CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Omar Mohammad
Hearing dates:	21 – 25 August 2023
Date of findings:	19 February 2024
Place of findings:	NSW Coroners Court Lidcombe NSW
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in custody; acute cocaine toxicity, first aid by police; adequacy of NSW Police first aid training; CPR: NSW Police access to automatic external defibrillators (AEDs)
File Number:	2020/277315

Representation:	Emma Sullivan, Counsel Assisting, instructed by Ms Bronwyn Lorenc (Crown Solicitor's Office) Kim Burke, for the Commissioner of the New South Wales Police Force, instructed by Ms Rebecca Atherton (Office of the General Counsel) Paul Madden, for Officers McCaffery, Davies, Cunningham, Joseph and Roche instructed by Mr Ken Madden (Walter, Madden, Jenkins) [I note that Mr Ben Bradley of counsel, instructed by Mr Nathan Guenette (Norton Rose Fullbright) gave advice to NSW Ambulance but did not appear during the hearing]
Non publication orders:	Non publication orders made on 22 August 2023 prohibit the publication of any evidence relating to the categorisation of police vehicles. A copy of the orders can be obtained on application to the Coroners Court registry.
Findings	**Identity** The person who died was Omar Mohammad **Date of death** Omar died on 23 September 2020 **Place of death** Omar died at St George Hospital, Kogarah NSW **Cause of death** Omar died due to irreversible hypoxic brain injury secondary to acute cocaine toxicity

	Manner of death His death occurred in the context of a police operation. Omar's death occurred as a result of a panicked ingestion of cocaine. Omar ingested the cocaine to hide it from NSW Police officers who were arresting him for trespass.
Recommendations	**To the Commissioner of the NSW Police Force** 1. As out-of-hospital cardiac arrests are one of the most common causes of death and because survival prospects are greatly improved where automatic external defibrillators (AEDs) are used, that **urgent consideration** be given to equipping **all** police response vehicles with AEDs for use as standard equipment by frontline police. 2. That as an interim measure pending the roll-out of AEDs for all police response vehicles, that **urgent consideration** be given to AEDs being provided to all mobile supervisor and duty officer vehicles in each Police Area Command. 3. That the NSW Police Force mandatory annual training for CPR include key emphasis upon the following messages: a. That CPR should be started if the person is unresponsive and not breathing normally (abnormal breathing); b. To assess breathing – rescuers should look, listen and feel: i. LOOK for movement of the upper abdomen or lower chest; ii. LISTEN for the escape of air from nose and mouth; and iii. FEEL for movement of air at the mouth and nose;

	c. That palpation of pulse is unreliable and should not be used to confirm the need for resuscitation; d. That abnormal breathing can be hard to identify - it is something that is “not normal”. Consider factors such as: i. Does the breathing look irregular or irregular? Is it very slow (which suggests it may be abnormal)? ii. Is the breathing noisy? If so, check that the airway is open. iii. Is there a colour change (for example, is the patient blue around the lips)? iv. Is there gasping or gulping? e. If in doubt about whether a person is experiencing cardiac arrest or not, the rescuer should start CPR without concern about causing additional harm (rib fractures and other injuries are common but acceptable consequences of CPR given the alternative of death); that is – “If in doubt, have a go.” f. That if unsure about ‘abnormal breathing,’ start CPR (even if the person takes occasional gasps or gulps); g. That agonal breathing is common in the first few minutes after a cardiac arrest – it is sudden, irregular gasps or gulps of breath. This should not be mistaken for normal breathing and CPR should be given straight away; h. That CPR should be continued until any of the following conditions are met: i. the person responds or begins breathing normally;

	ii. it is impossible to continue (e.g. exhaustion); iii. a health care professional arrives and takes over CPR; iv. a health care professional directs that CPR be ceased. i. That CPR should no be interrupted to check for response or breathing; j. That the faster the rescuer acts, the higher the chances of survival. 4. That CPR information as set out in (3) above is provided to all members of the NSW Police Force on an **urgent** basis (noting that the administration of CPR can be a matter of life and death), by way of: a. A state-wide NEMESIS message; and b. A module provided to officers who perform frontline general duties delivered via Police Education Training Environment (PETE) that requires the officer to acknowledge their review of the material; and c. Appropriate scenario training. 5. That having regard to (3) and (4) above, **urgent** consideration be given to the introduction of an external training course delivered by an appropriate organisation within the next 6 to 12 months, to ensure that there is a baseline level of understanding within the NSW Police Force as to the essentials of CPR and basic life support (after which time, the Commissioner may consider that it is appropriate to revert to an internal training delivery model);

	6. That **urgent** consideration be given to amending the 2023-2024 Session Plan for the CPR/Tourniquet Practical to ensure specific reference to the matters outlined in (3) above, together with inclusion of appropriate scenario training and an appropriate form of assessment to ensure that the content has been understood; 7. That consideration be given to introducing the requirement for police officers at the rank of Senior Constable and above who are involved in first response general duties policing, to be retrained and certified in first-aid every three years.

Table of Contents

Introduction

1. This inquest concerns the death of Omar Mohammad. Omar was 33 years of age when he died on 23 September 2020 at St George Hospital, Kogarah, NSW following the withdrawal of life support. Omar was admitted to St George Hospital on the morning of 10 August 2020 after being transported by NSW Ambulance paramedics from outside a house in Haig Street, Bexley where he had just been arrested for trespass by members of the NSW Police Force (NSWPF).

2. An interaction between Omar and NSWPF officers occurred in the driveway of these premises, during which Omar placed a small resealable bag into his mouth, ostensibly to hide it from police. With hindsight this action appears to have been a panic response precipitated by fear of being caught in possession of illegal drugs. However, this was not immediately clear to officers present. When questioned Omar told NSW Police that he had chewing gum in his mouth. The bag was only later discovered by medical personnel during emergency treatment. The bag was subsequently found to contain traces of cocaine.

3. Omar had experienced a seizure during the arrest and he ultimately stopped breathing. At first some officers present were unsure of whether Omar was experiencing a “real seizure” or was faking a seizure. An ambulance had already been called to assess Omar’s mental state. Once officers realised that Omar was also seriously physically unwell, they commenced first aid. There is no suggestion that Omar intended to cause himself harm. It is also clear that once officers of the NSWPF properly identified that Omar was having a serious medical crisis they immediately attempted to assist him to the best of their ability and in line with the training they had received. I note at the outset that involved officers approached these proceedings demonstrating a clear willingness to learn from what had occurred and for that they are to be commended.

4. Omar was loved by family members, some of whom attended the inquest. His death has caused enormous heart break.

5. Omar’s sister Mariam described Omar as smart, caring, and adventurous. He was a very capable and intelligent young man. Omar’s family shared with the Court photographs demonstrating his love of travel and the strong relationships he enjoyed with his extended family.

6. Omar's wife, Alisha, spoke of Omar's empathy for others, and how they had become best friends and soulmates. Omar leaves behind two beautiful children, his sons [redacted] and [redacted] who he deeply cherished. I acknowledge the family's profound grief and thank them for their attendance at these proceedings.

The role of the coroner and the scope of the inquest

7. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

8. This inquest was mandatory pursuant to ss 23 (1) (c) and 27 (1) (b) of the *Coroners Act* (2009) NSW, given the circumstances of Omar's arrest and the police operation that was underway at the time of the acute medical emergency which resulted in his death. In addition to that, the forensic pathologist who conducted the post mortem examination in the days after Omar's death was unable to ascertain a clear cause of death. This required further expert medical evidence which was then explored at inquest.

The evidence

9. The Court took evidence over four hearing days. The Court also received extensive documentary material in six volumes. This material included witness statements, medical records, photographs and video footage, policies and procedures.

10. The Court received documentary evidence from four eminent experts;[3] Professor Alison Jones, a medical practitioner and clinical toxicologist, Associate Professor Anna Holdgate, an experienced clinician in emergency medicine, Mark Molloy, an experienced intensive care paramedic and the National Training and Development Manager for St John Ambulance Australia (SJAA) and Associate Professor John Pearn, National Medical Advisor for Royal Life Saving Society Australia, an experienced doctor and pediatrician, who, among other things served on the Australian Resuscitation Council for 33 years.

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[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).
[3] Exhibit 1, Volume 6, Tab 149, page 1, Tab 150, page 1, Tab 151, pages 8 – 12, Tab 152, page; CV of Professor John Pearn AO (610 pages).

11. Professor Holdgate, Mr Molloy and Professor Pearn also gave oral evidence in a conclave before the Court.

12. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

13. A list of issues was prepared before the proceedings commenced. These issues guided the investigation and I intend to structure these findings by reference to the matters set out below:

    1. The medical cause of Omar's death (noting that the post mortem referred to the direct cause of death as 'unascertained').

    2. The manner of Omar's death, including the circumstances of the incident on 10 August 2020 and the adequacy of the police response, including as to:

        a) The *apparent* delay in contacting NSW Ambulance and the information conveyed by police to that service;

        b) The steps and approach taken to arrest and search Omar;

        c) Whether there was appropriate administration of first aid (including CPR);

        d) Whether the applicable processes, policies, procedures and training were followed;

    3. As to 2(d) above, the adequacy of the applicable processes, policies, procedures and training; and

    4. Whether any recommendations are necessary or desirable under s 82 of the *Coroners Act 2009* in relation to any matter connected with Omar's death.

Background and brief chronology

14. Prior to the commencement of proceedings, those assisting me drafted a chronological summary of the key events from the available documentary evidence. The parties agreed that this document[4], which was tendered, contained an accurate

[4] Exhibit 5, Annexure 1 to these findings.

summary of the chronological events. I attach a copy of that document as an annexure to these reasons and do not intend to repeat all the material contained in it. I adopt its content.

15. Counsel assisting also produced extremely comprehensive submissions summarising much of the oral evidence. Given the parties explicitly acknowledged the accuracy of her submissions, I have also relied heavily upon her document in recording my written reasons, at times directly adopting her words. I have reviewed the evidence carefully where differences in fact or emphasis are noted by the parties and in all matters the conclusions are my own.

The Issues

Issue 1 - Medical cause of death and manner of death

16. It was necessary to closely examine the medical cause of Omar's death. On 25 September 2020, a limited autopsy in the form of an external examination, postmortem CT scan and toxicology analysis was undertaken by forensic pathologist, Dr Jennifer Pokorny.[5] Ultimately, Dr Pokorny recorded the opinion that:

> *The cause of death remains unascertained after post mortem examination. The medical records and post mortem findings are in keeping with hypoxic ischaemic encephalopathy leading to death, with the history strongly suggestive of this being secondary to cocaine toxicity. However, in the absence of any suitable specimens from the time of the presumed cocaine ingestion for toxicological analysis, this is unable to be confirmed on the basis of the post mortem findings.*[6]

17. Dr Pokorny noted that although antemortem blood specimens were requested, as Omar's death occurred following a prolonged admission to St George Hospital, the earliest available sample was from 18 September 2020. Analysis of this sample, as one would expect, detected medications consistent with therapeutic use and no cocaine or cocaine metabolites were detected.[7]

18. In preparation for the inquest, expert evidence was sought from Professor Alison Jones, a medical practitioner and clinical toxicologist based at Fiona Stanley

[5] Exhibit 1, Coronial Brief of Evidence, Tab 3 (21 August 2023).
[6] Ibid, 3
[7] Ibid.

Hospital, Perth. Professor Jones provided a comprehensive expert report,[8] and also gave oral evidence at the inquest.[9]

19. In oral evidence, Professor Jones affirmed the opinion she had given in her report that Omar's death was ultimately caused by a hypoxic brain injury following cardiorespiratory arrest.[10]

20. Professor Jones confirmed that the presence of levetiracetam (Keppra), an anticonvulsant, in postmortem toxicology results was an incidental finding unrelated to the cause of Omar's death.[11]

21. Professor Jones explained the physiological effects of cocaine ingestion, which operates as a "very powerful sodium blocker".[12] The consequences of ingestion include "effects on the heart, the cardiac rhythm, and it [could] cause fitting…when the oxygen level in the blood drops."[13] Further, it could lead to "cardiac arrest" or "coronary artery vasospasm occasioning death."[14]

22. Evidence in support of the ingestion of cocaine as the precursor to Omar's cardiorespiratory arrest, affirmed by the oral evidence of Professor Jones, included the following:[15]

- Omar had a history of cocaine use;
- the chewed resealable bag retrieved from his throat on 10 August 2020 at St George Hospital was tested and found to contain traces of cocaine; and
- a urine drug screen conducted on a sample taken from Omar on 10 August 2020 at St George Hospital identified the presence of cocaine and opiates.

23. Having viewed the body worn video of police officers who attended Haig Street on 10 August 2020, Professor Jones was of the view that Omar's presentation from 7.37am onwards until he began seizing not long after 7.54am, around 15 – 20 minutes later, was "entirely in keeping with a clinical picture of cocaine toxicity."[16]

[8] Exhibit 1, Tab 149 (21 August 2023).
[9] On Day 3 (23 August 2023): see from T196ff.
[10] T203.10 – 23 (23 August 2023).
[11] T197.33 – 34 (23 August 2023).
[12] T199.15 – 20 (23 August 2023).
[13] T198.5 – 10 (23 August 2023).
[14] T198.35 – 40 (23 August 2023).
[15] T197.36-49; T203.10-23 (23 August 2023).
[16] T200.20-21 (23 August 2023).

Professor Jones stated that it would be around that time frame that a person intoxicated with cocaine would have peak plasma concentration and be expected to exhibit toxic effects: this was demonstrated in the video by Omar's repetitive seizing, followed by his apparent cardiac arrest.[17]

24. Professor Jones considered that given the four minute seizure, this indicated a "large dose of cocaine" which would cause catastrophic outcome, very quickly.[18]

25. Considering the evidence in its totality and that "…cocaine was in the bag, cocaine was in [his] urine and because of the timing of the events of 15 – 20 minutes after the bag was taken into Omar's mouth",[19] Professor Jones agreed that an appropriate formulation as to Omar's cause of death was:

> *That Omar Mohammad died on 23 September 2020 of death as due to irreversible hypoxic brain injury secondary to acute cocaine toxicity.*[20]

26. Notably, Professor Anna Holdgate (an emergency physician) and Emeritus Professor John Pearn (a senior paediatrician) gave oral evidence in conclave at the inquest. Both experts agreed with the evidence of Professor Jones as to the cause of Omar's death.[21]

27. I accept Counsel Assisting's submission that in those circumstances there is a strong evidentiary foundation for a clear cause of death – namely, that Omar died from irreversible hypoxic brain injury, secondary to acute cocaine toxicity. I note that there were no submissions against this finding.

Issue 2 - Manner (circumstances) of death

28. In broad terms, the manner of Omar's death encompasses the circumstances in which he ingested the cocaine on 10 August 2020.

29. Helpfully, the entire interaction between officers from the NSW Police and Omar from the time of police arrival at the Haig Street premises, until the time Omar was

[17] T200.7-14 (23 August 2023).
[18] T200.14-19 (23 August 2023).
[19] T202.3; T203.45-50 (23 August 2023).
[20] T203.10-23 (23 August 2023).
[21] T211.30; T215.35 (25 August 2023).

conveyed from the scene to hospital was recorded by a combination of CCTV footage from the Haig Street premises and body worn video of attending officers.[22]

30. Briefly, noting the facts are set out in the agreed chronology attached, on 10 August 2020, Sergeant Christopher McCaffery attended Haig Street in response to a radio broadcast at 7:12:31am regarding a trespass report. At 7:25am, the priority of the job was escalated after the person (Omar) was reported to have entered the rear yard of the premises. Sergeant McCaffery was the mobile supervisor attached to Kogarah that day, (one of the two stations within St George Police Area Command).[23] Sergeant McCaffery was accompanied by then Leading Senior Constable (**LSC**) Stuart Davies (who at the time of the inquest, had been appointed as a Sergeant). These two officers were the first police crew on scene.

31. Both officers gave evidence at the inquest. Upon arrival, Sergeant McCaffery approached the premises towards the driveway where there was a metal gate: almost immediately he encountered Omar as he walked down the driveway. The two met at the metal gate. A matter of seconds later, Omar placed something in his mouth, which was white in colour. Omar continually told the officers it was "chewy." Sergeant McCaffery and Sergeant Davies repeatedly told Omar to spit out the item. Sergeant Davies described the item as a "white substance" which had "…[what] looked like bite marks in [it]…which made [him] believe it was chewing gum."[24] In evidence, Sergeant McCaffery told the Court that "[He] didn't know whether it would be drugs or – that's the sort of the first thing that came to mind."[25]

32. The Court heard evidence from Senior Critical Incident Investigator (**SCII**), Detective Inspector Simon Fitzgerald (**DI Fitzgerald**), who was tasked with investigating the circumstances of Omar's death. DI Fitzgerald told the Court that although police had the power under sections 21A and 28 of the *Law Enforcement (Powers and Responsibilities) Act* 2002 (NSW) (**LEPRA**) to direct Omar to open his mouth to perform a "visual search", they had no power to do anything else in the circumstances, including using force to remove an item from his mouth.[26]

[22] Exhibit 3.
[23] T42.30-33 (21 August 2023).
[24] T25.39-40 (21 August 2023).
[25] T45.37-40 (21 August 2023).
[26] T12.49 – 13.4 (21 August 2023).

33. In the circumstances, although Omar's act of quickly placing the bag containing cocaine into his mouth was an intentional one, I accept that there is nothing to suggest that it was in any respect an act *intending* to cause self-harm. Instead, the evidence suggests that Omar was simply trying to conceal the drugs. It was an act no doubt precipitated by fear of being caught in possession of the cocaine, and thus an act taken without forethought or intention. Unfortunately, our current drug laws can have this unintended but extremely dangerous effect.

34. Accordingly, on the balance of probabilities, I accept Counsel Assisting's submission that Omar's overdose on 10 August 2020 was unintentional, as he ingested the plastic bag containing cocaine as a means of avoiding detection of the drugs by police. I note that no party urged a different finding.

Arrest and search

35. I accept Counsel Assisting's submission that the evidence established the following as to the circumstances of Omar's arrest and search.

36. Sergeant Davies stated that "Sergeant McCaffrey asked him for some identification … Omar put both of his hands in his jacket pockets" and "was asked a number of times by Sergeant McCaffrey to take his hands out."[27] He recalled that Omar "refused to take his hands out of his pocket", so Sergeant Davies "grabbed his left arm" and thought "that's when he's put something into his mouth."[28] Sergeant McCaffrey similarly recalled that Omar's "hands came out and his right hand had something in it and he's immediately put something into his mouth."[29] This is supported by the tendered BWV footage.[30]

37. Sergeant McCaffrey stated that they "were trying to point [Omar's] head towards the ground hopefully [so] something would fall out and then … wrestle to handcuff him."[31] Sergeant Davies stated that at this time, Omar "tried to pull his left arm out of his pocket, that's when he started to resist me … so we took him to the ground."[32] Once Omar was on the ground, Sergeant Davies recalled that they "tried to handcuff him";[33]

[27] T24-25.50 (21 August 2023).
[28] T25.10 (21 August 2023).
[29] T45.5 (21 August 2023).
[30] Exhibit 3 (the compilation recording of CCTV and BWV footage).
[31] T46-47.50-55 (21 August 2023).
[32] T25.15-20 (21 August 2023).
[33] T25.20-25 (21 August 2023).

he believed that he said to Omar "You're under arrest" but "didn't recall telling him the reason."[34] He recalled that "Constables Joseph and Roche turned up and they assisted in handcuffing Omar."[35]

38. Constable Joseph stated that once they "…were at the scene, I saw the two officers run over to them" and Sergeant McCaffrey "…put his hands together to the rear and he [Omar] was quite resistant" so she assisted him in putting the handcuffs on.[36] Constable Roche similarly recalled that, upon arriving at the scene, they "went straight over and assisted with the arrest"[37]and Constable Roche "grabbed his left arm"[38] and "mainly held the hands so that the handcuffs could go on."[39] Once they "handcuffed him" Constable Joseph recalls sitting "him down against a Colourbond fence."[40]

39. As to the reason for the arrest, Sergeant Davies understood it was for "a break and enter" or "at least an attempt to break and enter or trespass."[41] However, he said that they initially handcuffed Omar "because he was trying to get away."[42] Sergeant McCaffrey told the Court that they restrained Omar to "protect him or us" and "to stop him from leaving."[43]

40. In DI Fitzgerald's view Omar's arrest was "justified" on the basis that there were "reports of him being in the backyard and attempting to open the doors of the house" and as he was "informed by Sergeant Davies he was under arrest for trespass"[44] (noting however, the evidence did not disclose that this was in fact said).

41. As to the search of Omar, Sergeant Davies indicated he "was then searched on both sides"[45] where they found "a mobile phone, a set of keys and some money."[46] Beyond repeated requests to spit out what was in his mouth, the officers did not seek to forcibly

[34] T26.30-45 (21 August 2023).
[35] T25. 20-25 (21 August 2023).
[36] T110.30-35 (22 August 2023).
[37] T124.40 (22 August 2023).
[38] T125.20-25 (22 August 2023).
[39] T126.35 (22 August 2023).
[40] T110.5-10 (22 August 2023).
[41] T26.10-15 (21 August 2023).
[42] T25-26.50-5 (21 August 2023).
[43] T47.15-20 (21 August 2023).
[44] T12.5-10 (21 August 2023).
[45] T25.20-25 (21 August 2023).
[46] T27.15 (21 August 202.3).

remove the item Omar was chewing on. The search of Omar in the prone position was in accordance with police training, consistent with officer safety.[47]

42. Sergeant Henley, a senior operational safety instructor (**OSI**) within the Operational Safety Training and Governance (**OSTG**) unit, who reviewed the interaction between NSWPF officers and Omar, agreed that the officers' handcuffing technique with Omar on his stomach was in accordance with police training.[48] He indicated that "officer safety is paramount … he's already tried to escape" and it was "unknown … what he swallowed, what other weapons he might have had on him, but he was also irrational" so they had "to make sure we protect also us but also him."[49]

43. The evidence disclosed that Omar remained handcuffed from approximately 7.39am to 7.58 am when the handcuffs were removed; by this time, Omar had been seizing for at least around 4 minutes (from around 7.54am). Police were questioned about whether there was an opportunity to remove the handcuffs earlier than they did.

44. Sergeant Davies stated that the handcuffs should not have been taken off earlier, given it became apparent police were dealing with a mental health issue – he noted that Omar "might have still tried to get away", and so it was for his safety also:

> *… because it was a mental health incident we didn't know if he would try to hurt himself. There was obviously that previous incident with the large kitchen knife. So for his safety that he'd be still handcuffed.*[50]

45. Sergeant McCaffrey did not consider that it might have been more appropriate to take the handcuffs off earlier, given the presentation was more a mental health issue, stating:

> *Even if it's mental health it's still just so he doesn't leave, so that was the main reason for it, just so there was, that possibility wasn't there, especially when he was a mental health, we want him to get assessed. And cause obviously a bit erratic at the time as well. So, no, hadn't contemplated that at that time.*[51]

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[47] T148.44-149.8 (23 August 2023), per Sergeant Henley.
[48] T148.35-45 (23 August 2023).
[49] T149.30-40 (23 August 2023).
[50] T30.6-30 (21 August 2023).
[51] T50.23-30 (21 August 2023).

46. LSC Jayde Cunningham attended Haig Street on 10 August 2020. At the time she was an Acting Sergeant and was a mobile supervisor responding from Hurstville Police Station (St George 13).[52] LSC Cunningham disagreed that there was an opportunity to take the handcuffs off earlier during the almost five minutes that Omar was seizing. She stated:

> *… In order to take someone's handcuffs off you have to keep their hands together, especially when they're handcuffed to the rear. He was violently convulsing when he was convulsing. If I was to hold his arms still I would expect that I would hurt him, so I waited for an opportunity not to hurt him to take off the handcuffs … It wouldn't have even crossed my mind until there was an opportunity that I wasn't going to hurt him in doing that.*[53]

47. There was also this exchange with Counsel Assisting:

> *Q. With the benefit of hindsight, do you think there was likely an earlier opportunity to take the cuffs off during that 5 minute period?*
>
> *A. I mean I think anyone can learn from any experience. At the end of the day until he started having a full-blown seizure I wasn't sure if he was faking it to try and get an opportunity to get unhandcuffed to run away. So I probably would have unhandcuffed him at the same point again because for the same reasons, safety of himself and us.*[54]

48. Sergeant Henley agreed that there was an ongoing requirement for police to assess the use of restraints;[55] he did not have a view about whether the handcuffs ought to have been removed when Omar began to seize.[56] In response to matters raised with him by Counsel Assisting he stated:

> *There's a lot of factors that you've brought up there. As we said, officer*

[52] T42.30-33 (21 August 2023).
[53] T94.32-37 (22 August 2023).
[54] T95.9-15 (22 August 2023).
[55] T148.22-26 (23 August 2023).
[56] T29-35 (23 August 2023).

safety is paramount. So he's already tried to escape. It was given in evidence that he tried to push past Sergeant McCaffery, so he's already done that already. We're unknown if he's, what he swallowed, what other weapons he might have had on him, but he also was irrational and it was given in evidence also that he was irrational. These sort, these sort of people with those irrational behaviours are very unpredictable and the situation where they are, even though there's five, we've got to make sure we protect also us but also him, in the fact that he was very irrational. We remember where he is at the moment. He may be behind a gate but he's also in a backyard where there is also weapons that can be used again police or he can use for himself; shovels, knives and garden implements of any sort of that area where he's in. So there's more than just that he's under control, he may injure that one officer then run and jump over a fence. It's an uncontrolled area, even though he's controlled at that point, it's still an uncontrolled area.

49. Ultimately, I accept Counsel Assisting's submission that in all the circumstances there was a proper basis for police to suspect that Omar may have been in the process of committing an offence; there was also some basis to suggest that he was trying to "flee" from the location (as he was attempting to get through the metal gate and exit the driveway when approached by Sergeant McCaffrey). Overall police actions appear to largely accord with their obligations pursuant to 99(1)(b)(i) and (ii) of *Law Enforcement (Powers and Responsibilities) Act 2002 (**LEPRA**).*

50. Counsel Assisting submitted that there was one aspect of police conduct which was not entirely in conformity with *LEPRA,* in that it is not apparent that Sergeant Davies, who effected the arrest, nominated the reason for the exercise of the arrest power to Omar. A reason is required to be given under *LEPRA,* as soon as is reasonably practicable: per ss 202(1) and (2). Sergeant Davies did not recall at any point telling Omar the reason he was under arrest; nor was any such explanation recorded on the body worn video, after Sergeant Davies stated, "You're under arrest" (which he agreed, would have been the opportunity to nominate the reason for the exercise of this police power).

51. Counsel Assisting submitted that in the stressful circumstances of this interaction, nothing turns on this omission from a coronial perspective. I accept this view.

52. Otherwise, the search conducted by police appears to have been appropriate and in conformity with *LEPRA*, police policy, procedure and training.

53. I was surprised that police did not hold a stronger contemporaneous suspicion that Omar may have swallowed illicit drugs (and with that more clearly have foreseen the potential for danger to his health), given that it is not an uncommon occurrence in arrests of this sort. However, even if stronger suspicions had been held, I accept that police were not empowered to dig around in Omar's mouth in an attempt to check if he may be concealing illicit drugs.

54. It is clear from the s 21A of *LEPRA* that police are not permitted to forcibly search someone's mouth (which Sergeant Davies was aware of).[57] There are obvious policy reasons for the prohibition against the forcible opening of a person's mouth. The OIC, DI Fitzgerald, explained the issues, as he saw them, with an officer trying to get someone to open their mouth and extract an item:

> *Potentially committing an assault on the person would be one issue. Other dangers would involve perhaps causing the person to swallow something that they may otherwise not have swallowed, or other dangers. If you were to put your fingers into someone's mouth and health and physical dangers in that.*[58]

55. Sergeant Henley was asked what police should do in the circumstances that presented with Omar putting the item in his mouth:

> *… Do the best you can. Obviously they try and get them to spit it out. Control them to the point where you know we're not going to get spat on if they going to spit it out, but as best is control, and if they get them to remove it themselves if possible they can.*[59]

[57] T27.31-36 (21 August 2023 – per Sergeant Davies).
[58] T13.14-21 (21 August 2023).
[59] T147.4-8 (23 August 2023).

56. Thus, in the circumstances, it was not open to police to attempt to forcibly extract from Omar's mouth, the item he had ingested, notwithstanding that there should have been some level of suspicion that he may have ingested drugs.

57. Otherwise, the evidence established that Omar was handcuffed around at 7.38am (Exhibit 5 at [24]); he began having a seizure at 7.54am (having told police that he was having a seizure); and the handcuffs were removed at 7.58.50am (Exhibit 5 at [39]).

58. With the benefit of hindsight – noting that Omar was *not* in fact "faking" seizures – it was submitted by Counsel Assisting that there was scope to remove Omar's handcuffs in the four minute period during which he was suffering seizures, prior to removal of the handcuffs. However, it was not submitted, nor do I find that this period of time impacted upon Omar's clinical condition or prognosis. This much is clear from the evidence of Professor Holdgate, which I accept.[60] Similarly, Professor Alison Jones stated that she did not think "the presence of handcuffs altered that outcome" as the "cardiac events were unfolding and the seizures were prolonged, so were sadly already in that descending spiral from cardiac respiratory and neurological point of view."[61] I accept her view.

59. Counsel for the Commissioner urged me to keep in mind the "unravelling dynamic circumstances" experienced by Officers at the time when weighing up whether any criticism might be warranted. I accept that there were difficult judgment calls that had to be made and that at least some of the officers had little or no previous exposure to seizure activity. I accept that Officers were concerned that Omar might act unpredictably and that they were in an area where he may be able to find a weapon such as a garden implement or indeed harm himself or others if he tried to climb the fence.

60. I am confident, having reviewed the expert evidence, in finding that in the circumstances of this case, the handcuffs had no causative impact on Omar's death. In my view it is unnecessary to say anything further about the issue from a coronial perspective.

[60] T211.25-29 (25 August 2023).
[61] T201.40-50 (23 August 2023).

Apparent delay in contacting NSW Ambulance Service and information conveyed to that service

61. Following his arrest, the evidence clearly established that Omar was behaving erratically or unusually. In this regard, the officers variously recalled the following:

- Constable Joseph described Omar as "talking to himself and he seemed to be talking in English and a different language…he seemed quite fixated on the window of the top storey of the house;" he also kept yelling out "Alicia, Alicia", and also "Bring the kids down";[62] from Constable Joseph's discussion with the owner of the premises, there was no one called Alicia who lived there, Omar was in a house he didn't know, and where the owners didn't know him.[63] Constable Joseph recalled having concerns for Omar's mental health – and through conversation with the other officers, trying to ascertain if he had other mental health episodes prior.[64]

- Sergeant Davies stated that from very early on, Omar was:

> *… sitting there with his hands behind his back handcuffed, he was constantly looking up towards the roof or the second storey window of the house and just constantly talking, talking, talking and really, really, really fast. The conversation didn't make sense to me, he was calling out somebody's name, I believe it was Alicia, and obviously there was no one up there. So, I believed he was suffering from a mental illness.*[65]

- Sergeant McCaffrey observed Omar to be "… calling out a person's name thinking that they were actually living at that house …"; he was calling out in a "panicked" tone – at this point, he thought mental health issues might be involved;[66]

62. The evidence established that Constable Joseph called police radio to request an ambulance at 7.47.22 am for a "MHA" – being a mental health assessment (see

[62] T112.25-40 (22 August 2023).
[63] T112.30-34 (22 August 2023).
[64] T.112.41-47 (22 August 2023).
[65] T26.46-27.6 (21 August 2023).
[66] T48.125-135 (21 August 2023).

Exhibit 5, at [31]).

63. Sergeant McCaffrey agreed that a possibility going through his head was that Omar had ingested drugs, which would have raised concerns for his health. In hindsight, he agreed that an ambulance should have been called at that point (although noted that there was some ambiguity as the item was white, Omar was saying it was "chewy" and there was a smell of peppermint).[67]

64. Constable Joseph could not recall discussing the need for an ambulance for a mental health assessment with LSC Cunningham, who on the day was performing the role of mobile supervisor, along with Sergeant McCaffery.[68] Constable Joseph thought Omar was "probably drug affected based on the way he was behaving, but also probably coupled with some mental health".[69]

65. Following her arrival at the scene, LSC Cunningham determined that Omar needed a mental health assessment by an ambulance as he "was talking to someone that clearly wasn't there," behaviour that was "not normal."[70] LSC Cunningham also noted that Omar's "pupils…chewing and just his general mannerisms" might have been as a result of drug use.[71]

66. Around this time, LSC Cunningham asked other police on scene whether an ambulance had been called; as one had not, she requested that Constable Joseph call an ambulance via police radio.[72]

67. Constable Joseph agreed at the time of the request for the ambulance, she knew the information provided by Sergeant Davies and Sergeant McCaffrey that Omar had ingested something; this was not mentioned in the broadcast to VKG seeking an ambulance. With the benefit of hindsight, Constable Joseph agreed it was "very much" something that she should have mentioned.[73]

68. Reflecting back, Constable Joseph agreed that during this first call, she should have mentioned the information from Sergeant Davies and Sergeant McCaffrey that Mr Mohammad had ingested something.[74] She also offered the following:

[67] T46.7-33 (21 August 2023).
[68] T113.17-19 (22 August 2023).
[69] T113.45-48 (22 August 2023).
[70] T80.33-41 (22 August 2023).
[71] T80.33-41 (22 August 2023).
[72] T82 1-9; 28-35 (22 August 2023).
[73] T114.5-10 (22 August 2023).
[74] T113-114.50-10 (22 August 2023).

I suppose, now, going to an event, if someone's ingested something, just calling an ambulance whether I know what they have ingested or not, I'd rather an ambulance come and they make that assessment earlier than delaying the process.[75]

69. When Omar began to have a seizure at 7.54am[76] both LSC Cunningham and Constable Joseph agreed that the request for an ambulance should have been updated at that point in time.[77]

70. Sergeant Davies also agreed that with the benefit of hindsight, when Omar began to seize (twitch his legs), police radio should have been updated; from this experience, he would now "call an ambulance earlier."[78] He thought Omar was faking the seizure for the four minutes until the handcuffs were removed; however, Sergeant Davies agreed that he was not in a position to assess whether someone was "faking" a seizure or not.[79]

71. The officer in charge, DI Fitzgerald, told the Court that with the benefit of hindsight, an ambulance should have been called to assess Omar when he put the item into his mouth, given there was suspicion it may have been a drug.[80] This view was enshrined in police policy, the *'Operational Safety – Person Search Techniques Guide'* which stated: "If you suspect that a person has swallowed drugs or something that is harmful you should immediately arrange for them to receive medical attention."[81]

72. Additionally, DI Fitzgerald considered the ambulance or police radio should have been notified about the seizure "when they first identified that he was having a seizure,"[82] which was namely when "[Omar] had told them he's having a seizure."[83]

73. As set out in the Agreed Chronology, upon the arrival of the first paramedic from NSW Ambulance (paramedic Laura Hunter), Sergeant McCaffrey briefed her on Omar having "jammed something into his mouth … so I don't know whether he has taken something or …"

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[75] T122.40-46 (22 August 2023).
[76] (Exhibit 5 at [32](c), [33]-[34]),
[77] T87.15-39 (22 August 2023); T116.30 (22 August 2023).
[78] T34.15-25 (22 August 2023).
[79] T34.29-27 (22 August 2023).
[80] T12.40 (21 August 2023). See also the evidence of Sergeant Henley at T147.43-344 (23 August 2023).
[81] Exhibit 1, Tab 102, p 11.
[82] T14.17 (21 August 2023).
[83] T14.20 (21 August 2023).

74. Upon the arrival of the ambulance, Sergeant Davies also recalled informing the paramedics that "it looked like [Omar] had chewing gum in his mouth, and he may've choked on it."[84] LSC Cunningham agreed that she informed the paramedics that "he was chewing something. We weren't sure if it was his cheek or chewing gum."[85]

75. Paramedic Eduard Vaitikaitis provided a similar account in his statement "I recall at some stage I was advised that Mr Mohammad may have swallowed something, likely drugs, I don't recall when I was told this".[86] He also noted that even if Omar had ingested drugs "this was not a priority. In reality, there was little that I could do to counter the effect of illicit drugs". In oral evidence, he recalled that police "approach[ed] us quickly"[87] and "told us that … they have arrested individual that was in the backyard of this house that I was at [and he was] hav[ing] a seizure and [had] stopped breathing."[88]

76. I accept Counsel Assisting's submission that it has been established, with the benefit of hindsight, that an ambulance should have been called at the time that Omar ingested the unknown white substance, which was potentially a drug. This is particularly so when at least some officers had a suspicion he may be drug affected.

77. I note that the relevant police officers also accepted that, looking back, the request for an ambulance ought to have been upgraded when Omar began seizing at around 7.54am (and also told the officers he was seizing). They accepted – appropriately – that they did not have the medical expertise to assess whether he was in fact "faking it". In my view, it would always be a dangerous decision to make in the absence of medical training.

78. I was impressed by the way involved officers were willing to reflect on what had occurred and were open in sharing situations they would now approach differently.

79. I accept the submission that it is apparent that the officers provided an appropriate handover of key information to paramedics from the NSW Ambulance Service upon

[84] T35.10 (21 August 2023).
[85] T102.30 (22 August 2023).
[86] Exhibit 1, Tab 46B, at [8].
[87] T62-63.15-20 (22 August 2023).
[88] T62-63.50 (22 August 2023).

arrival and continued to relay relevant information on an ongoing basis: see Exhibit 5 at [78]; [81]; [86] and [88].

80. Additionally, I accept that to the credit of LSC Cunningham (and indeed, the other involved officers), it should be acknowledged that police were very willing to assist their paramedic colleagues in treating Omar. For example, LSC Cunningham stated: "Please let us help if there's anything we can do. Just give us direction we're one of your own".[89] The BWV clearly depicts cooperation between all the first responders.

Administration of first aid by police

Response to Omar's seizure

81. At around 7.54am Omar's legs began to twitch, and he told police that he was having a seizure. Police initially thought that Omar was "faking it", or otherwise doubted whether it was a real seizure. The evidence was to the following effect:

- Sergeant McCaffrey stated that when Omar said he was having a seizure, he:

  > *Didn't know whether it was a full seizure, because I have seen that in the past as well, like people say those things and, cause I do all different roles like custodies and things like that and I have had a number of times in there where they say it to try and get your attention. So at the time, obviously just monitoring anyway, but we weren't sure whether it was or wasn't a seizure.*[90]

- Sergeant Davies recalled that Omar's legs started to jerk, however, they "were just observing what he was doing and whether he was doing it on purpose;"[91] he said he would have been thinking "… is this real or is he putting it on, but to definitely make sure that we were monitoring him in case it turned worse";[92] Sergeant Davies had not seen a seizure before – he thought that Omar was acting for the four minutes until the handcuffs were removed;[93]

[89] T102.16-19 (22 August 2023).
[90] T51. 23-29 (21 August 2023).
[91] T33.5-10 (21 August 2023).
[92] T33.44-40 (21 August 2023).
[93] T33.50-34.14 (21 August 2023).

- LSC Cunningham also recalled that she was "watching him" and "asked questions to him;" she recalled asking "Do you have epilepsy? What makes you think you're having a seizure?", and Omar did not respond.[94] She was not actually sure that Omar was having a seizure.[95]

- Constable Joseph thought that in the initial stages when Omar said he was having a seizure, she thought it was putting it on; she explained:

> *Just because he was sitting upright and he was talking to himself or at – but also sort of conversing with us, and then he just started saying that, so we put him in the recovery position and I just wasn't sure if it was just his way of just not wanting to be in the situation that he was in, yep.*[96]

- Constable Roche stated that at that stage, his "priority was to monitor him and make sure whether his condition gets worse or not."[97]

82. Notwithstanding doubt about whether Omar was "faking it", the evidence indicates that the officers *treated* Omar as if the seizure were genuine,[98] with the exception of upgrading the request for an ambulance for the *physical* symptoms observed.

83. In particular, the steps taken by police included the following:

- LSC Cunningham explained that they "moved [Omar] away from the fence" and he "was on his left-hand-side in the recovery position."[99] She stood "in front of his groin … so that he couldn't flop forward onto his chest, and just keep him…on the side in the recovery position" and Constable Roche "stood behind him so if he was to jerk backwards, he'd go into the legs…rather than the fence."[100]

[94] T89.33-43 (22 August 2023).
[95] T89.38 (22 August 2023).
[96] T115.40-49 (22 August 2023).
[97] T129.5-20 (22 August 2023).
[98] See eg: T115.16-19 (22 August 2023) – per Constable Joseph; T89.10-13 (22 August 2023) per LSC Cunningham.
[99] T90.5-10 (22 August 2023).
[100] Ibid.

- Sergeant Davies recalled that Constable Joseph and LSC Cunningham rolled Omar "onto his side in case it was a real medical episode"[101].

- Constable Joseph said they put Omar into the recovery position"[102] with Constable Roche "at the back holding him up;"[103]

- Constable Roche said he did "not necessarily" accept that Omar was definitely having a seizure; however, he was monitoring as to whether his condition worsened or not;[104]

84. Around 7.56am, it was clear to police that Omar was having a "full blown" seizure (Exhibit 5, [36]); at this point, LSC Cunningham requested that Sergeant Davies notify the ambulance (at which time he contacted police radio asking for an ETA and stating, "*let them [Ambulance] know we think he's heavily affected by drugs"* (Exhibit 5, at [36]).

85. As to the training of police about care and treatment for a person having a seizure, Sergeant Henley told the Court officers are trained to "place [the person] on their side, make them comfortable, protect them from any danger that's possible, move them out of the way…and make sure they don't hit their head."[105]

86. While Omar continued to seize, police continued to monitor him, however, apparently noted that he was going blue, and was struggling to breath: see Exhibit 5 at [48]; [51].

87. LSC Cunningham recalled Omar "foaming in his mouth, his pupils had gone from pinpoint to dilated … his colour in the face had drained. I think his lips at that point had gone like lighter and blue"[106] and his "breathing for a very short period almost sounding like a snore."[107] Sergeant Davies heard Omar "snoring and grinding his teeth."[108] LSC Cunningham said police did not start CPR at that point as Omar was having a seizure; when he stopped seizing, he started "breathing and the colour

[101] T33.35 (21 August 2023).
[102] T115.40-45 (23 August 2023).
[103] T117.15 (22 August 2023).
[104] T129.18-22 (22 August 2023).
[105] T150.40 (23 August 2023).
[106] T95.30 (22 August 2023).
[107] T96.20 (22 August 2023).
[108] T34.40 (21 August 2023).

almost slightly [came] back."[109] Constable Roche recalled that Omar "was in the recovery position … while he was seizing. He did appear to still be breathing."[110]

Administration of CPR

88. The evidence establishes that by 8.03.07am, Constable Joseph could not find a pulse. At 8.03.15am, Constable Roche, at that time a Probationary Constable, commenced chest compressions on Omar for 10 seconds (20 compressions); he then leant over Omar's mouth and at 8.03.27am, stated: "*he's breathing."*

89. The entirety of the first aid administered to Omar is captured – from various angles – by both the CCTV footage from the Haig Street premises, and also the BWV footage of attending police. It was essentially consistent with the oral evidence given by the relevant officers.

90. In oral evidence, LSC Cunningham recalled that when Omar "stopped breathing entirely" she said to "roll him on his back, CPR."[111] Constable Roche stated that "once he's gone to that state where he's not responding or unconscious then obviously then it's more we're looking at possible DRSABCDs."[112] LSC Cunningham recalled that Constable Roche "was the closest to the chest, so he took over that … he did compressions for a short period, five seconds."[113] Constable Joseph said police commenced CPR when they could not find a pulse.[114] She recalled Constable Roche was doing CPR, and would check Omar's breathing "and I believe I also then checked for his pulse."[115]

91. LSC Cunningham recalled Constable Roche saying "he's breathing"; then "we put him in the recovery position" and "spoke among ourselves to monitor the breaths."[116] Similarly, Constable Joseph stated that from the "moment he was breathing, we put him on his side just ensuring he was in the recovery position,"; police "kept monitoring him to make sure he was continuing to breathe"; if Omar had "stopped or had no pulse, we would've gone back to CPR and just kept doing that until paramedics arrived."[117]

[109] T97-98.45-50 (22 August 2023).
[110] T132.10-15 (22 August 2023).
[111] T99.30-40 (22 August 2023).
[112] T131.3-6 (22 August 2023).
[113] T99.30-40 (22 August 2023).
[114] T119.10-20 (22 August 2023).
[115] T118.25-40 (22 August 2023).
[116] T99.30-40 (22 August 2023).
[117] T119.10-20 (22 August 2023).

To monitor Omar's breathing, Constable Joseph "was checking for his pulse on his neck"[118] and recalled that his breathing "sounded more of him struggling to breathe but still breathing, just more grunting."[119]

Review of the expert evidence

92. The Court was greatly assisted by the evidence of prominent independent experts much of which was accurately summarised by Counsel Assisting. I rely on the matters set out in her submissions in this regard.

Adequacy of first aid administered by police

93. In her report, on the issue of the adequacy of the first aid provided by police, Professor Holdgate stated the following:

> *When Mr Mohammad began to deteriorate at 07:54 the police remained by his side and observed him closely. When he began to kick his legs the officers were not initially convinced this was a genuine seizure but by 07:58 they had recognized that he was having a seizure and had updated the ambulance request with this information. The police continued to reassess his breathing and pulse frequently and at 08:03:15 briefly perform chest compressions. They were reassured when he apparently took a breath after 15 seconds and return him to the recover position. This 'breath' most likely reflected passive movement of the lungs following chest compressions. After this brief period of chest compression, Mr Mohammad was returned to the recovery position and they continued to closely monitor him and believed that he was breathing and had a pulse. The video footage does not clearly show any signs of respiratory effort but is somewhat obscured by clothing and the movement of police. When the paramedics assess Mr Mohammad at 08:09 he had no pulse or respiratory effort. I note that it took 75 second for the paramedic to confirm this and commence chest compressions.*

94. Professor Holdgate stated that Mr Mohammad was unresponsive with abnormal

[118] T119.25 (22 August 2023).
[119] T119.45 (22 August 2023).

breathing from approximately 08:03am. The Australian Resuscitation Council CPR guidelines[120] recommend that 'rescuers must start CPR if the person is unresponsive and not breathing normally'. Based on these guidelines, which are the standard reference source for Australian first aid courses, Professor Holdgate stated that CPR should have been commenced and continued from 08:03 as Mr Mohammad was unresponsive with abnormal breathing from that point.

95. However, Professor Holdgate highlighted that the video footage clearly shows the police empathically caring for Mr Mohammad, repeatedly reassessing his breathing and pulse, repeatedly reassuring him and confirming with each other that he was breathing and had a pulse. Professor Holdgate noted that "…when the well-trained paramedics arrived, even they took 75 seconds to confirm that he had no pulse or breathing and commence CPR. This is not a criticism of the paramedics but rather demonstrates the real life challenges of clinical assessment, when even a trained professional can not necessarily rapidly identify the need for CPR."

96. In summary, Professor Holdgate stated:

> *It appears that the police attending to Mr Mohammad were not aware that CPR was indicated once he was unresponsive with abnormal breathing. They diligently observed him throughout so it seems more likely that the failure to initiate CPR was due to a lack of training rather a lack of appropriate observation.*
>
> *In summary, the first aid provided by police was not adequate as they did not provide timely CPR in keeping with current guidelines. My observation is that the police were diligent in their care of Mr Mohammad but did not recognize that CPR was indicated. I believe this reflects a lack of training rather than any recklessness or carelessness on behalf of the police.* [121]

97. In oral evidence, Professor Holdgate expanded upon her view that CPR should have been commenced at 8:03am. She said,

> *So my opinion is based on what I see and the small amount I could*

[120] https://www.revive2survive.com.au/wpcontent/uploads/2016/09/anzcor-guideline-8-cpr-jan161.pdf.
[121] Exhibit 1, Tab 150, 5-6.

hear of the footage where the police did initially identify that he wasn't breathing properly; did commence CPR but then when he took a motion that they interpreted to be a breath, they rolled him back onto his side and continued to monitor him the--in the recovery position. But I think by their ongoing discussion between each other, they remained uncertain and articulated things that indicated to me that he was not breathing normally; there was a comment that he's breathing very shallowly. They were asking each other repeatedly, "Is he actually breathing?" Someone was checking his pulse repeatedly and a pulse check can be very difficult in those circumstances.

To detect a pulse; it might even be your own pulse you're feeling in your fingerprints which is why the resuscitation recommendations are not to rely on pulse checks to commence CPR. As I said, in my report, I have a lot of empathy for the police; I think they were doing their very best and didn't recognise the fact he wasn't - the fact [Omar]was unresponsive and not breathing normally was an indication just to continue CPR. But I think, from what I could observe - and it was - it was partially obscured by the police getting in between the cameras and by the fact that Omar had quite a thick jacket on - there was no evidence that he was breathing normally and he was certainly unresponsive throughout that six-minute period as he was when the ambulance arrived at about 8:09.[122]

98. Professor Holdgate explained that "the only indication to cease CPR was when professional help arrived, so when the paramedics arrived, if Omar was showing clear signs of life which would be actively pushing away the attempts of resuscitation or when it was deemed that further CPR is futile, so if it had been for a prolonged period of time and there was no prospect of any help arriving."[123]

99. As to potential areas for improvement in terms of learning and emphasis, Professor Holdgate commented as follows:

[122] T213.14-36 (25 August 2023).
[123] T214.47-215.2 (25 August 2023).

- although police recognised abnormal breathing from 8.03am, "they didn't know what to do about it";[124]

- police did not identify that once CPR had commenced, it should not have been ceased until the relevant criterion in the ARC guidelines were met;[125]

- police should not have interrupted the CPR to check for a response or breathing;[126]

- pulse should not have been used to indicate whether CPR was required.[127]

100. Professor Pearn agreed with the views of Professor Holdgate.[128] He added that it was challenging and confronting for police, and that he was impressed by their concern and compassion for Omar (including that the tragic scenario was playing out in freezing conditions with strong wind gusts), as seen in the video compilation (Exhibit [3]).[129]

101. Expert paramedic Mr Molloy also agreed with these views. He stated the following:

> *I think, by the letter of what's within the guidelines, CPR should have been started and continued. However, I want to add that the fact that from a pre-hospital point of view and from my experience, the circumstances of the rapid decline of Mr Mohammad was - it can be confronting and also very complex in terms of the correct actions to be taken and in line with the first aid training, a lot of the CPR advice and a lot of the expectation around the compliance of that course is down certain cardiac arrest within, you know, a civilian or out-of-hospital setting which is designed on sort of like following on from a heart attack or a sudden stop as opposed to a rapid decline caused by any other means which can be very confronting. I'd to, again, just acknowledge the difficulty in the situations and the amount of care that the officers put in and I also echo the fact that clearly there was some confusion*

[124] T214.4-9 (25 August 2023).
[125] T214.11-15 (25 August 2023).
[126] T214.17-20 (25 August 2023).
[127] T214.22-25 (25 August 2023). A/Professor Holdgate stated that: "resuscitation recommendations are not to rely on pulse checks to commence CPR".
[128] T214.27-30 (25 August 2023).
[129] T215.34-216.1 (25 August 2023).

amongst the correct actions to be taken.[130]

102. Subsequently, Mr Molloy stated that the officers did a "phenomenal job in terms of both their empathy and attention to the patient and trying quite clearly to look at the best outcome for Mr Mohammad, but ultimately I think it came down to … a lack of confidence and knowledge in those appropriate factors of what they were seeing, which are very confronting."[131]

Clinical prognosis

103. Professor Alison Jones was asked about whether Omar might have survived had the CPR been continued from 8.03am until the arrival of the ambulance at 8.09am. She noted that it was a complex question but explained the position as follows:

> *It's very difficult, this is bystander CPR. So this is not the sort of CPR that we would be seeing in a hospital department. This is the sort of CPR that we see in the community and to be honest the outcome of CPR, what is bystander CPR, in the community is not in general great. About 10% is my understanding of patients who have a cardiac arrest in the community, unless they happen to arrest in front of directly in front of a paramedic or doctor with equipment, only about 10% roughly survive. So the outcome of bystander CPR is not great.*
>
> *I also take a step back from that and say in my toxicology opinion, but for the presence of cocaine, I think Omar would have survived. It was the cocaine that was, in my view, it's the cocaine that was directly a cause of what then became the fatal sequence of events. And to have both the cardiac arrest and repeated fits, and I think at one point I counted more than 4 minutes of what looked to be fitting on video, that is associated, regardless of whether one is hospitalised or not, with a very bad outcome that originated back to that drug. So I'm trying to make it as understandable as possible, but I think from the moment that the cocaine got into his system and the fact that he was in the community when he had those events, those two things were the predictor of outcome in this case.*

[130] T215.6-19 (25 August 2023).
[131] T243.45-244.2 (25 August 2023).

> *… it's very complicated, but I feel the outcome was dictated from the moment that cocaine started to have its toxic effects and the fact that those toxic effects then occurred in the community.*[132]

104. Professor Holdgate agreed with this evidence, stating the moment there is an "onset of seizures and cardiac arrest" in the "context of severe cocaine toxicity", "the outlook is very, very poor, even with the best of resuscitation, even in a community setting or in a hospital setting, and unfortunately I think the primary cause of Omar's death was severe cocaine toxicity, which occurred very rapidly after he'd ingested the cocaine."[133] She further explained that Omar:

> *… probably would've had a higher chance of survival if it had occurred in a hospital setting but the way in which it happened, that wouldn't have occurred. Even in a hospital setting, once he'd had the onset of severe continuous seizures and then cardiac arrest, the likelihood of survival would've been low.*[134]

105. Having reviewed the expert evidence carefully, I accept Counsel Assisting's submission that although the Officers thought that Omar was 'faking' the seizure, they nonetheless treated him in an appropriate manner for someone having a seizure. That is except for the fact that the NSW Ambulance Service ought to have been updated that Omar was having a seizure sooner, that is when his legs began to twitch (at around 7.54am).

106. It is possible that by reporting these physical symptoms, the ambulance call may have been given upgraded priority. NSW Ambulance (NSWA) provided further information regarding the Medical Priority Despatch System (MPDS) and the triage of the calls made to the service that day regarding Omar. This information indicates that at 7:58:46am, when information was received that Omar was having a seizure, the NSWA response was upgraded from 2I to IC, permitting a response under lights and sirens.[135]

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[132] T200.29-201.12 (23 August 2023).
[133] T211.6-14 (25 August 2023).
[134] T211.19-23 (25 August 2023).
[135] Exhibit 4, Letter to CSO dated 21 August 2023, (a) – (h).

107. Involved officers conceded that deciding someone is “feigning” or “faking” an illness should be a diagnosis of last resort.[136] I have no doubt that these officers will take that important lesson into their future operational policing.

108. Otherwise, it warrants emphasis that the available video footage shows that as Omar deteriorated during the seizure, police showed genuine concern, including repeatedly re-assessing whether he was breathing and observing him closely; confirming whether he had a pulse and making comforting remarks to him. The officers were attempting to provide appropriate care to Omar, they were not reckless or careless in any respect. I accept that they were doing their best in the circumstances, which as Professor Pearn noted, involved adverse environmental conditions, including strong wind, rain and cold.

109. I have no trouble accepting that the involved officers were diligent and attentive, in particular, once the severity of Omar’s condition became apparent to them. Nevertheless, a close review of these events presents opportunities for improvement in training for officers faced with like situations. In saying this, I accept the submission of the Commissioner that it is important to remember that the officers were faced with a situation which would have been very difficult to assess. Counsel for the Commissioner properly reminded the Court that each of the experts explained that recognising abnormal breathing can be extremely difficult. She quoted Professor Pearn who noted “It’s a very difficult area: what constitutes normal breathing…it’s a matter of judgment about whether breathing is within the bounds of normality or not.”[137]

110. I also accept Professor Pearn’s evidence that even for those trained in first aid, a sudden collapse can create “confusion, fright and concern” and Mr Molloy’s comments that bystanders can feel scared of doing the wrong thing or doing something wrongly.[138]

111. In my view personal criticism of the officers is not warranted. I accept the Commissioner’s submission that they broadly implemented the principles of “look, listen and feel” which Mr Molloy stated was best practise in the circumstances.

[136] T34.29-37 (21 August 2023) per Sergeant Davies; T51-52.42-1 (21 August 20230 per Sergeant McCaffery; T89.4-12 (22 August 2023) as per LSC Cunningham.
[137] T213 14-36 25 August 2023.
[138] T223 21-23 25 August 2023.

Nevertheless, they were somewhat hampered by gaps in their knowledge or training.

112. As part of this Court's death prevention function it is useful to focus on areas where further training may be indicated. These include:

- whilst police recognised abnormal breathing from 8.03am,[139] they did not know how to respond to it;
- although CPR was commenced by police, it should not have been ceased until the relevant criterion in the ARC guidelines were met;
- police should not have interrupted the CPR to check for a response or breathing;
- police were not aware that pulse is an unreliable indicator of whether CPR was required or whether a person is breathing.

113. I accept without reservation Counsel Assisting's submission that; the involved officers were ready and willing to acknowledge shortcomings in the first aid provided to Omar and were clearly affected by the traumatic events of that day. Their evidence suggested proper reflection on the circumstances of Omar's death, and a willingness to take on board all potential opportunities to learn from these tragic events That is commendable. I accept from the manner in which each involved officer gave evidence (noting also that some attended throughout the inquest), that they appear to be caring and diligent members of the NSW Police Force.

114. Additionally, the officers gave helpful, frank evidence as to the efficacy of the current first aid training regime and potential future recommendations, for the Court's assistance.

115. Ultimately, it was apparent that the involved officers had sought to provide Omar with first aid and CPR, in confronting circumstances, to the best of their ability.

116. Also, importantly I accept Counsel Assisting's submission, supported by all parties, that on balance, no failings in the administration of CPR would have affected the

[139] A/Professor Holdgate stated: "They were very attentive. I think the fact that they were even having a conversation about whether or not the breathing was the indication that it was abnormal, but they were certainly attentive in addressing that." T243.6-9 (25 August 2023).

outcome, given the medical evidence as to Omar's likely clinical prognosis after severe cocaine toxicity.

Issue 3 – adequacy of NSWPF processes, policies and training

117. As set out above, the conduct of the involved officers was largely in accordance with NSWPF policy, procedure and training in relation to the search and arrest of Omar. However, the Court also reviewed police action in relation to existent NSWPF training, policy and procedure with regards to first aid.

118. A summary of the NSWPF first aid training system (as at April 2023) was prepared by those assisting, together with helpful input from the Commissioner of Police to ensure the accuracy and currency of that document.[140] To complete the picture, in closing submissions, Counsel Assisting also summarised the oral evidence of both OSIs Sergeant Nicholas Henley and Sergeant William Watt. Counsel for the Commissioner indicated that she did not disagree with the summary of the evidence provided.

119. Based on that extensive material, the salient points of the training are as follows:

- prior to attesting from the New South Wales Police Force (NSWPF) Academy, Probationary Constables are required to complete a First Aid qualification via a registered training organisation (RTO); (NSWPF is not a national RTO regarding the delivery of first aid training);[141]

- once attested, first aid/CPR training is provided to sworn NSWPF officers as part of Mandatory Operational Safety and Skills training ('mandatory training') requirements;[142]

- the mandatory training of sworn police is a competency requirement under the Crown Employees (Police Officers – 2021) Award for incremental progression of both Commissioned and Non-Commissioned Officers;[143]

- the People and Capability Command (PCC) within which is Education and Operational Skills (ESO) and Operational Safety Training and Governance

[140] Tab 37B.
[141] Exhibit 1, Tab 37B, at [1]; [14].
[142] Ibid, at [15].
[143] Ibid, at [16].

(OSTG) has corporate responsibility for mandatory training procedures and requirements.[144]

- Operational Safety Training & Governance (OSTG) is responsible for the design, administration, and delivery of mandatory First Aid/CPR training package to sworn NSWPF staff (including general duties police);[145] package is delivered periodically to align with the financial year;[146]

- the training package is designed in accordance with the Australian Resuscitation Council (ARC) guidelines and will always include a component on CPR. The training generally consists of a practical component, supplemented by a PowerPoint presentation;[147]

- once designed, the training package is subject to approval by the Commander of E&TC and other members of the Commissioner's Executive Team;[148]

- the content of the training package is reviewed annually by staff attached to OSTG/WTPR. This review is undertaken during the development process for the mandatory training year;[149]

- OTSG is currently consulting with the Police Medical Officer and an independent external doctor regarding annual review of the training package;[150]

- staff within the OSTG that deliver the training to operational police complete an Operational Safety Instructor ('OSI') course which includes components on teaching methodology, fault correction and coaching skills;[151]

[144] See Commissioner's written submissions [15]
[145] In oral evidence, Sergeant Henley stated that there are 20 officers within that unit: T139.44 (23 August 2023).
[146] Ibid, at [17].
[147] Ibid, at [18].
[148] Ibid, at [19].
[149] Ibid, at [36].
[150] Ibid, at [37].
[151] Ibid, at [38].

- staff from OSTG have undertaken training 'over and above the content of nationally accredited first aid training' being training focused heavily on the response to trauma related injuries;[152]

- OSTG instructors in the field are assessed by a senior instructor periodically throughout the year and undergo re-accreditation to ensure they can deliver the mandatory training package to sworn officers in the NSWPF.[153]

120. As to the 2022-2023 training package, the following was stated:

> *The current (2022-2023) mandatory training package consists of a practical assessment of the delivery of CPR, coupled with tourniquet use. The lesson consists of a demonstration of CPR by the instructor, followed by an opportunity for a short period of monitored training, before participants are expected to demonstrate 2 minutes of CPR, including breathing, with an overall effectiveness of 75%. The resuscitation dummies utilised provide constant feedback to a hand-held tablet, allowing an instructor to provide coaching related to rate of compression, lung inflation, depth of compression and chest release in real time. Should the participant fail to achieve the required standard of effectiveness, they will be given a maximum of two further attempts before they will be provided additional focused training. Until they demonstrate competency, they would be restricted from performing operational duties. Once this has been completed, tourniquet use is revised before participants are expected to apply a tourniquet to a tourniquet task trainer and stop the flow of fluid within 30 seconds.*
>
> *The intention is for this package to be employed again for the 2023-2024 training year, with an additional emphasis on the recognition of what constitutes abnormal (or not normal) breathing, and the need for CPR to commence and continue until the person responds or begins breathing normally on their own.[154]*

[152] Ibid, at [39].
[153] Ibid, at [40].
[154] Ibid, at [48]-[49].

121. Against that backdrop, the inquest heard evidence from two Senior Operational Safety Instructors, who 'train the trainers' within NSWPF, including as to first aid and CPR.

Evidence of Sergeant Nicholas Henley

122. Sergeant Henley, a senior OSI (within the OSTG unit) gave evidence, and also provided three statements for the inquest.[155] He explained that his unit "trains the instructors that actually go and train the police on our street"; he was also an instructor himself.[156] Sergeant Henley explained the mandate of OSTG as follows:

> *So we train instructors. We write the training for the instructors which we deliver to the NSW Police. We also do training in special areas. Obviously we do coroners matters, use of force matters and the like of that sort of stuff.*[157]

123. Sergeant Henley's qualifications, as a senior first aid officer included that he completed a first aid certificate in 2021 (the last update that he had) by an external provider, St John's Ambulance; he had otherwise obtained his first aid certificate before joining NSWPF. That qualification was then refreshed every three years.[158] This entailed a two day course, the CPR component of which was about half a day.[159] Sergeant Henley had also completed trauma training with TacMed in 2015,[160] an external company (relating to major trauma for gunshot wounds, car accidents and the use of tourniquets[161] etc); that training was a day.[162]

124. Sergeant Henley explained that as a senior officer within the unit, he would "compile training and deliver packages to our operational safety instructors in the field" in a range of areas, including first aid.[163]

125. As to first aid training that officers receive regarding dealing with seizures, Sergeant Henley stated he was not aware of anything other than the training they receive before

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[155] Statement dated 3 May 2021 (Tab 36); statement dated 23 February 2022 (Tab 36A); statement dated 17 May 2022 (Tab 36B).
[156] T142.18-26 (23 August 2023).
[157] T143.35-38 (23 August 2023).
[158] T140.16-141.5 (23 August 2023).
[159] T141.15-20 (23 August 2023).
[160] Which has not since been refreshed: T143.13 (23 August 2023).
[161] T143.25-27 (23 August 2023).
[162] T141.26-30; T142.43-143.10 (23 August 2023).
[163] T139.38-140.22 (23 August 2023).

joining the police force. He agreed it was a "possibility" that was a potential gap in the training curriculum.[164] He also said it was a "possibility" that a training message to the effect that a diagnosis of someone feigning or faking an illness should be one of last resort was an important message to convey.[165]

126. In his statement of 3 May 2021, Sergeant Henley gave the opinion that the actions of attending police was consistent with the ANZCOR Guidelines provided by the Australian Resuscitation Council.[166] As set out below, this view was not consistent with the view expressed by the medical experts called to give evidence.

127. Sergeant Henley referred to his working knowledge of the Guidelines.[167] There was this exchange with Counsel Assisting as to the use of pulse in determining the need for CPR:

> *Q. Are you aware of whether or not pulse is a reliable indicator as to the need for CPR?*
>
> *A. I'm not aware of that, no.*
>
> *Q. You don't know that?*
>
> *A. I'm not aware that pulse is a reliable indicator. It's just through our training - we train them for breaths, check for breathing as a part of our training.*
>
> *Q. You don't know one way or the other, is that you're—*
>
> *A. I'm not medically trained. I'm unaware, I'm not a doctor or medical officer.*
>
> *Q. I understand, but you have an understanding of the ANZCOR guidelines, don't you?*
>
> *A. Yes, I have it - a working understanding.*[168]

[164] T150.38-151.12 (23 August 2023).
[165] T151.14-27 (23 August 2023).
[166] See Tab 36 at [70].
[167] T150.17 (23 August 2023).
[168] T151.50-152.14 (23 August 2023).

128. Sergeant Henley was then taken to Guideline 6 of the ANZCOR Guidelines:

> *Q. You'll see it goes on, "Palpation of a pulse is unreliable and should not be performed to confirm the need for resuscitation"?*
>
> *A. Yes, that's correct.*
>
> *Q. Were you unaware of that?*
>
> *A. I was unaware of that, yes. At this point in time, yes.*
>
> *Q. Is it fair to say that there are aspects of the guidelines that you're unfamiliar with?*
>
> *A. It appears so.*[169]

129. Additionally, Sergeant Henley was examined in relation to his understanding of non-normal breathing, which he explained to be shallow or agonal breathing; it can also be gulping or gasping. Ultimately, he agreed it was an area that could use more clarification generally.[170]

130. Further, Sergeant Henley was taken to a slide-pack 'Mandatory Training 2018-2019, CPR/First Aid TECC'[171], which contained some 82 slides; it appeared that 45 minutes was the allotted time to work through that material – although it could take longer.[172] He agreed it was quite a lot of material, and that when training people, he would "go through every slide and read through, if anyone's got any questions".[173] Sergeant Henley explained:

> *So there's two separate components to this. So this the slide component of it. There's also the practical component which is completed in the same day but separate. So the 45 minutes would be, could be the practical component and then the slides be done externally, done beforehand or after depending on when they do it.*[174]

[169] T153.6-15 (23 August 2023).
[170] T153.30-154.11 (23 August 2023).
[171] Tab 78
[172] T166.3-9 (23 August 2023).
[173] T161.28-40 (23 August 2023).
[174] T162.4-12 (23 August 2023).

131. Ultimately, Sergeant Henley suggested that Sergeant William Watt was the best person to answer questions to regarding the slide pack, as he was "part of writing this package".[175] However, Sergeant Henley confirmed that in January 2023, the slide pack was not used for the mandatory annual training package; only the practical was conducted (although breathing on the dummy was not used due to COVID precautions).[176] It appears the decision not to use the slide pack was made by senior management (and related to the Crown Employees Award training requirements), as the practical component was considered more significant than the PowerPoint Presentation.[177]

132. Sergeant Henley explained that the practical training was separate from the power point presentation; the practical component included compression/breathing on the dummy (with feedback), and tourniquet application (with feedback): this was also a 45 minute session.[178]

133. Otherwise, Sergeant Henley confirmed that to his knowledge, there is no particular training for police in relation to the use of defibrillators at this time.[179]

Sergeant William Watt

134. Sergeant Watt provided two statements for the inquest (dated 18 April 2023,[180] and 1 August 2023[181]); he was also called to give oral evidence. Sergeant Watt is a Senior OSI within the OSTG unit.[182] Like Sergeant Henley, Sergeant Watt would also deliver training to officers (he explained that the unit is currently short-staffed: the authorised strength is 21 staff but presently they have 13, from Constables through to Senior Sergeant).[183]

135. As to first-aid qualifications, Sergeant Watt has the same first aid requirement that all OSIs are required to hold, stating "in relation to formal qualification, that's the limit of it"; he had also undertaken a 'Stop the Bleed training package' in the United States in relation to armed active offender training. From 1994 to 2000, Sergeant

[175] T164.40-165.9 (23 August 2023).
[176] T166.44-167.14; T168.18-26 (23 August 2023) (compressions and feedback were used): T167.16-20 (23 August 2023).
[177] T168.19-169.21 (23 August 2023).
[178] T166.11-42 (23 August 2023).
[179] T158.36-39 (23 August 2023).
[180] Tab 37A.
[181] Tab 36C.
[182] T170.42-43 (23 August 2023).
[183] T172.48-173.10 (23 August 2023).

Watt was in the Australian Army, and had additional training in relation to managing environmental illness or significant trauma, and "CPR training" in accordance with national training standards at the time.[184]

136. Sergeant Watt explained the mandatory training process as delivered by OSIs, being a "mandatory training directive is designed and approved at the executive level to address both the industrial award and any identified issues."[185] It might relate to new skills, or refresher training, or use of police equipment or police powers; the mandatory training usually involved a live fire shoot, some form of DEFTAC and a first aid component which always included a component on CPR.[186]

137. As to the development of the CPR component over time, Sergeant Watt explained:

> *The CPR is obviously an essential skill for a police officer. We're responding to incidents where we're going to find people who need CPR to have any hope to survive. The evolution has typically followed what has occurred in the national standards, primarily informed by the fact that we require all instructors to maintain a current first aid certificate, and because that occurs on a rolling basis, we'll end up with people accrediting at different times. Granted, particular units and mine included, we will tend to all conduct our reaccreditation at the same time simply for efficiency's sake, but we have at the current time about 360 instructors across the state spread across all the commands. So, they will be reaccrediting on a regular basis. That may be provided - that training's typically - or that reaccreditation is typically provided by a local provider in the area they're operating in. We don't mandate a particular supplier or particular deliverer of training, so if an OSI identifies a significant change that we haven't already identified, they will notify us of it.*[187]

138. "Significant changes", Sergeant Watt said were identified when an officer looked at the training package, and said: "Hang on, I've just done my recertification, and this

[184] T173.25-49 (23 August 2023).
[185] T173.7-8 (23 August 2023).
[186] T174.7-44 (23 August 2023).
[187] T174.49-175.12 (23 August 2023).

has changed."[188] He described his own experience in relation to the necessity for rescue breaths in this regard.[189]

139. Sergeant Watt confirmed that at various times, the NSWPF training package had been reviewed by external clinicians.[190] It was also proposed that an independent doctor with experience in "high threat environments" would review the training package – although those negotiations were ongoing at the time of the inquest, and thus further details could not be provided.[191] Sergeant Watt provided the Court with an overview of the changing landscape regarding police first aid training, including the shift in emphasis to trauma medicine.[192]

140. As to the slide pack PowerPoint presentation, Sergeant Watt confirmed that it was delivered during the 2018-2020 training period. He explained:

> *…In a practical sense, PowerPoint is generally designed to be delivered first. We'll run through it with the attending police. It is important to note that this is not new training, this is refresher training. So, while there will be depth and complexity where there needs to be, in some areas it's already very well understood principles*."[193]

141. When asked how it was confirmed to be "well understood", Sergeant Watt stated:

> *The first one is one, the amount of times that they've been trained in it. The reality is up until 2015, every police officer would've seen something - would've seen a package containing similar material every 12-18 months during that timeframe. It's built on top of the fact that prior to them joining the New South Wales police they have to have a current first aid certificate, which generally most people obtain just before they start at the academy, which means that they're qualified for three years anyway, and it is - it'll come down to the individual instructor delivering it and generally, if there's something that is considered important - and we certainly make sure instructors are*

[188] T175.15-16 (23 August 2023).
[189] T175.19-23 (23 August 2023).
[190] T175.31-49 (23 August 2023).
[191] T176.23-177.13 (23 August 2023).
[192] T177.44-178.21 (23 August 2023).
[193] T178.48-179.2 (23 August 2023).

aware of what's considered important - they will then emphasise that when they deliver.[194]

142. Sergeant Watt confirmed that although the course was a 'refresher', some content would be "relatively new" as the focus would shift for each training year.[195] OSIs would attend a mandatory, annual reaccreditation workshop to enable them to deliver the training package (with 20 to 30 instructors attending each workshop). For the upcoming mandatory training year, this workshop is four days long. In relation to the CPR component, Sergeant Watt stated: "essentially we run them through the lesson that they are required to deliver and ensure they hit the mandatory training components."[196]

143. As to the large slide-pack, Sergeant Watt explained that although the guideline is 45 minutes, "the expectation is the content is delivered", and that when the mandatory training package is designed, there is always time allowed for lessons to run long (some will run shorter, depending on the group involved – i.e. the standard of the medical training for the Bomb Disposal Unit is higher, so less time is spent addressing key issues).[197]

144. Sergeant Watt agreed "absolutely" that it would best to separate the medical training from the compulsory firearm training, given that the shoot was stressful for officers;[198] he also noted the "unfortunate truth is the training window is somewhat limited."[199]

145. In his statement of 1 August 2023 Sergeant Watt outlined some changes to the proposed training program for 2023/2024, as set out in the Session Plan for OSIs.[200] He explained the change to be that instructors should explicitly include "non normal breathing and a lack of response" in the plan.[201] The sessions plans are not

[194] T177.4-14 (23 August 2023).
[195] T179.16-25 (23 August 2023).
[196] T179.41-180.20(23 August 2023).
[197] T180.37-44 (23 August 2023).
[198] T181.8-29 (23 August 2023).
[199] T181.45-182.1 (23 August 2023).
[200] See Tab 37C [11]. The session plans are only available to OSIs on the PETE (Police Educational Training Environment) system: T182.19-50 (23 August 2023).
[201] T182.11-16 (23 August 2023).

available generally – although "the general intention is to move in that direction with a number of different parts of our training."[202]

146. For the training year 2023-2024, there is no accompanying PowerPoint. He explained:

> *So the session plan is the guidance for operational safety instructors. Whether or not there is a PowerPoint, we've reached the point now that if we're delivering a PowerPoint, there will be a session plan indicating yeah okay these are the things that you need to address, now deliver the PowerPoint. The primary reason for the lack of a PowerPoint is again given a directive that we [are] to include all the components to satisfy award requirements into a single day, not all the ranges we use has the ability to run PowerPoint presentation. We don't own enough ranges.*[203]

147. For this current training year, Sergeant Watt confirmed that there is additional emphasis placed on the recognition of abnormal breathing; the criteria for commencing CPR; the normal respiration rate for adults; and a description of agonal respiration which emphasises the fact that agonal respiration is not normal respiration.[204] The training with this particular emphasis has started to be delivered.[205]

148. Further, on 19 July 2023, Sergeant Watt sent an email to OSIs as follows:

> *"Hello all,*
>
> *Given the commencement of the new training year, can all instructors reinforce the definition of "not normal breathing" during the CPR/TECC lesson please. The normal respiration rate for adults is 12-20 breaths per minute. Anything outside this may be indicative of a problem, especially if it is below 12 breaths per minute. Agonal respiration is described as gasping, gulping or laboured indrawn breaths with little or no exhalation and is indicative of a significant health issue. If this is accompanied irregular muscle twitching it is*

[202] T182.43-50 (23 August 2023).
[203] T183.11-20 (23 August 2023).
[204] T183.28-43 (23 August 2023).
[205] T189.42-43 (23 August 2023).

even more significant. A good video example of agonal respiration is contained in slide 21 the 2018-2019 first aid PowerPoint. It is located at: P:\NSWP Statewide\OSI\Mandatory Training\2018-2019 Mandatory Training\First Aid

Please emphasise the need to commence and continue CPR if thesubject is unresponsive to not breathing normally. The decision to commence CPR is critical, and we want to make sure operational police understand the criteria clearly. If there are questions or suggestions please contact OSTG."[206]

149. Sergeant Watt confirmed that the email was sent in part as a response to a general review of Omar's death.[207] The link in the email was to a video used as part of the 2018-2019 PowerPoint presentation.[208] Counsel Assisting played two additional recordings depicting agonal respiration.[209] Sergeant Watt agreed that this form of visual aid would "absolutely" be beneficial for OSIs and officers receiving the training to see.[210]

150. Otherwise, Sergeant Watt provided the following further evidence on aspects of CPR training:

- it is difficult to identify when a person is not breathing normally;[211]
- if in doubt or unsure, it was correct to start CPR (as operationally he had done before);[212]
- emphasis upon pulse being an unreliable indicator might be a worthy amendment/addition to the current session plan;[213] and
- in terms of feedback on the new training emphasis for the current training year, given staff shortages, it is "somewhat difficult for us to conduct any

[206] See Tab 37C, Annexure B, p 10.
[207] T185.35-46 (23 August 2023).
[208] T186-187 (23 August 2023) (being an example of agonal respiration): this recording was played in Court.
[209] Exhibit 6.
[210] T188.20-34 (23 August 2023).
[211] T188.36-39 (23 August 2023).
[212] T188.41-189.11 (23 August 2023).
[213] T189.13-31 (23 August 2023).

sort of quality assurance given our other task loadings;"[214] there is an "OSI shortage at the moment".[215]

151. Noting the capacity issues, the potential benefit of outsourcing first aid training to an external provider was canvassed with Sergeant Watt. He agreed there was "absolutely" potential benefits if it was the right provider, but noted it was an "exceptionally large task", given around 17,500 officers needed to be trained, and there was a significant amount of content for the nationally accredited first aid course that was not useful for police.[216] He stated this was an "executive level decision", given the amount of money and training time it would take.[217]

152. As to which officers should potentially have higher levels of first training, Sergeant Watt stated:

> *If I was to focus specialist additional training, I wouldn't be focusing it on - in the ideal world if I was to be asked to focus additional medical training for particular individuals, I would probably be looking at Senior Constables as the primary mechanism because their operators, they're not incident commanders, they're not incident managers.*[218]

153. Sergeant Watt agreed that although having a mobile supervisor with additional training to provide direction to junior police under their command was desirable, the supervisor is generally not the first vehicle at an incident.[219] There was this exchange:

> *Q. On that point, what do you think might be more effective?*
>
> *A. Ultimately, additional medical training for all police. Whether or not that can be accomplished is a different story, but ultimately that would be the best solution.*[220]

[214] T190.5-6 (23 August 2023).
[215] T190.15-16 (23 August 2023).
[216] T190.34-191.3 (23 August 2023).
[217] T191.5-8 (23 August 2023).
[218] T191.18-22 (23 August 2023).
[219] T191.34-38 (23 August 2023).
[220] T191.40-43 (23 August 2023).

154. As to communications with OSIs, Sergeant Watt referred to a "shared mailbox which is kept up to date": as soon as he sent an email, it would be automatically disseminated to everyone on the list.[221]

155. Sergeant Watt otherwise reiterated that the lack of definition as to non-normal breathing was "somewhat problematic", and that police were reliant upon the appropriate medical authority to provide an accepted definition ("It would be helpful").[222] Some of the training content in this regard was sourced from the ANZCOR Guidelines, and some of it was based on training undertaken during first aid accreditation.[223]

156. On the issue of defibrillators, Sergeant Watt explained that as there were many different models available, none of the first aid training courses focus on specific ones.[224] Sergeant Watt's personal view was that it would be beneficial for frontline police to have access to a defibrillator (although he did not believe that presence in a supervisor or duty officer vehicle was the most appropriate location).[225]

157. With respect to training formats within NSWPF, Sergeant Watt explained that:

- a Commissioner's Training Directive is a direction from the Commissioner to undertake specific training (as where there is an emerging issue that requires immediate rectification); it is typically used for something that the entire organisation is expected to undertake; it relates to the delivery of training (not the message);[226]
- NEMESIS messaging is most commonly used to deliver information to frontline police (there are a lot of such messages);[227]
- a training package via PETE involving an 'online training acknowledgment' could be used to deliver training as to identifying abnormal breathing.[228]

[221] T185.10-15 (23 August 2023).
[222] T194.32-45 (23 August 2023).
[223] T183.28-48 (23 August 2023).
[224] T192.2-8 (23 August 2023).
[225] T192.25-30 (23 August 2023).
[226] T192.35-193.30 (23 August 2023).
[227] T193.20-194.10 (23 August 2023).
[228] T194.14-28 (23 August 2023).

Views of involved officers in relation to the adequacy of NSWPF first aid training

158. The involved officers gave evidence as to their views regarding the first aid training provided by NSWPF, particularly in relation to CPR.

Nature of training provided

159. LSC Cunningham stated that "before you join the police you're required to do a first aid course" which is an "external source, it's actually proper first aid training" where they are trained by "medical professionals, not police officers."[229] However, once in NSWPF, police received "remedial training for shooting. We shoot our guns for hours…We get assessed on that and then we do a CPR and first aid component after that, so it's all on the one day" but the CPR component is "15 minutes, maximum" as it's "more of a refresher" and "you do compressions for two minutes. You get assessed on that."[230] LSC Cunningham said that she had asked educational development officers several times to be put on a first aid course (in 2018).[231] As to the CPR component of the training she stated:

> *It's simply a refresher. It definitely could be more detailed. If it's time for my opinion, I think that we should get taught by an external agency, we should get refreshers on that. And I agree with a smaller course but every couple of years at least, an updated first aid course, I think, would be really beneficial. But at the time, I believed it was adequate, I believed that obviously. I wanted more, obviously, because that's just sort of the person I am. I was relieving a lot, I wanted to be confident in my decision-making so I - it's not what I was questioning CPR component. I wasn't saying it wasn't adequate, I just wanted more.*[232]

160. Additionally, when asked about potential recommendations, LSC Cunningham stated:

> *An external course every now and then would be great. I'm not saying every year; I think that's a bit unreasonable to expect that and then a bit of a waste of money; you don't need to get an updated course every year but first aid training changes. An external provider providing that*

[229] T104.5-15 (22 August 2023).
[230] T103.30-50 (22 August 2023).
[231] T104.19-31 (22 August 2023).
[232] T104.32-50 (22 August 2023).

to a command would be very beneficial….Perhaps we wouldn't be here today if we'd had that, so, yes. I actually had a first aid course recently provided by work, now at Wollongong, which we volunteered for. I really appreciated having it. I wasn't at all upset that I was taken off the road for a minute to do it."[233]

161. LSC Cunningham explained that this course was over two days; about 40 police from Wollongong attended; and it was a basic first aid course, including a refresher on CPR which was half a day long.[234]

162. Sergeant Davies similarly indicated that the CPR training is the "same day that we do live fire" and as part of the CPR component, "we do two minutes of CPR on a dummy."[235] He referred to absorbing a "small amount" from the training day.[236]

163. Constable Joseph noted that "once a year, we have a training day which involves half live-fire which is our shooting component and the other being first aid training which incorporates CPR on a mannequin for a couple of minutes and tourniquets."[237]

164. Constable Roche said "we do our shoot and then we go over Active Armed Offender Training and performing CPR on people" which "would have been a small component to the actual shooting."[238]

165. Sergeant McCaffrey referred to working in Byron Bay and completing a four-day mandatory training course where they used "dummies" with an "iPad attached to them" for CPR training.[239] He said, "you go and you do the compressions and … you've done it for two minutes and that's about it."[240] He thought the CPR training was "probably not" enough.[241]

166. DI Fitzgerald, the OIC, noted that police receive mandatory training in "first aid that accompanies firearm" training and includes a "practical with the mannequin is over a

[233] T105.6-27 (22 August 2023).
[234] T105.39-42 (22 August 2023).
[235] T37-38.55 (21 August 2023).
[236] T38.40 (21 August 2023).
[237] T121.15-20 (22 August 2023).
[238] T135.45-50 (22 August 2023).
[239] T55-56, paras 20-25-40-5(21 August 2023).
[240] T56.10 (21 August 2023).
[241] T56.5 (21 August 2023).

two-minute period."[242] The first aid training takes "probably an hour" in which "half of that" is spent on CPR.[243]

CPR training – when to commence and cease CPR

167. In relation to the critical issue of when to commence and cease CPR, the evidence was as follows.

168. Sergeant Davies understood that CPR should be commenced "when someone is not breathing"; "check to see if they're breathing. If they're not, then continue."[244] At the time of the incident, LSC Davies said he did not have an understanding of the difference between normal and abnormal breathing in terms of delivering CPR.[245]

169. Sergeant McCaffrey indicated that he "wouldn't really say I'd know the exact extent of what to look for"[246] in relation to CPR. Further, he had not heard of agonal respiration.[247]

170. LSC Cunningham indicated that "there isn't really training in relation to" normal and abnormal breathing.[248] Her understanding of "abnormal breathing was if … there was an obstruction" and you "need to roll them on the side and get this intrusion out."[249]

171. Constable Roche said his only understanding of agonal breathing at the time was "from an episode of Bondi Rescue"[250] and that "there are issues with breathing when performing CPR where once you begin, sometimes the air escaping from the lungs can appear to give the appearance of someone breathing."[251]

172. Constable Joseph told the Court that based on her training CPR should be commenced "when someone's not breathing, and you can't feel a pulse."[252]

[242] T16.5-15 (21 August 2023).
[243] T16.15-20 (21 August 2023).
[244] T38.20 (21 August 2023).
[245] T37.10 (21 August 2023).
[246] T56-57.45-50 (21 August 2023).
[247] T57.5 (21 August 2023).
[248] T98-99.50-5 (22 August 2023).
[249] Ibid.
[250] T134-135.50 (22 August 2023).
[251] T135.5 (22 August 2023).
[252] T118-119.50 (22 August 2023).

173. As to when CPR should be stopped:

- Sergeant Davies understood CPR should cease "either [when] the ambulance are on the scene or the person regains consciousness or starts breathing on their own;"[253]

- Sergeant McCaffrey understood that CPR should stop when there is "normal breathing or … the ambulance or someone turns up and they can … continue or do an assessment;"[254]

- Constable Roche understood that CPR should be ceased "once other help arrives, once you're too tired to continue, or pretty much one they're up and awake;"[255]

- Constable Joseph stated that, based on her training, CPR should be ceased "when they're breathing or … you can start feeling a pulse."[256]

Conclave evidence on NSWPF first aid/CPR training

174. The conclave, Professor Holdgate, Professor Pearn and Mr Molloy, addressed a number of issues, including potential improvements to the NSWPF first aid training regime.

175. I accept Counsel Assisting's summary of their evidence.

ARC Guidelines

176. Professor Pearn explained that the ARC Guidelines are the summary of best practice resuscitation, and "that there is nobody currently teaching resuscitation in Australia that does not follow this basic guideline."[257] There is a specific process for review or development of individual guidelines that is done every two to four

[253] T38.15 (21 August 2023).
[254] T57.5-10 (21 August 2023).
[255] T136.35 (22 August 2023).
[256] T120-121.50 (22 August 2023).
[257] T212.9-20 (25 August 2023). Professor Pearn also stated, in terms of "abnormal breathing": The important thing is hands-on scenario training, regular upskilling at least once a year in this basic skill which can confront anyone of us as bystanders at any time." T220.15-28 (25 August 2023).

years.[258] It is possible for member organisations of the ARC or interested individuals to bring amendments to the notice of the ARC (including Professor Pearn).[259]

Recognition of abnormal "not normal breathing"

177. The Guidelines require that "Rescuers must start CPR if the person is unresponsive and not breathing normally." There is no relevant distinction between "not normal breathing" and "abnormal breathing".[260] On this topic:

- Professor Pearn:

  i. noted "this is one of the most difficult of all areas in practice; what constitutes normal breathing, and of course, there's a huge spectrum from normal breathing right through to total absence of breathing, with everything in between";[261]

  ii. agreed that "gasping" and "gulping" is a form of abnormal breathing;[262] so too, "extremely shallow breaths";[263]

  iii. agreed that "not breathing normally or abnormal breathing on a person who is unresponsive is a trigger for CPR", but it's a matter of judgment about whether the breathing is within the bounds of normality or not – that is the "great difficulty";[264] and further, "it's an infinitely sliding scale";[265]

  iv. believes that every member of the community, and "certainly every uniformed member of the community", should have current certification in CPR resuscitation;[266]

  v. agreed that in terms of first-responders, and given the risk of not doing CPR can be death, it is better to have a go than not ("Yes, indeed. Because if that CPR is effective, the casualty would very quickly respond

[258] T212.35-213.1 (25 August 2023).
[259] T212.44-213.6 (25 August 2023).
[260] T220.5-8 (25 August 2023).
[261] T216.27-30 (25 August 2023).
[262] T216.40-48; T217.40-45 (25 August 2023).
[263] T221.48-222.2 (25 August 2023).
[264] T216.50-217.5 (25 August 2023).
[265] T218.9-11 (25 August 2023).
[266] T216.18-21 (25 August 2023).

and would start to move and that would be then the signal to stop the CPR");[267]

vi. agreed that it would assist first responders to have some factors to identify whether breathing is abnormal or not, but stated:

> *Yes, but there is no alternative to scenario training in this context. It's no good just reading about it. There has to be hands-on training and upskilling, in my view, for certainly uniformed colleagues*.[268]

vii. agreed that changes to the rate and rhythm of breathing can indicate abnormal breathing;[269] as to guidance to police in this regard:

> *I'd say that there should be hands-on mannequin training and also that there should be scenario training and discussion about various types of abnormal breathing, with simulated gasping, agonal gasping, for example, but that regular shallow breathing would, in my view, not require CPR. These are very fine points and their counsels of perfection.*[270]

viii. stated that the necessary resuscitation training requires "barely half an hour", when taught by bodies such as St Johns and Surf Lifesaving; extensive research shows that skills of hands-on resuscitation start to degrade within six months; so the CPR component only has a currency of 12 months;[271]

ix. emphasized that scenario training is "absolutely" important;[272]

x. agreed that the critical message in the CPR space, is that if in doubt about whether a person has abnormal breathing and is unresponsive, start CPR immediately;[273]

[267] T218.20-23 (25 August 2023).
[268] T218.47-50 (25 August 2023).
[269] T219.1-4 (25 August 2023).
[270] T219.23-26 (25 August 2023).
[271] T220.22-34 (25 August 2023).
[272] T220.35-38 (25 August 2023).
[273] T220.39-42 (25 August 2023).

xi. reference to normal respiration rate was too specific ("I wouldn't myself have put a rate of breathing");[274]

- Mr Molloy:

i. agreed that normal respiratory rates of 12 to 20 can be a "misleading"; he stated:

> *I'd say in the case of a collapsed unconscious patient we go by the teaching of the patient is breathing abnormally, such as sort of gasping, and that we encourage people to look, listen and feel, so it's actually to look, listen and feel with your hand on the chest and feeling the breaths and looking at the rise and fall of the chest for a minimum of ten seconds to gauge the normality and that rate.*
>
> *I guess the complexity comes down to the fact that each person, depending on their anatomical makeup in terms of everything down to, you know, the length of their neck, the amount of weight they have around their neck, the size of their tongue, the positioning that they're in, will slightly make that grasping respiration at the point of the person being in need of respiration being slightly different. I think we can give advice and we do within our classrooms about understanding agonal respirations and the fact that it can be a snore or a grunt or fairly different, but the key factors are that the patient is unconscious and potentially unable to maintain their own circulation and respiration. So, as you said yourself, some intervention is better than nothing and we would encourage the starting of CPR until the point where the patient either becomes able to sort of resist and remove you away or a health professional tells you to stop*.[275]

[274] T221.36-41 (25 August 2023).
[275] T222.24-44 (25 August 2023).

ii. emphasised that identifying abnormal breathing can be very hard "until it gets to the point where we need to step in and do something about it";[276] thus, the critical message to emphasise is, "if in doubt, have a go";[277]

iii. as to factors to assist identifying abnormal breathing, it is "very complex", but "you're looking for a lack of regularity within that respiration": one of the important factors is "abnormal, gasping, irregular" breathing;[278]

iv. agreed that irregular snoring is an indicator of abnormal breathing;[279]

v. noted that having some visual or audible clues for what is meant by "abnormal breathing" is a good recommendation to have within the training, and can be helpful;[280]

vi. explained that a normal CPR course is four hours; for "refreshers", there are versions covered in two hours, although there is some pre-learning involved; normally, between two to four hours would cover CPR, including abnormal breathing and compressions;[281]

- Professor Holdgate:

i. agreed that it is difficult to define "abnormal breathing", it is a diffuse term. She stated:

> *… it's very hard to give a precise black and white description of what is abnormal. It's essentially something that is not normal, and I think if you over rely on descriptors which will be interpreted differently by different people, that can sometimes be more confusing.*[282]

[276] T222.48-223.7 (25 August 2023).
[277] T223.25-28 (25 August 2023).
[278] T223.33-41 (25 August 2023).
[279] T224.10-13 (25 August 2023).
[280] T225.35-42 (25 August 2023).
[281] T225.6-21 (25 August 2023).
[282] T225.28-31 (25 August 2023). Professor Holdgate also stated: "I think it is very difficult. I think the term, "Abnormal breathing" is there for a reason because it's too difficult to define specifically, but there are descriptors that would be helpful." T226.5-7 (25 August 2023).

ii. appreciated that it would be helpful to have more specific guidelines about what “abnormal breathing is”, and stated:

> *I think you can add in those sorts of descriptors, you know, consider factors like, “Does the breathing look regular or irregular”. If there’s noise associated with the breathing, the first step is to open the airway. If the breathing appears very, very slow, those are all factors that would increase the likelihood that it's abnormal. If it’s associated with a colour change, particularly if the patient is noticed to be blue around the lips, that would also increase the likelihood that this is abnormal breathing.*[283]

iii. noted the following:

> *… most of the training and up and involved in, for you know, basic life support refresher courses is the focus is very heavily on the technical aspects of actually doing the CPR and not as much of an emphasis of the indications for CPR. So, I think particularly for the police who are likely to face this, that probably would be helpful to emphasise more, like when do you have to do it, because I think the police officers here obviously knew how to do CPR, the difficulty for them was knowing when to do it.*[284]

iv. stated that scenario training is “crucial” – “because then you can help look at different - "Is that abnormal or not? Would you think that's abnormal or not? Talk amongst each other". I think if you're having a discussion about breathing, its abnormal.[285]

178. The panel was asked about the challenges associated with identifying agonal breathing, which Mr Molloy described as “a gasping respiration at the point … not connected to the normal respiratory impulse, so it’s at the point where potentially it’s more of a nervous response from the body as opposed to a respiratory response from the - within the normal course of breathing.”[286] It is linked to a “dying brain

[283] T225.42-48 (25 August 2023).
[284] T225.9-15 (25 August 2023).
[285] T225.19-22 (25 August 2023).
[286] T226.45-50 (25 August 2023).

impulse".[287] Agonal breathing is often misunderstood for normal breathing in CPR[288] (Mr Molloy identified Omar as having agonal respiration shortly after the initial seizure).[289] Mr Molloy agreed with the definition of agonal respiration as "gasping, gulping or laboured indrawn breaths with little or no exhalation" (derived from Tab 37C, p 7 – the current session plan for the CPR unit).[290]

179. Professor Pearn and Professor Holdgate agreed with this evidence.[291] Professor Holdgate specifically agreed that identifying agonal breathing can be "very challenging".[292]

NSWPF first aid training regime

180. The conclave had the benefit of the transcript of the evidence of Sergeants Henley and Watt,[293] together with relevant training material contained in the brief and the training summary document (Tab 37B). An overview of the training regime was also outlined (and subject to helpful clarification by Counsel for the Commissioner of Police).[294]

181. The experts commented as follows:

- Mr Molloy:

    i. the number of slides to cover in 45 minutes is "quite a lot" to gain information "and the take-away"; although he applauded the evolution to the refresher of skills and the hands-on component, he stated "they should be supported with continued knowledge refreshers as well";[295]

    ii. stated:

> *Again, it's always easy as a trainer and as somebody that works in my field to be wanting to push for further time within that training and to extend it out to ensure that we have better*

[287] T226.12 (25 August 2023).
[288] T227.4 (25 August 2023).
[289] T226.30-40 (25 August 2023).
[290] T227.14-22 (25 August 2023).
[291] T227.24-47 (25 August 2023).
[292] T227.3 (25 August 2023).
[293] Save for A/Professor Holdgate; T228 (25 August 2023).
[294] T228.21-230.4 (25 August 2023).
[295] T230.19-24 (25 August 2023).

feedback, we have better knowledge content, and I think that's possibly the only things that's lacking there; that the challenges, operationally, within the force, to get people through this training and the amount of that they need to include across or that they're operational training has reduced this down to a point where possibly some of the continued importance of the narrative, such as what we've talked today, in terms of identifying respirations may be being lost …[296]

iii. noted that CPR courses can be run effectively across two hours, which goes through the knowledge component, the airway, what effective CPR looks like, as well as using AEDs: that's the short acceptable "industry standard" course;[297] "very rarely" could the CPR unit of competency in a first aid course be delivered in less than two hours properly;[298]

iv. there are a lot of benefits to partnering with a reputable organisation or provider, with a background in delivering training effectively to a period of time. Mr Molloy stated:

Because having done this myself with both police and fire, it's quite amazing the questions that get raised in the room which adds to that conversational aspect that we've all spoke about today that comes up through the benefits of scenario-based training.[299]

v. the benefits of external training also included:

1. the ability for that training to be accredited by the external provider, which provides additional credibility and no suggestion of institutional influence;

2. further, the "crucially important factor" of delivering training by subject matter experts with a full breadth of knowledge;[300]

[296] T230.32-40 (25 August 2023).
[297] T231.8-15 (25 August 2023).
[298] T2412.6-20 (25 August 2023).
[299] T231.30-33 (25 August 2023).
[300] T231.39-232.3 (25 August 2023).

vi. internal training through an appropriately qualified person is suitable – although he challenged the "knowledge component" about what had been delivered in the timespan of the current reaccreditation;[301]

vii. scenario training is "of great benefit", and can take a number of different forms;[302]

- Professor Pearn agreed with Mr Molloy's evidence, adding his view that every uniformed officer (including police) should have a current first aid certificate, and should certainly have the CPR component of that up to date, as a "fundamental, almost an ethical requirement"; the financial cost and time investment was acknowledged by Professor Pearn, however, he stated in the spectrum of police training, he regarded CPR skills "as almost nondiscretionary and certainly for a uniformed colleague in any of the uniformed services that are part of our society."[303]

- Professor Holdgate stated the following:

> *The training does seem heavily focused on the practical skill of CPR and I think the issue of interest today is it's about recognition of when to do it, so I think it should be more broadly about basic life support which incorporates CPR rather than just the practical skill of delivering the CPR, and basic life support includes the recognition of when CPR is required, the steps before you start chest compressions such as simple airway manoeuvres and calling for help, as well as actually doing the CPR. I think I would agree with my colleagues about the challenges of using external versus internal providers as the challenge of cost and time. In the hospital system we also have about 500 mandatory things we have to do and working out which are the most important is very challenging for any big organisation, but I think my main thing would be that it's not just a focus on how to press on the chest and blow on a mask, but on how to make the decision to do that and what are the steps you have to go through before you get to that point because I think*

[301] T241.21-26 (25 August 2023).
[302] T232.8-27 (25 August 2023).
[303] T232.47-233.25 (25 August 2023).

in this situation that's what the primary issue was.[304]

Defibrillators

182. In his report, Professor Pearn stated the following as to the use of defibrillators:

> *I certainly agree that semiautomatic defibrillators should now be standard equipment in all police responding vehicles and should no longer be regarded as an optional extra. Without defibrillation, the chance of an unconscious heart attack victim (the commonest cause of collapse) leaving hospital with an intact brain is only 12%; but with the application of a semiautomatic defibrillator by a bystander, this figure can be raised to at least 50%.*[305]

183. This view was reiterated in Professor Pearn's oral evidence: he explained that semi-automatic defibrillators require minimal training as apart of annual CPR recertification: they can be operated by lay people, and protect a collapsed patient in the prehospital domain, delivering a shock if there is shockable rhythm.[306] In the great majority of cases where a person has a cardiac arrest, in theory there is potentially a shockable rhythm for several minutes after the initial heart attack.[307]

184. Professor Holdgate explained that approximately 50% of people who end up being monitored during a cardiac arrest have a potentially shockable rhythm.[308] She explained further:

> *The value of AED's is that it can be used by pretty much anyone. I mean, they're in sports stadiums. They can be used by laypeople, they require – you can follow the instructions just by pressing the on button, you get verbal instruction, and it will allow people who have a shockable rhythm to be delivered an early shock which vastly increases their chance of survival. Of course, if you have a non-shockable rhythm, they'll make no difference whatsoever.*[309]

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[304] T233.29-44 (25 August 2023).
[305] Tab 152, at [39], p 6.
[306] T234.45-235.3 (25 August 2023). A shockable rhythm being ventricular tachycardia or ventricular fibrillation: T235.80 (25 August 2023).
[307] T235.29-32 (25 August 2023).
[308] T235.37-45 (25 August 2023).
[309] T235.46-50 (25 August 2023). A non-shockable rhythm is asystole or pulseless electrical activity: T236.4-7 (25 August 2023).

185. Additionally, Professor Holdgate agreed that out of hospital cardiac arrests are a leading cause of death in Australia. As to the significance of early defibrillation, she stated:

> *… there's definitely a proportionate – the risk of nonrecovery increases with every delay to defibrillation which is why there's such a strong focus on continuous CPR followed by early monitoring and defibrillation because we know early defibrillation is the key to survival.*[310]

186. Mr Molloy considered the proposal to have AED as standard equipment in all police response vehicles a "very sensible recommendation", given that police respond across the community and are often first on scene for a lot of incidents.[311] He also noted that:

> *They are reasonably cheap,*[312] *they're very simple to use, they don't take up a lot of space and from the evidence that we see both clinically and without a doubt what I've seen on the road, is it makes a huge difference if an AED is applied and utilised prior to emergency services - as in ambulance - arriving.*[313]

187. A copy of proposed recommendations (in the form of Exhibit 7) was provided to the expert panel.

188. As to proposed Recommendation 3(d) regarding identification of abnormal breathing, A/Professor Holdgate provided further input about relevant factors in that regard.[314] Save for those matters, Professor Holdgate supported the recommendations.

189. Professor Pearn also agreed with the proposed recommendations, although reiterated as to recommendation 6 that "every uniformed person should be trained in first aid" irrespective of rank, and should have a current recertification in CPR.[315]

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[310] T236.11-15 (25 August 2023).
[311] T236.37.237.6 (25 August 2023).
[312] Mr Molloy explained that the cost varies, depending on the model: T236.10-20 (25 August 2023). Further, they do not require any maintenance, save for regularly checking the battery in terms of shelf life; the AEDs themselves are "very robust": T237.25-31.
[313] T236.2-6 (25 August 2023).
[314] T237.48-238.22 (25 August 2023).
[315] T238.36-239.4; T240.45 (25 August 2023).

Professor Pearn agreed that the CPR component could be done internally "by any provider".[316]

190. Mr Molloy agreed with the recommendations, although also provided further input as to identification of abnormal breathing.[317] Mr Molloy also agreed with Professor Pearn on the topic of police first aid training, stating:

> *So, I agree with that and just to add on to Professor Pearn in terms of the training, I think while I acknowledge the police force has a huge amount to train with, I agree that I think uniformed officers of all services should be trained in first aid and in CPR with a requirement to requalify every three years for first aid and every year for CPR. I think in terms of - perhaps for internal safety, but also for the community. When we look at work safe regulations around first aid, it's often put in as one to every 50 people within a workplace, and obviously within uniformed services, we move through the community in a way that it's very often that a uniformed member would be the first person that somebody sees on or off duty if something were to happen in that group of 50, wherever it may be, which means that the responsibility often falls to whether they feel confident and comfortable or not*.[318]

191. All experts agreed with a proposal to add to the recommendations, the need for scenario training relation to CPR.[319]

Issue 4 – The need for Recommendations

192. As noted above, Counsel Assisting prepared draft recommendations[320], including for the purposes of consideration during the expert conclave. Those recommendations were then revised, having regard to the evidence received during the conclave.

[316] T240.50-251.7 (25 August 2023).
[317] T239.9-20 (25 August 2023).
[318] T230.22-35 (25 August 2023).
[319] T239.35-240.1 (25 August 2023).
[320] Exhibit 7.

193. Counsel Assisting submitted that the revised list of draft recommendations should be considered pursuant to section 82 of the Act as being necessary and desirable in relation to the circumstances of Omar's death. I will deal with those recommendations now.

Recommendation 1 and 2 – use of automatic external defibrillators

194. Recommendation 1 states:

> **As out-of-hospital cardiac arrests are one of the most common causes of death and because survival prospects are greatly improved where automatic external defibrillators (AEDs) are used, that urgent consideration be given to equipping all police response vehicles with AEDs for use as standard equipment by frontline police.**

195. Recommendation 2 states:

> **That as an interim measure pending the roll-out of AEDs for all police response vehicles, that urgent consideration be given to AEDs being provided to all mobile supervisor and duty officer vehicles in each Police Area Command.**

196. These recommendations were strongly supported by the expert conclave: I accept that there is clear evidence to support the view that early defibrillation can be key to survival.

197. Additional evidence in support of these recommendations was as follows:

- LSC Cunningham agreed that AEDs would be helpful equipment for frontline police officers;[321]
- DI Fitzgerald's evidence as to an incident where police provided first aid to a driver in a motor vehicle collision, and there was delay due to the need to retrieve an AED from the police station.[322] Following this, the Commander purchased three AEDs to place in the car of the duty officer and each of the

[321] T106.14 – 20 (22 August 2023).
[322] T15.41-16.50 (21 August 2023).

supervisors' vehicles. The AEDs have since been used at scenes where police have attended.[323] DI Fitzgerald stated that "ideally… [AEDs would] be in all police vehicles," however agreed that a good interim measure was to have an AED in the mobile supervisor's car and with the duty officer. [324]

- Sergeant Watt's personal view that it would be beneficial for frontline police to have access to a defibrillator (although he did not necessarily consider the most appropriate location to be the supervisor or duty officer's vehicle).[325]

198. The Court was informed that the NSWPF does not support recommendation one at this time. However, Counsel for the Commissioner submitted that the NSWPF had commenced a trial of AEDs in police vehicles at North West Metropolitan Region Field Operations (NWMR Field Ops). The AED trial was due to conclude in October 2023, after which the data and recommendations from the trial would be reviewed and considered.

199. Counsel for the Commissioner also submitted that recommendation 2 is "Not supported at this time", but again noted the AED trial which will be reviewed.

200. The Commissioner had also provided evidence in relation to a trial of AEDs currently in progress in the Hills Police Area Command (**PAC**), as detailed in a statement from Superintendent Darrin Batchelor.[326] The trial began on 26 October 2022; it involves six AEDs in first response vehicles and a further six AEDs in highway patrol vehicles based at Castle Hill Police Station.[327]

201. Of note, Superintendent Batchelor states that officers have attended several incidents where an AED has been prepared for use (although not placed on the patient); in one incident, the device was used although the patient did not survive. Significantly, Superintendent Batchelor states that police officers involved in using the AEDs as part of the trial "feel confident and reassured by having them."[328]

[323] T16.15 – 23 (21 August 2023).
[324] T16.34 – 39 (21 August 2023).
[325] T192.25-30 (23 August 2023).
[326] Statement of Superintendent Darren Batchelor dated 19 September 2023.
[327] Ibid, at [9].
[328] Ibid, at [11].

202. The 'Automated External Defibrillator (AED) Procedures' Policy Document (published October 2022) for The Hills PAC, states the following:

- "The importance of timely defibrillation in conjunction with effective CPR is well documented as a key factor influencing the survival of patients suffering sudden cardiac arrest (SCA) …" (at [1.2]);
- "In its key role as a widely distributed emergency service, the NSW Police Force (NSWPF) is uniquely placed to afford the community and NSW Ambulance added support" (at [1.3]);
- "AEDs form an important component within the chain of survival and the basic life support, although no formal training is required to used AED" (at [3.3]);[329]

203. The Hills PAC trial concluded in October 2023, and the Commissioner has indicated that the data and recommendations from the trial will now be considered (and cannot be provided at this time).[330]

204. Against that backdrop, and the persuasive evidence from the expert conclave in these proceedings, I accept Counsel Assisting's submission that recommendations 1 and 2 are formulated in relatively modest terms, requiring only that the Commissioner give *urgent consideration* to the proposal to equip police vehicles with AEDs as standard frontline equipment, and also give *urgent consideration* to rolling out AEDs to a limited number of vehicles as an interim measure (i.e. mobile supervisor and duty officer vehicles in each PAC).

205. I note that the trial referred to by the Commissioner has now concluded and given the importance of the issue, urge the Commissioner to reconsider implementing the recommendation, taking into account the expert and other evidence in these proceedings.

206. Counsel for the Commissioner noted that there was no evidence before the Court that an AED would have assisted in the particular circumstances of this case (i.e. where Omar's seizures and collapsed state related to the ingestion of cocaine

[329] Ibid, Annexure A – NSWPF 'Automated External Defibrillator (AED) Procedures), The Hills Police Area Command'.
[330] Letter dated 10 November 2023 from the Commissioner of NSWPF, OGC.

causing an acute reaction).[331] Further she submitted that the Court should accept the opinion of Professors Jones and Holgate that Omar's prognosis was "very very poor, even with the best resuscitation."[332] I accept those submissions, but having received evidence on the value of AED in the context of this inquest, the recommendation remains worthy of further consideration. Given the life-saving capacity of an AED, and the comparative ease of use – the obvious utility of such devices cannot be doubted. The Hills PAC policy acknowledges the value of such devices, and also the unique position of police to provide first response first aid. Certainly, the logistics, and financial detail underlying any such AED roll-out is a matter that will require close and careful consideration by the Commissioner. Nevertheless, I recommend such consideration should now urgently commence, in conjunction with the Hills PAC trial data. A single AED, in a single vehicle, in the right place, at the right time – may well save another person's life. Given their role as first responders, police are uniquely placed to deploy this life-saving equipment.

Recommendation 3 – mandatory annual training in relation to CPR

207. Recommendation 3 states:

That the NSW Police Force mandatory annual training for CPR include key emphasis upon the following messages:

- **a. That CPR should be started if the person is unresponsive and not breathing normally (abnormal breathing);**
- **b. To assess breathing – rescuers should look, listen and feel:**
  - **i. LOOK for movement of the upper abdomen or lower chest;**
  - **ii. LISTEN for the escape of air from nose and mouth; and**
  - **iii. FEEL for movement of air at the mouth and nose;**
- **c. That palpation of pulse is unreliable and should not be used to confirm the need for resuscitation;**
- **d. That abnormal breathing can be hard to identify - it is something that is "not normal". Consider factors such as:**

[331] Commissioners Submissions [18].
[332] Commissioners Submissions [20].

i. **Does the breathing look irregular or irregular? Is it very slow (which suggests it may be abnormal)?**
ii. **Is the breathing noisy? If so, check that the airway is open.**
iii. **Is there a colour change (for example, is the patient blue around the lips)?**
iv. **Is there gasping or gulping?**

e. **If in doubt about whether a person is experiencing cardiac arrest or not, the rescuer should start CPR without concern about causing additional harm (rib fractures and other injuries are common but acceptable consequences of CPR given the alternative of death); that is – "If in doubt, have a go"**
f. **That if unsure about 'abnormal breathing,' start CPR (even if the person takes occasional gasps or gulps);**
g. **That agonal breathing is common in the first few minutes after a cardiac arrest – it is sudden, irregular gasps or gulps of breath. This should not be mistaken for normal breathing and CPR should be given straight away;**
h. **That CPR should be continued until any of the following conditions are met:**
i. **the person responds or begins breathing normally;**
ii. **it is impossible to continue (e.g. exhaustion);**
iii. **a health care professional arrives and takes over CPR;**
iv. **a health care professional directs that CPR be ceased;**
i. **That CPR should not be interrupted to check for response or breathing;**
j. **That the faster the rescuer acts, the higher the chances of survival.**

208. Recommendation 3 is 'acknowledged' (and apparently supported) by the Commissioner, who indicated that the content will be incorporated into the NSWPF first aid and CPR training.[333]

209. This is commendable and, in due course, the Court is keen to be advised of the Commissioner's timetable for implementation.

[333] OGC Recommendation Table dated 20 September 2023; Annexure to Commissioner's Submissions.

Recommendation 4 – provision of CPR information to all members of the NSWPF on an urgent basis via NEMESIS; PETE and scenario training

210. Recommendation 4 states:

> **That CPR information as set out in (3) above is provided to all members of the NSW Police Force on an urgent basis (noting that the administration of CPR can be a matter of life and death), by way of:**
>
> **a. A state-wide NEMESIS message; and**
> **b. A module provided to officers who perform frontline general duties delivered via Police Education Training Environment (PETE) that requires the officer to acknowledge their review of the material; and**
> **c. Appropriate scenario training**

211. Recommendation 4 was supported by the expert conclave. The deficiency in the CPR training to date is borne out by the issues identified by the experts as to when to commence and when to cease CPR, as well as what constitutes abnormal breathing and the use of pulse as unreliable indicator for CPR.

212. The Commissioner has acknowledged and apparently supports, Recommendation 4 in part, stating:

> Education & Operational Skills (EOS) will distribute a NEMESIS message in consultation with the Commander of the People and Capability Command and the Commander of the Workforce Safety Command. EOS will consider including a CPR scenario training for DEFTAC in the next training period.[334]

213. The Court recommends the Commissioner considers the recommendation in full, calling as it does for delivery of a module via PETE, requiring also that officers acknowledge their review of the relevant material.

214. The need for a CPR training module that officers must both complete and acknowledge completion of, arises in circumstances where there is some doubt as to the efficacy of the training foundation to date (for example, as borne out by senior OSI staff not having clear knowledge of the ANZCOR Guidelines to provide the necessary instruction as to CPR). Additionally, I am concerned about whether the

[334] Ibid, p 3.

content of the previous, complex and detailed 82 page slide-pack has actually been absorbed by officers particularly when it has been presented on the same day as the live shoot.

215. I intend to make the recommendation as drafted.

Recommendation 5 – external training for NSWPF in relation to the essentials of basic life support

216. Recommendation 5 states:

> **That having regard to (3) and (4) above, urgent consideration be given to the introduction of an external training course delivered by an appropriate organisation within the next 6 months, to ensure that there is a baseline level of understanding within the NSW Police Force as to the essentials of CPR and basic life support (after which time, the Commissioner may consider that it is appropriate to revert to an internal training delivery model).**

217. It is understood that this recommendation is "not supported", with the Commissioner stating:

> *The evidence adduced during the hearing of the Coronial inquest, demonstrated that police officers have a good understanding of the essentials of CPR and basic life support. Prior to entering the Police Academy, police officers must hold a senior first aid certificate and every year thereafter, must successfully complete refresher training on CPR.*[335]

218. The Court has trouble accepting that statement on face value. While I accept that the involved officers were clearly diligent and attentive, the evidence disclosed systemic problems in relation to their understanding of when to commence CPR, when to cease, how to check for abnormal breathing and in relation to the use of pulse as an indicator for CPR. Those issues were apparent from the ranks of Constable, Senior Constable through to Sergeant. There were also issues at the operational safety instructor level as to knowledge of the basic ANZCOR Guidelines in relation to CPR.

[335] Annexure to the Commissioners Submissions.

219. Additionally, as the evidence unfolded during the inquest, it became clear that the format of 45 minutes of CPR training, in addition to the "large" slide-pack presentation (covered over a further 45 minutes, in the ordinary course), is not a format in which CPR training can be properly delivered. Indeed, according to Mr Molloy, very rarely could CPR competency in first aid be taught in less than two hours.

220. Further support for Recommendation 5 is grounded in the evidence of LSC Cunningham in terms of her desire to undertake a more comprehensive first aid course provided by an external organisation, and ultimately, her appreciation for having completed such a course.

221. In the circumstances, Recommendation 5 accepts the reality that the NSWPF has both time and financial constraints with respect to the training curriculum, and that it may not be feasible to provide *ongoing* external training. Moreover, Sergeant Watt repeatedly referred to staffing shortages within his unit; amongst other matters, that apparently impact training delivery in terms of the ability to conduct any sort of quality assurance.

222. As the inquest has highlighted a significant, systemic issue in relation to the current format of CPR training and raises questions as to the broader efficacy of the training regime to date, Recommendation 5 constitutes an appropriate 'remedial' measure in the short term – so that all officers have a clear baseline knowledge of the essentials of CPR and basic life support, from which to build upon. It bears repeating that CPR competency can be a matter of life and death.

223. Having reconsidered all the evidence and the submissions made by Counsel for the Commissioner in relation to this issue, I have decided to make the recommendation as drafted.

Recommendation 6 – amendments to 2023-2024 Sessions Plans and use of scenario training and assessment to ensure content understood

224. This Recommendation states:

> **That urgent consideration be given to amending the 2023-2024 Session Plan for the CPR/Tourniquet Practical to ensure specific reference to the matters outlined in (3) above, together with inclusion of appropriate scenario training**

and an appropriate form of assessment to ensure that the content has been understood.

225. This recommendation, as supported by the expert panel, is apparently acknowledged, and impliedly supported by the Commissioner.

226. It is also apparent that there has been no form of review or assessment to date, to assess the extent to which officers may have absorbed the content as to CPR (and basic life support) from past sessions.

227. Given the systemic issues identified during the inquest as to the CPR training regime, I accept the submission that this recommendation is clearly necessary and desirable.

Recommendation 7 – first aid training and recertification for certain officers

228. Recommendation 7 proposes the following:

That consideration be given to introducing the requirement for police officers at the rank of Senior Constable and above who are involved in first response general duties policing, to be retrained and certified in first-aid every three years.

229. It appears that this recommendation is supported *in principle* by the Commissioner. However, the Commissioner advised that "logistical and financial considerations for training needs need to be explored further prior to implementing."[336]

230. The recommendation draws upon the powerful evidence of Professor Pearn (who in fact proposed a recommendation in much broader terms), and was supported by Mr Molloy, and also Professor Holdgate.

231. The recommendation as drafted sought to balance the financial and time costs involved in requiring *all* police to continually undertake first aid training/recertification every three years by restricting it to those of the rank senior constable and above.

232. The recommendation received support from the operational policing perspective in the form of the compelling evidence of LSC Cunningham, who told the Court that

[336] Commissioners Submissions, [22].

following the events that led to Omar's death she diligently sought out external first aid courses.

233. The problem is an obvious one: whilst a police officer may have 'current' first aid certification upon joining the police force (as this certificate is a mandatory requirement), there is never a recertification or even first aid refresher (unless officers specifically request it, as LSC Cunningham did).

234. Counsel Assisting submitted that as police are frequently the first on scene to incidents requiring the administration of first aid, this is both surprising and concerning. Senior police may not have undertaken a further first aid refresher or recertification training for many years – conceivably, decades. I agree with her submission that this is troubling, and places police in a situation where they confront challenging first aid scenarios, without the requisite training to render current first aid.

235. Recommendation 7 is formulated in pragmatic terms, directed at Senior Constables and Sergeants, in particular, with first response general duties responsibilities, being the cohort most likely to attend incidents where there may be a need to direct junior officers in relation to the provision of first aid.

236. I accept the submission that it is both necessary and desirable, having regard to the evidence received during the inquest. I intend to make the recommendation as drafted.

Findings and Recommendations

237. For reasons stated above I make the following formal findings pursuant to section 81 of the Coroners Act:

Identity

The person who died was Omar Mohammad.

Date of death

Omar died on 23 September 2020.

Place of death

Omar died at St George Hospital, Kogarah NSW 2217.

Cause of death

Omar died due to irreversible hypoxic brain injury secondary to acute cocaine toxicity.

Manner of death

Omar's death occurred in the context of a police operation. Omar's death occurred as a result of a panicked ingestion of cocaine. Omar ingested the cocaine to hide it from NSW Police officers who were arresting him for trespass.

Recommendations pursuant to section 82 *Coroners Act 2009*

238. For reasons stated above I make the following recommendations pursuant to section 82 of the Coroners Act:

To the Commissioner of the NSW Police Force

1. As out-of-hospital cardiac arrests are one of the most common causes of death and because survival prospects are greatly improved where automatic external defibrillators (AEDs) are used, that **urgent consideration** be given to equipping **all** police response vehicles with AEDs for use as standard equipment by frontline police.
2. That as an interim measure pending the roll-out of AEDs for all police response vehicles, that **urgent consideration** be given to AEDs being provided to all mobile supervisor and duty officer vehicles in each Police Area Command.
3. That the NSW Police Force mandatory annual training for CPR include key emphasis upon the following messages:
    a. That CPR should be started if the person is unresponsive and not breathing normally (abnormal breathing);
    b. To assess breathing – rescuers should look, listen and feel:
        i. LOOK for movement of the upper abdomen or lower chest;
        ii. LISTEN for the escape of air from nose and mouth; and
        iii. FEEL for movement of air at the mouth and nose;
    c. That palpation of pulse is unreliable and should not be used to confirm the need for resuscitation;
    d. That abnormal breathing can be hard to identify - it is something that is "not

normal". Consider factors such as:

i. Does the breathing look irregular or irregular? Is it very slow (which suggests it may be abnormal)?

ii. Is the breathing noisy? If so, check that the airway is open.

iii. Is there a colour change (for example, is the patient blue around the lips)?

iv. Is there gasping or gulping?

e. If in doubt about whether a person is experiencing cardiac arrest or not, the rescuer should start CPR without concern about causing additional harm (rib fractures and other injuries are common but acceptable consequences of CPR given the alternative of death); that is – "If in doubt, have a go."

f. That if unsure about 'abnormal breathing,' start CPR (even if the person takes occasional gasps or gulps);

g. That agonal breathing is common in the first few minutes after a cardiac arrest – it is sudden, irregular gasps or gulps of breath. This should not be mistaken for normal breathing and CPR should be given straight away;

h. That CPR should be continued until any of the following conditions are met:

i. the person responds or begins breathing normally;

ii. it is impossible to continue (e.g. exhaustion);

iii. a health care professional arrives and takes over CPR;

iv. a health care professional directs that CPR be ceased.

i. That CPR should no be interrupted to check for response or breathing;

j. That the faster the rescuer acts, the higher the chances of survival.

4. That CPR information as set out in (3) above is provided to all members of the NSW Police Force on an **urgent** basis (noting that the administration of CPR can be a matter of life and death), by way of:

a. A state-wide NEMESIS message; and

b. A module provided to officers who perform frontline general duties delivered via Police Education Training Environment (PETE) that requires the officer to acknowledge their review of the material; and

c. Appropriate scenario training.

5. That having regard to (3) and (4) above, **urgent** consideration be given to the introduction of an external training course delivered by an appropriate organisation within the next 6 to 12 months, to ensure that there is a baseline level of understanding within the NSW Police Force as to the essentials of CPR and basic life support (after which time, the Commissioner may consider that it is appropriate to revert to an internal training delivery model);

6. That **urgent** consideration be given to amending the 2023-2024 Session Plan for the CPR/Tourniquet Practical to ensure specific reference to the matters outlined in (3) above, together with inclusion of appropriate scenario training and an appropriate form of assessment to ensure that the content has been understood;

7. That consideration be given to introducing the requirement for police officers at the rank of Senior Constable and above who are involved in first response general duties policing, to be retrained and certified in first-aid every three years.

Conclusion

239. I offer my sincere thanks to counsel assisting Emma Sullivan and to her instructing solicitor Bronwyn Lorenc for their very great assistance in this matter.

240. I thank the OIC, Detective Inspector Simon Fitzgerald, for his assistance in these proceedings.

241. I recognise the stress of these proceedings on the involved officers, and I thank them for the open and conscientious participation in proceedings. I echo Professor Pearn's sentiments in acknowledging the difficulties inherent in the situation police faced on the day. He stated, "one's heart goes out to the police officers managing this very confronting situation, with compassion and manifest professional care in the context of their experience."[337] Mr Molloy also drew the Court's attention to the need to acknowledge "that this was a difficult case to manage without further clinical knowledge and appropriate equipment and training."[338] I accept his view. This was a mandatory inquest and the Court's focus has been on identifying issues where

[337] Exhibit 1, Volume 6, Tab 152, page 2, [8].
[338] Exhibit 1, Volume 6, Tab 149, page 7, [43].

there may be potential to find systems improvements that might in the future assist police on the ground to prevent death in similar circumstances.

242. Finally, once again I offer my sincere condolences to Omar's family. As Omar's sister Mariam said, this inquest has considered Omar only at the very end of his journey and does not portray the whole person he was. I have no doubt that his family will always feel the profound pain and grief caused by his death but will remember him with love.

243. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner,
NSW State Coroner's Court, Lidcombe
19 February 2024

ANNEXURE 1

Inquest into the death of Omar Mohammad
2010/277315 | CSO Ref: 202101068

CHRONOLOGY OF KEY FACTS (19 AUGUST 2023)

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1. Omar Mohammad (Mr Mohammad), born 14 March 1987, died on 23 September 2020 at St George Hospital, Kogarah, NSW following withdrawal of life support. He was 33 years of age.

2. Mr Mohammad was admitted to St George Hospital on the morning of 10 August 2020 after being conveyed by ambulance from 13 Haig Street, Bexley, where he had been arrested for trespass by police.

3. During Mr Mohammad's arrest, Body Worn Video (**BWV**) footage shows that he can be seen to have swallowed "something white" in colour[339] which later turned out to be a resealable plastic bag which contained traces of cocaine.[340] An ambulance was initially called by police for a mental health assessment. However, whilst in police custody, Mr Mohammad's physical condition declined. Police attempted to apply first aid by monitoring Mr Mohammad's signs of life and applying chest compressions.

4. Ambulance officers attended 13 Haig Street and treated Mr Mohammad before conveying him to St George Hospital Emergency Department (ED) where he was later transferred to the Intensive Care Unit (ICU) following a diagnosis of 'unsurvivable severe irreversible hypoxic brain injury'.[341] Mr Mohammad did not regain consciousness and a decision was ultimately made by his family to withdraw life support.

BACKGROUND

5. Mr Mohammad was born in Sydney, Australia on 14 March 1987, to parents Younas and Jamila, who were born in Islamabad, Pakistan. Mr Mohammad's older siblings Ali, Mariam and Savana, were born in Greece. Mr Mohammad had two younger siblings born in Sydney: sister Mishame, born in 1989, and brother Ibraheem, born in 1994.[342]

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[339] Statement of Detective Sergeant Fitzgerald [32]; BWV 7;39:40; Vol 1, Tab 1, P79A.
[340] FASS Certificate D2020005017) of Daniel Moawad dated 19 August 2020, Vol 1, Tab 4.
[341] Report of Dr Binu Vijayarajan Thampan dated 29 March 2021, Vol 2, Tab 48, [8].
[342] Statement of Mariam Scattini dated 24 November 2020, Vol 1, Tab 10, at [3] – [5].

6. Mr Mohammad attended Botany Primary School with his siblings. At the end of 1998, his family returned to Islamabad, Pakistan, where Mr Mohammad completed his high school studies.[343]

7. In 2005, Mr Mohammad returned to Sydney and attended Macquarie University where he completed a Bachelor of Professional Accounting.[344]

8. In 2016, Mr Mohammad married Alisha Simkhada. Mr Mohammad and Ms Simkhada shared two sons, Aydin/Aiden, born in 2018 and Xavier/Zaviyar, born in 2020.

9. At the time of his death, Mr Mohammad resided at a town house in Haig Street, Bexley.

Criminal history

10. In 2011, Mr Mohammad was charged and convicted of 'malicious damage' and 'perverting the course of justice'; he was sentenced to 6 months imprisonment for these offences.[345]

11. During the period November 2019 to August 2020, there were various interactions between police and Mr Mohammad, namely:

    a) **23 November 2019** (COPS Event E 7581906): Police were contacted by Alisha Simkhada following a verbal argument between her and Mr Mohammad, during which it was alleged that he threatened her.[346]

    b) **12 December 2019** (COPS Event E 73516049): Police attended Mr Mohammad's residence, having been notified of a man behaving erratically and knocking on several doors on Waratah St, Bexley. He was taken to the Police station, assessed by a PACER clinician and scheduled under s 19 of the *Mental Health Act*.[347]

    c) **16 March 2020** (COPS Event E 74475371): Police were contacted by Mr Mohammad's neighbour, Shaddy Baddah, in response to an incident during which Mr Mohammad was seen in his garage 'with a knife yelling'. Drugs were found in Mr Mohammad's possession. An ambulance was called, and Mr Mohammad was scheduled under s 20 of the *Mental Health Act*.[348]

    d) **28 March 2020** (COPS Event E73624105) Mr Mohammad called police to his residence, stating there were two people on the roof of his house. Police attended but did not find anyone else present on the premises. Police noted that Mr Mohammad was 'screaming

[343] Ibid at [6] – [7].
[344] Ibid at [9]; information from family.
[345] Statement of Detective Sergeant Simon Fitzgerald dated 4 May 2021, Vol 1, Tab 8, at [8]; Statement of Mariam Scattini dated 24 November 2020, Vol 1, Tab 10 at [12].
[346] NSW Police COPS Event E75819067, Vol 3, Tab 71.
[347] *2007 (No 8)* (NSW).
[348] NSW Police COPS Event E74475371 dated 16 March 2020, Vol 3, Tab 67.

and running around saying there is someone on the roof'. There was abundant dog faeces around the premises, and possible 'cocaine residue on a table' was also noted. Mr Mohammad was conveyed to St George hospital by ambulance and scheduled under s 22 of the *Mental Health Act*.[349]

e) **9 August 2020** (COPS Event E280843698): at about 1pm, police were called to Waratah St in Bexley, following an incident during which Mr Mohammad attended properties near his own residence. Police were unable to locate Mr Mohammad at this time

f) At about 5.30pm, police returned to Waratah Street following reports that Mr Mohmmad had allegedly entered the grounds of a property.[350] Police spoke with Mr Mohammad at his home address through a locked fly screen door. Mr Mohammad admitted to police that he had taken cocaine and alcohol.[351] Police and a PACER (Police, Ambulance, Clinical, Early Response) clinician attended. The Acute Care Team as St George Hospital were contacted in relation to Mr Mohammad's mental health. Police applied for a Personal Violence Order (**PVO**) in relation to one of the neighbours and his family.[352] At 10.00pm, police attended Mr Mohammad's residence to serve the PVO however he did not open the door to accept service.[353] (Further details regarding this incident appear below at [13 (e)]).

Mental health history

12. Around October 2019, Ms Simkhada noted a rapid decline in Mr Mohammad's mental health to the point that she decided to move out of the home they shared.[354]

13. Between October 2019 and March 2020, Mr Mohammed received the following mental health treatment:

a) **16 October 2019**: Mr Mohammad was assessed by Dr Robin Ousley at St George Hospital, following an overdose on cocaine;[355]

b) **12 December 2019**: PACER clinician Felicity Cox assessed Mr Mohammad at Kogarah Police Station, following the interaction with Police that same date (see [11 (b)] above).[356] Ms Cox spoke with Mr Mohammad in an interview room for a period of 40 minutes.[357] During the assessment, Mr Mohammad reported experiencing auditory

[349] NSW Police COPS Event E73624105 dated 28 March 2020, Vol 3, Tab 65.
[350] NSW Police COPS Event E280843698 dated 9 August 2020, Vol 2, Tab 51A, page 5.
[351] Ibid, page 6.
[352] Ibid.
[353] Ibid, page 7.
[354] Statement of Alisha Simkhada dated 24 November 2020, Vol 1, Tab 9, [9].
[355] St George Hospital Medical Records, Vol 3, Tab 73, page 8.
[356] Statement of Felicity Cox dated 19 March 2021, Vol 2, Tab 52, at [4]-[8],
[357] Ibid.

hallucinations (hearing the voice of his wife and an unknown male).[358] Ms Cox formed the view that Mr Mohammad met the criteria for detention under section 19 of the *Mental Health Act 2007*. Ms Cox completed a "Schedule 1" and assisted police to convey Mr Mohammad to St George Hospital for admission.[359]

c) **16 March 2020 – 18 March 2020**: following the events referred to at [11 (c)] above, Mr Mohammad was admitted to St George Hospital and diagnosed with psychosis,[360] possibly secondary to drug use.[361] On 18 March 2020, he was discharged.[362] Mr Mohammad received a follow up message from the St George Community Mental Health Acute Team, however, did not apparently engage with the service following discharge.[363] It was documented that Mr Mohammad had not taken his prescribed medication following his December 2019 admission.[364]

d) **28 March 2020 – 30 March 2020**: following the events referred to at [11 (d)] above, Mr Mohammad was admitted to St George Hospital and diagnosed with drug-induced psychosis.[365] It was noted he had not followed up with the Acute Care Team following his prior admission.[366] He was discharged on 30 March 2020 after his psychosis was determined to have resolved.[367] His discharge plan involved ongoing medication and a follow-up at his address.[368] On 3 April 2020, Mr Mohammad engaged in a follow up phone call with the Acute Care Team where it was noted that he was engaged and his symptoms had resolved successfully with medication.[369] He was discharged from the Acute Care Team with a plan for further scripts to be obtained via his GP.

e) **9 August 2020**: PACER clinician Felicity Cox again assessed Mr Mohammad at his home in Haig Street, Bexley (see [11 (e)] above).[370] Prior to attending, Ms Cox reviewed Mr Mohammad's medical records and recalled her previous interaction with him (see [13(c)] above). Ms Cox discussed Mr Mohammad's presentation with on call psychiatrist, Dr Simpson who agreed with her assessment that he did not meet the criteria for detention under the *Mental Health Act*.[371] Mr Mohammad was agreeable

[358] Ibid.
[359] Ibid.
[360] St George Hospital Records, Vol 3, Tab 70, p. 11.
[361] Ibid, p. 10.
[362] Ibid, p. 11.
[363] Ibid, p. 31.
[364] Ibid, p. 26.
[365] Ibid, p. 13.
[366] Ibid, p. 15.
[367] Ibid.
[368] Ibid, p. 9.
[369] Ibid, p. 41.
[370] Statement of Felicity Cox dated 19 March 2021 Vol 2, Tab 52, [4]-[8].
[371] Ibid.

to follow up by the St George Mental Health Acute Team and at 8.40pm, upon her return to St George Police Station, Ms Cox made a referral to Kevin Clifford from the Acute Team by phone.[372]

Events of 10 August 2020

Trespass at 10 Haig Street

14. At about 6:41am on 10 August 2020, Mr Mohammad was captured on CCTV entering the front gate of the detached house at 13 Haig Street Bexley, the residence of Mr Jihad Sabra.[373]

15. At about 7:00am, Mr Sabra heard yelling noises coming from outside of his house and noticed a man walking back and forth in his front yard on his home CCTV cameras.

16. At 7:12am, Mr Sabra called triple zero and informed them that there was an intruder in his front yard.[374] Mr Sabra stated that the intruder had tried to open the front door to the house a few times.

17. At 7:12.31am, a CAD message was disseminated as follows in relation to this job (which was a priority 3): [375]

> INFT CAN SEE A MAN IN HIS FRONT YARD -THE MAN IS YELLING AND PACING – INFT DOES NOT KNOW THE POI - POI 20-30 YR OLD POSS ASAIN APP BEARD DARK BLUE JACKET - NK IP - NWS

18. At 7:25am, Mr Sabra called triple zero again, and reported that the intruder had entered the side gate and gone into the rear yard; he had tried to open the front door and could be heard yelling.[376] Mr Sabra was advised by triple zero to stay inside and that they would try and hurry a response.[377]

19. At 7:25am, the CAD job is broadcast as a priority 2, with the following details:

> RE, 13 HAIG ST, WESTBOURNE ST, BEXLEY, BAYSIDE (LGA) , 2207
>
> RE CAD 988682 - POI OPENED SIDE GATE & GONE INTO REAR YARD - NIL POP[378]

[372] Ibid, [9] – [10], pages 13 – 15.
[373] Statement of Detective Sergeant Simon Fitzgerald dated 4 May 2021, Vol 1, Tab 8, [27].
[374] Statement of Jihad Sabra dated 10 August 2020, Vol 2, Tab 40, [4]-[5].
[375] CAD Message, Tab 38, p 1; VKG audio, Tab 55, 02:15.
[376] Statement of Detective Sergeant Simon Fitzgerald dated 4 May 2021, Vol 1, Tab 8, [29].
[377] Statement of Jihad Sabra dated 10 August 2020, Vol 2, Tab 40, [7].
[378] CAD Message, Tab 38, p 1.

Arrival of Police at 13 Haigh St

20. At 7:36am, 'St George 14' - Sergeant Christopher McCaffery and Leading Senior Constable (LSC) Stewart Davies - arrived at the address.[379] Mr Mohammad was inside on the driveway beside the house.[380]

21. At 07:37:41, LSC Davies activated his body worn video.[381] At this time, LSC Davies was walking along a side passageway towards the back of the premises at 13 Haig Street Bexley. He proceeded across the back yard and then down a passageway on the other side of the premises.

22. At 07:37:56, Sergeant McCaffery encountered Mr Mohammad who had walked towards a double gate along the side of the premises, connecting to the driveway.[382] Sergeant McCaffery told MR Mohammad to "*just wait here, mate*" and asked him "*do you have something with your name on it mate*?[383] Mr Mohammad placed his hands in his jacket pocket and Sergeant McCaffery said to him "*hands out, hands out*."[384] Mr Mohammad then quickly raised his right hand to his mouth and placed something inside.[385] Sergeant McCaffery saw "a white packet*"* but "[he] didn't know what it was".[386]

23. Sergeant McCaffery and LSC Davies took hold of Mr Mohammad and "restrained" him before there was "a bit of a wrestle" and Mr Mohammad was "[taken] to the ground".[387]

24. At 07:38:25, officers Constable Jesse Roche and Constable Naomi Joseph (St George 17) arrived and ran to assist Sergeant McCaffery and LSC Davies, who were struggling to arrest Mr Mohammad. Mr Mohammad's hands were placed behind his back and he was handcuffed.[388]

25. The following exchange occurred whilst Mr Mohammad was placed under arrest on the ground:[389]

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[379] Police Computer Aid Dispatch (CAD), Vol 1, Tab 38, p. 2.
[380] Statement of Detective Sergeant Simon Fitzgerald dated 4 May 2021, Vol 1, Tab 8, [30].
[381] BWV of LSC Davies, Tab 62, 07:37:42; sound of BWV activation.
[382] Notebook statement of Sergeant Christopher McCaffery, Vol 1, Tab 16, page 5 (notebook); CCTV footage of 13 Haig Street, Tab 57, 07:37:41.
[383] BWV of LSC Davies, Tab 62, 07:38:06 – 07:38:10; Notebook statement of Sergeant Christopher McCaffery, Vol 1, Tab 16, page 5 (notebook).
[384] BWV of LSC Davies, Tab 62, 07:38:12 – 07:38:19; Transcript of interview with Sergeant McCaffery dated 10 August 2020, Vol 1, Tab 14, pp. 7 – 8; Notebook statement of Sergeant Christopher McCaffery, Vol 1, Tab 16, page 7 (notebook).
[385] BWV of LSC Davies, Tab 62; 07:38:18.
[386] Transcript of interview with Sergeant McCaffery dated 10 August 2020, Vol 1, Tab 14, pp.7-8; page 24.
[387] Ibid, pp.7-8.
[388] Statement of Detective Sergeant Simon Fitzgerald dated 4 May 2021, Vol 1, Tab 8, [32]; Transcript of interview with Constable Jesse Roche dated 11 August 2020, Vol 1, Tab 25, [A25]; BWV of LSC Davies, Tab 62; 07:38:41.
[389] Statement of Detective Sergeant Simon Fitzgerald dated 4 May 2021, Vol 1, Tab 8, [32]; BWV of LSC Davies, Tab 62; 07:39:10 - 07:39:17.

Sergeant McCaffery:	*"What did you take, what did you put in your mouth?"*
Mr Mohammad:	*"Chewy."*
Sergeant McCaffery:	*"It's not chewy mate. What did you put in there?"*
Mr Mohammad:	*"It's chewy mate."*
Sergeant McCaffery:	*"Spit it out, stop chewing it up and spit it* out."

26. Police searched Mr Mohammad's clothing, locating a mobile phone, car keys and a fifty dollar note. Whilst being searched, Mr Mohammad said:[390] *"I'm not resisting, I said I'm not resisting."*

27. At 7:39:40am, on the body worn video of LSC Davies, a white coloured substance is apparent in Mr Mohammad's mouth.[391] LSC Davies said to Mr Mohammad, "*My name's Senior Constable Davies, I'm from St George Police, this is a body worn camera so everything you say and do is going to be recorded, do you understand? At this point in time, you are under arres*t."[392]

28. At 07:40:29am, Mr Mohammad is sat upright against a fence. [393]

29. At 7:40:39am, LSC Davies informed police radio that Mr Mohammad was in custody.[394]

30. At 7:43:27am, Acting Sergeant Cunningham (St George 13) arrived on scene and was in the driveway of 13 Haig Street.[395]

Ambulance request

31. At 7:47:22am, Constable Joseph requested via police radio (VKG) that Ambulance officers attend the address to complete a mental health assessment of Mr Mohammad.[396] Constable Joseph, using callsign St George 17, asks "*Radio, can we get an ambulance to our location for a 33 year old male, conscious and breathing…for a mental health assessment*."[397] The CAD messages notes: "AMBOS RE 33 OLD M C AND B RE MHA".[398]

32. CCTV from 13 Haig Street indicates the following of Mr Mohammad's behaviour at this time:

[390] BWV of LSC Davies, Tab 62, 07:39:10 - 07:39:39.
[391] Ibid; 07:39:40.
[392] Ibid: 07:39:43.
[393] Ibid; 07:40:29
[394] BWV of LSC Davies, Tab 62, 07:39:10 - 07:40:34.
[395] CCTV footage of 13 Haig Street, Tab 57, 07:43:27.
[396] Police Computer Aid Dispatch (CAD), Vol 1, Tab 38, p. 4; AEMS Case # 10275, Tab 46B, page 6.
[397] VKG Broadcast, Tab 55, 36.26 – 36.40.
[398] Police Computer Aid Dispatch (CAD), Vol 1, Tab 38, p. 5.

a. By 07:47:24am: police approach Mr Mohammad, who is standing; he then sits back down with his back against the fence;

b. At 07:54:17am: Mr Mohammad's behaviour becomes more sluggish and he appears to lean to his left;

c. At 07:54:48am: Mr Mohammad's legs begin to move and his body moves to the left and then he rolls onto his front, apparently suffering a seizure.

33. Around this time, Mr Mohammad, who was "excessively shivering" according to A/Sgt Cunningham, told police "I'm having a seizure."[399] A/Sgt Cunningham stated Mr Mohammad then:

> "… continued the sporadic jerking movements and the shivering, but, at this time I suspected he was faking a medical episode as he appeared to be in control of the movements and was looking around in what seemed like he was making sure someone was watching these movements."[400]

34. At 7:54:54am, Constable Roche and Acting Sergeant Cunningham moved Mr Mohammad back onto his left side. Acting Sergeant Cunningham placed her left foot next to Mr Mohammad's hip area to keep him on his side in the recovery position.[401] Constable Roche positioned his foot behind Mr Mohammad's head so that he wouldn't bang his head against the fence.[402]

35. At about 7:55:32am, Mr Mohammad began to shake again, with his motions described as "jerking movements", his legs kicking and his "upper body tensing."[403]

36. At 7:56:09am Mr Mohammad was having a "full blown seizure."[404] Acting Sergeant Cunningham asked for LSC Davies to notify the ambulance.[405] A short time later, LSC Davies contacted police radio asking for an "ETA" and stated, *"let them [Ambulance] know we think he's heavily affected by drug*s."[406]

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[399] Statement of A/Sergeant Jayd Cunningham, Tab 11, [20]; ERISP interview of Constable Jesse Roche, Tab 23, page 25, Q202.
[400] Ibid, Tab 11 at [20].
[401] Notebook entry of Acting Sergeant Cunningham dated 10 August 2020, Tab 12, page 4; CCTV footage of 13 Haig Street, Tab 57, 07:54:58.
[402] CCTV footage of 13 Haig Street, Tab 57, 07:43:27; ERISP interview of Constable Jesse Roche, Tab 23, page 21, Q166.
[403] Statement of Acting Sergeant Jayd Cunningham, Tab 11, page 6.
[404] Ibid.
[405] Statement of Acting Sergeant Cunningham dated 10 August 2020, Vol 1, Tab 11, [20].
[406] VKG Broadcast, Tab 55, 45:54 – 46:34.

37. At 07:57:20am, the CAD record states "SG17/M/ETA FOR AMBO POI HEAVILY AFFECTED BY DRUGS."[407]

38. At 07:58:20am, Mr Mohammad appears to stop moving.

39. At 07:58:31am, Acting Sergeant Cunningham, Constable Roche and Constable Joseph move Mr Mohammad, his head appears to droop. Mr Mohammad is positioned face down on the pathway and his handcuffs are removed.

40. At 07:58:46am, LSC Davies sought a further update on the status of the Ambulance and "Yeah, St George 14, can you get that Ambo to hurry up it looks like he's having a seizure[408] with the CAD record stating "SG14/M/URGENT FOR AMBOS POI NOW HAVING A SEIZURE".[409]

41. At 07:58:56am, LSC Davies' BWV starts to capture footage, with sound commencing at 07:59:52.[410]

42. At 07:58:57am, Acting Sergeant Cunningham's BWV starts to capture footage, with sound commencing at 07:59:51.[411]

43. At 07:59:55am, Mr Mohammad is apparently having a seizure lasting around 8 seconds (his upper body and head appear tense and then relax).[412]

44. At 08:00:05am, VKG (police radio) updated LSC Davies that the ambulance was "five minutes off."[413]

45. At 08:00:07am, Mr Mohammad can be heard breathing loudly (similar to snoring).[414]

46. At 08:00:11am, Mr Mohammad appears to have a further seizure lasting around 13 seconds [415]

47. At 08:00:18am, Acting Sergeant Cunningham can be heard to say: "…*I think he's grinding his teeth; can you hear that?*"[416]

[407] Police Computer Aid Dispatch (CAD), Vol 1, Tab 38, p. 5.
[408] VKG Broadcast, Tab 55, 47:50 – 48:56.
[409] Police Computer Aid Dispatch (CAD), Vol 1, Tab 38, p. 5.
[410] BWV of LSC Davies, Tab 62, 07:58:57 - 07:59:52
[411] BWV of A/Sgt Cunningham, Tab 61; 07:58:56 - 07:59:51.
[412] BWV of LSC Davies, Tab 62, 07:59:55 – 08:00:03
[413] Ibid, 08:00:05 – 08:00:07.
[414] Ibid, 08:00:07 – 08:00:11.
[415] Ibid, 08:00:11 – 08:00:24
[416] Ibid, 08:00:18.

48. At 08:00:28am, Acting Sergeant Cunningham says: "*…his lips are going more and more blue…he's not getting any oxygen in*."[417]

49. At 08:00:38am, Acting Sergeant Cunningham says "…*he's still breathing*."[418] LSC Davis and Constable Joseph respond "…*yep".*[419]

50. At 08:02:38am Acting Sergeant Cunningham says "*…he's stopped breathing…*"[420] and proceeds to rub on Mr Mohammad's chest saying "*…come on Omar, stay awake for us*…"[421]

51. At 08:02:55am, LSC Davies used police radio to broadcast the following:

> *LSC Davies: "Let the Ambos know he's struggling to breathe every now and then ..."*

The radio operator acknowledges the message, saying "copy." [422]

52. At 08:03:02am, Acting Sergeant Cunningham says to Constable Joseph "*…has he got a pulse Naomi?*"[423]

53. At 08:03:03am, Constable Joseph, who at this time is positioned near Mr Mohammad's waist, replies "*…I can't feel one, now...".* Acting Sergeant Cunningham responds "…*can you go the neck*?".[424]

54. At 08:03:07, Constable Joseph placed her right hand on Mr Mohammad's neck and states "*Nuh. He hasn't…*"[425]

55. At 08:03:10, Acting Sergeant Jayd Cunningham says "*…alright let's go CPR…roll him.*" Mr Mohammad was rolled onto his back.

56. LSC Davies then notified police radio, "*St George 14 just letting you know we are starting CPR".*[426] The CAD record at 08:03:25 states "STARTING CPR".[427]

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[417] Ibid, 08:00:24 – 08:00:30.
[418] Ibid, 08:00:37.
[419] Ibid, 08:00:39
[420] Ibid, 08:02:38.
[421] Ibid, 08:02:38 – 08:02:52
[422] Statement of Detective Sergeant Simon Fitzgerald dated 4 May 2021, Vol 1, Tab 8, [35]; VKG Broadcast, Tab 55, 52:16 – 52:25.
[423] BWV of LSC Davies, Tab 62, 08:03:02.
[424] Ibid, 08:03:03
[425] Transcript of BWV of Constable Jesse Roche, page 6.
[426] VKG Broadcast, Tab 55, 52:41 – 52:44.
[427] Police Computer Aid Dispatch (CAD), Vol 1, Tab 38, p. 5.

57. At 08:03:15am, Constable Roche commenced chest compressions on Mr Mohammad. Constable Roche conducted 20 compressions on Mr Mohammad's chest until 08:03:25 (10 seconds); he then leant towards Mr Mohammad's mouth with his ear.[428]

58. At 08:03:27am, Constable Roche states "*… he's breathing.*"

59. At that time, Acting Sergeant Cunningham stated "*recovery, recovery*" and she, Constable Roche and Constable Joseph moved Mr Mohammad back onto his side. Constable Roche placed his head near Mr Mohammad's mouth and confirmed he was still breathing. Constable Joseph then noted that there was a pulse and that Mr Mohammad's mouth was moving. Constable Joseph noted that Mr Mohammad's pulse was "*much better than it was*".[429]

60. LSC Davies contacts police radio, "*St George 14, did you get my last [transmission]?*" to which the radio operator replies, "*I did, I've just sent it off to the Ambos, I'm sorry I can't get any update from them as yet.*[430]

61. At 8:04:14am LSC Davies broadcast:[431]

> *LSC Davies:* *"Yeah, you're alright. Just letting you know he is breathing again now, he's back on his side."*

62. At 8:04:40am, LSC Davies said "*see if we can get that chewy out of his mouth*".[432] Acting Sergeant Cunningham responds "…*don't know if its chewy*…*I don't think its chewy*". Constable Joseph says to Mr Mohammad, "*can you open your mouth?".* Acting Sergeant Cunningham says to Constable Joseph "*… just be careful Naomi, cos he'll bite down if he has a seizure*."[433]

63. At 8:04:55am, Constable Joseph leans towards Mr Mohammad's face. LSC Davies says *"I saw like a white piece"* and Constable Joseph turns towards him and says, "*I saw a white piece*." Acting Sergeant Cunningham responds "*…I never saw that I only saw like the pink colour."*[434]

64. At 08:05:08am, Constable Joseph places her right hand on Mr Mohammad's neck and states: "*… I can't … I can't feel anything right now,".* Acting Sergeant Cunningham responds "…*no pulse again?*". Constable Roche responds, "*no pulse*". Mr Mohammad is rolled onto

[428] Body worn video footage of Constable Jesse Roche, Vol 2, Tab 63; 08:03:15 – 08:03:25.
[429] Ibid; 08:03:15 – 08:03:25.
[430] VKG Broadcast, Tab 55, 53.28 – 53:37.
[431] Statement of Detective Sergeant Simon Fitzgerald dated 4 May 2021, Vol 1, Tab 8, [36]; VKG Broadcast, Tab 55, 53:37 – 53:40.
[432] BWV of LSC Davies, Tab 62, 08:04:38.
[433] Ibid, 08:04:47.
[434] Ibid, 08:04:54 – 08:04:59.

his back to recommence CPR, however Mr Mohammad appeared to exhale. Constable Joseph and Constable Roche then roll him back into the recovery position.

65. At 08:05:16, Acting Sergeant Cunningham says "*… actually that could just be the air coming out of his lungs*" and says to Constable Joseph, "*… keep feeling for that pulse mate, if there's no pulse we've got to pump on that chest*."[435]

66. At 08:05:25, Constable Joseph feels Mr Mohammad's neck. Acting Sergeant Cunningham says "*…you got it?*". Constable Joseph responds "…*yeah…like it's really faint*."[436]

67. At 08:05:25, sirens can be heard on LSC Davies' BWV recording.[437]

68. At 8:05:38am, Acting Sergeant Cunningham asked LSC Davies "*…has he been searched?"* to which LSC Davies responded "*yeah.*" Acting Sergeant Cunningham asks "*… there was no drugs on him or packets on him or anything like that?*". LSC Davies responds "*… not unless they're down his pants … like in his undies."*[438]

69. At 08:05:48am, Acting Sergeant Cunningham asks Constable Joseph "*…and yesterday Naomi the event said he had cocaine was it?".* Constable Joseph replied "…*it says cocaine and alcohol*…"[439].

70. At 08:06:10am, Acting Sergeant Cunningham states "*… yeah he's not responsive at all … how are his pupils?".* Constable Joseph leans towards Mr Mohammad's face and lifts his eyelids and Acting Sergeant Cunningham states "*…they're not responsive either to light are they?*" Constable Joseph says, *"he's still breathing.*"[440]

71. At 08:06:24am, LSC Davies states "*… you can see his neck move every now and then … his jaw.*" Acting Sergeant Cunningham says "*… I can see a slight movement, it's very weak isn't it?"*[441]

72. At 08:06:33, LSC Davies states "where's the ambos?"[442]. Constable Joseph says "you can hear 'em".[443]

[435] Ibid, 08:05:16 – 08:05:22.
[436] Ibid, 08:04:54 – 08:04:59.
[437] Ibid, 08:05:27.
[438] Ibid, 08:05:38 – 08:05:46.
[439] Ibid, 08:05:48 – 08:05:51.
[440] Ibid, 08:06:10 – 08:06:24.
[441] BWV of LSC Davies, Tab 62, 08:06:23; BWV of Constable Jesse Roche, Vol 2, Tab 63, 08:06:23 – 08:06:29.
[442] BWV of LSC Davies, Tab 62, 08:06:33.
[443] BWV of LSC Davies, Tab 62, 08:06:36.

73. At 08:06:48am, Acting Sergeant Cunningham asks "*what have you got? Any pulse guys?"* Constable Joseph moved her fingers towards Mr Mohammad's neck and says "*…he's still breathing there*…".[444]

74. At 08:07:17, Acting Sergeant Cunningham asks, "*is he breathing at all, like is there anything actually going in or out? Or is it just moving?"*[445] Constable Joseph leans down towards Mr Mohammad's face and then Acting Sergeant Cunningham states "*…I think I felt a slight movement there. Come on, Omar, stay with us, buddy*"[446]

75. At 08:07:50, Acting Sergeant Cunningham says "*Are you there, Omar? Can you squeeze our hand if you can hear us? Omar, squeeze my finger if you can hear me."*

Ambulance officers arrive at Haig Street

76. At 08:07:51, an ambulance with paramedics Laura Hunter and Adrian de Bari arrived on scene.[447]

77. Sergeant McCaffery flagged down the ambulance and gave Paramedic Hunter a briefing lasting around 40 seconds whilst she was donning gloves and getting her equipment.[448]

78. At 08:08:07, body-worn camera footage records the following exchange:

Sergeant McCaffery:	*"He's … jammed something in his mouth and we couldn't get it out, so I don't know whether he has taken something or…"*
Ms Hunter:	*"He's jammed something in his mouth…?"*
Sergeant McCaffery:	*"Yeah it was white, I don't … he said it was chewing gum, but whether there was something with it…"*[449]

79. At 08:08:26, LSC Davies says "come on guys".[450]

[444] BWV of Constable Jesse Roche, Vol 2, Tab 63, 08:06:48am.
[445] Transcript of BWV of Acting Sergeant Jayd Cunningham, Tab 61A, page 8.
[446] Ibid; BWV of LSC Davies, Tab 62, 08:07:17 – 08:07:42
[447] Statement of Detective Sergeant Simon Fitzgerald dated 4 May 2021, Vol 1, Tab 8, [36]; Transcript of interview with Sergeant McCaffery dated 10 August 2020, Vol 1, Tab 14, [A29]; BWV of Sergeant Christopher McCaffery, Tab 60, 08:07:51.
[448] BWV of Sergeant Chris McCaffery, Vol 2, Tab 60, 08:08:00 – 08:08:37
[449] BWV of Sergeant Chris McCaffery, Vol 2, Tab 60, approximately 08:08:06 – 08:08:15.
[450] BWV of LSC Davies, Tab 62, 08:8:31.

80. At 08:08:57, Paramedic Hunter walks down the side pathway through the side gate to Mr Mohammad. At the same time, Acting Sergeant Cunningham says "can you still feel a pulse or not?".[451]

81. At 08:09:00 Acting Sergeant Cunningham told Paramedic Hunter that Mr Mohammad "*… [was] not in a good way… he's not responsive, he started having a fit … he did tell us before having a proper fit that he was starting to have a fit*."[452]

Treatment of Mr Mohammad at 13 Haig Street: 10 August 2020

82. At 08:09:14am, Paramedic Hunter held Mr Mohammad's right wrist and called his name.[453] At 08:09:33am, she placed her left hand on Mr Mohammad's chest.[454] Mr Mohammad was unresponsive, with no pulse, no spontaneous breathing; he was pale and had blood-tinged sputum around his mouth.[455]

83. At 08:10:15, Paramedic Hunter commenced chest compressions on Mr Mohammad.[456] Cardiac arrest management was carried out by Paramedic Hunter and Paramedic De Bari, which included the use of a defibrillator and oxygen therapy

84. Whilst administering oxygen, it was "noisy" suggesting that something may have been in or near Mr Mohammad's airway however, according to Paramedic Hunter, this did not interfere with her treatment of him.[457]

85. At 8:12:30am, intensive care paramedics Eduard Vaitkaitis and Lisa Frow arrived on scene. Paramedic Vaitikaitis noted that Paramedic De Bari was managing Mr Mohammad's airway and there was an oropharyngeal airway (OPA) in place which was operating effectively.[458]

86. At 8:16:35am, during treatment of Mr Mohammad, BWV footage of Acting Sergeant Cunningham captured her advising the paramedics that "*…[Mr Mohammad] was spoken to by police yesterday, and they mentioned that he was intoxicated by cocaine and alcohol…*"[459]

87. Around 08:17:28, Mr Mohammad was intubated by Paramedic Vaitikaitis who was able to seal Mr Mohammad's airway with an endotracheal intubation (ETT).[460] Paramedic Vaitkaitis

[451] BWV of LSC Davies, Tab 62, 08:08:57.
[452] BWV of Acting Sergeant Jayd Cunningham, Tab 61, 08:09:00 – 08:09:12.
[453] BWV of LSC Davies, Tab 62, 08:09:14.
[454] Ibid, 08:09:33.
[455] Statement of Laura Hunter dated 27 August 2020, Vol 2, Tab 45A, [7].
[456] CCTV footage from driveway of 13 Haig Street, Bexley; Vol 2, Tab 56.
[457] Statement of Laura Hunter dated 27 August 2020, Vol 2, Tab 45, [16].
[458] Statement of Eduard Vaitikaitis dated 8 December 2021, Tab 46B, [7].
[459] Body worn video footage of Constable Jesse Roche, Vol 2, Tab 63, from 8:16:35am; Transcript of body worn video of Acting Sergeant Jayd Cunningham, Tab 61A, page 15.
[460] Statement of Eduard Vaitikaitis dated 8 December 2021, Tab 46B, [7].

and Paramedic Frow assisted with cardiac arrest management.[461] Paramedic Hunter noted that Mr Mohammad was hypoxic.[462]

88. At 08:17:36, Acting Sergeant Cunningham told the paramedics "…*he was chewing something, we weren't sure if it was his cheek or chewing gum."*[463]

89. Paramedic Vaitikatis, who had inserted the ETT, had a direct view of Mr Mohammad's airway from his mouth all the way down to his trachea and vocal cords and did not observe anything blocking his airway or any obvious signs of trauma.[464] Paramedic Vaitikaitis observed Mr Mohammad's airway to be clear and only containing saliva and was satisfied that the ETT was correctly placed and effective.[465]

90. Several rounds of cardiac arrest management were applied to Mr Mohammad for a period of 8 to 13 minutes,[466] including the administration of adrenaline.

91. At 08:20:00, Paramedic Vaitkaitis identified that Mr Mohammad's pulse had returned.[467] Mr Mohammad's breathing was supported with a mask and oxygen therapy. Intravenous fluid therapy was commenced to support Mr Mohammad's blood pressure. With assistance from police, Mr Mohammad was placed on a stretcher and loaded into the ambulance.[468]

Care and Treatment at St George Hospital – 10 August 2020 until death

92. At 8:32am,[469] Mr Mohammad was loaded into the ambulance and conveyed to St George Hospital Emergency Department. The ambulance arrived at 8:43am.[470]

93. During the handover from paramedics following their arrival on the morning of 10 August 2020, Dr Skye Macleod, Emergency Department Registrar at St George Hospital, noted that there was no mention of the presence or absence of an upper airway foreign body.[471]

94. Suction was applied to Mr Mohammad's airway and a small, chewed bag was removed from Mr Mohammad's throat. The bag was handed to police Inspector Grant Lister following his request for the nurse to "bag the items" in a "hazardous material bag".[472] The bag

[461] BWV of LSC Davies, Tab 62, 08:17:29.
[462] Statement of Laura Hunter dated 27 August 2020, Vol 2, Tab 45A, [9]-[10].
[463] BWV of LSC Davies, Tab 62, 08:17:36
[464] Statement of Eduard Vaitikaitis dated 8 December 2021, Tab 46B, [9].
[465] Ibid.
[466] BWV of LSC Davies, Tab 62, 08:10:15.
[467] Ibid, 08:20:00.
[468] Statement of Laura Hunter, Vol 2, Tab 45A, [11]-[13].
[469] Ibid, page 4.
[470] Ibid.
[471] Statement of Dr Skye Macleod dated 17 November 2020, Vol 2, Tab 47, [6].
[472] St George Hospital Medical Records, Tab 49, page 6; Statement of Chief Inspector Grant Lister dated 31 December 2020, Vol 1, Tab 35, [5]-[6].

underwent forensic examination. It was found to contain trace levels of cocaine and lidocaine.[473]

95. Given observed electrocardiographic findings and the history of drug-induced psychosis in Mr Mohammad's electronic medical records, treatment included administration of sodium bicarbonate as therapy for potential toxicological aetiology of cardiac arrest.[474]

96. Mr Mohammad remained an inpatient at St George Hospital Intensive Care Unit (ICU) and underwent an MRI of his brain on 11 August 2020 where it was identified that he had likely sustained a hypoxic brain injury.[475]

97. On 7 September 2020, a further MRI of Mr Mohammad's brain showed progression of his hypoxic brain injury. Mr Mohammad's diagnosis was of an "unsurvivable irreversible hypoxic brain injury."[476]

98. On 21 September 2020, Mr Mohammad was taken off life support. He was pronounced deceased on 23 September 2020.

Autopsy Report

99. On 25 September 2020, a limited autopsy (involving an external examination and toxicological analysis) was conducted by forensic pathologist, Dr Jennifer Pokorny.[477]

100. No blood specimens were available from the time of admission (the earliest being 18 September 2020), with no cocaine or cocaine metabolites detected; only certain medication was found (levetiracetam and lignocaine, at levels in keeping with therapeutic use).[478]

101. As to cause of death, Dr Pokorny opined as follows:

> 244. <u>The cause of death remains unascertained after post mortem examination</u>. The medical records and post mortem findings are in keeping with hypoxic ischaemic encephalopathy leading to death, with the history strongly suggestive of this being secondary to cocaine toxicity. However, in the absence of any suitable specimens from the time of the presumed cocaine ingestion for toxicological analysis, this is unable to be confirmed on the basis

[473] Statement of Detective Sergeant Simon Fitzgerald dated 4 May 2021, Vol 1, Tab 8, [38], [45]; Certificate of analysis D2020005017, dated 19 August 2020, Vol 1, Tab 4.
[474] Statement of Dr Skye Macleod dated 17 November 2020, Vol 2, Tab 47, [9]; Medical Records of St George Hospital, Tab 49, p. 10.
[475] Report of Dr Binu Vijayarajan Thampan dated 29 March 2021, Vol 2, Tab 48, [8.
[476] Ibid.
[477] The limited autopsy was conducted in accordance with the Coroner's direction and noting Mr Mohammad's family's objection to a full autopsy on religious grounds.
[478] Limited Autopsy Report for the Coroner, Vol 1, Tab 3, p. 2.

of the post mortem findings.[479]

END

[479] Ibid, p. 3.