arrest warrant
File number:	2021/00077932
Representation:	Ms L Coleman, Counsel Assisting, instructed by Ms A Jez (Crown Solicitor's Office) Mr S Lawrence for the family of Mr Sullivan, instructed by Hearn Legal Ms A Spies for the New South Wales Commissioner of Police, instructed by the New South Wales Police Force Office of General Counsel

Findings:

Anzac Sullivan died on 18 March 2021 at Broken Hill Base Hospital, Broken Hill NSW 2880.

The cause of Mr Sullivan's death was the combined effects of coronary atherosclerosis and cardiomegaly, with methylamphetamine use being a significant condition contributing to the death but not relating to the disease causing it. Mr Sullivan's underlying cardiac pathology independently and in combination increased his risk for developing a fatal cardiac arrhythmia, with recent methylamphetamine use also increasing this risk and lowering the threshold for the development of a fatal cardiac arrhythmia.

Mr Sullivan died of natural causes after fleeing from police who were attempting to execute a warrant for his arrest in relation to an alleged breach of his bail conditions. There is no clear evidence that Mr Sullivan's flight, or any physiological consequence of it, caused or contributed to his death.

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1. Introduction

1.1 Anzac Sullivan was a 38 year old Barkandji man from Broken Hill. On the morning of 18 March 2021, Mr Sullivan was seen by police officers outside a property in Broken Hill. At that time, there was an outstanding warrant for Mr Sullivan's arrest in relation to an alleged breach of his bail conditions. The police officers approached Mr Sullivan with the intention of executing the warrant. However, Mr Sullivan fled and was briefly pursued by the police officers.

1.2 After losing sight of Mr Sullivan, the police officers conducted a search of the surrounding area in their police vehicles and by foot. Whilst this occurred, Mr Sullivan approached a residential property and knocked on the door. When the door was opened, Mr Sullivan was found to be lying on the ground and he became unresponsive a short time later. Police officers subsequently arrived at the scene and attempted to resuscitate Mr Sullivan. An ambulance was called and Mr Sullivan was conveyed to hospital. Despite continued resuscitation efforts, Mr Sullivan could not be revived and was tragically pronounced deceased.

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 are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 Following Mr Sullivan's death, a New South Wales Police Force (**NSWPF**) Critical Incident was declared. This is because Mr Sullivan's death occurred shortly after police officers, in execution of their duties, were attempting to execute the outstanding warrant for Mr Sullivan's arrest. Mr Sullivan's death was investigated by an independent Senior Critical Incident Investigator, Detective Inspector Paul Quigg, and a team of investigators.

2.3 As information from the critical incident investigation emerged and was provided to Mr Sullivan's family, a number of questions arose regarding the circumstances leading up to and surrounding Mr Sullivan's death. The coronial investigation which followed sought to address and answer these questions, to the extent allowed, and provided for, by the Act. An inquest was ultimately held so that the relevant evidence gathered during the coronial investigation could be presented and examined in a transparent and independent manner.

2.4 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.

2.5 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.

3. Mr Sullivan's personal background

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. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Mr Sullivan was born to Cheryl Sullivan and Brian Williams. He was the oldest of three children, and has four older half siblings from his mother's earlier relationship. Mr Sullivan grew up in Wilcannia. Sadly, Mr Sullivan was exposed to violence and alcohol abuse within his extended family and wider community as a child. He had previously been removed from his parents' care and placed in foster care.

3.3 Whilst growing up in Wilcannia, Mr Sullivan met his long-term partner, Cissy Dutton. During the course of their relationship, they had four children together.

3.4 Regrettably, little else is known about Mr Sullivan's personal background. However, many family members, friends and other persons within Mr Sullivan's community expressed their support for Mr Sullivan both prior to, and on the day of, the inquest. There is therefore no doubt that Mr Sullivan's loss is still deeply felt by those who love and miss him the most. There is also no doubt that there is much healing that has occurred, and still needs to occur, in relation to Mrs Sullivan's untimely and tragic loss.

4. Background to the events of 18 March 2021

4.1 On 26 August 2020, Mr Sullivan was arrested and charged with a number of offences relating to alleged incidents on 23 and 26 August 2020. After being refused bail at Broken Hill police station, Mr Sullivan was brought before the Local Court at Broken Hill where he was refused bail.

4.2 On 23 November 2020, Mr Sullivan applied for, and was granted, bail in the Supreme Court. Relevantly, one of the bail conditions imposed included that Mr Sullivan not be absent from his sister's home, where he was to reside, between the hours of 8:30pm and 6:30am unless in the company of his sister. Another condition required Mr Sullivan to report daily to Broken Hill police station between 8:00am and 8:00pm.

Previous alleged breaches of bail

4.3 At 11:45pm on 4 December 2020, police officers conducted a bail compliance check at the home of Mr Sullivan's sister. Mr Sullivan was not home and allegedly found to be in breach of his curfew

condition. On 5 December 2020, when Mr Sullivan attended Broken Hill police station to report on bail, a Field Court Attendance Notice (**CAN**) was issued for this alleged breach.

4.4 At 10:50pm on 18 December 2020, Mr Sullivan was allegedly found in the company of two male persons at a public location in Broken Hill. He was arrested for allegedly breaching a condition of his bail. Mr Sullivan later appeared at Dubbo Local Court on 19 December 2020 where his bail was revoked.

4.5 On 21 December 2020, Mr Sullivan appeared before Broken Hill Local Court and was granted conditional bail. The bail conditions imposed were the same as those imposed on 23 November 2020.

4.6 At 11:30pm on 14 February 2021, Mr Sullivan was allegedly seen by police officers at another public location in Broken Hill. The police officers attempted to approach Mr Sullivan regarding the alleged breach of his bail conditions but he ran from them. When Mr Sullivan reported to Broken Hill police station on 16 February 221, a further Field CAN was issued.

4.7 On 26 February 2021, Mr Sullivan allegedly failed to report to Broken Hill police station in accordance with his bail conditions. This failure allegedly continued until 9 March 2021 when police officers saw Mr Sullivan walking along a street in Broken Hill. Following a short foot pursuit, Mr Sullivan was arrested.

4.8 Later that same day, Mr Sullivan was brought before Broken Hill Local Court. His bail conditions were continued but varied to require that Mr Sullivan not leave his sister's home, unless in her presence and only for the purpose of attending Court, reporting bail or a medical emergency. Mr Sullivan was released from police custody at 5:00pm.

4.9 At 10:00pm later that evening, police officers attended the home of Mr Sullivan's sister to conduct a bail compliance check. Mr Sullivan was allegedly found not to be present. His sister told attending police officers that she had not seen Mr Sullivan since his arrest and was unaware that he had been granted bail.

Issuing of arrest warrant

4.10 On 10 March 2021, police officers reviewed the alleged breach of Mr Sullivan's bail conditions. An application for a warrant for Mr Sullivan's arrest was submitted to Broken Hill Local Court. The Local Court Registrar considered the application and subsequently issued a warrant for Mr Sullivan's arrest for allegedly failing to comply with a bail condition.

4.11 It is not clear where Mr Sullivan stayed between 9 and 17 March 2021. Ms Dutton later told police officers that after Mr Sullivan was released from custody, they stayed together at a duplex at 5/63 Silver Street in Broken Hill. This residence is rented by persons known to Ms Dutton. However, one of the occupants subsequently told police that she only saw Mr Sullivan for the first time in about a week on 17 March 2021.

4.12 At around 5:30pm or 6:00pm on 17 March 2021, Mr Sullivan and Ms Dutton left 5/63 Silver Street looking to purchase ice (methylamphetamine). According to Ms Dutton, she and Mr Sullivan later

shared a quantity of ice equally between them at an empty house. Mr Sullivan may also have consumed methylamphetamine with other persons during the course of the evening. Mr Sullivan and Ms Dutton reportedly stayed up the entire night, walking around the streets of Broken Hill.

5. What happened on 18 March 2021?

5.1 Shortly before 6:50am on 18 March 2021, Mr Sullivan and Ms Dutton arrived at the premises of Outback Ooba, a rideshare service, at 119-121 Chloride Street, Broken Hill. Senior Constable Joshua Weathersbee was driving to work at Broken Hill police station at the time when he saw Mr Sullivan and Ms Dutton sitting outside Outback Ooba. Senior Constable Weathersbee believed that Mr Sullivan may have been the subject of an outstanding arrest warrant and later confirmed this once he arrived at the police station.

5.2 An Outback Ooba subcontractor arrived at the premises a short time later and met Mr Sullivan and Ms Dutton who asked to be driven to Silver Street. Mr Sullivan and Ms Dutton departed at around 6:49am and stopped at a deli about two minutes later to purchase some items along the way.

5.3 Mr Sullivan and Ms Dutton soon arrived at Silver Street. After exiting the rideshare vehicle, they were seen to enter a property at 93 Silver Street. According to Ms Dutton, after arriving at the property, she and Mr Sullivan consumed the items purchased from the deli. They later sat outside the property.

5.4 Meanwhile, after Senior Constable Weathersbee confirmed that there was indeed an outstanding warrant for Mr Sullivan's arrest, two separate police crews departed Broken Hill police station to execute the warrant:

(a) Sergeant (as he then was) David Gallagher and Senior Constable Weathersbee in an unmarked police vehicle; and

(b) Senior Constable Michael Greenwood, Probationary Constable (as he then was) Hamish McCrindell and Probationary Constable (as she then was) Lorelle Smith in a marked police vehicle.

5.5 Sergeant Gallagher and Senior Constable Weathersbee drove to Outback Ooba and were informed that Mr Sullivan and Ms Dutton had been dropped off at a house on Silver Street opposite Jubilee Oval. Sergeant Gallagher suspected the location to be 93 Silver Street and made a radio broadcast to this effect.

Arrival of police officers at 93 Silver Street

5.6 Senior Constable Greenwood, Probationary Constable McCrindell and Probationary Constable Smith were looking for Mr Sullivan when they heard the radio broadcast. They drove to 93 Silver Street and found Mr Sullivan and Ms Dutton standing outside of the house. Probationary Constables McCrindell and Smith got out of the car and approached Mr Sullivan and Ms Dutton, whilst Senior Constable Greenwood remained in the police vehicle. Probationary Constable McCrindell approached, said, "*Anzac*", saw Mr Sullivan look at him, and then said, "*Come here*".

5.7 Mr Sullivan did not respond and instead ran around the left side of the property, jumped over a fence into Boron Street and ran towards Beryl Street. Probationary constables McCrindell and Smith followed Mr Sullivan along the side of the house, but decided not to similarly jump over the fence as it was uncapped and consisted of exposed iron.

5.8 Probationary Constables McCrindell and Smith instead returned to the police vehicle. Senior Constable Greenwood made a radio broadcast indicating that they had lost sight of Mr Sullivan, before driving into Boron Street. Sergeant Gallagher and Senior Constable Weathersbee met Senior Constable Greenwood, and Probationary Constables McCrindell and Smith in Boron Street. The police officers searched nearby yards without success before returning to their respective vehicles and driving into Beryl Street.

5.9 Meanwhile, Ms Dutton walked towards some units at 63 Silver Street and saw Mr Sullivan hiding in a vacant block. Ms Dutton did not speak to Mr Sullivan who subsequently ran towards a residence on the corner of Silver and Beryl Streets. Ms Dutton saw Mr Sullivan knock on the front door before running away and falling over in the street. Ms Dutton asked if Mr Sullivan was alright but he did not respond. Instead, Mr Sullivan got up and kept running towards 63 Silver Street.

5.10 Sergeant Gallagher and Senior Constable Weathersbee saw Ms Dutton walking along Beryl Street. They pulled up beside her and asked about Mr Sullivan's whereabouts. According to police, Ms Dutton said words to the effect of, "*He's be [sic] long gone, he'll be up there somewhere*", pointing towards Beryl Street and away from Silver Street. Sergeant Gallagher and Senior Constable Weathersbee then drove in that direction.

Events at 5/63 Silver Street

5.11 Douglas Jones was staying at 5/63 Silver Street on 18 March 2021. Sometime after 6:00am, Mr Jones was sleeping near the front door when he heard the sounds of a person knocking on the front door and groaning. After hearing the groaning for an uncertain amount of time, Mr Jones opened the front door and saw Mr Sullivan, who was known to him. Mr Jones described what he saw in this way:

> I saw Anzac. Anzac's right leg was twisted back like he was lying on top of it. His head was on the pot plant near the left of the door (as you face out of the door) and his legs were facing away from the door.

5.12 Mr Jones asked Mr Sullivan what happened but he did not respond. Mr Jones saw that Mr Sullivan's eyes were open and that he was trying to help himself up. Mr Jones reached out to grab Mr Sullivan's forearm but noticed that Mr Sullivan had stopped breathing. Mr Jones called out to Mr Sullivan without any response and formed the view that Mr Sullivan had died.

5.13 Mr Jones went inside to wake up his niece, Tameaka Jones, and told her that he had found Mr Sullivan at the door. Ms Jones looked through the open door and saw Mr Sullivan "*pretty much just laying on the pot plants at the door*".

5.14 Meanwhile, Senior Constable Greenwood, and Probationary Constables McCrindell and Smith drove along Beryl Street and back into Silver Street, where they saw Ms Dutton walking towards 63 Silver

Street. After parking their vehicle and walking through the set of units, the police officers saw Ms Dutton at the rear entrance of 5/63 Silver Street. Ms Dutton was heard to yell out words to the effect of, "*Anzac, the cops are here*" or "*the police are here*". Probationary Constables McCrindell and Smith went to the front of the unit in case Mr Sullivan exited via the front door.

5.15 Upon approaching the front door Probationary Constables McCrindell and Smith saw Mr Sullivan slumped against the front door, unresponsive. Probationary Constable McCrindell described what he saw in this way:

> When I found [Mr Sullivan] he was slumped against the door in a very awkward position that appeared unnatural to me. He was collapsed on his knees, his back twisted and his back up against the wall with his mouth and eyes open, um, staring, not blinking, and he wasn't breathing.

5.16 Probationary Constable Smith described her observations as follows:

> [Mr Sullivan] was laying there with his arms out, eyes open, mouth was open, arm, one leg out flat, the other leg was spent behind, like, bent, foot tucked in behind.

Resuscitation efforts

5.17 Probationary Constable Smith used her radio to call for an ambulance whilst Probationary Constable McCrindell ran back to seek the assistance of Senior Constable Greenwood. Probationary Constable Smith moved Mr Sullivan into a flat position and commenced cardiopulmonary resuscitation (**CPR**). Once Senior Constable Greenwood and Probationary Constable McCrindell arrived they assisted with the resuscitation efforts until the arrival of New South Wales Ambulance (**NSWA**) paramedics.

5.18 Sergeant Gallagher and Senior Constable Weathersbee heard the radio broadcast for an ambulance and proceeded to 63 Silver Street. A second broadcast was made requesting an automated external defibrillator (**AED**) which was obtained by another police officer and brought to the scene. Probationary Constable McCrindell applied the defibrillator pads and two shocks were administered to Mr Sullivan before NSWA paramedics arrived.

5.19 NSWA paramedics and intensive care paramedics arrived at the scene at 7:30am. They found the police officers at the scene to be performing chest compressions and operating the AED. Whilst the police officers continued to perform chest compressions, the attending NSWA paramedics delivered a shock from the AED and administered adrenaline intravenously. A return of spontaneous circulation was achieved at 7:42am and Mr Sullivan was placed onto a stretcher to be taken to Broken Hill Base Hospital.

5.20 Shortly before departing the scene, Mr Sullivan went into cardiac arrest again at 7:50am. NSWA paramedics recommenced resuscitation in the ambulance. Mr Sullivan arrived at Broken Hill Base Hospital still in cardiac arrest at 7:59am. Emergency Department clinicians took over Mr Sullivan's care. Despite continued resuscitation efforts, Mr Sullivan could not be revived and was pronounced deceased at 8:38am.

6. The postmortem examination

6.1 Mr Sullivan was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Hannah Elstub, forensic pathologist, on 24 March 2021. That examination identified the following relevant findings:

(a) An enlarged heart with left ventricular and septal hypertrophy[1], with the features consistent with those seen in chronic stimulant use;

(b) Atherosclerosis[2] of the three major coronary arteries with almost complete occlusion of the left anterior descending coronary artery;

(c) Concentrations of methylamphetamine and its metabolite detected in antemortem and postmortem blood samples at a level within the range seen in deaths attributed to this drug;

(d) Low-level concentrations of delta-9-tetrahydrocannabinol (**THC**) and delta-9-THC acid in keeping with previous exposure to cannabis;

(e) From radiology review, two buckle-type fractures of the left anterior ribs consistent with CPR; and

(f) Minor abrasions of the arms, legs and focally the left torso but no significant injuries that could account for death.

6.2 In the autopsy report, Dr Elstub noted the following:

> Severe coronary artery occlusion due to atherosclerotic plaques can result in death through acute myocardial infarction, with death occurring too soon to provide histological evidence, or cardiac arrhythmia. Enlargement of the heart (cardiomegaly) can also result in cardiac arrhythmias. Chronic methylamphetamine use can result in exonerated atherosclerosis, sudden cardiac death due to arrhythmia and cardiomyopathy. Acute use can also increase the risk of sudden death in the context of underlying heart disease. Sudden death following exertion is often linked underlying heart disease.

6.3 As part of the coronial investigation, an opinion was sought from Dr Pieternel van Nieuwenhuijzen, a forensic pharmacologist and toxicologist. Dr van Nieuwenhuijzen expressed the view that Mr Sullivan would have been affected by the methylamphetamine that he administered on 17 March 2021 given that the concentration detected was relatively high and despite Mr Sullivan's tolerance to it. Dr van Nieuwenhuijzen also noted that Mr Sullivan's "*long-term regular use of this drug probably contributed to his cardiovascular issues detected after his death*".

[1] An increase in growth of muscle cells.
[2] The build-up of fats, cholesterol and other substances in and on the artery walls, causing thickening or hardening of the arteries.

7. What issues did the inquest examine?

7.1 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 for consideration:

(1) The medical cause of Mr Sullivan's death;

(2) The conduct of officers of the New South Wales Police Force in executing the arrest warrant for Mr Sullivan; and

(3) Whether it is necessary or desirable to make any recommendations.

7.2 In order to assist with consideration of some of the above issues, an opinion was sought from Associate Professor Mark Adams, consultant cardiologist and Head of the Cardiology Department at Royal Prince Alfred Hospital. Associate Professor Adams provided an independent expert report and also gave evidence during the inquest.

8. What was the medical cause of Mr Sullivan's death?

8.1 Dr Elstub gave evidence that in her opinion Mr Sullivan's cardiomegaly, atherosclerosis and methylamphetamine use in combination resulted in a cardiac arrhythmia or sudden cardiac death. As to the significance of the methylamphetamine detected in the antemortem and postmortem blood samples, Dr Elstub explained:

> So stimulant drugs cause the same sort of effects adrenalin might cause, so they cause the heart rate to increase, they cause blood pressure to increase, and they have an effect on the heart which can result in sudden cardiac arrhythmia or sudden death and this is particularly amplified in the presence of underlying heart disease, so when there is already heart disease present, the presence of stimulant drugs such as methylamphetamine can increase the risk of a cardiac arrhythmia that might develop in the presence of heart disease, such as, coronary atherosclerosis or narrowing of the arteries or an enlarged heart.

8.2 Associate Professor Adams explained that Mr Sullivan had a number of cardiovascular conditions that he was largely unaware of and which were most likely asymptomatic during life. This is because most of these conditions are only evident on autopsy. The conditions were:

(a) Advanced atherosclerotic coronary artery disease with a 90% narrowing of the left anterior descending coronary artery and 70 to 75% of the right coronary and left circumflex coronary artery.

Associate Professor Adams noted that these type of findings are not rare as coronary artery disease develops over a significant period, and usually the first sign of the disease is sudden death. Further, Associate Professor Adams noted that Mr Sullivan had a number of risk factors for developing coronary artery disease including some elevation of his lipids, that he likely had type II diabetes mellitus (or at least impaired glucose tolerance), regular cannabis smoking, a

family history of coronary artery disease, his Aboriginal background, time spent incarcerated and other psychosocial stressors, and chronic use of methylamphetamine.

(b) A dilated cardiomyopathy[3] with a significantly enlarged heart and patchy interstitial fibrosis seen through the myocardium.

Associate Professor Adams considered it the most likely that Mr Sullivan's cardiomyopathy may have been secondary to chronic methylamphetamine use.

(c) Possible QT interval prolongation[4], based on the results of an electrocardiogram (**ECG**) taken in July 2017 which showed QT interval measurements outside of normal parameters, which greatly increased his risk of a fatal cardiac arrhythmia.

Associate Professor Adams explained that at the time this QT interval prolongation was observed it was possibly due to Mr Sullivan's drug induced psychosis, agitation and methylamphetamine intoxication.

8.3 Having regard to the above, Associate Professor Adams expressed the following regarding the relevance of each of these conditions to Mr Sullivan's death:

> Mr Sullivan's death was sudden and unexpected with little to find on autopsy apart from cardiac problems [of advanced coronary artery disease, cardiomyopathy and possible QT interval prolongation]. In this situation death is almost certainly due to development of a fatal arrhythmia secondary to his cardiovascular disease.

8.4 Further, Associate Professor Adams noted that any of the three conditions might have caused death and also may have possibly potentiated each other. By way of example, Associate Professor Adams explained that QT prolongation due to methylamphetamine use and the presence of myocardial fibrosis[5] due to cardiomyopathy "*may have lowered the threshold for developing arrhythmias which were then triggered due to myocardial ischaemia caused by intensive physical exercise in the presence of flow limiting coronary artery disease*".

8.5 In evidence, Associate Professor Adams was asked whether any or all of the cardiovascular diseases that he had identified caused or contributed to Mr Sullivan's death. He similarly explained:

> I think they all could've contributed to his death, to be honest, and in some ways they could almost have interacted with each other to cause his death, in that someone who has a cardiomyopathy and possibly a prolonged QT interval at the time might be much more likely to develop an arrhythmia in the context of having ischemia as well. These things are often when you develop almost a perfect storm of conditions that it disturbs the heart rhythm and can be fatal.

[3] A disease of the heart muscle in which the heart becomes enlarged making it harder for the heart to pump blood to the rest of the body, that can lead to heart failure and arrhythmias.
[4] A heart rhythm disorder caused by changes in the heart's electrical recharging system where it takes longer than usual to recharge between beats.
[5] Thickening or scarring of the muscles of the heart.

8.6 Relevantly, Associate Professor Adams considered that whilst Mr Sullivan was at increased risk of cardiovascular disease, there is no clear evidence of him presenting with any signs or symptoms. Although certain risk factors (a raised blood sugar level and a family history of diabetes and heart disease) had been noted in November 2012, Associate Professor Adams expressed the view that the only intervention that would have been required at that stage was monitoring and treatment of diabetes as well as lifestyle changes such as cessation of drug use, diet and exercise. However, Associate Professor Adams noted that from Mr Sullivan's medical records, it appeared that he "*was reluctant to comply with medical treatment for diabetes or to alter his drug use pattern*".

8.7 As to the events of 18 March 2021 Associate Professor Adams relevantly noted two additional matters:

(a) First, Associate Professor Adams explained that Mr Sullivan's "*flight from the police would have had a number of physiological effects that would have potentially been deleterious*". This matter is discussed further below.

(b) Second, Associate Professor Adams explained that the rib fractures identified on postmortem radiology review are almost always secondary to CPR efforts, with the particular type of buckle fracture found to be typical of that seen secondary to CPR. Associate Professor Adams noted that rib fractures are quite common for persons who receive effective CPR.

8.8 **Conclusions:** As at the morning of 18 March 2021, Mr Sullivan had a number of significant cardiovascular conditions (advanced coronary artery disease, cardiomyopathy and possible QT prolongation) which independently and in combination increased his risk for a sudden and the fatal cardiac arrhythmia. Further, the methylamphetamine use engaged in by Mr Sullivan on 17 August 2021 likely increased this risk and lowered the threshold for the development of a fatal cardiac arrhythmia. There is no clear evidence of Mr Sullivan presenting with any clear signs or symptoms prior to 18 March 2021 that would have warranted any intervention other than monitoring and treatment of diabetes, and lifestyle changes such as cessation of illicit drug use, diet and exercise.

8.9 Having regard to the above, and in particular the expert evidence, the cause of Mr Sullivan's death was the combined effects of coronary atherosclerosis and cardiomegaly, with methylamphetamine use being a significant condition contributing to the death but not relating to the disease causing it.

9. The conduct of the NSWPF officers in executing the arrest warrant for Mr Sullivan

9.1 Sergeant Gallagher, Senior Constable Greenwood, Senior Constable Weathersbee, and Probationary Constables Smith and McCrindell all gave oral evidence during the inquest. The following consistent features regarding the evidence given by these various police officers should be noted. It should also be noted that the evidence was unchallenged:

(a) First, all of the police officers gave evidence that other than the resuscitation efforts performed on Mr Sullivan they did not themselves make, or see any other police officer make, any physical contact with Mr Sullivan on 18 March 2021;

(b) Second, all of the police officers gave evidence that they did not themselves use, or see any other police officer use, any NSWPF appointments on Mr Sullivan on 18 March 2021;

(c) Both Probationary Constables McCrindell and Smith gave evidence that they saw Mr Sullivan outside the front of 93 Silver Street, approached him, and saw him run away. Both police officers also gave evidence that they ran after Mr Sullivan, with Probationary Constable McCrindell ahead of Probationary Constable Smith, as Mr Sullivan ran down the side of the house towards the backyard. Both police officers said that they saw Mr Sullivan jump over the back fence heading towards Boron Street before losing sight of him and not following him over the fence. Probationary Constable McCrindell indicated that he was approximately 10 to 15 metres behind Sullivan.

(d) Both Sergeant Gallagher and Senior Constable Weathersbee gave evidence that after leaving 93 Silver Street, they travelled to the area surrounding Boron Street where they conducted a foot search for Mr Sullivan, and looked over several fences in an attempt to locate him. In answer to questions from counsel for Mr Sullivan's family, both police officers gave evidence that they could not recall entering a fenced, triangular shaped piece of land near Boron Street but that in any event they did not see or have any interactions with Mr Sullivan.

(e) Both Sergeant Gallagher and Senior Constable Weathersbee gave evidence that between leaving Broken Hill police station and hearing the radio broadcast for an ambulance they did not have any physical contact with Mr Sullivan.

9.2 During the critical incident investigation, investigators identified a number of CCTV cameras which captured footage of relevant events on 18 March 2021. A review of the collected footage establishes the following:

(a) No more than approximately 40 seconds elapsed between Probationary Constables McCrindell and Smith leaving the front of 93 Silver Street before returning to the front of the property. Whilst this period of time was not captured on CCTV footage, it represents the only occasion on 18 March 2021 that any police officers were engaged in a pursuit of Mr Sullivan. Further, given the period of time, there was only a very limited opportunity for any potential physical interaction to occur between a police officer and Mr Sullivan. However, there is no actual evidence to establish that any interaction did in fact occur.

(b) CCTV footage captures Mr Sullivan moving between various properties from about 7:09am before being seen by Ms Dutton at around 7:11am, and then running towards 63 Silver Street at around 7:13am. During this period, the CCTV footage does not show Mr Sullivan to be affected by any apparent injury, apart from moving with a limp that is consistent with a pre-existing injury to Mr Sullivan's leg (which required the insertion of a metal rod).

(c) The attending police officers departed 93 Silver Street at around 7:08am. The marked and unmarked police vehicles used by the police officers are captured on CCTV footage at 7:13am and 7:14am to travel down Beryl Street and then onto Silver Street before parking so that the police officers could conduct a foot search for Mr Sullivan.

Whilst the exact time that the police officers later arrived at 63 Silver Street is not clear, NSWPF Computer Aided Dispatch (**CAD**) records indicate that the incident was created at approximately 7:19am. This timeline is consistent with the evidence of Mr Jones who estimated that police did not arrive at the scene until about 5 to 10 minutes after Mr Sullivan was found unresponsive. This means that there was only a very limited opportunity - approximately five to six minutes – between when the police vehicles were last captured on CCTV footage and the creation of the CAD incident for there to have been any potential interaction between Mr Sullivan and a police officer. However, there is no actual evidence that any such interaction occurred.

9.3 During the course of the inquest, Counsel for Mr Sullivan's family explored with Detective Inspector Quigg the possibility that certain CCTV cameras may have recorded footage of possible interactions between Mr Sullivan and police officers during the period that Mr Sullivan was seen leaving 93 Silver Street and when he was found at 63 Silver Street. The evidence given by Detective Inspector Quigg establishes the following:

(a) A service station was found to have three CCTV cameras which captured footage of some of the events on 18 March 2021. However, none of these cameras covered the entrance of 5/63 Silver Street Detective Inspector Quigg explained that the operators of the service station "*were in the process of getting a fourth camera to cover that particular area and if they had the fourth camera that would have covered across the road at 5/63 but unfortunately that was something they were going to do in the future*".

(b) A security camera was attached to a shed at the rear of 81 Silver Street but it was motion-activated. After speaking to the owner of the property, enquiries revealed that at the relevant time on 18 March 2021, the camera did not record any footage as a result of Mr Sullivan activating the camera.

(c) Approximately 47 seconds elapsed from the time that the police officers left 93 Silver Street and the time that a CCTV camera captured Mr Sullivan moving towards Beryl Street. This again represents only a very limited period of time for there to have been any potential interactions between Mr Sullivan and any police officer. Again, there is no actual evidence that any such interactions occurred.

(d) The radio communications logs for 18 March 2021 were reviewed with no inconsistencies found between the content of the logs and the accounts given by Sergeant Gallagher and Senior Constable Weathersbee regarding their movements on the day.

(e) A review of the various pieces of CCTV footage for 18 March 2021 was conducted and it was found that there were "no timings that's [sic] been unaccounted for".

(f) The triangular-shaped, fenced area between Boron and Silver Streets was examined and it was found that that "*there was no correlation that that particular area that was undisturbed had anything to do with this particular investigation*".

9.4 **Conclusions:** Sergeant Gallagher, Senior Constable Greenwood, Senior Constable Weathersbee, Probationary Constable McCrindell and Probationary Constable Smith all gave evidence that they did not make any physical contact with Mr Sullivan, or use their NSWPF appointments, at any stage on 18 March 2021. All of the police officers also gave evidence that they did not see any other police officer make any physical contact with Mr Sullivan other than for the purpose of conducting CPR. There is no physical or electronic evidence, or any evidence from a witness, which contradicts the evidence given by any of the police officers.

9.5 Further, the electronic evidence establishes that the periods of time that Probationary Constables McCrindell and Smith were in pursuit of Mr Sullivan, and when the police officers departed 93 Silver Street and when Mr Sullivan was captured on CCTV footage again after leaving that address, were extremely short in duration. This makes the possibility of any physical interactions between Mr Sullivan and any police officer highly implausible.

9.6 Having regard to the above matters, there is no evidence that any police officer on 18 March 2021 had any physical contact or interactions with Mr Sullivan, apart from attempting to resuscitate him after he was found unresponsive.

10. Are any recommendations necessary or desirable?

10.1 Counsel for Mr Sullivan's family made the following submission:

> At paragraph 7 of his report dated 8 April 2022, Professor Mark Adams sets out his expert opinion that the exertion of flight (along with various other matters) **would have** contributed to the development of arrhythmia, and ultimately the fatal ventricular fibrillation [emphasis added].

10.2 For clarity, paragraph 7 of Associate Professor Adams' report is reproduced in its entirety below:

> Mr Sullivan's flight from the police would have had a number of physiological effects that **would have potentially** been deleterious. Firstly the pure exertion would have led to need for increased coronary flow and in the presence of significant coronary artery disease this **may have** caused myocardial ischaemia that **could have** triggered a fatal arrhythmia such as ventricular tachycardia (VT) or ventricular fibrillation (VF).
>
> Secondly the increased adrenergic drive would have along with the level of methylamphetamine that was present in Mr Sullivan's bloodstream **could have** further increased his QT interval potentially triggering an arrhythmia such as VT or VF. It is **quite possible** that all of these factors were at play in Mr Sullivan's death, that his level of methylamphetamine would have lowered his threshold to develop an arrhythmia and that this was further lowered by his adrenergic drive due to stress and exertion and that finally the myocardial ischaemia due to the combination of increased cardiac demand and severe coronary artery disease led to development of VT which was ultimately fatal [emphasis added].

10.3 It is evident from the above that the opinion expressed by Associate Professor Adams was not so definitive as Counsel for Mr Sullivan's family submitted. In other words, Associate Professor Adams opines only as to the possibility that the "*exertion of flight*", together with Mr Sullivan's pre-existing

cardiac pathology, could have triggered a fatal cardiac arrhythmia such as ventricular tachycardia or ventricular fibrillation.

10.4 Notwithstanding the above, Counsel for Mr Sullivan's family also submitted:

> While it is impossible to know whether Mr Sullivan may have taken advantage of a voluntary surrender scheme, if he had - or was able to, the contributing fact of exertion would not have been present on the morning of 18 March 2021.

10.5 Having regard to the above, counsel for Mr Sullivan's family indicated that Mr Sullivan's family request that a recommendation be made that the NSWPF and NSW Department of Justice give consideration to "*the implementation of a scheme for voluntary surrender on warrants".* In support of this request, Counsel for Mr Sullivan's family referred to the *"Northern Territory Local Court Practice Direction*".

10.6 First, as already noted above there is no clear evidence that any exertion on the part of Mr Sullivan on 18 March 2021, whether in response to police seeking to execute the warrant for Mr Sullivan's arrest or otherwise, contributed to, or caused, his death. The opinion expressed by Associate Professor Adams only goes so far as to recognise the possibility that exertion, together with Mr Sullivan's pre-existing cardiac pathology, could have resulted in a fatal cardiac arrhythmia. It is therefore incorrect to describe the "*contributing fact of exertion*" as submitted by Counsel for Mr Sullivan's family.

10.7 Second, the inquest did not receive any evidence regarding "*Northern Territory Local Court Practice Direction*", the provisions of the practice direction, the circumstances to which it applies, the manner in which it operates, or its efficacy. As Counsel for Mr Sullivan's family recognised in submissions, consideration of any scheme (that may exist in any Australian State or Territory) that provides for the voluntary surrender of persons to whom an arrest warrant has been issued was not an issue which the inquest examined. This is precisely because such an issue is not sufficiently connected with the circumstances of Mr Sullivan's death and is so broad and far-reaching as to be arguably beyond the scope of an inquest to consider.

10.8 Third, the inquest did not receive any evidence from either the NSWPF or the NSW Department of Justice regarding the utility of such a voluntary surrender scheme, or the processes and procedures that presently exist regarding the execution of arrest warrants. Whilst the Commissioner of the NSWPF was a sufficiently interested party in the inquest, this interest did not in any way arise in relation to consideration of any matter relating to a proposed voluntary surrender scheme

10.9 Fourth, even if the evidentiary matters submitted on by Counsel for Mr Sullivan's family were accepted, the evidence establishes that an opportunity existed for Mr Sullivan to surrender himself when approached by Probationary Constables McCrindell and Smith outside 93 Silver Street. The evidence relevantly establishes that Mr Sullivan did not take that opportunity.

10.10 **Conclusions:** Having regard to the matters set out above, it is neither necessary nor desirable to make the recommendation requested on behalf of Mr Sullivan's family. Further, the inquest did not identify any other matter connected with Mr Sullivan's death regarding which a recommendation is necessary or desirable.

11. Findings pursuant to section 81(1) of the Act

11.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Louise Coleman, Counsel Assisting, and her instructing solicitors, Ms Aleksandra Jez from the Crown Solicitor's Office. I am also grateful to Ms Kate Lockery, the previous solicitor with carriage of this matter. The Assisting Team has provided enormous assistance during the conduct of the coronial investigation and throughout the course of the inquest. I am extremely grateful for their meticulousness, and for the sensitivity and empathy that they have shown during all stages of the coronial process.

11.2 I also acknowledge the assistance of Detective Inspector Quigg in conducting the comprehensive critical incident investigation and for 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 Anzac Sullivan.

Date of death

Mr Sullivan died on 18 March 2021.

Place of death

Mr Sullivan died at Broken Hill Base Hospital, Broken Hill NSW 2880.

Cause of death

The cause of Mr Sullivan's death was the combined effects of coronary atherosclerosis and cardiomegaly, with methylamphetamine use being a significant condition contributing to the death but not relating to the disease causing it. Mr Sullivan's underlying cardiac pathology independently and in combination increased his risk for developing a fatal cardiac arrhythmia, with recent methylamphetamine use also increasing this risk and lowering the threshold for the development of a fatal cardiac arrhythmia.

Manner of death

Mr Sullivan died of natural causes after fleeing from police who were attempting to execute a warrant for his arrest in relation to an alleged breach of his bail conditions. There is no clear evidence that Mr Sullivan's flight, or any physiological consequence of it, caused or contributed to his death.

12. Epilogue

12.1 There is no doubt that Mr Sullivan's death was tragic and untimely, and that his loss is still very deeply felt by those who miss him the most.

12.2 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Sullivan's family, friends and loved ones for their heartbreaking loss

12.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
10 February 2023
Coroners Court of New South Wales