REPORT BY THE NSW STATE CORONER

into deaths in custody/ police operations

2002

(Coroner's Act 1980, Section 13A.)

attorney general's department of new south wales

The Honourable Robert John Debus
Attorney General of New South Wales
Level 20, Goodsell Building
8-12 Chifley Square
SYDNEY NSW 2000

24 June 2003

Dear Attorney,

In accordance with the provisions of *Section 12A(4), Coroners Act 1980*, I present a written report containing a summary of the details of the deaths of persons in circumstances referred to in *Section 13A*.

Pursuant to *Section 12A(4)* the Report is required to be furnished within two months of the end of the year. Heavy listing of inquests and human resource problems at this office have prevented me from complying with the requirement.

The Report illustrates, however, that a heavily increased number of cases were finalised during the year, including several particularly old matters.

Under the provisions of *Section 13A:*

(1) A coroner who is the State Coroner or a Deputy State Coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died or that there is reasonable cause to suspect that the person has died:

(a) While in the custody of a police officer or in other lawful custody, or while escaping or attempting to escape from the custody of a police officer or other lawful custody, or

(b) as a result of or in the course of police operations, or

(c) while in, or temporarily absent from, a detention centre within the meaning of the *Children (Detention Centres Act 1987*, a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999* or a lock-up, and of which the person was an inmate, or

(d) while proceeding to an institution referred to in paragraph (c), for the purpose of being admitted as an inmate of the institution and while in the company of a police officer or other official charged with the person's care or custody.

(2) If jurisdiction to hold an inquest arises under both this section and section 13, an inquest is not to be held except by the State Coroner or a Deputy State Coroner.

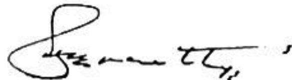
Inquests into such deaths are mandatory and must be heard by the State Coroner, or a Deputy State Coroner. These deaths not only include deaths of persons in the custody of the NSW Police and Department of Corrective Services, but also of those in the custody of the Department of Juvenile Justice and the Federal Department of Immigration. Persons on home detention are considered to be subject to the legislation.

Police operations deaths can include shootings by police officers, shootings of police officers, suicide and other types of unnatural death in front of police officers and deaths occasioned during police pursuits or "urgent duty call-outs."

35 cases in circumstances referred to in *Section 13A* were reported during 2002.
58 matters were completed by way of inquest finding, including 9 that were terminated because of person/s being charged with an indictable offence in which an issue will be that the person charged caused the death. There are 30 outstanding matters that have been listed for hearing or are currently under investigation with hearing dates yet to be allocated.

I hereby enclose my report for 2002 into deaths in custody/police operations deaths for your information and for the information of both Houses of Parliament.

Yours sincerely,



(John Abernethy)
NSW State Coroner,
Chambers.
Glebe. NSW.

STATUTORY APPOINTMENTS

Under the 1993 amendments to the Coroners Act 1980, only the State Coroner or a Deputy State Coroner can preside at an inquest into a death in custody or a death in the course of police operations. The inquests, the subject of this report, were conducted before the following Coroners:

MAGISTRATE JOHN ABERNETHY
New South Wales State Coroner

1965 Joined the (then) Petty Sessions Branch of the New South Wales Department of the Attorney General and of Justice

1971 Appointed Coroner for the State of New South Wales

1975 Admitted as a Barrister-at-Law in the State of New South Wales

1984 Appointed a Stipendiary Magistrate for the State of New South Wales

1985 Appointed a Magistrate for the State of New South Wales under the Local Courts Act 1982

1994 Appointed New South Wales Deputy State Coroner

1996 Appointed New South Wales Senior Deputy State Coroner

2000 Appointed New South Wales State Coroner

MAGISTRATE JACQUELINE MILLEDGE
Senior Deputy State Coroner

1996 Appointed a Magistrate for the State of New South Wales under the Local Courts Act 1982 and Coroner.

2000 Appointed Deputy State Coroner.

2001 Appointed Senior Deputy State Coroner.

MAGISTRATE CARL MILOVANOVICH

1976 Appointed a Coroner for the State of New South Wales.

1990 Appointed a Magistrate for the State of New South under the Local Courts Act 1982.

2002 Appointed Deputy State Coroner.

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Introduction by the New South Wales State Coroner

What is a death in custody?

It was agreed by all mainland State and Territory governments in their responses to the Royal Commission into Aboriginal Deaths in Custody recommendations, that a definition of a death in custody should, at the least, include[1]:

1 the death wherever occurring of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the (Commonwealth) Migration Act, 1958.;

2 the death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care whilst in such custody or detention;

3 the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and

4 the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

Section 13A, Coroners Act expands on this definition to include circumstances where the death occurred:

1. while temporarily absent from a detention centre, a prison or a lock-up; as well as

2. while proceeding to a detention centre, a prison or a lock-up when in the company of a police officer or other official charged with the person's care or custody.

It is important to note that in respect of those cases where an inquest has yet to be heard and completed, no conclusion should be drawn that the death necessarily occurred in police custody or during the course of police operations. This is a matter for determination by the Coroner after all the evidence and submissions, from those granted leave to appear, have been presented at the inquest hearing.

In fact, in recent years the Department of Corrective Services has been releasing prisoners from custody prior to death, in certain circumstances. This has generally occurred where such prisoners are hospitalised and will remain hospitalised for the rest of their lives. Whilst that is not a matter of criticism it does indicate a "technical" reduction of the actual statistics in relation to deaths in custody. In terms of *Section 13A*, such prisoners are simply not "in custody" at the time of death.

[1] *Recommendation 41, Aboriginal Deaths in Custody: Responses by Government to the Royal Commission 1992 pp 135-9*

Standing protocols provide that such cases are to be investigated as though the prisoners are still in custody.

What is a death as a result of or in the course of a police operation?

A death as a result of or in the course of a police operation is not defined in the Act. Following the commencement of the 1993 amendments to the Coroners Act 1980, New South Wales State Coroners Circular No. 24 contained potential scenarios that are likely deaths 'as a result of, or in the course of, a police operation' as referred to in Section 13A of the Act.

The circumstances of each death will be considered in reaching a decision whether Section 13A is applicable but potential scenarios set out in the Circular were:

- any police operation calculated to apprehend a person(s);
- a police siege or a police shooting
- a high speed police motor vehicle pursuit
- an operation to contain or restrain persons
- an evacuation;
- a traffic control/enforcement;
- a road block
- execution of a writ/service of process
- any other circumstance considered applicable by the State Coroner or a Deputy State Coroner

The Deputy State Coroners and I have tended to interpret the subsection broadly. We have done this so that the adequacy and appropriateness of police response and police behaviour generally could be investigated where we believed this was necessary.

It is most important that all aspects of police conduct be reviewed even though in a particular case it may be unlikely that there will be grounds for criticism of police. It is important that the relatives of the deceased, the New South Wales Police Service and the public generally have the opportunity to become aware, as far as possible, of the circumstances surrounding the death.

In most cases where a death has occurred as a result of or in the course of a police operation, the behaviour and conduct of police was found not to warrant criticism by the Coroners. However criticism of certain aspects were made in a number of matters, including:

> *1304/1999:* The Senior Deputy State Coroner noted the fact that supervising police did not recognise a police pursuit to be a Section 13A death, thus not invoking the appropriate "death in custody" protocols. Despite this she found that pursuing police acted appropriately in the circumstances of the case;

2565/1999: In circumstances where a serving police officer's mental health had been markedly deteriorating over a nine month period prior to his death by drowning, the Senior Deputy State Coroner found that the NSW Police Service did not respond adequately to that deteriorating, failing to case manage him appropriately;

2092/2000 and *2093/2000:* The Senior Deputy State Coroner criticised police for the time it took them to respond to a scene after shots had been fired;

337/2001: The Senior Deputy State Coroner criticised officers of the Queensland Police who pursued a motorist into New South Wales. They were not Special Constables for the State of New South Wales and should not have continued the pursuit across the border. She commented (that from a police operation perspective) 'I have never seen a matter involving police where so many matters have gone wrong from start to finish'.

In the following matter, the action of a police officer was commended:

1100/2000: The State Coroner commended two young police officers for their efforts in attempting to return a mentally ill man to hospital; he also commended the female probationary constable for her "remarkable maturity' in saving the life of her partner.

We will continue to remind both the Police Service and the public of the high standard of investigation expected in all coronial cases.

Why is it desirable to hold inquests into deaths of persons in custody/police operations?

I agree with the answer given to that question by Mr Kevin Waller a former New South Wales State Coroner.

The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and it is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated[2].

I agree also with Mr.Waller that:

In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution. When the death is by deliberate

[2] *Kevin Waller AM, Coronial Law and Practice n New South Wales, Third Edition, Butterworths, page 28*

self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an event pertaining to an individual. The focus there is far more upon the individual and that individual's pre-morbid state. It is entirely proper that any death in custody, from whatever cause, must be meticulously examined'[1].

New South Wales coronial protocol for deaths in custody/police operations

Immediately a death in custody/police operation occurs anywhere in New South Wales, the local police are to promptly contact and inform the Duty Operations Inspector (DOI) who is situated at VKG, the police communications centre in Sydney.

The DOI is required immediately to notify the State Coroner or a Deputy, who are on call twenty-four hours a day, seven days a week. The Coroner so informed, and with jurisdiction, will assume responsibility for the investigation into that death. The Coroner's supervisory role of the investigations is a critical part of any coronial inquiry.

The DOI is also required promptly to notify the Commander of the State Coroner's Support Section, a small team of police officers who are directly responsible to the State Coroner for the performance of their duties.

Upon notification by the DOI, the State Coroner or Deputy State Coroner will give directions that experienced detectives from the Crime Scene Unit (officers of the Physical Evidence Section), other relevant police and a coronial medical officer or a forensic pathologist attend the scene of the death. The Coroner will check to ensure that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Where aboriginality is identified the Aboriginal Legal Service is contacted.

Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit and the coronial medical officer or the forensic pathologist. A member of the Coroner's Support Section must attend the scene that day if the death occurred within the Sydney Metropolitan area and, when practicable, if a death has occurred in a country district. The Support Group Officer must also ensure that a thorough investigation is carried out. He or she will continue to liaise with the Coroner and with the police investigators during the course of the investigation.

The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during it. If the State Coroner or one of the Deputy State Coroners is unable to attend a death in custody/police operations occurring in a country area, the State Coroner may request the local coroner in the particular district, and the local coronial medical officer to attend the scene.

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[1] *Kevin Waller AM, Waller Report (1993) into Suicide and other Self-harm in Correctional Centres, page 2*

A high standard of investigation is expected in all coronial cases. All investigations into a death in custody/police operation are approached on the basis that the death may be a homicide. Suicide is never presumed.

In cases involving the police

When informed of a death involving the NSW Police, as in the case of a death in *police* custody or a death in the course of police operations, the State Coroner or the Deputy State Coroners may request the Crown Solicitor of New South Wales to instruct independent Counsel to assist the Coroner with the investigations into the death. This course of action is considered necessary to ensure that justice is done and seen to be done.

In these situations Counsel (in consultation with the Coroner having jurisdiction) will give attention to the investigations being carried out, oversee the preparation of the brief of evidence, review the conduct of the investigation, confer with relatives of the deceased and witnesses and, in due course, appear at the mandatory inquest as Counsel assisting the Coroner. Counsel will ensure that all relevant evidence is brought to the attention of the Coroner and is appropriately tested so as to enable the Coroner to make a proper finding and appropriate recommendations.

Prior to the inquest hearing, conferences will often take place between the Coroner, Counsel assisting, legal representatives for any interested party, and relatives so as to ensure that all relevant issues have been addressed.

In respect of all identified Section 13A deaths, post mortem examinations are conducted by experienced forensic pathologists at Glebe, Westmead or Newcastle.

Responsibility of the coroner

Section 22, Coroners Act provides:

(1) The Coroner holding an inquest concerning the death or suspected death of a person shall at its conclusion .... record in writing his or her findings .... as to whether the person died, and if so:

(a) the person's identity,

(b) the date and place of the person's death, and

(c) except in the case of an inquest continued or terminated under section 19, the manner and cause of the person's death.

Section 19 provides:

1. if the Coroner is of the opinion that the evidence given at the inquest establishes a prima facie case against any known person for an indictable offence; and

2. the indictable offence is one in which the question whether the known person caused the death is in issue the Coroner must terminate the inquest.

The inquest is terminated after taking evidence to establish the death, the identification of the deceased, and the date and place of death. The Coroner then forwards to the Director of Public Prosecutions a transcript of the evidence given at the inquest together with a statement signed by the Coroner, specifying the name of the known person and particulars of the offence.

An inquest is an inquiry by a public official into the circumstances of a particular death. Coroners are concerned not only with how the deceased died but also with why.

Deaths in custody are personal tragedies and have attracted much public attention in recent years. A Coroner inquiring into a death in custody is required to investigate not only the cause and circumstances of the death but also the quality of care, treatment and supervision of the deceased prior to death, and whether custodial officers observed all relevant policies and instructions (so far as regards a possible link with the death).

The role of the coronial inquiry has undergone an expansion in recent years. At one time its main task was to investigate whether a suicide might have been caused by ill treatment or privation within the correctional centre. Now the Coroner will examine the system for improvements in management, or in physical surroundings which may reduce the risk of suicide in the future. In other words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist and, if so, to ensure, as far as possible, that remedial action is taken.

Recommendations

The common law practice of Coroners (and their juries) adding riders to their verdicts has been given statutory authorisation in *Section 22A* of the *Coroners Act 1980*. This section indicates that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations *(S.22A(2))*.

Any statutory Recommendations made following an inquest hearing should arise from the facts under inquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. Coroners require, in due course, a reply from the person or body to whom a Recommendation is made.

Acknowledgment of receipt of the Recommendations made by a Coroner is received from Ministers of the Crown and other authorities promptly. Some weeks are required for the inquest evidence and exhibits to be studied and consideration given to the Recommendations made by the Coroner. A formal reply as to the outcome of those considerations is then received by the Coroner. Recommendations arising from 13 inquests were made during 2002.

Contacts with outside agencies

During 2002 the State Coroner's office maintained effective contact with:

the New South Wales Department of Forensic Medicine (Department of Health);

the Division of Analytical Laboratories at Lidcombe (Department of Health);

the Aboriginal Prisoners and Family Support Committee (New South Wales Attorney General's Department);

the Aboriginal Deaths in Custody Watch Committee;

the Indigenous Social Justice Association;

the Aboriginal Corporation Legal Service;

the Aboriginal and Torres Strait Islander Commission;

the Australian Institute of Criminology in Canberra;

the Office of the State Commander New South Wales Police Service;

the Department of Corrective Services; and

Corrections Health.

Close links were also maintained with Senior Coroners in all other states and territories.

Overview of deaths in custody/police operations reported to the New South Wales State Coroner during 2002

All deaths pursuant to *Section 13A, Coroners Act 1980*, must be investigated by the State Coroner or a Deputy State Coroner.

Deaths in custody/police operations which occurred in 2002.

There were 18 cases of deaths in custody and 17 cases of death as a result of or in the course of police operations reported to the State Coroner in 2002. These cases have either been listed for hearing in 2002 or are still under investigation.

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	**37**
1996	26	6	**32**
1997	41	15	**56**
1998	29	9	**38**
1999	27	7	**34**
2000	19	20*	**39**
2001	21	16	**37**
2002	18	17	**35**

Table 1: Deaths investigated by Coroners during 1995 to 2002

Aboriginal deaths which occurred in 2002

Of the 35 deaths reported during 2002 pursuant to *Section 13A, Coroners Act* 1980, four (4) of the deceased were adult aboriginal males, 3 of whom died in custody in prison and 1 of whom died as a result of a police operation.

Inquests into the deaths of 7 adult aboriginal males were heard and findings given. A synopsis for each of these deaths is contained in this report.

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	7	0	**7**
1996	2	0	**2**
1997	6	2	**8**
1998	2	3	**5**
1999	3	1	**4**
2000	4	1	**5**
2001	5	-	**5**
2002	3	1	**4**

Table 2: Aboriginal deaths in custody/police operations during 1995 to 2002.

Deaths investigated by the State/Deputy State Coroners during 2002.

During the year 32 "deaths in custody" cases and 26 "police operation deaths" were finalised *(Appendix 1)*.

Findings were recorded as to identity, date and place of death, and manner and cause of death. No findings were entered as to the manner and cause of death in 9 cases as the inquest in each case was terminated pursuant to *Section 19, Coroners Act 1980*, on the basis that a known person had been charged with an indictable offence in which an issue will be that the known person caused the death.

Information relating to the 49 deaths into which inquests were held.

Circumstances of death

Persons who died in custody:-

- 13 by taking their own life by hanging
- 2 by accidental drug overdose
- 11 of natural causes
- 1 from injuries received as a result of a jump/fall
- 1 by way of intentional drug overdose.

Persons who died as a result of or in the course of police operations:-

- 3 from injuries received whilst in a vehicle being pursued by police
- 3 shot by police
- 5 from self inflicted gun shot wound
- 1 from drowning
- 5 from injuries received as a result of a jump/fall
- 2 from natural causes
- 1 from electrocution
- 1 from a gunshot wound inflicted by a person since deceased.

Unavoidable delays in hearing cases

The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is unavoidable. There are many different reasons for delay.

One 2000 matter remains outstanding - the inquest is listed for hearing in 2003.

The view taken by the State Coroner is that deaths in custody/police operations must be fully investigated. This will often involve a large number of witnesses being spoken to and statements being obtained.

It is settled coronial practice in New South Wales that the brief of evidence be as complete as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case. It has been found that an initially comprehensive investigation will lead to a substantial saving of court time in the conduct of the actual inquest.

In some cases there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services. The results of those investigations may have to be considered by the Coroner prior to the inquest as they could raise further matters for consideration and perhaps investigation.

In some cases expert medical or other opinion may need to be obtained. This will necessarily require the selected expert to read and assess the whole file before providing the Coroner with an independent report.

The concerns of the family and relatives of the deceased and possible other interested parties must also be fully addressed.

In the case of country deaths, delay can sometimes occur due to the unavailability of a suitable courtroom because of Supreme, District or Local Court commitments in a particular district.

Deaths occurring in police custody or during the course of police operations demand compliance by officers with the NSW Police Service Handbook as they relate to such deaths. The Crown Solicitor instructs independent Counsel to assist with the investigation of this type of death. The official police instructions are closely analysed by the Coroner.

Conclusion.

Despite the delay in publication of this report, it can be seen from the report that substantial arrears of work were overtaken during 2002. It should be mentioned that twenty one (21) cases were heard and determined at country centres. Included amongst these was one eight week case involving a Coroner's jury.

SUMMARIES OF INDIVIDUAL CASES COMPLETED IN 2002.

Following are brief summaries of each of the cases of deaths in custody/police operations which were heard by the NSW State Coroner, Senior Deputy State Coroner and the Deputy State Coroner in 2002.

These summaries include a description of the circumstances surrounding the death, the Coroner's findings and any recommendations that were made.

Further information about any of these cases can be obtained from the Executive Officer to the NSW State Coroner, State Coroner's Office, Glebe.

948 of 1995

Male aged 25 years died on 22nd May, 1995 at Prince of Wales Hospital, Randwick Finding handed down on 27 June 2002 at Glebe by John Abernethy, NSW State Coroner.

The NSW State Coroner apologised to the family of the deceased for the length of time taken to conclude his inquest into the death. The matter was adjourned generally in late 1997 to enable further investigation of certain allegations made by the mother of the deceased.

For various reasons involving both the Office of the State Coroner and the NSW Police Service as it then was there was a substantial period where little was done by way of investigation. The State Coroner accepted the blame for that delay.

Facts:

This 25 year old (sentenced) aboriginal prisoner died in the Prince of Wales Hospital, Randwick on 22nd May, 1995. He had collapsed after ingesting heroin in a safe cell in the Reception and Induction Centre, Long Bay Complex of Prisons, Malabar on 14th May, 1995 following a visit from his mother, her boyfriend and his girlfriend. The day after he was hospitalised a "Vicks" inhaler was taken from his rectum. That inhaler (a common vehicle for secreting contraband) contained traces of heroin and needles.

At autopsy he was found to have died from hypoxic encephalopathy due to heroin toxicity. The State Coroner was satisfied that his death was accidental and that he voluntarily ingested the drug.

The subsequent police investigation did not ascertain how the prisoner came to have the heroin. The probability is that he received it from another prisoner or one of his visitors on 14th May. The visitors and the sweeper who had access to the prisoner in his safe cell denied supplying him with drugs.

Issues.

Aboriginality.

The State Coroner accepted that the deceased was of indigenous origin though he denied his aboriginality in his reception interviews by an officer of the Department of Corrective Services and a registered nurse of the Corrections Health Service.

Cause of Death.

The Coroner found that the prisoner died accidentally after voluntarily ingesting heroin. The "Vicks" inhaler found inside him after hospitalisation was a clear indicator to that effect.

The prisoner's mother suggested that the prisoner may have been given a "hot shot" and named several prisoners. The inquest was adjourned to enable her allegations to be fully investigated. That investigation disclosed that the prisoners named were not in the same prison on the day the prisoner ingested the heroin or in the days before that. The Coroner found that the prisoner chose to receive drugs from an unknown person and to ingest those drugs.

Care and Treatment at hospital.

The State Coroner found that the care and treatment received by the deceased at Prince of Wales Hospital was appropriate. He found, in fact that from the moment it was noted that the prisoner had collapsed there was little likelihood of his successful recovery.

Movements in the prison system prior to death.

The prisoner was transferred from the Goulburn Correctional Centre on 17th April, 1995 and placed in the Long Bay Hospital Psychiatric Unit. He had attempted to hang himself and then to slash an antecubal fossa or elbow. He remained in the Unit for assessment until 12th May, on which date he was discharged as being "not suicidal" and "not psychiatrically ill".

He was told he was to be transferred to Lithgow Correctional Centre and immediately began to reopen the elbow wounds. On being told by the Corrections Health Service that the prisoner would not be readmitted to hospital the Governor of the prison ordered that he be placed in a safe cell. He was regularly seen by a Risk Intervention Team during his days in the cell. Again the State Coroner found this placement in the safe cell was appropriate.

The Governor, concerned that the deceased was not going to be readmitted to hospital, spoke personally to the deceased assuring him that he would not be moved to Lithgow but to the Parklea Correctional Centre the following Monday. The deceased appeared satisfied with this arrangement and in fact shook hands with the Governor.

Had death not intervened he would have been transferred to a suitable facility and the problems he had been having, resolved.

Conclusion.

The NSW State Coroner found death to be accidental and that the prisoner had been dealt with appropriately by both the Department of Corrective Services and the Corrections Health Service (and their officers) after being transferred from Goulburn Correctional Centre to Sydney.

He commented in the following terms:

"What is heartening is that the death rate of prisoners, particularly indigenous prisoners in this particular State, is falling perceptibly whilst the actual prisoner intake is rising dramatically. I am cautious about being optimistic but hope that things in NSW are finally improving."

Formal Finding:

That N.B. died on 22 May, 1995 at Prince of Wales Hospital, Randwick, of hypoxic encephalopathy due to heroin toxicity, such heroin being ingested by him on 14 May, 1995 whilst a prisoner in the Reception and Induction Centre, Long Bay Complex of Prisons, Malabar.

1265/98 **Male aged 44 years died on 23 June 1998 at Royal Prince Alfred Hospital, Camperdown. Finding handed down on 1 February 2002 at Glebe by Jacqueline Milledge, Senior Deputy State Coroner.**

Whether the deceased injected himself with heroin in Room 214 at the FO Motel, St Peters on 19 June, 1998 or whether he was assisted in the administration or forcibly injected, the evidence does not allow me to say.

Profile

The deceased had been an inmate at the Long Bay Correctional facility since 1989. He had been sentenced for supply drug and robbery offences. For all accounts, he was considered a model prisoner.

Since 4 August 1997, PH had been on the Work Release Programme and worked as a baker in premises at Mascot. He was classified as a C3 prisoner which entitled him to weekend leave. He was due for parole 11 August.

PH had a strong attachment to his daughter and only availed himself of weekend leave when he was able to spend time with her. Out of 18 possible weekends, he took advantage of 8. His girlfriend's mother was his sponsor for weekend leave and he had to reside at her home when he was away from the prison.

PH was looking forward to living with his daughter and her mother on his release. This was complicated, as his girlfriend had established another 'live in' relationship. The evidence disclosed that both the girlfriend and her new partner were unhappy about PH's intended living arrangements and there was considerable animosity between them for this reason.

PH and his use of drugs

PH was very close to his family. His mother stated he was a generous and loving son. It was her belief that PH was not a drug user.

Whilst he was a convicted drug supplier, he was known by fellow inmates and correctional officers to be intolerant of drug users within the prison environment.

Contradictory evidence was found in a letter written by the deceased where he says (regarding the use of heroin) "I have never told any one (sic) before

but I was using for over two years and had a habit" This letter of course, is written in the past tense.

One witness who was a part of the Work Release Programme stated that it was easy to use heroin and 'flush' out the kidneys over time to ensure a negative 'urinalysis' on returning to prison. The inmate stated the deceased had supplied drugs from the premises where he was working and that he was known to 'use'.

Evidence from the officer in charge of urinalysis testing stated PH was tested on his return from weekend leave on every occasion and each time provided a negative result. The Coroner was satisfied that the testing was 'tamper proof' ensuring the complete integrity of the process.

Further evidence was that the deceased was also randomly drug tested and his cell searched. Again nothing was discovered to indicate he was involved in the distribution or use of drugs.

His Probation and Parole Officer was shocked to hear he died a drug related death. He stated it was so contrary to his performance in custody, his urinalysis results and his known history.

Whilst the syringe that was used in the fatal injection was never recovered, the full syringe found in his girlfriend's handbag had 7 times more heroin found in any lethal dose.

Circumstances of death

On the Friday he died, PH was not intended to have weekend leave. It was expected that he return to Long Bay that Friday afternoon.

It was very clear from evidence of other witnesses involved in the Works Release Programme at the bakery at Mascot, the inmates took their time returning to the prison in the afternoon. Evidence was given that they would attend a hotel at Maroubra for dinner prior to returning.

On 19 June, PH was picked up from work by his girlfriend at 4pm. They travelled to a motel in St Peters. She stated she left the motel room to buy cigarettes returning to find the deceased preparing his 'fix'.

After the drug is administered, he immediately falls to the floor. Management is contacted and subsequently the police and ambulance arrive. The deceased was transported to hospital where he died 4 days later.

The syringe the deceased used was never found. His partner said she was scared he'd loose his parole so she disposed of it. Without examination of the syringe, the strength and quality of the drug administered remains undetermined.

PH's girlfriend was not a witness of truth. Her version of events changed not only throughout the police investigation, but also during the inquest. It was impossible to piece together the last moments of his life.

The issues

The suspicious circumstances of his death - there was conflicting evidence regarding PH's drug use. Regardless of the information from other inmates that he 'used', the evidence of the correctional officers is that he passed all urine tests and was never found to have contraband when his cell was randomly searched.

Given the very lax conditions for the inmates at the bakery, it would have been possible for the deceased to involve himself in the purchase and supply of drugs, however the evidence did not support any finding of 'fact' in this regard.

It was also established that his girlfriend did not want him to 'pick up where he left off' with her. She did not want him living with her on his release. There was the added complication of the third person, her boyfriend, who was also concerned for his position when PH was released.

The girlfriend disposed of his syringe and tried to conceal other items from police at the scene.

The syringe in her purse had seven times the lethal dose of heroin.

The girlfriend didn't choose to remain silent when questioned over his death, she chose to mislead police and the court.

The 'relaxed' supervision at the bakery - the evidence of the officer in charge of the Work Release Programme was that all work places were carefully scrutinised and the management and supervisors screened to ensure the programme's integrity.

Strict rules were in place ie the inmates were not to leave the premises during the day, phone calls were prohibited and they were to return to prison immediately at the completion of their shift. The bakery supervisor's evidence was that he was unaware of the need to enforce strict rules under the Programme.

Evidence was that PH had, on a number of earlier occasions, booked into the motel after work on a Friday with his girlfriend. It was also established that PH regularly left the bakery during the day to make phone calls and draw money from an automatic teller machine. Whilst the deceased's hours were 8am to 5 pm, Monday to Saturday he often left the bakery earlier than the scheduled finishing times.

This extremely lax supervision allowed the prisoners to come and go as they pleased.

The police investigation - two junior police officers had attended the motel at the time of the overdose. Their inexperience allowed PH's girlfriend to tamper with evidence, attempting to secrete some items and dispose of others. Despite their lack of expertise in attending the crime scene, the young officers conducted a very good record of interview with the girlfriend and promptly brought the incident to the attention of their supervisor. They also advised the supervisor that PH was on work release.

As PH was an inmate his death was a 'death in custody' falling within Section 13A of the Coroner's Act. The supervisor failed to ensure the correct protocols were adopted in dealing with this as a '13A' investigation. Police Crime Scene was never called. Detectives should also have been advised immediately of the drug overdose.

Formal Finding

PH died on 23 June 1998 at Royal Prince Alfred Hospital, Camperdown. His cause of death is Hypoxic Encephalopathy due to Morphine Toxicity.

Whether the deceased injected himself with heroin in Room 214 at the FO Motel, St Peters on 19 June, 1998 or whether he was assisted in the administration or forcibly injected, the evidence does not allow me to say.

Recommendations:

1. **That the commissioner for Corrective Services, together with the NSW Police Commissioner, consider the introduction of a computer register of all inmates currently subject to workplace and external leave programmes. The register should be available to all police requiring the information.**
2. **That the Commissioner for Corrective Services continue to develop (where technology allows) an effective centralised system of monitoring work release and external leave inmates.**
3. **That the Commissioner of Police ensure that 'Death in Custody Protocols' be activated where the prisoner (either in goal or on a work release or external leave programme) overdoses and is hospitalised with the possibility that he/she will die.**
4. **That the Commissioner for Police ensure that the Officer in Charge of all coronial investigations have carriage of the matter to finality, except with the formal leave of the Coroner.**

1328/98 **Male aged 36 years died on 5 July 1998 at long Bay . Finding handed down on 18 December 2002 at Glebe by John Abernewthy, State Coroner.**

The deceased, RC, was an inmate at Long Bay Gaol when he was stabbed. A known person has been charged with an indictable offence which resulted in the death of the deceased. In those circumstances the inquest was terminated under section 19 of the Coroners Act 1980.

1304/99 **Male aged 24 years died on 12 November 1999 at Glossodia . Finding handed down on 31 May 2002 at Westmead by Jacqueline Milledge, Senior Deputy State Coroner.**

Overview

On the 11 November the deceased, MRJ, had arranged for a friend to take his motor vehicle to another friend's house as the deceased intended to have a night 'on the town' and he didn't want to drive after drinking.

This was consistent with the deceased's usual responsible approach to driving.

After his evening out, MRJ was driven to his friend's place where his car had been housed. He arrived in the company of M. His friend was asleep, however the keys to the friend's motorcycle were taken by the pair who set off riding it down Spinks Road.

The evidence did not allow the Coroner to make a finding as to who was driving the motorcycle at the time of impact, the witness M refused to answer on the grounds of 'self incrimination'.

The deceased had a blood alcohol content of .243 and M had a reading of .077.

At about 1.10am the cycle was spotted by police and it was noticed that the headlight was 'dim' and both rider and passenger were not wearing helmets. As they passed the police it was noticed the motorcycle accelerated harshly.

The police made a 'U' turn to follow. The police were travelling at the speed limit, 90kph with high beam and spotlights activated only.

They lost sight of the motorcycle, however they continued along Spinks Road and 1.3 kilometres further south, they saw the motorcycle laying on the roadway.

A search of the area located MRJ on a grass verge obviously deceased and his friend M further down the embankment with serious head injuries.

Issues

There was concern that the Police had 'pursued' the motorcycle at great speed which may have pushed the rider of the cycle to take risks. The Coroner was satisfied that the police acted appropriately in the circumstance, and that there was sufficient distance between the cycle and the police vehicle from the moment they started to follow.

The death was not considered to be a 'Section 13A death', that is a death in a 'police operation' at the time of the incident. That meant that the Death in Custody Guidelines were not followed to ensure the integrity of the investigation.

Whilst the police were not interviewed after the event they were breath tested and drug tested with negative results.

It should, however, have been obvious to the supervisor that this incident met the Section 13A criteria in 3 categories:

- any police operation calculated to apprehend
- a police pursuit
- a traffic control/enforcement situation

The Coroner was satisfied that although the protocols were not invoked, the investigation was not compromised.

Formal Finding

MRJ died on 12 November, 1999, at Spinks Road, Glossodia. The cause of death is head injury sustained when the motorcycle he was travelling on hit an Armco barrier, propelling the deceased into a signpost before coming to rest on the side of the roadway. Whether the deceased was the driver or pillion passenger at the time of the collision, the evidence does not enable me to say.

2217/99 Male aged 53 years died on 26 October 1999 at Bathurst. Finding handed down on 8 May 2002 at Bathurst by Jacqueline Milledge, Senior Deputy State Coroner.

The deceased, PD, was serving a five year minimumsentence, eight year maximumsentence for manslaughter. He was sentenced on 25 October 1995 and was due forrelease in 2000, so it can be seen he was close to his release date. PD was well knownto Corrections Health Service with medical records back to 1969. He had beenintermittently incarcerated over a thirty year period. At his reception assessment he gave a past history of high blood pressure, chest pain and diabetes and also outlinedhis current medications.

PD was seen regularly by Corrections Health Service staff for his poorly controlled diabetes, hypertension and angina. Nitrate patches were added to his treatment resume because of regular angina. Repeated electrocardiographs did not show any change from those recorded on reception.

In September 1999 PD was transferred to the new Correction center at Ivanhoe. Hesuffered repeated attacks of chest pain and on the advice of the Royal Flying DoctorService he was returned to the Broken Hill Correctional Centre on 5 October. On 17 October 1999 he was reviewed by the Visiting Medical Officer at the Broken HillCorrectional Centre suffering chest pains on three occasions. The Medical Officerrecommended transfer to a gaol with a greater amount of medical cover and he was accordingly transferred to Bathurst Correctional Centre on 20 October 1999.

The Coroner was satisfied that the medical history of PD was well known to theDepartment of Corrective Services and that he had been treated appropriately and in a timely fashion.

On 23 October 1999 he complained of chest pains and he was taken to the Bathurst District Hospital Intensive Care Unit where he remained for treatment. On the 26 October his breathing became rapid and shallow, he appeared to be having a seizure and despite extensive efforts by nursing and medical staff, he died. The Coroner was satisfied there was nothing suspicious in relation to PD's death and that no fault rested with Corrective Services in their treatment of PD.

Finding:

That PD died on 26 October 1999 at Bathurst District Hospital whilst an inmate at Bathurst Correctional Centre. He died of natural causes, the cause of death being myocardial infarction due to coronary atherosclerosis.

2491/99 **Male aged 25 years died on 3 December 1999 at Long Bay Correctional Centre. Finding handed down on 20 September 2002 at Glebe by Jacqueline Milledge, Senior Deputy State Coroner.**

ER was an inmate of Long Bay Prison Complex at the time of his death and therefore an inquest is mandatory pursuant to Section 13A, Coroners Act 1980.

ER was a 25 year old aboriginal male who was serving a 7 year minimal sentence with an additional term of four years. He had been sentenced at the District Court on 11 December 1993 for offences of violence and was due for release on 10 December 2000.

ER had been housed in a number of centres since 1993, the last transfer being 12 April 1999 when he was moved from Cessnock to the MMTC, Long Bay.

He was classified an 'E2' inmate as he had previously escaped from lawful custody. The details of this escape have been provided by ER's family. They said ER had been in police custody waiting the processing of charges when he left the holding cell and was found hiding in the family car parked close to the police station. Having discovered him, his family encouraged ER to return to the police station, which he did. ER was sentenced to Community Service as a result of that escape.

At the time of his death, 61/2 years later he was still classified an E2 prisoner as a result of the earlier escape.

On Monday 29 November, 1999, ER told Aboriginal Welfare Officer RC, "I'm going to hang myself". RC and Nurse J, acting in the capacity of a Risk Intervention Team (RIT), placed ER in a safe cell as they were concerned for his welfare.

On Tuesday 30 November, a further Risk Intervention Team, comprising Nurses H and S, Intern Forensic Psychologists DM and RC, met and determined that ER should remain in the safe cell with referral to a psychiatrist.

The following day, the 1 December, the Psychiatric Registrar, alone, examined ER and determined he was no longer at risk. As a result of her assessment, the RIT had effectively been 'terminated' and a new placement for ER was to be found. This proved to be problematic.

ER could not be returned to Wing 12 as he had assaulted prison officer B in November. Immediately following that assault, he was housed in the Intensive Care Management Unit until his placement in D ward on 19 November.

Now on release from the safe cell he could not be returned to Wing 12 due to his previous assault on Officer B. Whilst awaiting proper placement he was accommodated in the 'observation' cell in Wing 13. It was in this cell, in the

early hours of 3 December that he was found hanged.

There are a number of issues arising from the detention and management of ER that are of concern to the Coroner.

They are:

1. The classification of ER as E2 which significantly restricted his placement and management within the system.
2. The management of him as an inmate with obvious developmental, physical and behavioural problems.
3. The problems that presented in trying to accommodate him '2 out' due to his behaviours and the apparent unwillingness of some inmates to share with him.
4. The lack of proper placement as an inmate identified with significant disabilities.
5. The general management of ER as an Aboriginal inmate.
6. The management of ER as an inmate diagnosed with a lengthy psychiatric history.
7. The management of ER as an inmate who had been considered 'at chronic risk of self harm'.
8. The ineffective use of the Risk Intervention Team Management strategies.
9. The lack of understanding of the Psychiatric Registrar in undertaking her role and the need for RIT protocols to be strictly observed.
10. The release of ER from the 'safe cell' environment where he was constantly observed to Wing 13 where he was not.
11. The lack of an 'inter-mediate' system of observation when an inmate is released from a safe environment to the general prison population.
12. The lack of appropriate parental assistance in the care of ER.
13. The possession of contraband material ie the speaker wire, that ER used to bring about his demise.
14. The obvious problem of failed information sharing between Corrections Health and Corrective Services when considering the safe custody of ER.
15. The obvious difficulties that present for an inmate with disabilities in seeking a review of any administrative decision affecting them.
16. The effectiveness of the Indigenous Support Unit.
17. The lack of attention given to comments of sentencing and appeal judges as to the need for the inmate to be appropriately managed within the correctional system.

It must be recognised that ER was an extremely difficult inmate to manage. He was serving a very long period of incarceration for violent offences and was 'chronically' at risk of self harm. He did however, have a very supportive family who were keen to involve themselves in the care and management of ER if the prison authorities had called on them.

The E2 Classification

The main impediment to the parents involvement with their son was the distance they lived from the facility. Mr and Mrs R resided at Walgett and, unless their son's classification was changed, ER could not be moved closer to home.

I accept that Corrective Services must be extremely careful to ensure prisoners who have been shown to be 'flight risks' are managed appropriately. However there needs to be some flexibility when considering the viability of that severely restrictive classification remaining in place for a number of years.

Evidence was given that prior to 1996 it was not possible for the E2 classification to be removed. All prisoners who committed an 'escape offence' had to be classified this way, regardless of the circumstances of the escape.

In 1996, legislation allowed for the establishment of an 'Escape Review Committee' to enable the review and re-classification of prisoners. Whilst all prisoners who have involved themselves in an 'escape offence' must be classified either E1 or E2 it is possible for them to have this classification reviewed in time.

To trigger a review by the Escape Review Committee, the inmates themselves had to make the application. This would be difficult for an inmate like ER. His case file suggests a referral process was commenced at one time, but not completed and he remained classified E2.

The E2 classification meant that ER had to be held in a medium security environment. This prevented his movement closer to home and therefore isolated him from his family.

ER's disabilities were also of concern to the authorities when considering his possible placement in other country centres. He was considered vulnerable, and ER would not agree to be placed 'on protection' to allow his movement to another facility in the country.

Some witnesses have suggested ER was child like and it was well known that he suffered developmental disabilities. He was known to throw tantrums and lash out when he did not get his own way. His case file suggests he was a prisoner who was extremely difficult to deal with.

His lengthy history of disciplinary matters and his ongoing behavioural problems must be seen in the light of his mental and physical condition. He presented as a prisoner with special needs and should have been managed accordingly.

ER also suffered hearing problems. This was acknowledged by some but not diagnosed. Mrs R believes her son may have sustained an ear injury when he was struck by another child at six months of age.

Dr L, the Forensic Pathologist, who examined ER at Post Mortem, found 'chronic otitis media', inflammation of the middle ear. Dr L stated that this

could have been a long standing problem suggesting ER may have had multiple episodes of inner ear infection which had gone untreated.

ER's hearing impairment may also have contributed to his difficult behaviour.

Whilst I accept the old legislation was severely binding on prison authorities, reviews were possible for the last 31/2 years of ER's life.

Had there been a structured 'management' approach to his care, the E2 classification should have been removed to allow valuable and, no doubt, timely input into his care by his parents. It is accepted that the parents would have a limited but important role, after all the report into Aboriginal Deaths In Custody stresses the need for indigenous inmates to have contact with family members.

The Disability Unit was the appropriate placement for ER, however his E2 classification severely restricted access to the Department's Disability Unit. Only one unit was within a secure setting, the other units were 'one out' meaning the aboriginal inmate would be placed on his own.

His family

Mr and Mrs R have impressed the Coroner with their commitment and dedication to their son, and the Coroner's understanding, from evidence taken in this inquest, is that they were well regarded by the prison authorities.

They felt very much on the outside when it came to their son's welfare. They believe if they had been advised of ER's condition they would have been able to assist him.

Here is a situation where a decent family is pleading to be told of the welfare of their son, but, to them, appear to be receiving very little feedback of ER's situation.

Not all inmates' families are as supportive as ER's and, indeed, quite often, it is the family that causes the inmate the most grief. Prison authorities must be very careful in their dealings with inmates and their families. Confidentiality is important, particularly where there are medical or mental health issues, then doctor patient confidentiality is a consideration.

But too often during the course of these inquests do we hear the same complaint from family members regarding lack of feedback.

There needs to be some balance between the family's need to know and the inmates right to privacy.

'At Risk' Status

ER had been assessed as being at 'chronic risk' of self harm. Dr S's evidence was that there was always some degree of risk he could develop suicidal ideation and act on it. Her last assessment of him before his death, was that he was 'not at risk', she believed he was now at a level where his risk could be managed, therefore terminating his RIT status. Acting on her own, it is very clear that Dr S flew in the face of established RIT protocols.

The degree of management between chronic long term risk and 'at risk' differ considerably. If 'at risk', the inmate is housed in a safe cell and observed. When the 'risk' has resolved, the inmate is returned to the general prison population.

As a lay person, the Coroner finds it extremely difficult to comprehend how an inmate can be suicidal and considered 'at risk' one day and then return to 'normal' within 48 hours. Dr S said one determining factor was that he hadn't attempted self-harm in the safe cell. Given the sterile environment of that placement, no attempt to self-harm is not surprising. Another indicator for Dr S was that 'he is retracting his threat of suicidal ideation'. It seems a great deal of reliance was placed on what she was told by the inmate.

Dr S's approach was clearly wrong as was her assessment of ER.

The Coroner is satisfied that ER was not placed in the 'observation cell' in wing 13 as he was not to be 'observed'. I accept that it was used for overflow purposes, and ER was to be housed more appropriately.

Whilst I accept there were difficulties in finding a willing cell mate to go '2 out' with ER, the Coroner was not satisfied that all was done to ensure his safety whilst awaiting a more appropriate placement.

An aboriginal inmate, recently suicidal, being placed on his own without observation was not appropriate.

The Coroner agrees that the use of the safe cell must be limited. There needs to be a balance between the need to keep the prisoner safe and under observation with the rights of the prisoner to have privacy and some comfort.

Whilst the Coroner was critical of Dr S acting alone in assessing ER, there was no system of checks and balances to ensure the protocols were observed. ERwas released on the 1st and between then and his death no-one queried the appropriateness of Dr S's decision.

Whilst the Coroner felt this is, for the most part, a fault on the part of Corrections Health, Corrective Services should also have been alert to the fact that her dealing with the inmate that way was inappropriate.

Case Management

When considering the many difficulties ER presented as an inmate with disabilities, the lack of a structured and purposeful case management plan was unacceptable.

Mr L of the Inmate Classification and Management Section stated after ER's death that the management of E classification inmates with intellectual disability was 'reactive' with no strategic planning. "No case management File provided the reader with an understanding of the inmate. It was not possible to glean from the files if the inmate was progressing or regressing".

Whilst this comment was made almost 6 months after ER's death, it appears to reflect that lack of structure in dealing with the inmate.

This 'reactive' approach to case management is extremely problematic, particularly in the light of Dr S's comments that ER's risk had returned to a manageable level. What does 'manageable' mean in this context?

In managing inmates from a medical perspective, it is absolutely imperative that Corrections Health and Corrective Services let each other know the 'status quo'. The problem that arises is one of 'conflict of interests'. The medicos are very much bound by the confidentiality between patient and doctor and this does not allow for the sharing of information that is so important when looking at safe custody of inmates

Observation Cell

Cell 28, Wing 13, is an observation cell with monitoring cameras. Evidence is that ER was placed in there because of the difficulty in finding other main stream accommodation. It was never intended to be used to 'observe' him.

Whilst Officer B has stated the use for the observation cell was solely for observation purposes, other evidence is that it was sometimes used as an 'overflow' cell where inmates were placed awaiting other cells.

It could easily be thought in this situation, that ER was meant to be 'observed' as a safeguard given his earlier 'at risk' status. After all, the monitor for his cell had his name underneath.

The Coroner is however, satisfied that because of the difficulty placing him 'main stream', Cell 28 was used as a temporary housing measure.

The issue of 'Suicide'

It has been asked, by Counsel assisting the family, to leave the Coroner's finding 'open' on the issue of suicide. The family believe the police took a narrow view in their investigation from the outset treating ER's death as a 'suicide' and therefore adopted a 'blinkered' approach.

I agree that some elements of the police investigation were left wanting. Very important examination of 'blood' found under ER's fingernails was not carried out until well into the inquest, and then it was found not to be Mr Russell's blood. As no data bank was in existence, the blood could not be compared.

I find it difficult however to accept the criticism that the wire should have been identified as speaker wire and not 'aerial'. Many witnesses identified it as an 'aerial' except for Mr C, who correctly named it. Regardless of what it was called, it was used as an aerial.

It was not part of ER's property when his television and other items were returned to him, the Property Officer stating that had it been seen during the inventory, it would have been confiscated.

Prisoners are very resourceful and it would be very difficult indeed to ascertain the origin of that item.

Whilst the issue of the blood under ER's nails remains unresolved, I am satisfied that given his recent admission to Ms C that he was going to hang

himself and his chronic risk of self harm, I find that no other person was involved in the demise of ER. As to his state of mind, I am satisfied that he hanged himself for the purpose of ending his life.

Conclusion

ER had been incarcerated for most of his 7 year minimum sentence and was very much on the home stretch, anticipating his release in December the following year.

It is clear that for the period of his imprisonment he was considered a 'chronic risk of self harm' and for the most part he remained safe.

It is very clear from the evidence that systems failed and he was not given the appropriate attention required for a problematic prisoner with developmental disabilities.

There is no doubt that this inquest has exposed some systemic failures in ER's management. The Coroner is however, very pleased with the Department's response to the inadequacies in the present system, particularly the proposals for change detailed by Ms JB, Clinical Co-ordinator, At Risk Inmates. Indeed, many of her proposals have been embraced in the Coroner's recommendations.

The State Coroner and the Coroner have only recently been discussing the great improvement that has been made in the prison system and the impact that many changes have had on reducing the number of deaths in custody and the willingness of the Correctional authorities in bringing about those changes.

ER's death has highlighted the need for a concentrated approach to Inmates at Risk, particularly those with the added complication of physical or mental disabilities.

Formal Finding

That ER died on 3 December 1999 in the Cell 28, 13 Wing, Metropolitan Medical Transit Centre, Long Bay Correctional Complex.

The cause of death is 'hanging', self-inflicted by ER with the intention of ending his life.

Recommendations.

To the Minister for Corrective Services:

1. **That the Minister for Corrective Services audit all correctional facilities to ascertain the level of compliance regarding the recommendations of the Royal Commission into Aboriginal Deaths in Custody.**
2. **That a copy of the audit be provided to the NSW State Coroner within one month of its completion.**
3. **That the Minister for Corrective Services and the Minister for Health both review the current partnership of Corrections Health**

and Corrective Services regarding protocols for the exchange of information to ensure safe custody procedures are adopted for all inmates 'at risk' or 'chronically at risk'

4. That recommendations made by Judges and Magistrates concerning the placement and management of the prisoner be considered at the time of reception and an assessment made of the inmate in the light of those comments. A reply should be forwarded to the judicial officer for inclusion in the court papers.

5. That each correctional centre establish the position of Risk Intervention Team (RIT) Co-ordinator to ensure the strict adherence to RIT protocols.

6. That all Corrective Services staff and Corrections Health staff be re-apprised of the strict protocols when dealing with RIT management.

7. That the recently introduced Acute Crisis Management Units be maintained to ensure a referral point and management area for inmates 'at risk'.

8. That a 'tiered' or 'stepped down' approach in dealing with inmates 'at risk' be adopted. This would ensure inmates do not go from intensive observation to 'normal' placement without a management plan and consideration for the inmates involvement in appropriate programmes.

9. That the recently established Aboriginal Offender's Social and Emotional Wellbeing Committee be supported and that a copy of its report and recommendations be provided to the State Coroner within one month of its publication.

10. That support be given to the current proposal to ensure all RIT Management plans have four components ie accommodation, human interaction, and referral components as well as observation and monitoring.

11. That the current RIT termination procedures be replaced with a 'discharge' protocol to ensure long term management of inmates 'at risk'.

12. That all case management plans be regularly reviewed and assessed as to their efficacy.

13. That a Mental Health Assessment Unit be established at the Metropolitan Remand and Reception Centre to enable the identification of inmates with mental health problems.

14. That the Indigenous Support Unit be supplied with sufficient human and financial resources to act as advisors and advocates on behalf of Aboriginal inmates.

15. The Indigenous Support Unit be required to conduct an annual review of Aboriginal Services within Corrective Services Correctional Facilities.

16. That Corrective Services comply strictly with the requirement to review classifications every six months.

17. That the Minister for Corrective Services implement strategies to provide sufficient and appropriate gaol accommodation for inmates who have intellectual impairment and/or mental health problems.
18. That any placement of a prisoner 'at risk' or diagnosed with mental illness, be done in consultation with the treating psychiatrist.
19. That on reception, the relationship between the inmate and his/her family be ascertained. The inmate should have to indicate on reception forms whether they do not want family members notified of their health and management issues.
20. That Aboriginal inmates be placed in facilities nearest their families unless there are security and management concerns.
21. That the Indigenous Support Unit assist aboriginal inmates in accessing administrative review processes. The Unit should ensure all aboriginal inmates are aware of these rights and assist them in their applications.
22. That the Minister for Corrective Services formalise the role of the Special Placement Committee to assist in the management and placement of multi-problem inmates.
23. Where family members or their representatives make written requests for the reclassification of a relative, that detailed reasons for any refusal be given to them in writing within 30 days.
24. That the proposed revised RIT protocols be completed and fully implemented, including staff training, as a matter of urgency
25. That the Custodial Director Therapeutic Programmes be delegated the appropriate authority to direct the placement of inmates
26. That all televisions, radios and other appliances be checked to ensure compliance with appropriate leads and electrical cords when property is being returned to an inmate. Electrical goods should not be returned to inmates where leads or cords are missing or they do not comply with prisoner property guidelines

2565/99

Male aged 28 years died on 15 December 1999 at Queanbeyan. Finding handed down on 1 November 2002 at Glebe by Jacqueline Milledge, Senior Deputy State Coroner.

Overview

JP died on 15 December, 1999, and his death was regarded by the then State Coroner, Derrick Hand, as a 'death in custody' as the involvement of NSW Police had been triggered when Jonathan was to be transported to hospital pursuant to an order under Schedule 2 of the Mental Health Act 1990.

JP had been a serving police officer at the time he developed symptoms of mental illness. Efforts by family, work colleagues and his supervisors to encourage him to seek assistance proved fruitless. He developed a persecutory complex believing he was under police investigation that would result in his incarceration.

Police first noticed his odd behaviour early April 1999, and, later that month, senior police had alerted the Police psychologist and the Southern Area Mental Health Team to his condition.

All attempts to have him assessed and treated were resisted. His response to these requests was to take annual leave and subsequently resign. The Police Service allowed him to take this inappropriate course.

The following months saw him deteriorate to such a state that he had planned the joint suicide of himself and his father by drowning. At the time of his death, he believed that the suicides must be carried out before the coming weekend.

On the afternoon of 15 December, Dr W, a general practitioner, had prepared a Schedule 2 for J. He had arranged to meet him at the Queanbeyan Hospital, intending to have him escorted to the Chisolm Ross Centre, ACT. A Queanbeyan Police Inspector and JP's father were present with him at the hospital when Dr W told him the schedule had been struck. JP asked to go outside for 'fresh air'. The Inspector accompanied him.

When outside, J lunged at the Inspector, knocked him off balance, and ran towards the river. Sadly his body was located floating, but snared, in the river on the 18 December. The cause of death was drowning.

Profile

JP was a 28 year old single male residing in his own unit at Queanbeyan. He had a loving and supportive family, his parents residing in Canberra.

He joined the NSW Police Service in January, 1990. After spending the first three years of his service attached to North Sydney, he was transferred to Queanbeyan. He worked there until he resigned in 1999.

He was well regarded by his work colleagues at Queanbeyan and they have established a memorial for him at the police station.

His deteriorating mental health

JP had mentioned to his supervisor on a number of occasions, that he was being followed by under-cover, anti-corruption police. JP said there was no justification for this and appeared flippant and unconcerned. This was late 1998/early 1999.

Around the same time, JP told Inspector K, that $50M had been set aside for his investigation and that it was the largest investigation ever seen in Australia. It was clear at that stage to the Inspector that "JP was suffering from some mental condition".

At the end of April, JP called his family together to meet at the family home. At that time he asked his father where his father's rifle was. His father told him it was in the steel cupboard where it was always kept. JP left the house, returning later with two ACT police following shortly after. After checking the father's current firearms licence they left with the gun. The family did

not ask why that happened, however JP told them that although he was innocent, he would be arrested 'any minute' regarding extremely serious charges and it would be 'national news'.

He believed he and other family members were being 'bugged' at home, at the workplace and in their cars. He was so sure of these facts that he sounded convincing. His father noted JP seemed to be 'elated' as he was soon to become a 'public figure'.

The Friday following this incident, JP again called the family together to explain "police had bought half the houses at Queanbeyan and had taken possession of all the houses surrounding our home. They have street lights bugged to record everything and own one in six cars on the road". JP suggested they all resign from their jobs because of the 'embarrassment'.

Police told the family that JP had been speaking in an 'alien' language, going to work on his days off to do paperwork and requesting to work in the station to save his work colleagues from danger due to his investigation.

After resigning from the Police Service, he pretended to his family he had found other work, stating that the police investigation was 'still on foot'. He went so far as to do large diagrams for his father setting out the structure of the investigation and giving his father an absurd overview of how the investigation was progressing.

On Friday 10 December Mr and Mrs P were at their home with JP. He told them he was going to gaol for something he didn't do and began to sob. He went on to say his father was now the main suspect and there was only one way out of it and that was for his father to commit suicide. His mother suggested he see his doctor but JP replied "He will only give me drugs, the drugs will make me say what they want me to say, they will make me incriminate myself".

On Tuesday 14 December JP told his father to be at home alone at lunchtime. At that meeting JP told his father that as his father was being investigated "the only thing that you can do is kill yourself straight away or at least before the weekend".

JP left the house and returned an hour later. When he found his father hadn't killed himself he became angry. Again he urged his father to suicide and told him how to do it.

Later that evening JP took his father to the Lake. They walked around the Lake and JP told his father to get ready to 'do it'. A crowd of people interfered with JP's plan and he said they'd come back later. They returned to JP's unit.

About 9pm when his father attempted to leave, JP again told his father to come with him. JP stopped his car in the middle of the Kings Avenue Bridge and said to his father "You have to do it now, just jump off the bridge". His father left the car and sat by the Lake. Mr P managed to delay JP's plans, however JP had planned to revisit the Lake with his father the next night to continue.

When reviewing his conduct over a 9 month period, it is easily seen that JP's condition was deteriorating to the point where neither he nor his father was safe. However, even before the attempts to commit suicide with his father presented, JP's mental state was alarming and needed expert and timely attention.

In terms of the Mental Health Act, JP met the criteria for involuntary admission ie ***"for the person's own protection from serious harm, or for the protection of others from serious harm"***. Both J and his father were at serious risk.

Should JP have been considered for involuntary admission earlier than 15.12.99

Mental health professionals, find it difficult to strike a balance between the need for 'involuntary admission', often by force, and the objectives of the Mental Health Act 1990 that are set out in Chapter 2 Section 4.

Section 4 (2) It is the intention of Parliament that the provisions of this Act are to be interpreted and that every function, discretion and jurisdiction conferred or imposed by this Act is, as far as practicable, to be performed or exercised so that:

> ***(a)*** *persons who are mentally ill or who are mentally disordered receive the best possible care and treatment* ***in the least restrictive environment*** *enabling the care and treatment to be effectively given, and*
>
> ***(b)*** *in providing for the care and treatment of persons who are mentally ill or who are mentally disordered,* ***any restriction on the liberty*** *of patients and other persons who are mentally ill or mentally disordered and* ***any interference with their rights, dignity and self-respect are kept to the minimum necessary in the circumstances.***

Therefore to be detained against their will, they must be mentally ill or mentally disordered as defined, and **no other care of a less restrictive kind is appropriate and reasonably available to the person.**

Prior to the events of the 14 December, JP's superiors were of the opinion that he needed expert attention.

D, the Chief Police Psychologist, "formed the opinion there was a psychiatric illness present I thought that he needed immediate psychiatric evaluation and by that I don't necessarily mean by a psychiatrist but by psychiatric services". He suggested the Mental Health Team should become involved.

N, a very experienced psychiatric nurse with the Queanbeyan Mental Health Team opined he was developing a 'psychotic episode'. So convinced was she that he required admission, N had arranged an assessment in Canberra by Dr A, a psychiatric registrar. This was done to save JP embarrassment in attending a local hospital. JP refused to attend and the further assessment was abandoned.

At that time JP had not stated he contemplated suicide, therefore a forced admission was not pursued.

N further states her reasons for not continuing with JP's care "because the police force has doctors, psychologists and relevant other professionals, they would have been the best course of looking after their own colleague". This obviously was not the case as it was the police psychologist who rang her for assistance.

When JP resigned from the Police Service no one from the mental health team checked on his welfare and N's belief in the capacity of the Police Service to look after JP was far from correct as it tragically transpired.

Section 9 Mentally ill persons

(1) A person is a mentally ill person if the person is suffering from a mental illness and, owing to that illness, there are reasonable grounds for believing that care treatment or control of the person is necessary:

(a) for the person' own protection from serious harm, or

(b) for the protection of others from serious harm.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

Section 10 Mentally disordered persons

A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care treatment or control of the person is necessary:

(a) for the person's own protection from serious physical harm, or

(b) for the protection of others from serious physical harm.

The police psychologist assessed him as having a 'psychiatric illness', N assessed him as 'developing a psychotic episode'. Without a diagnosis of 'mentally ill' or 'mentally disordered' he could not be considered for an **involuntary** admission.

By the 15 December, the Queanbeyan Police together with the Mental Health Team believed JP was 'in crisis' and needed immediate assessment. They engaged Dr W, a general practitioner, to go to JP's unit to assess him for the purpose of immediately issuing a Schedule. Both the Police and the Mental Health workers were convinced that once Dr W met with JP that he would be persuaded to issue the Schedule.

Unfortunately Dr W was not sufficiently experienced to easily or quickly assess JP in the environment of his unit. Dr B had not spoken to the family beforehand and when he arrived at the unit, J refused him entry. A more experienced practitioner in the mental health field would not have acquiesced.

Police and a mental health worker were talking to JP inside the unit and Dr W had to 'overhear' what was being said, a difficult task in that the Doctor had another of the mental health workers speaking to him at the same time he was trying to listen in an effort to assess JP's state of mental heath. The conditions were less than ideal.

There was considerable benefit in having JP Scheduled at his unit. Police had accompanied the mental heath team inside the unit and other police and police vehicles were at the premises ready to transport him immediately to hospital for further assessment. His avenue for 'escape' was extremely limited.

The doctor stated the reason he did not Schedule JP at the unit was that he did not believe JP satisfied the criteria under the Act. An added pressure on the doctor was his patients he had waiting for him in his surgery. He believed he had spent as much time as he could at that stage with JP.

If any one of the experienced Mental Health Team had been an 'accredited person' under the Act, JP would have been Scheduled there and then and an inexperienced general practitioner would not have needed to be involved.

This case highlighted the need for experienced mental health professionals to be 'accredited' under the Act to allow speedy and appropriate assessments.

The Act provides for it happening. Dr B, an psychiatrist and expert in the field of mental health, in his excellent submission to the Mental Health Select Committee and indeed his earlier 'Report', sets out in real terms the crisis that face our Mental Health System in recruiting and indeed keeping psychiatric registrars and psychiatrists in the public system.

Dr B, in his evidence, opined that, at the unit, JP did meet the criteria set out in Section 24(1)(b) because of the events of the previous evening. He believed JP had been developing a paranoid psychosis since (at least) last December. The delusion had become more expansive over time.

He said the likely diagnosis was 'Paranoid Delusional Disorder or DSM 4 - Delusional Disorder, Persecutory Type.

JP displayed no insight into his condition and, true to persons suffering this illness, he would not seek voluntary treatment.

Events at Queanbeyan Hospital - the attendance of Inspector G

Queanbeyan police were called by the hospital when it was known J was to be Scheduled. Inspector G states he was only there to support J and organise transport if needed and he was not meant to provide a secure escort. The hospital asserts that the police were called for the purpose of secure transport.

The Coroner was satisfied that the substantive reason for the Inspector's attendance was to assist the hospital during the Scheduling process and to escort him to Chisolm Ross. For these reasons, the Inspector was 'on duty' and JP's escape and subsequent death occurred during a 'police operation'.

There is no evidence that Dr W informed the Inspector that he had signed the Schedule and that formally he was required to take JP into custody. That was

an oversight by Dr W due to his lack of understanding of his duties and responsibilities under the Act.

Too little, too late

There is no doubt that the Mental Health Team and JP's supervisors were concerned for his welfare and did what they believed they could to have him seek treatment.

The mental health experts, Dr B and Dr H stated the best treatment programme is one undertaken voluntarily. Every effort was made to have him seek treatment himself.

The real and urgent push came at the last minute after the events of the 14 December. This meant that there was great emphasis on Dr W urgently assessing J for the purpose of Scheduling him.

JP had been deteriorating for months. He was desperate for treatment earlier than the last two days of his life. The Coroner found the Mental Health System failed JP and his family and everyone who tried to help him.

The Coroner was also very critical of the Police Service and its lack of response to JP's desperate situation.

From the moment JP's supervisors contacted the Chief Police Psychologist JP should have been managed appropriately. Whilst the Police Service had 5 psychologists on staff, no one was given the task of 'case managing' JP.

Whilst his firearm was taken off him and secured, he was still allowed to wear the police uniform, kept his police ID, had access to the police computer and worked at the police station during this critical period where his mental health was deteriorating.

The Chief Psychologist made no notes about his limited involvement in the matter. Whilst he contacted the mental health team initially, he felt he had no further role to play in JP's management.

He was keen to 'outsource' JP's care. He failed to 'follow up' on JP's progress, he didn't feel the need to travel to Queanbeyan to provide assistance or indeed interview JP personally. The Police Service had a duty of care to do the best they could for JP. Leaving the problem to be dealt with at a 'local level' was completely inappropriate. The Chief Psychologist was contacted for 'expert advice'. His response to that request was less than adequate.

It was of concern that the Chief Psychologist had no knowledge of the Memorandum of Understanding that existed between Mental Health and the New South Wales Police Service.

The Police Service, through its Health Services, should have 'case managed' JP from the initial request for assistance by his supervisors.

NSW Police Human Resources was also contacted by senior police seeking advice on JP's resignation. They were told to accept it. It was an easy option for the Police Service to allow him to leave.

Formal Finding

JP died on 15 December 1999 in the Queanbeyan River, Queanbeyan. The cause of death is drowning. I am satisfied his death was as a result of suicide.

Recommendations.

1. The policy for the appointment of accredited persons under section 287A of the Mental Health Act 1990 be revised so that the precondition for appointment is no longer a demonstrated lack of medical practitioners available to participate in the scheduling process under the Mental Health Act. Mental Health professionals who have the appropriate training and experience as set out in paragraph 2 and 3 of the Guidelines for Accredited Persons under the Mental Health Act 1990- should be appointed in their own right as recognition of the following

   (a) Mental Health professionals specialise in dealing with mentally ill people including conducting assessments under the Mental Health Act;

   (b) Mental Health professionals are usually best placed in terms of time to conduct assessments;

   (c) Mental Health professionals are usually the first to obtain and are best placed to obtain corroborative histories directly from the families, GPs etc because they are the first line of response.

2. General practitioners and accredited persons should have similar powers to doctors and mental health officers in the ACT in relation to apprehending a person and entering premises for the purpose of conducting assessments. I refer specifically to section 33(3) of the Mental Health Treatment and Care Act 1994.

3. Section 24 of the Mental Health Act should be amended in the following ways:

   (a) the situations in which police may apprehend a mentally disturbed person as set out in section 24(1)(b) should be extended to the circumstances where a person has threatened or attempted to kill himself or herself or has threatened or attempted to cause serious bodily harm to himself or herself or has threatened or attempted to inflict serious bodily harm on another person;

   (b) the powers of entry available to police pursuant to section 24 should be clarified by using similar wording in section 24(2) as section 22(3).

4. A set of protocols be devised for external general practitioners who attend hospitals or other places for the purposes of conducting examinations, observations under section 21 of the Act. These

protocols should be in a similar form to those for general practitioners in emergency departments. Particular emphasis needs to be placed on the responsibility of the GP to obtain a corroborative history including making direct contact with those who can provide information about the person's condition as well as requesting medical records and any history of contact with the mental health team prior to undertaking any examination or observation. The protocols should note that any medical or hospital records are to be provided to the doctor on engagement. In relation to home visits doctors should consider whether they have sufficient time and information to carry out a thorough examination or observation of the person. Doctors should be mindful that a home visit which does not result in a schedule being signed can have negative consequences hence the need to ensure that any such decision is taken on the merits of the case and not extraneous factors such as lack of time to prepare for and conduct the assessment. The protocol should also note that it is the responsibility of the general practitioner signing a schedule under section 21 to ensure that the appropriate security measures are in place before informing the person of his or her involuntary apprehension. Specifically where police assistance has been requested under part 2 of schedule 2 the documents should be provided to police officers and particular safety concerns explained to them before they are expected to undertake their responsibilities in respect of a scheduled patient. In the period during which these protocols are being developed all external GPs who are to be involved in conducting section 21 assessments should be given copies of the Mental Health for Emergency Departments.

5. Police officers required to provide assistance under section 22 of the Act should be informed in as much detail as possible about the condition of the person which gives rise to the request for assistance, that is danger of absconding, violence towards self or others. Police should be in no doubt when part 2 of the schedule 2 has been signed, hence part 2 of the schedule should be amended to include another heading on relevant details of the person's condition. It should also be amended so that there is provision for the police officer to sign part 2 when that is handed to him or her. Similarly when the need for police assistance has ended because the person has arrived at the hospital the appropriate person at the hospital should also sign part 2 indicating that police involvement has ended. The standing operating procedures Mental Health Monaro Local Area Command as well as the memorandum of understanding between NSW Police and NSW Health should be amended to incorporate the suggested amendments to part 2 of schedule 2 under the Act.

6. There needs to be a section in the memorandum of understanding or other appropriate document dealing with the situation where a serving police officer is referred for a mental health assessment. The lines of communication should be set out clearly ensuring that the

case manager, the police medical officer is aware of the current involvement of the mental health team or other psychiatric services and similarly when that involvement has ceased.

7. Standard operating procedures in the Mental Health Monaro LAC should be altered so that in the segment under "for urgent cases" the powers which police have under section 24 of the Act are set out accurately, for example police do not have powers under section 24 to apprehend a person and take them to hospital in situations giving rise to harm, to reputation or financial harm as suggested in the procedures. Similarly police do not have to ascertain whether a person appears to be mentally ill, which is precisely defined in the Act, but rather, whether the person appears to be mentally disturbed.

8. The document entitled "The Commanders Role in Helping Maintain the Psychological Wellbeing of Their Staff" should be reviewed to ensure:

   (a) where it appears to the Local Area Commander that a police officer in his or her command is mentally disturbed he or she must be referred for review to the Police Medical Officer if the officer will not agree to voluntary assessment;

   (b) the Police Medical Officer or Police Psychologist to whom an officer is referred becomes the case manager who is responsible for ensuring the appropriate assessments and/or treatment is provided to the officer;

   (c) if a police officer who appears to be mentally disturbed will not seek voluntary assessment treatment the Police Medical Officer must access a specialist psychiatrist for input into the case management.

9. NSW Police undertake a review based on the facts of this case in which a serving police officer who appeared to be mentally disturbed and had his resignation accepted rather than being offered the possibility of a medical discharge.

10 Within the hospital system triage forms should be faxed or emailed to the recipient immediately after the phone call has been made from the triage. This should ensure that all of the details from triage are passed on to the mental health team.

11. NSW Health should acknowledge that families and relatives of those with mental illness often recognise the problems as they develop but have difficulty in being heard within the mental health system until the problem has escalated into a crisis which requires acute intervention. NSW Health should assess the possibility of establishing some form of mental health consumer advocacy system which could be accessed directly by families, relatives and others closely connected to the person.

12. **NSW Health should ensure that protocols are developed in each area so that mental health professionals in that area can access an experienced consultant psychiatrist on both a regular and urgent basis.**

13. **There needs to be a better room at the Queanbeyan Hospital for conducting psychiatric interviews unlike the interview room in which Jonathan's assessment was conducted. The room should be essentially an internal room with two doors so that if a scheduled patient escapes he or she will still be within the confines of the hospital building.**

14. **The triage form module (a) be changed so that the numbering for the response and risk categories is consistent either from low to high or high to low as long as they move in the same direction.**

15. **The Commissioner of Police and the NSW Senior Deputy State Coroner consult on the revised protocol of the Commander's role in helping maintain the psychological wellbeing of their staff.**

180/00

Male aged 37 years died on 27 January 2002 at Tamworth Correctional Centre. Finding handed down on 3 June 2002 at Tamworth by Carl Milovanovich, Deputy State Coroner.

The deceased was charged on the 20/1/2000 with the Indictable offence of Murder in relation to his defacto. When he appeared before the Local Court Magistrate he was bail refused and the Magistrate requested that his warrant be endorsed in relation to harm issues for the prisoner. It was not clear if the warrant endorsement was placed on the warrant because the prisoner had indicated an intention of self harm or because he had concerns that family members of his deceased defacto may have access to him in the Prison system.

The deceased was recognised by Police as being at risk and was placed on 15 minute observations until his hand over to Correctional Service Staff. Upon admission at Tamworth Correctional Centre he was assessed as being at risk and was placed in a safe cell for a 24 hour period and was then moved to a "two out" cell with two hourly observations which continued for a further period of two days. It appeared that the prisoner's state of mind had improved after three days. Evidence was given that he became more communicative, was playing cards, had resumed painting and was looking forward to a prison visit. It was apparent that he was future orientated at this stage. The deceased was locked into his cell at 5.30pm on the 26/1/2000 with his cell mate. His cell mate gave evidence that they watched videos until 10.30pm when his cell mate went to sleep and noticed that the deceased was still watching television. Some time in the early hours of the morning the deceased's cell mate woke up and noticed that the deceased was writing letters. They had a smoke together and the deceased's cell mate went back to sleep, last seeing the deceased alive at this point, still writing letters.

Shortly before 5.00am the cell knock up button was activated by the deceased's cell mate who informed prison staff that "my cell mate has done something to himself."

Immediate action was taken to open the cell. The deceased was found hanging from bars and was cut down immediately. The deceased's cell mate has expressed no concerns in regard to the time lapse between reporting and cutting the deceased down.

Medical staff attended, attempted resuscitation, however the prisoner was deceased.

Letters found in the cell written by the deceased indicated an intention to take his own life.

The Coroner was satisfied that the risk assessment for the deceased was appropriate and the main area of concern was the existence of the bars which provided an obvious hanging point. The Coroner made recommendations that the bars be removed or otherwise effectively screened.

Finding

That the deceased, NC, died on the 27th January, 2000, at the Tamworth Correctional Centre, Tamworth, in the State of New South Wales, from hanging, self inflicted with the intention of taking his own life

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Male aged 25 years died on 7 February, 2000 at premises in Bondi. Finding handed down on 12 March 2002 at Glebe by John Abernethy, NSW State Coroner.

Facts:

To and including the shooting of R.S.

R.S. was a 25 year old part-time fork lift driver. At the time of his death on 7 February, 2000 he was working about three days per week. R.S. appears to have had reasonable family ties - his family are decent people. Nevertheless he has had convictions for dishonesty and has been to prison. Those who dealt with him there spoke well of him. He had during his lifetime overcome a real alcohol problem. R.S. was good at sports but also had a history of depression. He was generally regarded as a good worker. He was a powerfully built young man.

R.S. came to Australia at the age of 15 years and was of Maori background.

R.S. was shot dead by an officer of the NSW Police Service at about 1.40 am on 7 February, 2000, in the front yard of the home in which he was residing - Bondi. At the time of his death, R.S. was living with his girlfriend S.M. and the F family. The premises were owned by the F family and R.S. and S.M. utilised the front bedroom (a sunroom off the living room) as their own, (which had floor to ceiling windows looking onto the front courtyard) but had the use of the rest of the premises for cooking, eating and bathing. They paid the sum of $50-00 per week for the privilege. The room they lived in could only be called adequate, comprising a single or three quarter mattress on the floor and a few other items of furniture. R.S. and S.M. came to rent the room through J.F., son of Mr & Mrs F. S.M. and J.F. were friends.

At the time of the shooting three officers of the NSW Police Service were present. They had attended as a result of a "domestic violence" call out from a neighbour who lived two doors up. Other neighbours also heard a disturbance. R.S. was unarmed, whilst each of the three police officers wore their service appointment hand guns. One, Probationary Constable N.R. was also carrying a night stick or baton. Two wore canisters of Oleoresin capsicum ("OC") spray, and had been trained to use the substance.

As Counsel assisting the Coroner Mr. I.G. said in his opening, the time span between arrival of police at the house and the shooting of the deceased is a feature of this case. The entire incident, from the entry of the police onto the property until the death of R.S. was less than four minutes.

The Police Operation.

At 1.27:40 am on 7 February, 2000, a "000" call was made by a neighbour, Mr. Q, to the police. In his conversation with the operator he said:-

> *"I think there's something going on a couple of doors down from my apartment here. Um, I can hear, like, glass getting smashed and things getting chucked around and ....."*

The operator then obtained the address and the caller went on:-

> *"There's a guy in there that's a bit of a fruitcake and I can hear a woman in there screaming out. 'Get off...'"*

The operator then obtained the nearest cross street, the name of the caller and the fact that he wished to remain confidential. The caller then went on:-

> *"A woman screaming out 'Get off me, get off me, get off me.' And there's um, all this glass getting smashed down there and stuff. And I went down and stuck my head over the fence: some guy in there going all over the place. There's a young guy in there, he's a bit loopy. He's gone off quite a few times before and chased his family out with knives and all kinds of stuff."*.

Whilst I am able to find most of the information to be factually accurate, the last two sentences do not refer to R.S. at all. They refer in fact to a member of the F family. The caller was examined and I found him to be a believable witness. He did peer over the gate and see R.S. "moving aggressively in the front room of the house". In fact he did recognise the silhouette to be that of R.S. whom he knew by sight and not that of the member of the F family he told the operator about. His explanation for so doing was, I suppose acceptable. He was giving background about the place as one might do in such circumstances. Unfortunately the information he gave was given to the police who were called out - that he has chased his family out with knives - their reasonable assumption was to take great care as the person may be armed with a knife or other weapon.

As I have said, in all other respects Mr Q was a good witness. He did not exaggerate and I am satisfied was genuinely alarmed at the noise coming from the premises. He felt it his duty to notify the authorities, as he feared domestic violence.

This "000" call resulted in the dispatch of the job to the Waverley Police Station. Two officers, Senior Constable S.D. and Probationary Constable N.R. received the call at 1.30:50 am to attend the address. They went to a police truck and drove there, receiving further information on the way. That further information consisted of a "residence check" carried out by VKG.

Thus the information they had on hand on arrival at the Bondi residence came from two sources:-

(1) From police radio through the police computer system:-

> *"Domestic occurring there: a female screaming to get off. Informant can hear glass smashing ..... ". (1.30:20).*

Then:-

> *" ..... information ..... stated that there has been prior domestic with knives involved ....."*

Then:-

> *" ..... Just for information, a female by the name of J. F. has warnings that she's wanted for assault, and intel, intel re drugs at that location."*

(2) Senior Constable S.D.'s knowledge that the address had been mentioned in the course of another police operation in which he had been involved.

Meanwhile, one minute later (at 1.31.40 am Sergeant D.H. answered a back-up call from a different police vehicle and drove to the address, arriving at about the same time as Constable S.D. and Probationary Constable N.R. The arrival of these two vehicles with three police was called off by Sergeant D.H. at 1.36.20 am. This call is important in terms of the measurement of the time of the police operation as it appears to be when H left his vehicle and walked towards the gate of 67 Imperial Avenue, Bondi. The police response to the call was not criticised. The call-off by D.H. was only six minutes after the start of the "000" call by the neighbour, Mr Q.

The three officers.

a) **S.D.:** is a Senior Constable of police aged 43 years at the time of this incident. He has a somewhat unusual background in that he was for most of his working life a schoolteacher. He entered the NSW Police Service in 1994 and was generally reasonably physically fit. Despite his few years in the job he was reasonably experienced in general duties policing and had relevant domestic violence call-out experience.

b) **D.H.:** D.H. is now retired from the Service but at the time of this incident was a Sergeant of Police aged 50 years. He was very experienced in general policing but some question arose as to his fitness for the demands and rigours of general duties.

c) **N.R.:** Was a Probationary Constable of Police, aged 23 at the time of the incident. Her experience in the Service totalled six weeks. She was being supervised by Senior Constable S.D. that night. She is of very small stature.

When the officers entered the property they carried the following appointments:

i) S.D.: Glock firearm, OC Spray. (baton remained in motor vehicle).

ii) N.R.: Glock, Baton and OC Spray.

iii) D.H.: Glock. (baton remained in motor vehicle).

It is relevant that two of the officers were carrying police torches as they entered the premises.

Entry into the premises.

The officers approached through the gate into a walled front garden. In the garden on one side of the path was an ornamental pond and its surrounds. A high front wall to the premises meant that the garden area and particularly the ornamental pond was darkened. Vegetation around the pond, together with the darkness of the walled garden hid the pond from the view of the officers as they entered the premises. They had no idea of what they were facing other than what had come over the radio.

As the officers walked along the path to the house, one of them saw that someone was standing in the dark on the other side of the windows of the front room. All that could be seen by the officer was a foot and a hand. After some moments the person moved from view. Constable S.D. called out and tapped on the window. He said something to call the person outside. There was no reply.

The officers then approached the porch and the porch door. The porch light may have been on. S.D. tapped on the window of the sunroom again and called out before he went to the door, whilst the other two officers waited at the end of the porch. The circumstances caused S.D. to feel some caution and anxiety. After a delay in which S.D. could hear what he described as sounds of packing from inside the house, R.S. opened the door and walked through it. He was carrying a bag and did not apparently intend to stop and talk. S.M. appears to have been standing behind him. According to S.M. a blond officer, probably Constable S.D. then said words to the effect "where are you off to mate". Again according to S.M., R.S. said something. The officer was apparently blocking his path out of the premises.

Inflammatory Words.

All of the experienced officers who gave evidence said that from training and experience, domestic violence calls were a potentially dangerous and volatile part of police work. All acknowledged the importance of using pacifying rather than inflammatory language and behaviour when attending a domestic violence call-out. The issue is of some importance in this matter as the use of inflammatory or racist language by a police officer would have been one explanation for the subsequent violent behaviour of R.S.

S.M. who had been the other party to the domestic dispute heard by neighbours made statements in evidence that inflammatory and racist

language was used by police - That was denied by the officers who gave evidence. The evidence of neighbours who were listening from adjacent and nearby properties did not support it. Indeed, both neighbours and officers said that words used were like *"calm down"* and *"settle down mate, we only want to talk"*. One neighbour heard the words *"don't swear at me"* but it is unclear who said those words. In any event, they seem to have been said, whether by R.S. or a police officer, well after the struggle had commenced.

The evidence of S.M. was taken over two days. On both occasions, it was by video link at her request and on medical advice in part, so that she would not have to give evidence in front of the man who had shot her fiancÈ. S.M.'s evidence was that she hates Constable S.D. and regards him as evil. She was, in my assessment, greatly affected by the events of that night. That in turn has affected her evidence. More specifically, S.M. provided two statements to the Inquest. The first statement was given to the police within hours of the shooting in the presence of family members in the family home. S.M. read it and alterations were made and initialled by her. That statement provides a version of events consistent with that of the officers, neighbours and with objective physical evidence at the scene. The second statement which was provided many months later and only on the morning of the opening of the Inquest sets out a version of events which are completely in conflict with the first statement and with objective evidence. S.M.'s versions are dealt with in more detail below but for present purposes I find that there is insufficient evidence that the officers used inflammatory or racist language when confronting Mr Stephens and I reject the allegations of S.M.

The Attempted Arrest.

According to S.D., he then said words to the effect: "Matey, you can't leave - we need to talk to you,"whereupon R.S. brushed past him. Sergeant D.H. then blocked his path off the porch by stepping forward. He also said words to the effect that R.S. was not allowed to leave. No formal words are required to effect an arrest but knowledge that the person is under compulsion is a necessary requirement *Alderson v Booth (1969) 2QB 216 and Inwood 1973 1 W.L.R. 647.* In this case no more formal words of arrest appear to have been pronounced than the statements set out above but the intention of the police to bring about an arrest must have been abundantly clear to R.S. Certainly, then the situation quickly transformed from one that was tense to one of violent physical struggle. This appears to have been a "de facto" arrest.

The deceased at this stage grabbed Sergeant D.H. who had stood in his path whereupon Probationary Constable N.R. sought to take hold of his arm. S.D. then became locked in a struggle with R.S. throughout this period, at one time using his torch to subdue R.S. and to attempt to free himself.

During this struggle the deceased and Senior Constable S.D. moved from the porch area to a raised patio area. The struggle halted at least once but then re-commenced with movement towards the path and ornamental pond. It is probable that they stumbled on a stump protruding a short height above the ground. In any event, S.D. found himself on his back, across the ornamental pond. The area of his head was surrounded by bushes and his back was actually

in the water, with R.S. on top of him, grabbing him around his throat. Bruising to the throat was visible in photographs and was later medically confirmed.

Despite ambient lighting, the area of the ornamental pond was quite dark. S.D. maintains that at some stage his head was actually under the water and that he swallowed some. Sergeant Howard who could not tell what the body of water was tried to step into the pond to help Constable S.D. but could not get his footing and stepped back out after slipping on the floor of the pond. Constable S.D. called out in what was described as a desperate voice, to the other officers, telling them to call for back-up. Sergeant D.H. seems to have done that as there is a VKG recording at 1.39.40 am (3.20 minutes) since he had called off before entering the premises in which he can be heard saying: *"Urgent ..... backup here immediately down at ah 67 Imperial Avenue."* He stepped aside to be heard over the screaming of S.M who was reported by the neighbour Mr. Q to be yelling words like: *"Don't do it. You'll make it worse for yourself. Stop it."*

At about the same time, Probationary Constable N.R. used her baton to strike two blows to the right thigh of R.S. Weals from those blows were examined by Dr. P.B., forensic pathologist, who gave evidence. The blows were still visible in post mortem photographs. The blows did not affect R.S.'s actions other than that he turned around, made eye contact with Probationary Constable N.R. and used words which were violent and threatening. She stepped back and was about to strike elsewhere when she heard the sound of a "racking" of Constable S.D. police issue Glock pistol. Sergeant D.H. also heard the racking immediately at the end of his radio call.

The Shooting.

Senior Constable S.D. exercised his right to silence pursuant to *Section 33, Coroners Act 1980* and did not give evidence. For reasons detailed in a number of recent inquests *(Dobson: Coram, Abernethy, State Coroner; Carroll: Coram, Milledge, (then) Deputy State Coroner)*, a Certificate pursuant to Section 33AA was considered worthless in respect of any proceedings involving the possible imposition of a civil penalty by the Industrial Commission of NSW. In any event he fully cooperated with investigating police insofar as he underwent ERISP Records of Interview and a "Video Walk through". There is a real contemporaneity to his evidence and, pursuant to coronial protocols in relation to the investigation of critical incident fatalities, he and his fellow officers had little time to interfere with the scene or contrive to present the investigators with a false scenario.

He said that he very strongly felt that his position was desperate and in the absence of effective assistance from the other officers, decided to draw his weapon and shoot. He said:

> *"..... at that stage I realised I'm gone, I lost confidence in Sergeant D.H., I believe that I was going to be killed, I nearly lost consciousness a couple of times through being bashed around ..... I thought the only thing I can do to protect my own life and to eliminate the threat was shooting ..... ."*

He had to struggle to reach and draw it and could not see what he was doing. It was not ready to fire and there was no response when he attempted to do so. It had to be "racked" or cocked. In fact he did this twice, expelling into the water of the pond one round which was later located. According to S.D. and N.R., at some stage near the time the pistol was racked, R.S. called out words to the effect *"Fucking shoot me"* either to challenge S.D. or to question him. In a situation where Senior Constable S.D. was on his back across the pond, at times with his head under or in the water, and with R.S. over him with his hands to his neck or upper body, he managed to fire off three rounds from his service revolver. S.D. said that the first shot appeared not to affect R.S. so he fired two further shots.

After the shooting.

The Duty Officer, a Sergeant B arrived at the scene within minutes. Two ambulance paramedic officers arrived at 1.47 am, about 7 minutes after the shooting. Another two arrived several minutes later. They made observations, heard things and had conversations at the scene. Their evidence is in the brief and in the transcripts. They satisfied themselves that R.S. was deceased.

S.M. was asked the name of an appropriate support person and nominated her friend, B.C. who arrived and accompanied her to hospital by ambulance. She was interviewed at her father's home at 6 am and a statement was taken.

Pursuant to appropriate protocols the matter was investigated as a "death in a police operation, or death in custody" and an independent critical incident team was formed, led by then Detective Inspector D.M. Physical evidence police attended, as did ballistics. The officers' appointments were removed and secured for ballistics examination and assessment. The officers were medically examined and where appropriate, photographed. Their clothing was retained as necessary. They were reasonably quickly separated and directed not to discuss the events of the night. Each was drug and alcohol tested. They were subsequently interviewed in videotaped ERISPS and in "walk throughs" of the scene. Probationary Constable N.R. and Sergeant (now Mr.) D.H. each gave evidence.

Issues.

1) **Domestic Violence Call-out procedure.**

   Specific training is given to all general duties officers. Domestic Violence call-outs are always regarded as volatile and dangerous. The NSW Police Academy *"Domestic Violence Procedures and Training Manual"* at Part 2.1 states:

   > *"Treat every incident as potentially dangerous to Police as well as to the parties".*

At *Part 3.1*, officers are advised as follows:

> On arrival at the scene of a domestic violence incident, police should employ officer survival techniques to prevent any unnecessary danger."

2) **Adequate strength and fitness to properly carry out general duties.**

The evidence was that from Waverley Police Station, two officers would normally attend a domestic violence call. On this occasion, because Probationary Constable N.R. was under the supervision of Constable S.D., there were three officers in attendance. Two of those officers were experienced. Sergeant D.H. was in a supervising back up role but had almost 30 years of policing experience.

The issue of fitness nevertheless arose because there existed a reasonable early impression that three trained, armed officers, two of whom were equipped with OC Spray, should have been able to overpower one unarmed man even if, as in this case, he was young, powerful and fit. In the course of investigating the issue, information was obtained about fitness requirements for the Police Service. A persistent question arose during the investigation as to a suggested inadequacy of fitness and fitness standards and requirements among serving officers on general duties.

The Police Service provided some material that acknowledged an issue about such matters and indicated that the question of fitness and fitness standards was under review within the Service. It has been noted above that the Police Service General Handbook describes domestic violence calls as dangerous and volatile work. Although I have concluded that the cause of death in this case cannot be attributed in a legally causal way to an issue of police officer fitness, I encourage the actions of the New South Wales Police Service in dealing with what appears to be an important and pressing issue.

3) **Power to Arrest in these circumstances.**

Certainly there were no words of arrest pronounced. There was an attempt to detain R.S., at least until police could satisfy themselves that, firstly no offence had been committed by him, and secondly they were satisfied that he, himself was all right.

The first of those reasons, in my view is entirely reasonable and I am of the view that in these particular circumstances there is, at least common law authority for a police officer, seized of advice and having reasonable suspicion of a likely criminal offence in premises, to detain a person coming out of those premises until they can be satisfied that no offence has occurred.

They were seized of advice of domestic violence, breaking glass, a knife, prior history of an occupant wanted for assault and knowledge that these premises were involved in a police drug operation.

4) **Alternatives open to police.**
Could more have been done to avoid a shooting?

Much attention was directed during the hearing to the question of whether more could have been done to overcome R.S. The starting

point seemed to be the presence of three armed officers and only one unarmed opponent. Evidence was heard as to the size, strength and state of mind of R.S. Expert evidence was heard as to difficulties of overcoming the struggles of a determined or desperate person. The use of batons was examined, as were the reasons given for not using OC spray. In addition the actions of each officer during the period of physical conflict was scrutinised. Also considered, so far as it was feasible to do, was the question of fitness of officers sent on duties such as potentially dangerous domestic violence call-outs. That issue is dealt with separately below.

a) **Use of OC Spray.**

Sergeant D.H. was trained in the use of OC Spray but had never been issued with it. He said he was aware that Probationary Constable N.R. would have been carrying OC Spray but that even if it had been issued to him he would not have used it in those circumstances. Probationary Constable N.R. considered using her OC Spray but decided against it for the same reason as Sergeant H. Both thought the situation too confined to use it without affecting Constable S.D. and one another.

Expert evidence on the point is conflicting with two very senior police officers taking different stances on the matter. A reasonable view is that whilst the area itself was not "too confined", it may be that the position of S.D. and R.S. at the pond, and of all four at earlier stages of the struggle, may have made it extremely difficult to use effectively. Almost certainly had it been used at the pond, S.D. may have suffered along with R.S. There was expert evidence that some persons in a particular state of mind can be unaffected by OC Spray. R.S. seems to have been in an enraged state of mind. Under the circumstances, I consider that the decision not to use OC Spray was both considered and justifiable.

There can be little doubt that the availability of OC Spray to police officers is an advantage, but the expert evidence of Chief Inspector D and Mr L, which I accept, is that OC Spray is but one resource to be used, depending on the circumstances. It is not always effective and sometimes should not be used.

b) **Use of Baton and other options.**

Probationary Constable N.R. attempted to use a baton and did so in accordance with her training. She struck in an area she had been trained to strike. Expert evidence from the same two experts who had differed on the issue of OC Spray (D and L) was to the effect that they were of one mind that while certain a person should not normally be struck with a baton, officers should not hesitate to strike any area in an emergency. It was apparent from her evidence that Probationary Constable N.R. was unaware that non-advised strike areas could be struck in an emergency, but in this case it was hardly relevant. By the time her first blows proved to be ineffective she heard Constable S.D. racking his weapon.

There was a very short time frame available for action of any type. The situation had become desperate very quickly. I am satisfied that each

officer did as much he or she could in the circumstances. Other larger, stronger or fitter officers may have handled the situation differently, for example throwing themselves on to R.S. "Rugby style" whilst he was over S.D. with his hands to the throat area. An additional officer more experienced than a Probationary constable may have acted differently but it would be speculation to try and determine whether in the time frame and all subjective circumstances of this incident, the outcome would have been different.

5) The Shooting of R.S. by Senior Constable S.D..

Police officers on general duties are equipped with loaded weapons. They are required to have a round ready in the chamber of their weapon at all times. They are entitled to use the weapon but only on a very strict basis. The Police Service Handbook communicates the basis of use. It provides that:

> *You are only justified in discharging your firearm when there is an immediate risk to your life or the life of someone else, or there is an immediate risk of serious injury to you or someone else and there is no other way of preventing the risk.*

A question was raised in the course of the hearing as to whether, even if the first or second shots were justified, the third shot was necessary. The grouping of the shots fired by Constable S.D. was the subject of detailed evidence. Probationary Constable N.R. and Sergeant D.H. recollect two shots in quick succession followed by one more. The recollections of neighbours differed. One recalled four shots but conceded it may have been three. Mr. Q recalled one shot followed by two more in quick succession. Two other witnesses Mr K who made a detailed diary entry the next day, and his partner Ms G recollected three shots consisting of one shot followed by two more in quick succession. Another neighbour Ms S.M. heard three shots but thought them evenly spaced. A neighbour from across the road Ms C also thought the shots to be evenly spaced. S.M. thought there were four shots.

> It must be said at this point that the version of the shooting given by S.M. in her second statement is so at odds with both her first statement and with the balance of the evidence that I am unable to give it any weight at all. It is also inconsistent with the (very contemporaneous) version of events she gave to her friend B.C. in the ambulance immediately after the shooting. You will recall also the evidence of the Ambulance Officer who was also in the rear of the ambulance. S.M.'s second, much later statement places the struggle at the end of the pool, which appears from photographs to have been undisturbed. It has Constable S.D. as attacker, standing over R.S. who is said to be low in the water, some distance from Constable S.D. and shot while the two men are distant from one another. I reject this version of events. I also reject the veiled and vague suggestions by S.M. that her first statement to the police officers was in some way interfered with or altered. The statement was given in the presence of her family. It was contemporaneous with the events. It was consistent with the other

evidence. It was read and corrected by S.M. and she initialled alterations. One of the officers who took the statement was called to give evidence to respond to the suggestion that the statement had been tampered with and I note that no suggestion was made to that officer of improper conduct. Mr R.C. who appeared for S.M. expressly said he made no such criticism and accordingly the second officer involved in the taking of S.M.'s first statement was not called. I have no doubt that the first statement of S.M. reflected her views and recollection at the time. Accordingly, I specifically reject the description of the shooting and what occurred during it, as given by S.M. in her second statement.

Ballistics evidence established that in all likelihood there were three bullets fired. All who gave evidence thought all shots were close together. The likely grouping of the three shots is difficult to determine, but whatever the grouping, the closeness of the shots and the descriptions of R.S.'s body as he was shot, produce a picture consistent with the reasons given by S.D. for the three shots.

The first shot appeared to have little or no effect on Mr Stephens. After the third shot, S.D. got to his feet whilst R.S. fell to his hands and knees and then into the pond. S.M., very distressed, endeavoured to approach the body of her boyfriend and was pushed away by S.D. Probationary Constable N.R. attended to her as best she could whilst the other police officers pulled the deceased from the water.

Three bullets entered the body and none exited. One of the bullet entry points was close to the navel. Another, adjacent to the left nipple whilst the third was behind the left shoulder. Dr. P.B., Senior Staff Forensic Pathologist at the NSW Department of Forensic Medicine, who attended the scene and who conducted the Post Mortem Examination, was of the view that by the time the third shot had been fired and almost certainly earlier, the conditions for death had occurred. Any faint pulse, if found as thought by one officer, was not consistent with continued viable life.

6) **Application in this instance of State Coroner's/Critical Incident Protocols.**

I am satisfied that the protocols were adequately put in place as set out earlier. The officers were separated, separately interrogated and their appointments were removed for ballistics examination.

Conclusion.

A domestic disturbance caused neighbours to call the police and to ask them to attend a residence at Bondi. Three police officers attended that domestic violence call-out. Upon arrival at the house, R.S., no doubt emotionally charged by the earlier incident with his fiancee, S.M., ignored police requests to remain at the premises. The officers had reasonable grounds at that stage to suspect the commission of an offence, no doubt heightened by the suspicion of flight. They attempted to arrest the deceased. He resisted the officers and commenced to engage in a struggle with them in which the officers

endeavoured to subdue him. R.S. was larger and stronger than any of the officers and overcame the largest of the three. The other two officers tried to assist but by reason of size and strength, were unable to do so in sufficient time to assist Senior Constable S.D. Constable S.D. had immediate fear for his life and had sufficient grounds for that fear. He drew his weapon for the protection of his life and fired shots until the threat ceased with the death of R.S.

Finding:

R.S. died at a residence in Bondi at 1.40 am on 7 February, 2000, from gunshot wounds to the torso, inflicted by S.D., a member of the New South Wales Police Service in the execution of his duty and in the justifiable belief that such killing was necessary for the preservation of his own life.

612 of 2000

Male aged 51 years died 27th March 2000 at Bathurst Correctional Centre, Bathurst. Finding handed down on 5 December 2002 at Glebe by John Abernethy, NSW State Coroner.

A known person has been charged with an indictable offence in relation to the death of the prisoner. In those circumstances the inquest has been terminated under the provisions of section 19 of the Coroners Act, 1980.

857/00

Male aged 33 years died on 16 April 2000 whilst serving a sentence of Home Detention.
Finding handed down on 29 January 2002 at Kurri Kurri by Carl Milovanovich, Deputy State Coroner.

The deceased was a 33 year old male who had received a brain injury following a serious motor vehicle accident in 1991. He had a number of appearances in Court for primarily drink driving and driving whilst disqualified offences and was on a good behaviour bond when he re-offended in 2000. His brain injury and poor quality of life, together with his loss of licence made him very depressed and he had indicated to his case worker that he would commit suicide if he was sent to Gaol. He had previously served a full time sentence of 6 months.

The Pre-Sentence Report identified his medical problems and the sentencing Magistrate imposed a sentence of 2 months to be served by way of Home Detention. On the 16th April, 2000 the deceased took his own life. He was found hanged in the pergola of his residence. There are no suspicious circumstances.

Finding:

That the deceased died sometime between the hours of 12.30pm and 6.00 pm on the 16th April, 2000, at Thornton, from hanging, with the intention of taking his own life.

1100 of 2000

Male aged 29 years died 5 June 2000 at Randwick. Finding handed down on 1 February, 2002 at Glebe by John Abernethy, NSW State Coroner.

Facts.

The deceased, (A.H.) a 29 year old man died at premises in Randwick after being shot by a member of the NSW Police Service in the execution of her duty. He was 29 years of age and married with two daughters (in Lebanon) and one infant son. He had been in Australia since 1995.

On 25 May, 2000 A.H. presented at his general practitioner's with a laceration to the scalp. He told the doctor that he struck his head while working. The wound was sutured and he was referred to Bankstown Hospital for observation. He appeared to be anxious, depressed and panicked. Sedatives were prescribed. The deceased, (A.H) was unemployed.

In the days prior to his death on 5 June, 2000 he was noted to be displaying uncharacteristically bizarre and irrational behaviour. Many examples of it were in evidence before the State Coroner.

By 4 June the deceased was stating that he needed to go to the Lebanese Embassy in Canberra to obtain assistance about travelling to Lebanon to visit his daughters. His wife by this stage was most concerned about his behaviour and had sought assistance from a number of friends in the Moslem Lebanese community and from officials at the Lakemba Mosque. Nevertheless she agreed to drive him there but only if he would seek medical help. Not far from his home, however, the deceased (A.H.) alighted from his vehicle and sat by the roadway with his luggage, reading the Koran. The evidence before the Coroner was that this type of behaviour was completely out of character - the deceased was a gentle man, good natured and a family man. He was obviously ill.

After awhile the deceased (A.H.) agreed to go to the home of a family friend. There he appeared paranoid, indicating that the television was watching them and that he had a bomb and could blow up the whole world. He calmed down and told his wife that they should return home. Instead of doing so, however, he drove with wife and infant son to Sydney (Kingsford Smith) Airport, arriving at the International Departure Lounge late on 4 June, 2000. Again he spread his religious books out on the ground. Ignoring the pleas of his wife the deceased went onto a construction site and spoke to a supervisor there who pointed out that the site was closed. The supervisor told him of the stress he was causing his wife.

Two Australian Protection Service personnel also spoke to the deceased (A.H.) who said that he would wait until the airport opened the next morning so that he could fly to Lebanon. Despite it being cold and he underdressed he declined an offer to wait in the terminal building. The wife again sought the assistance of the construction supervisor and after speaking to the deceased the supervisor lent her petrol money so that she could drive home with the child.

At 4.02 am the deceased (A.H.) dialled 000 on his mobile phone and stated that he needed an ambulance and that there was something wrong with his stomach. Ambulance officers attended him and described his behaviour as non-compliant and uncooperative. The officers described his physical symptoms as "inconsistent". They conveyed him to the Prince of Wales Hospital, Randwick, arriving at 4.38 am.

He was triaged there and the Registered Nurse who attended him believed that he may have been mentally ill. He refused to enter a "quiet room" with the ambulance officers, remaining erratic and uncooperative. After a short period of time the deceased (A.H.) jumped onto a counter with a glass barrier above it, climbed through a narrow gap in the glass and ran out of the hospital via the waiting area.

The ambulance officers in their paper work described (A.H.) the deceased as very unpredictable, irrational, hostile and as posing a genuine threat to himself, themselves and the public.

Maroubra Police were notified and a CIDS message was despatched and acknowledged by "Eastern Beaches 15" crewed by a constable and a (female) probationary constable of police. The deceased had by then walked to a telephone box and made two further 000 calls. In one of those he indicated that he was lost. He then walked to a service station. His behaviour was reported by the console operator. The two police officers located him and he was again escorted back to the hospital in the rear seat of a 4 door caged truck, arriving there at 6.40 am.

He was again triaged by the same Registered Nurse who indicated that as he had complained of a head injury he would have to be medically examined before being transferred to the Psychiatric Unit at the hospital. He was escorted by the two police officers to a resuscitation bay within the Emergency Department. He was in full view of the nursing station. This time, instead of being assessed as Triage Category 3, he was assessed as a Category 2 (to be seen by a medical practitioner within 10 minutes).

The emergency registrar was informed but was treating another Category 1 (cardiac) patient. She had not been able to attend to the deceased (A.H.) before he again absconded from the hospital. This time he walked from the resuscitation bays to the area near the ambulance doors. He began pacing up and down. The probationary constable attempted to persuade him to return to the bed and during the shift change he ran out into the ambulance bay towards Barker Street.

The police officers pursued him, catching up with him in Barker Street (one drove the caged truck). The probationary constable attempted to pacify the deceased, placing his hand on her arm. He was asked to return to the hospital in the rear of the caged truck. Clearly he did not want to go and pushed the probationary constable, causing her to fall. This was seen by several civilians. The constable then attempted to restrain the deceased, ripping his shirt off in the process, before he broke free. The deceased walked towards the two officers and the constable withdrew his Oleoresin Capsicum Spray, spraying in the direction of the deceased's face. It had no apparent effect.

The deceased (A.H.) then ran towards the car park of a drive-in dry cleaning shop, chased by the police officers. He ran straight at a plate glass window, causing it to smash. He fell into the shop among the broken glass. He picked up a long (perhaps 30 cm) shard of glass and came back out through the broken window. He came at the probationary constable with the shard of glass pointed out in front. She sprayed her OC spray into the area of the face with no apparent effect. She then ran away a short distance.

The deceased (A.H.) turned his attention to the constable who again discharged his OC spray to no effect. Whilst that officer, attempting to draw his revolver, backed around a parked motor vehicle containing a woman, the deceased came at him causing the officer to fall or be pushed to the ground. The deceased (A.H.) then began stabbing at the constable repeatedly with the shard of glass. The probationary constable withdrew her Glock firearm and at the constable's plea, fired at the deceased. She fired several rounds but he continued to stab at the constable. Finally he stopped and fell to the ground. An ambulance was summoned. The constable had suffered serious injuries including "significant penetrating injury to the posterior chest just right of the midline with resulting right pneumothorax, with glass in the pleural cavity". He underwent surgery. He had also suffered a number of less serious injuries to the ear, head, hand and finger. He required surgery for several of his wounds and left hospital on 10 June, 2000.

The deceased (A.H.) had died either immediately or very soon after he had been shot. He had been shot five times by the probationary constable.

Several civilians closely corroborated the officers' versions of events.

Police arrived and an investigation was set up in accordance with police and coronial protocols. It was led by a commissioned officer of the Homicide and Serial Violent Crime Agency. The two officers, separated almost immediately underwent ERISP Records of Interview and "video walkthroughs". Their appointments were checked by ballistics. The scene was properly preserved and closely examined by Physical Evidence police. The Duty Forensic Pathologist attended and examined the body in situ. The State Coroner attended.

On 6 June a post mortem examination was conducted and the cause of death found to be "gunshot wounds of the torso". Most of the wounds were clustered in that area. The weapon had been fired from a distance of more than 1 - 2 metres. Toxicological analysis was negative in respect of both the deceased and police officers.

Issues.

The Police Operation.

The NSW State Coroner found that the two young officers did their best to return the mentally ill man to the Prince of Wales Hospital. He noted that police are not greatly trained for such a duty which can be extremely difficult even for those who are. He found that they spoke quietly to him and that he appeared to have become upset by being told to get into the rear of the caged truck rather than the rear seat. The ambulance officers had earlier indicated that they saw him as a threat to himself and others and in those circumstances the officers felt compelled to attempt to get him back to the hospital for treatment. It was when they attempted to do that that the deceased became angry and began to react in a manner completely different to the way he had been in earlier dealings with ambulance, police and hospital personnel.

a) First use of Oleoresin Capsicum Spray by the constable.

The NSW State Coroner was satisfied, in all the circumstances that the first use of OC Spray by the constable was appropriate. The constables attempted to negotiate with the deceased who only became aggressive when they required him to get into the caged part of the police vehicle. There were reasonable grounds for that requirement.

In his ERISP Record of Interview the constable said this:-

> "Q.256. *"And did you feel threatened at that stage?"*
> A. *"Yes, that's why I had my spray out because I thought, you know, I will have to use it."*
>
> 257. *"And did you use it?" A. "I did".*
>
> 258. *"At what point of time did you make that decision to use it?"*
> A. *"When he, after I told him a number of times to stay there, you know, calm down and he didn't so he's still fired up so I thought, he's not going to back down so rather than him attack me and my partner I sprayed."*

The constable gave similar viva voce evidence before the State Coroner.

The State Coroner accepted that the use of the spray was not predicated on any perceived threat of injury to the probationary constable per se, but was because of the general threat the constable saw as arising from the deceased's suddenly altered state, and action of coming towards him aggressively.

b) The shooting itself. Were the probationary constable's actions justified?

The State Coroner said this:

"As to the shooting itself, civilian witnesses and forensic evidence closely corroborates the versions of the two police officers. I am satisfied that had the Probationary Constable not fired repeatedly at A.H. there was a real risk that partner Constable ..... may have lost his life. The Constable he was in real and immediate danger of losing his life. Her only option was to shoot A.H. and she did. As it was, he suffered severe injuries. Significantly both officers utilised their Capsicum Spray first, but to no effect. It is relevant that the constable called upon his partner to fire. She stopped doing so only when A.H. stopped stabbing at the constable.

In the circumstances that the Constable found herself, a baton, had she had one with her would not have been the appropriate force to use in view of the injuries being inflicted on the Constable. In view of the fact that earlier the two officers had, in good faith, attempted to persuade A.H. to return to the police vehicle, it was appropriate that they did not get their batons out of the vehicle.

The officers are to be commended for their attempt to return A.H. to hospital and the Probationary Constable in particular, is to be commended. For a young woman with six months policing experience she showed remarkable

maturity and behaved generally very appropriately. I am satisfied that she probably saved her partner's ..... life, whilst tragically shooting A.H.

I am satisfied that the Probationary Constable committed a justifiable homicide in the execution of her duty and as was necessary to protect the life of partner Constable ..... ."

The illness of the deceased.

The State Coroner stressed, that faced with her husband's severe illness, the wife, with infant child did all that she reasonably could do to deal with the stresses caused by his mental illness. She sought assistance from within the Muslim community from family friends. She went to the Lakemba Mosque for help; and she attempted to get her husband to a doctor.

Dealing with mentally ill/disordered persons at emergency departments of hospitals.

The Coroner found that there was effective triaging of mentally ill patients at the emergency department of the Prince of Wales Hospital. He found that A.H. was triaged Category 2 on his second attendance at hospital as he had earlier absconded from the hospital, and perhaps to enable the police more quickly to go about their business. He found that the deceased (A.H.) on presentation, did not exhibit the "violent or aggressive behaviour, immediate threat to self or others, need for restraint or severe agitation or aggression of the Category. In fact A.H. was clinically no different on his second presentation.

That being so A.H. did not need to be seen by a medical practitioner within 10 minutes. However, he had not been seen at the end of 30 minutes when he again left the hospital.

The Coroner found the reality to be that, the deceased (A.H.) did not need to be seen within 10 minutes as he simply did not appear to be that ill. On the other hand at least one other Category 1 patient presented at the hospital after A.H. had been triaged. That person did require priority attention. In those circumstances A.H. was left where he could clearly be seen by staff, with a Registered Nurse with him and close to him part of the time, a constable with him part of the time and a probationary constable with him most, if not all of the time.

In those circumstances the State Coroner did not criticise the Prince of Wales Hospital and its Emergency Department staff for any failure to comply with the requirements of the triage.

The State Coroner also noted that a Memorandum of Understanding (MOU) existed between the NSW Department of Health and the NSW Police Service, covering dealings between police and emergency departments throughout the State. It was, he said, developed to provide a framework for the effective management of people with mental illnesses who are brought to Emergency Departments by police officers. It covers issues such as notifying time of arrival in advance, setting aside a suitable area, triage and assessment

and psychiatric consultation. It was the intention of the MOU that specific protocols be developed at local levels utilising local service components and addressing local needs.

The Coroner said:

"The MOU is commendable but I am concerned that it may not have been fully implemented (locally) in this particular area, or for that matter State wide. I have heard of a 'verbal agreement' between Prince of Wales Hospital and the Local Area Command. I suspect that, at best, this may be the case throughout much of the State."

He noted a recommendation of the Final Report and Recommendations of the Working Group for Mental Health Care in Emergency Departments - 1998" (Professor Beverley Raphael):-

> "61. *That memoranda of understanding between police, ambulance, emergency department and mental health services be established at a local level to establish formalised agreement on issues of mutual concern.*"

Education of police to better deal with the mentally ill/disordered.

The NSW State Coroner said this:

> "Dr. V.D. in her 1990 - 1997 study of police shootings in Australia found that of the 75 deaths during that period, *'information contained in this paper confirms that a large number of those who die as a result of a gunshot wound were either mentally ill or psychologically disturbed at the time of the incident.'*

Leaving aside the deaths, it is clear that a large element of general duties police work involves dealing with mentally ill/disordered people. It appears obvious, when one considers the difficulties in properly dealing with such people, that police should be fully trained to do so.

I am satisfied that trainee police officers receive inadequate training in this area. According to Senior Constable Peter Holland of the School of Operational Safety and Tactics at the Police Academy, Goulburn, *'I noticed a large deficiency (in 1999) in training when it came to dealing with mentally ill/disordered people.'* Holland has prepared a package and submitted it to the Academic Board but it has not been implemented. It may be that it is not considered ready for implementation.

Similarly, operational police receive some annual training in the subject but that training could not be considered to be in any way comprehensive. The court is familiar with the training video 'Similar Expectations' produced in the early 1990's by the Victorian Police Service. In my view, while representing a valuable and relevant teaching aid towards, at least, an elementary understanding of the problems associated with dealing with mentally ill persons, the video does not provide sufficiently comprehensive material to be of great assistance today.

Coronial Recommendations have been made by State and Deputy State Coroners following inquests such as *Levi, Carroll* and others.

In *Levi*, (Bondi Beach police shooting), then NSW State Coroner Hand recommended *inter alia:-*

> "That police training in dealing with mentally ill persons be reviewed and constantly updated and reinforced."

Clearly, to date no adequate final training package has been formulated and applied in accordance with such recommendations, despite the Levi Inquest concluding in March, 1998. This is a topic which must be addressed as a matter of urgency."

Formal Finding:

That A.H. died on 5 June, 2000 at Randwick of Gunshot wounds to the torso inflicted on him by Probationary Constable, a member of the NSW Police Service in the execution of her duty, and as necessary to protect the life of partner Constable ..... .

Recommendations:

Pursuant to Section 22A, Coroners Act 1980.

1. That the NSW Police Service and the NSW Department of Health reviews, so far as it relates to Emergency Department presentations, the extent to which the guidelines provided by the "Memorandum of Understanding between NSW Police and NSW Health" (June 1998) have been implemented by Emergency Departments and relevant Local Area Commands throughout the State.
2. That the NSW Police Service urgently provides comprehensive training to all NSW Police Academy students and operational police officers in the appropriate dealing with the mentally ill. Such training should include issues such as the recognition of common and significant psychiatric problems, techniques for dealing with mentally ill persons and legal issues associated therewith.

2092/00 and 2093/00.

Female aged 27 years and a male aged 38 years died on 23 October 2000 at Oberon. Findings handed down on 11 December 2002 at Bathurst by Jacqueline Milledge, Senior Deputy State Coroner.

Overview

LA was a 27 year old woman working part time as a guide for the Jenolan Caves Trust Authority. She lived in Oberon with her mother and stepfather.

BS was a 38 year old fitter and turner with the Jenolan Caves Trust Authority, living on site in one of the Trust's cabins.

BS was suffering depression and had struggled for years with alcohol, undertaking counselling, attended Alcohol Anonymous meetings and was

hospitalised in 1999 after a suicide attempt. He had a history of suicide attempts. Three months prior to his death, he had become increasingly depressed. His work performance had deteriorated with periods of unexplained absences.

In 1998 LA & BS's friendship intensified and, by December 1999, it had developed into a serious relationship.

BS had a relationship with another woman, PF, who he had previously lived with in a de-facto relationship. BS had been convicted of assaulting PF and she gave evidence of a long 'on again/off again' violent relationship with him, where she often instigated contact after a 'break up'.

Despite knowing BS was violent and often uncontrollable in anger, PF continued to pursue him for furtherance of their relationship even though she knew he was in a serious relationship with LA. BS sent messages to PF asking to be left alone and that he wanted to 'give it a go with LA'. PF continued to push for attention.

One month before the deaths, PF had reported a break in at her premises where a number of items were stolen. It was obvious during the course of the hearing, that BS was responsible for the theft although he was never spoken to by police or charged over the incident.

Days later PF and BS spent an intimate weekend together, BS giving PF and her child gifts. They continued to remain in contact.

One week before her death, LA was told of BS's 'two timing' and she decided to ring PF to ascertain the truth of the matter. The two women became friends and spoke to each of on a number of occasions.

On 21 October, BS offered to LA, as a gift, a stolen beaded skirt belonging to PF. LA kept one of the beads to show PF. Both women took the bead to the Dubbo Police as proof of theft by BS.

A junior police officer asked her supervisors what could be done about the stolen property and the 'break and enter' and was advised by her senior officers that it was not sufficient proof for police to become involved. The young constable, however, told the women to contact her later to see if something could be done after she consulted a more senior police officer. The women told the officer they would confront BS themselves. The constable advised them against this action.

They did in fact approach BS at the cabins in the Jenolan Caves Trust compound. He became angry and threatened them with a shovel. He paid particular attention to LA, and looked at her in such a hateful way it frightened her and her companions.

The next day LA was killed by BS.

Issues

Was the Dubbo Police response appropriate when the women presented with evidence of BS's theft?

Was the Oberon Police response timely and appropriate when LA rang for help as BS was outside her premises on the morning of her death?

Licensing and storage of firearms by the Jenolan Caves Trust Authority.

The Police Response

After the confrontation at the cabin, LA and PF went immediately to Oberon Police Station. PF had a statement taken by one of the two officers that staff the Station. Whilst it primarily related to the theft of her property and her violent relationship with BS, her evidence was that they had presented to the police in an effort to have an Apprehended Violence Complaint struck, as well, to protect them from BS.

At 11pm LA left the police station without making her statement. She was to return the next day.

LA, PF another female friend and her child stayed with LA's family that night and left early the next morning.

During that night BS leaves Jenolan Caves and his friends are concerned for his welfare. One of his colleagues rings Bathurst Police and explains they are concerned because he left the compound in a depressed state and they believed he may 'self harm'. The closest police station to the area was Oberon but it was not staffed until 8am.

Bathurst Police contact Oberon Police at 8.12 am and gives the officer the 'concern for welfare' message, stating BS is suffering from depression.

At 8.25am LA rings Oberon speaking to Senior Constable B. According to this Officer, she tells him BS' s car is parked near her home and that they had experienced problems with their electricity (it was later determined that BS had turned the electricity off in her premises).

Her friends gave evidence that LA told them she asked for help from the police but they said they could not do anything as 'he had not done anything'.

At 8.40am LA makes a phone call to a friend asking if she knew the whereabouts of BS. Her girlfriend said that while she was on the phone she heard LA tell her stepfather that BS was walking up the driveway with a gun. She told LA to ring the police immediately.

At 8.55 am LA made a '000' call seeking help. The VKG audio tape recorded the last few moments of her life. BS, after trying to gain entry through doors that were locked, smashed his way through the front window, shooting her stepfather at close range, and fired two shots at LA killing her instantly. Her little dog was also struck by the bullet as she held it in her arms.

When LA first rang police telling them BS's car was parked near her, Oberon Police rang Jenolan Caves and told them they had found BS's car. Both police officers stated they each took turns to read PF's statement, made the night before, prior to them leaving the station.

The police went to the car park where BS's car was parked and noticed a rifle and ammunition in the back seat. Police had forgotten their portable radios and as one of the officers left to retrieve them, they heard the first gunshot.

Whilst evidence from LA's friend and PF was that police said they could not do anything, the Coroner found that police were responding to the call, albeit slowly.

The Coroner found that LA's original phone call was indeed a call for help, but that the police response was not timely and appropriate in the circumstances. LA made her phone call at 8.25am and police did not attend the car park until 9.55am, some 30 minutes later. Oberon Police Station was just metres away from the car park.

When the shots were heard, the police officer's set up a 'command post' overlooking the area.

The Coroner was also critical of the time Police took to respond to the scene after the shots were fired. They relied on neighbours, putting themselves in danger, to report back to police before they moved into the crime scene.

Formal Finding

That LA died on 23 October 2000, at Hawkes Drive, Oberon. The cause of death is a gunshot wound to her head and to her torso, inflicted by a person, now deceased.

That BS died on 23 October 2000, at Hawkes Drive, Oberon, from a gunshot wound to the head, self-inflicted, with the intention of taking his own life.

Recommendations:

To the Minister for Police and to the Attorney General of New South Wales

- **That there be imposed an obligation pursuant to the provisions of the Firearms Act and Regulations upon any person issued with 'a Firearms Licence' to the effect that upon any change of permanent location as to where firearms are kept under the licence, the Commissioner of Police be advised within 48 hours of any change of such address.**

To the Minister for the Environment

- **That the Jenolan Caves Reserve Trust appoint an appropriately trained and suitably qualified person to fill the position of and take over the responsibilities of a 'Human Resources Manager' in relation to the operations of the trust.**

- **That the Jenolan Caves Reserve Trust give consideration to reviewing the security arrangements currently in force in relation to the possession and storage of firearms and:-**

i) whether additional precautions and safety measures should be adopted and set in place over and above the minimum requirements imposed under the Firearms Act and Regulations enacted thereunder, and

ii) whether such firearms and ammunition be stored in an area not readily accessible to members of staff,

iii) whether such firearms be stored in a place separate and apart from where ammunition is stored,

iv) whether an alarm system be employed to protect the area where firearms are stored with access to the alarm system and code being restricted to specified senior personnel.

To the Commissioner of Police

- That the Commissioner of Police review effectiveness of response times to critical incidents at all non 24 hour police stations. Particular attention should be given to the circumstances in the homicide of LA and the suicide of BS.

- In his review the Commissioner should have regard to :-

  i) call out procedures, particularly after hours.

  ii) the need to ensure an immediate, timely and appropriate response to any critical incident in that location.

2181/00 **Male aged 29 years died on 9 or 10 November 2000 at Goulburn Correctional Centre. Finding handed down on 21 January 2002 at Goulburn by Carl Milovanovich, Deputy State Coroner.**

The deceased was serving cumulative sentences, had served four and a half years and was due for release on parole in April 2003. There were 3 prior self harm incidents, including one of attempted hanging.

The prisoner was in a segregated ward at his request as he was a prosecution witness in a serious criminal charge. He had a number of personal problems, including the break up of his relationship with the mother of his daughter and was also intense in pursuing further appeals in regard to his belief that he was innocent of the charges which caused his incarceration.

The prisoner left a suicide note. There were no indications immediately before that he would take his own life. The prisoner hanged himself in his cell.

The family raised concerns regarding the fact that his body was not located until 8.30am and that more regular checking of the cells may have discovered him earlier.

The Coroner elected to make no recommendations as the privacy and interruption of other prisoners had to be taken into account if regular checks (which would have required the cell to be unlocked, lights turned on etc.) were undertaken.

Formal Finding:

That J.O. died between 1600 hours on 9 November 2000 and 0830 hours on 10 November 2000 at the Goulburn Correctional Centre due to hanging.

2274/00 **Male aged 64 years died on 26 November 2000 at Prince of Wales Hospital, Randwick. Finding handed down on 15 January 2002 at Glebe by Carl Milovanovich, Deputy State Coroner.**

The deceased was due for early release on 6 January 2002. He was a heavy smoker and had a right enguinal hernia repaired in 1998 and was being treated for peripheral vascular disease.

On 23 November 2000 he was admitted to Prince of Wales Hospital where he underwent a left iliac artery endarterectomy on 24 November 2000. At about 9.30am on 26 November 2000 he was taken by toilet trolley to a bathroom after complaining of stomach pains. The deceased was accompanied to the toilet by a nurse and a surgical dresser. The deceased was under supervision accept for a number of seconds when the surgical dresser turned around to operate a shower. He turned to find the deceased slumped but still seated on the toilet.

The deceased was returned to his bed, CPR commenced immediately, an arrest team arrived and life was pronounced extinct at 10.47am.

Formal Finding:

That W.M. died on 26 November 2000 at Prince of Wales Hospital, Randwick due to Haemoperitoneum and Retroperitoneal Haemorrhage following surgery for left Iliac Artery Endarterectomy and Peripheral Vascular Disease.

2363/00 **Male aged 18 years died on 13 December 2000 at St.Peters. Finding handed down on 17 April 2002 at Glebe by Carl Milovanovich, Deputy State Coroner.**

The deceased was seen driving a vehicle of the type often used in ram raids. A Police Operation was targeting particular types of vehicles in a particular area. The vehicle driven by the deceased fitted that description. Police attempted to pull the vehicle over for a routine check.

The deceased did not come under notice for speeding or any other traffic offence. When the fully marked Highway Patrol vehicle positioned itself behind the vehicle driven by the deceased, he accelerated.

A Police pursuit which lasted approximately 20 seconds took place. During the pursuit the Police lost sight of the vehicle driven by the deceased and then came upon a major collision in which 7 motor vehicles were involved. The vehicle driven by the deceased had overturned and caught on fire before he could be released.

The vehicle was in fact a stolen vehicle. The family had no concerns regarding Police actions.

Formal Finding:

That S.F. died on 13 December 2000 at St. Peters from the combined effects of multiple injuries and burns as a result of a motor vehicle collision.

2385/00

Male aged 46 years died on 15 December 2000 at Loftus . Finding handed down on 26 March 2002 at Glebe by Jacqueline Milledge, Senior Deputy State Coroner.

Overview.

MD was a 46 year old man living with his elderly parents at Loftus. MD had a history of mental illness, and as recently as the 10 December he had auditory hallucinations causing him to be admitted to hospital.

On 12 December he was released. Doctors stated he was rational and had insight. Whilst he was still dependent on alcohol, the doctor believed he could not legally detain him further within the terms of the Mental Health Act. The doctor also believed 'the least restrictive care' was to release MD with follow up community care.

Up until his admission, MD had been attending his doctor for fortnightly injections. Whilst he suffered from Schizophrenia he kept telling his medico that he was not suffering from any hallucinations and was keeping well. It was however, clear on his last admission that MD had been ill for a along time without telling his doctor.

On the day of his death, police had been called to his premises by a neighbour who said MD was approaching cars in the street, shouting and behaving in a threatening manner. The neighbour told police she had a history with MD in that he had threatened on a prior occasion and had been threatening with an axe.

Police attended outside his house, but MD was not on the street. He was inside his premises.

Some police knocked on his door and spoke to MD who told them in no uncertain terms to leave his property. Two other police entered the premises from the back door. They were not invited to do this. Police spoke to MD's elderly and demented parents who told them he had been unwell for some time.

Police determined to take him to hospital for treatment, summoned the assistance of ambulance officers and proceeded to apprehend MD to take him to hospital. MD resisted these attempts forcefully. It was during this struggle that MD died.

Issues.

Did the police have power to forcibly restrain MD, given that he was inside his own premises when they apprehended him?

Should police have vacated his home when he asked them time and time again?

Should the Mental Health professionals have detained MD longer at the hospital before release?

Was there 'community care' available for MD?

Did the medication 'Flupenthixal' contribute to his demise?

The Police.

The Coroner found that police powers were severely limited under section 24 of the Mental Health Act. That Act allows a member of the Police Force who 'finds' a person in **any place** who appears to be mentally disturbed and after other criteria is satisfied, to take them to a hospital.

MD was safely in his home. Police had not witnessed the commission of any offence, and apart from swearing at police telling them to leave his property, they had not witnessed signs of mental disturbance. MD did become angry and resisted police, but only after his repeated efforts to get them to leave.

Other police entering the family home did so without invitation and had no right to go inside without permission.

The Coroner was satisfied that 'but for' the strenuous arrest, MD would not have died at that time.

Whilst the Coroner found that the police should have retreated after being told to leave by MD, she was satisfied that the police were acting, **in their belief**, in the best interests of MD in taking him for a mental assessment and treatment at hospital. At inquest, the family of the deceased did not take objection to the police action.

The Mental Health Professionals.

Like so many matters before the Coroner's Court, there was a real issue as to the appropriateness of the treatment MD received at the time of his last admission.

The Coroner found that whilst the doctors believed they were working within the legal framework of the Mental Health Act, his treatment was inadequate in the circumstances.

Doctors did not factor his dependency on alcohol into his treatment, saying that the Mental Health Act does not allow for substance abuse to be considered when determining admission of treatment. They also felt constrained to consider **the least restrictive care** which meant to them, release back in to the community as quickly as possible.

Whilst doctors stated that MD told them he did not have any of his earlier symptoms, ie. Hallucinations, the Coroner found a two day admission was not sufficient time to stabilise the patient and be confident that he was well enough for release.

The 'community care' component of his release could not be satisfied due to severe resource problems.

Flupenthixol.

Flupenthixol, an anti-psychotic medication, was given to MD to treat his condition 8 days prior to his death. Whilst it was shown that this medication can cause death in persons with a pre-existing heart condition, the Coroner found it was not a factor in the death of this man.

Finding

MD died on 15 December, 2000 at his home at 78 National Avenue, Loftus. He died of the combined effects of ischaemic heart disease, obesity and limitation to respiration because of position. At the time of his death he was being restrained by police.

Recommendations:

1. That the Minister for Health cause a review of all deaths of mentally ill or disordered persons where their deaths occurred soon after treatment at a mental health facility or following presentation before a psychiatric registrar.

   The Mental Health Act provides that the 'least restrictive option/treatment' is to be considered in determining the treatment and care of patients and this gives rise to an earlier discharge than is warranted when considering the continuing stresses that may confront the patient when returning to their environment.

2. That the Minister for Police and the Minister for Health give effect to the recommendation of the State Coroner following the Inquest into the death of Ali Hamie:

   - That the NSW Police and the NSW Department of Health reviews, so far as it relates to Emergency Department presentations, the extent to which the guidelines provided by the "Memorandum of Understanding between the NSW Police and NSW Health" (June 1998), have been implemented by Emergency Departments and relevant Local Area Commands throughout the State.

   - That the NSW Police Service urgently provides comprehensive training to all NSW Police Academy students and operational police officers in the appropriate dealing with the mentally ill. Such training should include issues such as the recognition of common and significant psychiatric problems, tecniques for dealing with mentally ill persons and legal issues associated therewith.

36/01 **Male aged 40 years died on 8 December 2000. Finding handed down on 7 February 2002 at Wauchope by Carl Milovanovich, Deputy State Coroner.**

The deceased was a member of the Aboriginal community at Greenhills, West

Kempsey and grew up in the area. The Greenhill's Mission is located on the northern side of River Street, West Kempsey and is directly opposite what is now commonly known as the Greenhill's Lookout, but it is in fact a man made structure being the remnants of an old quarry. Two days prior to his death, the deceased cut his wrists and stabbed himself in the stomach. He was hospitalised and contrary to medical advice discharged himself from hospital.

On the day of his death he consumed some alcohol and the toxicology reports indicate that he had a very high level of cannabis in his blood at Post Mortem which had been recently ingested. On the night of his death he attacked 3 German tourists who had stopped at the lookout to watch the sunset. He was armed with a tomahawk and smashed windows in their camper van and threatened them. Two of the female tourists flagged down a passing motorist who called Police. The deceased was very agitated and positioned himself near the edge of the lookout. He also further mutilated himself with the axe by cutting off 3 fingers from his left hand.

A total of 10 Police arrived and a time frame of 6 minutes ensued between the first Police arriving and the deceased diving from the cliff top. The deceased was surrounded by Police, he was waving the axe and the Police moved closer in a tightening semi circle with a view of apprehending the deceased. The evidence at Inquest suggested that the Police did not get any closer than approximately 4 meters as the use of Capsicum Spray was ineffective in that it fell short of the deceased's face. The deceased ran to the edge of the cliff and dived over, landing some 17 meters down the cliff face and died almost instantly from multiple injuries.

A number of issues were raised at the Inquest which included the appropriateness of the use of Capsicum Spray and whether the Police should have tried to contact family members, members of the Aboriginal Community or Aboriginal Elders who could have negotiated with the deceased. A further issue was raised in regard to concerns the family had as to the appropriateness of a sign erected by the Local Council which depicted a cliff face, with loose rocks falling and a stick figure falling over the cliff. This sign would appear to have been an international type standard sign, triangular with black inscription on a yellow background.

The Coroner made a number of recommendations.

Use of Capsicum Spray.

It was considered that the use of Capsicum Spray was the most appropriate and least lethal of the appointments that Police had at their disposal. An issue arose during the Inquest as to whether the deceased was actually struck with Capsicum Spray in the face or on parts of his body. He had wounds to his abdomen area and had severed three fingers and it would have been important for the Coroner to come to some conclusive view as to if and where the Capsicum Spray struck the deceased. It was a relevant issue as it may have been one of the reasons the deceased decided to run and dive over the cliff. It was apparent that the Forensic Pathologist did not test for Capsicum Spray resin. He may well have not done the tests because Police Reports

indicated that the Spray had not reached him, however, other witnesses and Police tests as to the range over which Capsicum Spray can be used, suggested that it was most likely that some of the spray did strike him on parts of his body.

The Coroner was informed that an ultra violet test can be conducted within 24 hours on the body and clothing and that toxicology tests can be conducted on tissue samples to determine the presence of Capsicum Spray. The Coroner has recommended that in every death that occurs during a Police Operation (whether Capsicum Spray was used or not) that a mandatory test should be done at Post Mortem Examination as to the presence or otherwise of Capsicum Spray.

The Coroner also made recommendations regarding the concerns expressed by the family in regard to the sign placed at Greenhill's Lookout. The Coroner recommended that the Council consult with the family of the deceased and the Aboriginal Community in regard to an appropriate sign or barrier. It was noted by the Coroner that the family would not have objections to a sign of a similar nature to the one presently in place being replaced after a suitable period of mourning and that that sign should not have any reference to a stick figure in black on a yellow background.

The Coroner did not make any recommendations in regard to the concerns the family expressed in regard to the purported failure of the Police to contact a family member or elder to act as a negotiator. The Coroner noted that it was Police practice not to involve family or friends in negotiations and in any event the time frame over which the events took place (6 minutes) would not have made it possible.

Finding.

That (the deceased) died on the 8th December, 2000, at Greenhill's Lookout, West Kempsey from multiple injuries when he dived from the cliff, whether with the intention of taking his own life, the evidence does not allow me to deduce.

110/01

Male aged 33 years died on 29 January 2001 at Nepean Hospital, Penrith. Finding handed down on 23 April 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.

The deceased was an insulin dependent diabetic. He also has severe cardiovascular disease. On the day of his death he was seen by Police to be driving in an erratic manner (mounting the kerb, weaving from lane to lane) and was followed by Police with lights and sirens activated.

He continued to drive, apparently oblivious to the presence of Police. At one stage he travelled onto the incorrect side of the road and eventually collided with traffic control lights. The deceased was not injured and appeared to Police to be either affected by alcohol or drugs. A breath test was negative. He was placed under arrest and taken to Nepean Hospital for the purposes of a blood/urine test.

At the Hospital his medical history became known and Doctors attempted to inject him with Dextrose as his sugar level was found to be as low as 1.7 mil/litre.

It is apparent he went into acrdiac arrest as a result of his low blood sugar levels which exacerbated his existing cardiac condition. He died shortly thereafter at the Hospital and could not be resuscitated.

Formal Finding:

That J.K. died on 29 January 2001 at Nepean Hospital, Penrith from insulin dependent Diabetes Mellitus.

185/01 **Male aged 33 years died on 19 February 2001 at Silverwater Correctional Centre. Finding handed down on 3 April 2002 at Westmead by Jacqueline Milledge, Senior Deputy State Coroner.**

Whilst the Coroner was satisfied that no other person was involved in his demise and there were no suspicious circumstance, due to his mental state at the time of his death, a finding of suicide was not made.

Overview

The deceased was a 33 year old male serving a six months sentence for Break Enter and Steal. He had a history of drug use with a previous suicide attempt , by hanging, in 1997.

On his initial intake into the correctional facility on 10 February, 2001, he was assessed as not having a mental illness or thoughts of self harm.

On 18 February he complained to prison officers of 'hearing voices'. He was seen by a nurse and a 'Risk Intervention Team' (RIT) was convened and MB was transferred to an 'observation cell' with half hourly observations by Corrections Health staff.

On 19 February, he was again interviewed by the RIT and during the 20 minute interview he assured them he was no longer 'at risk' and they arranged for him to be moved from the safe cell to the holding cell. He was to be reviewed by the Case Management Team the following day.

The deceased was placed 'one out' in cell 107, E Block. The correctional officer moving MB asked him if he was going to be all right. He answered, "I'm fine boss".

The officer asked, "You're not going to do anything silly?" The deceased replied, "No".

Shortly after 5.30 pm when his evening meal was being delivered, he was found hanging from the shower partition.

Issues

Should the deceased have been removed from the 'safe cell'? Was his final assessment appropriate in the circumstances?

Corrections Health and the RIT

The Coroner was satisfied that the Corrective Services staff acted in a timely and appropriate manner when dealing with the deceased.

However, the Coroner was highly critical of Dr T who was part of the RIT on 19 February. Dr T said she was pressed for time and could not spend time with MB as she was under pressure to see a number of people. She said she had been continually pressured attending the facility for only one day a week. She admitted she did not consult MB's records as she did not have the time. She simply left things undone.

The psychiatrist Dr T did not, as it would be expected, have any interaction with the psychologist as the Coroner said, "They were like ships that passed in the night".

Given that Dr T failed in her duty to assess the deceased in light of his history, the other members of RIT were also not privy to it and the decision to release him from the 'safe cell' was not soundly based.

During his time in the 'safe cell' he did not receive medication or counselling. How then could he be considered to have resolved his 'self harm' issues?

The Coroner found that Dr T had failed to adequately assess his 'mental health' at his last assessment.

Whilst the Coroner was satisfied that no other person was involved in his demise and there were no suspicious circumstances, due to his mental state at the time of his death, a finding of suicide was not made.

Formal Finding

MB died in Cell 107, E Block, Silverwater Goal on 19 February, 2001. He died as a result of hanging.

Recommendations:

1. **That all shower rails be removed from holding cells in all correctional facilities.**
2. **That close circuit television cameras be installed in all holding cells in all correctional facilities.**
3. **That these cells be monitored 24 hours, 7 days per week.**
4. **That the complete Corrections Health file (medical and psychological) travel with the prisoner when moved from facility to facility within the Corrections network.**
5. **That the full Corrections Health medical file be used during all medical/ mental health assessments and interviews, to ensure the medical/psychological history of the prisoner can be ascertained.**

6. That Corrective Services staff should enforce compliance, ensuring that observation windows remain free of obstruction to allow 'observation'.

7 That the Department of Corrective Services and Corrections Health jointly review the systems failure that presented at the time MB was being assessed by the Risk Intervention Team and the consultation with Dr T.

8. That the Risk Intervention Team Assessment form include notation that medical/psychological files have been read in conjunction with the interview.

275 of 2001

Male aged 36 years died at Shelly Beach Headland, Manly on 7 February, 2001. Finding handed down on 25 January 2002 at Glebe by John Abernethy, NSW State Coroner.

Police were called to Shelly Beach Lookout near Manly at about 1.30 pm on 7 February, 2001. An artist sketching on the cliffs had become concerned about the behaviour of the deceased. He left the area and borrowed a mobile telephone. He dialled 000. Two police officers ("A" and "B") attended and were quickly joined by another constable and a probationary constable ("C" and "D"). The latter attended the lookout and commenced talking to the deceased who said very little. He did indicate that he had been charged with murder.

At about 2pm a sergeant of police who was also a trained police negotiator joined the constables. Although he tried to speak to the deceased he left Constable C and Probationary Constable D to continue to do so, on the basis that they were building a rapport with him.

Shortly before 3pm another trained negotiator from outside the Local Area Command arrived. She too briefly spoke with the deceased. She and the other negotiator were both of the view that they should remain in the background, allowing the constables to continue to deal with the deceased.

Significantly, the negotiators discussed involving the deceased's mother by bringing her to the site. They decided against taking that course on the basis that they did not know enough about the relationship between mother and son at the time to make an informed decision about involving her.

At 3.38pm, despite the best efforts of the officers involved, the deceased deliberately jumped to the rocks below. He died instantly from the head injuries received.

The deceased had been suspected of committing a murder on 7 May, 2000. From the late 1980's however, he had begun to become clinically depressed, probably due to issues in his life such as the death of his father and workplace problems. Towards the end of 1998 he began seeing a medical practitioner and the family of the deceased took issue with the care and treatment the deceased had received. At inquest, however, it (the family) agreed that the coronial inquest was not the appropriate forum to deal with that issue.

Issue:

That being so, the only real issue was that of the police operation itself.

All interested parties at inquest took the view that the police operation was carried out appropriately. The State Coroner shared that view and commended the police officers efforts in attempting to negotiate with the deceased. He asked the Officer-in-Charge of the case to take that commendation to their superior officer. In particular the State Coroner noted that coronial death in custody protocols were put in place; that the two officers involved submitted to Records of Interview, and that the decision to use untrained negotiators in the particular circumstances was an appropriate one, as was the decision not to involve the mother of the deceased.

Formal Finding:

That S.T. died on 7 February 2001 at Shelly Beach Headland, Manly, of multiple injuries sustained when he jumped from a cliff with the intention of taking his own life.

337/01 **Male aged 18 years died on 18 February 2001 at Oak Avenue. Finding handed down on 7 March 2002 at Tweed Heads by Jacqueline Milledge, Senior Deputy State Coroner.**

Circumstances leading up to his death

WRM was 18 years old. He had only just had his drivers licence restored after a 12 month disqualification period.

He and his friend were 'cruising' Coolangatta in a 'borrowed' turbo charged car when they were stopped by two Queensland police officers for the purpose of a random breath test. They were stopped a short distance from the Queensland/New South Wales boarder.

WRM held a New South Wales Provisional Driver's Licence. Her was breath tested away from his motor vehicle at the police car. He registered .061 on the roadside 'line alcometer' unit and the police were making arrangements to convey him to Coolangatta Police Station for 'breath analysis' testing. Queensland's drink driving limit for inexperienced drivers was 'zero concentration' and New South Wales was .02.

The police failed to secure the deceased or his motor vehicle, leaving the keys in the ignition. After giving them his driver's licence, he asked to return to his car to get his wallet. The police allowed him back to the car, unaccompanied, where he simply drove off. A police pursuit followed.

The Issues

1. Was WRM being **pursued** by police at the time of his death?
2. What were the protocols for cross border pursuits for both Queensland Police and New South Wales?

3. Were the pursuing police 'special constables' and therefore entitled to enter New South Wales and deal with the deceased?

4. What were the protocols to be observed by police once the pursuit was 'terminated'?

5. How and why was the 'time coded' VKR audio tape destroyed, particularly when the investigating officer ordered it be retained for the Coroner?

The Pursuit

WRM was pursued by police for approximately 17.6 kilometres, starting in Coolangatta, Queensland and ending 240 metres south of Cudgen Road, Stotts Island, New South Wales.

The Coroner found that a short pursuit was warranted initially when WRM first fled from police, but due to his 'condition' a lengthy and high speed pursuit could not be justified in the circumstances.

WRM was a young inexperienced driver who had only recently had his driving licence returned after a twelve month period of disqualification. He was alcohol and drug affected, having, amongst other things, 6 times the therapeutic dose of methamphetamine in his system. Toxicology results indicated either a recent heavy use of drugs or drugs used over a period of time. He was driving an unfamiliar 'turbo charged' motor vehicle. The roads were wet due to earlier rain.

Whilst there was evidence of an estimated pursuit speed of 160 kph, the Coroner was unable to calculate the speed in relation to the distance travelled as crucial audio tape evidence was destroyed by the Queensland Police.

VKR police radio had recorded the entire pursuit on a 'time coded' audio tape. Despite a direction by the Coroner that the tape be preserved for the investigation, the tape was destroyed after the request.

The Coroner could only rely on available evidence when considering speeds reached by both vehicles during the pursuit. The Coroner found speeds of 130kph and 140kph were reached by pursuit vehicles. The Queensland Police Officers engaged in the pursuit denied exceeding 100 kph at anytime during the event. This was not feasible given the distance travelled and the time taken.

The two initial officers called for assistance and when across the New South Wales border the asked if any New South Wales cars could 'pursue' the target vehicle. At the time of engaging the New South Wales Police, the original pursuers were told by their Commander to 'terminate the pursuit'.

Queensland Police Safe Driver Policy directs police to return to their duties they were engaged in prior to any pursuit once the pursuit is terminated. These police ***were not*** 'special constables' for the State of New South Wales and should not have crossed the border. In New South Wales they were 'impotent' as police officers.

Whilst the police stated that they were simply 'following' WRM, they were acting contrary to their direction to 'terminate' the pursuit as 'terminate' means ***'stop following'***.

At the time of the horrific collision that claimed the life of WRM, the Coroner found the Police ***were pursuing*** him, at speed.

The Collision

WRM's vehicle, according to a police witness, seemed to 'loose control' on a curve in the roadway prior to the collision. Expert testimony regarding the manoeuvrability of the turbo charged vehicle was that the 'turbo' component could sometimes 'surge' unexpectedly causing the driver to loose control. Whilst it was suggested by Counsel representing the Queensland Police that WRM may have deliberately swerved towards the truck, the Coroner rejected this suggestion based on all the available evidence.

During her finding the Coroner commented that from a police operation perspective "I have never seen a matter involving police where so many matters have gone wrong from start to finish". The Coroner also commented about the police pursuit "Why push somebody to the limit when you feel they are not capable of driving in the first instance, that is the very reason you are trying to take them off the road".

The tragedy of this pursuit is that police knew who the driver was and where he lived as he had left them with his licence prior to fleeing the situation.

Formal Finding

I find that WRM died at 12.09am on 18 February 2001 on the Pacific Highway, Oak Avenue and that the cause of death is 'multiple injuries'. Those injuries were sustained when the car he was driving collided with a prime mover on that highway, in a 'head on' collision, whilst he was being pursued by police.

Recommendations:

- **That the Minister for Police propose the adoption of a national "Safe Driving Policy" and that this proposal be placed on the agenda of the Australian Police Commissioners Conference.**
- **The New South Wales Police Safe Driving Policy definition of "terminate" be amended to say "terminate means cease to pursue AND stop following". This definition should be adopted in the National Safe Driving Policy.**
- **The National Safe Driving Policy should stipulate that a pursuit should only be reinitiated after approval is granted by the District Officer/Supervisor and, only then be approved if further pertinent information was received to alter the complexion of the original response.**

- **The National Safe Driving Policy to state that "loss of radio communication means automatic termination of the pursuit".**
- **That the Queensland Commissioner of Police give consideration to amending the definition in the Queensland Safe Driving Policy in relation to "abandon" and "disengage"**
- **That the National Safe Driving Strategy include further training to operational police in relation to pursuits and "urgent duty" driving. In particular, the subject matter of this inquest be used as part of any training course; and that statistics on fatalities and injuries be incorporated in any training course.**
- **All operational police stationed at state border police stations should be appointed "special constables".**
- **That a more streamlined and uniform procedure for the appointment of "special constables" within Australia using NSW procedures as a model of "best practice".**
- **That all "special constables" should receive an information package tailored to the region where they are attached, which explains in clear and simple language their duties and scope of power as "special constables"**
- **That radio operators in every state be provided with Safe Driving Policies of all border States.**
- **That the New South Wales Standard Operating Procedures (29.2) in relation to pursuits be amended to include the requirement to ask "Are you a Special Constable?".**
- **That the trialing of the "dual radio" system, VKG and VKR, be immediately introduced at the Coolangatta and Tweed Heads command areas**
- **That an electronic communication system between VKG operators and supervisors, Newcastle, be installed to enable the immediate notification of a supervisor that a pursuit or other urgent business is "on foot"**
- **That the Commissioner for Police, Queensland, reinforce the standing policy for the retention of records pursuant to the Administration Manual and the obligations of all Queensland Police personnel to ensure records are properly dealt with.**

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Male aged 33 years died on 5 April 2001 at Parramatta Gaol. Finding handed down on 12 December 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.

K.H. had suffered depression for about two (2) years prior to his death and was in a defacto relationship. K.H. was taken into custody on 27 January 2001 and granted bail on 29 January 2001. The following day he was again taken into custody on fresh charges and bail refused but then granted bail

some days later. On the 22 February 2001 the deceased again came into custody after being charged with Assault Occasioning Actual Bodily Harm on his defacto's daughter. On the 23 February 2001 he received a sentence of 6 months imprisonment for that matter. He was initially transferred to Malabar Special Programs Centre on 2 March 2001 and on 21 March 2001 was transferred to Parramatta Gaol.

In regard to all receptions the deceased was considered to be a prisoner at risk. He had prior suicide attempts when he was 16 years old (attempt hanging) and had attempted to overdose on drugs and alcohol only one (1) month prior to his incarceration. He was quite open in regard to the fact that he may commit suicide and on each admission K.H. was assessed by the Risk Intervention Team as a Prisoner at Risk. He was on each admission placed in a safe cell and then placed "two out".

In the days before his death, K.H. did not exhibit any signs of depression or suicidal ideation. His cellmate considered that he was his normal self. K.H. was receiving regular medication from the clinic and it was apparent that he was taking his medication. On the morning of his death he was visited by his de-facto and appeared in good spirits, although she did comment that he was teary and gave her a hug when she left which was most unusual for him.

On the 5 April 2001 the deceased's cell mate had a Court appearance and was taken from the cell at 5.30 am The deceased was left in the cell "one out" for three and a half hours which was clearly in breach of the "two out" policy. The deceased was let out of his cell at 8.30 am for morning muster, he was seen again during the midday muster and was locked in his cell at about 3:30pm after receiving his meal. At this stage his classification was still "two out" and his cellmate had not yet returned from Court. The Corrections Officer who last saw him alive and who locked him into his cell at 3.30pm had assumed that his cell mate would return from Court shortly. As it transpired the cell mate was not returned to his cell until 8.00 pm and only when the cell door was opened for the cell mate to enter was the body of the deceased found hanging from a window with a ligature made from a sheet.

The family of the deceased had no concerns regarding the treatment of the deceased or his assessment and his placement. They had concerns as did the Coroner as to why the protocols and instructions in regard to the "two out" policy had been overlooked, not once but twice within a 12-hour period. K.H. should not have been left in his cell alone at 5:30am nor should he have been left locked in his cell alone for the period from 3.30pm to when found, deceased at 8:00pm. The Department of Corrective Services conceded that the "two out" policy had not been followed and new directions have now been issued which are State wide in regard to the policy that "two out" detainee's are not to be left alone in a cell for any period of time.

The Coroner also noted the easy access to hanging points as being of concern. It was argued that Parramatta Gaol had been closed and only recently opened due to cell shortages and that very little can be done in relation to Cell Bars due to the historical classification of the building. Whilst the Coroner did not make any recommendations following this Inquest, mainly due to the fact

that the main recommendation that would have been made had already been implemented ("two out" Policy) he did comment that deaths in custody will continue if obvious hanging points are not removed or covered. This issue of screening hanging points has been the subject of a number of comments by Coroners this year and regrettably they persistently surface as the main mechanism of facilitating asphyxiation or hanging.

Formal Finding:

That K.H. died on the 5 April 2001, at Parramatta Gaol, Parramatta in the State of New South Wales, from hanging, self inflicted with the intention of taking his own life.

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Male aged 57 died on 24 February, 2001 at Adjungbilly via Tumut. Finding handed down on 10 May, 2002 (Recommendations finalised 27th September, 2002) at Tumut by John Abernethy, NSW State Coroner.

This inquest was conducted with a jury of six, in the Southern New South Wales town of Temora over eight weeks. The jury was empanelled in accordance with Section 18, Coroners Act 1980 which states:-

> "18. *Inquests and inquiries with or without juries. (1) An inquest ... shall, except as provided by subsection (2), be held before a coroner without a jury.*
>
> (2) *An inquest* ***shall*** *be held before a coroner with a jury if-*
>
> (a) *the Minister or the State Coroner so directs; or*
>
> (b) ***a relative of the person*** *who has died or is suspected of having died or the secretary of any society or organisation of which that person was, immediately before his death or suspected death, a member* ***so requests.***

Therefore the NSW State Coroner had no discretion and had to conduct an inquest with a jury. The case was inordinately expensive to conduct and more importantly the family was left dissatisfied with the process.

Despite it being explained to it that a jury, beyond making recommendations pursuant to Section 22A, Coroners Act 1980, could not "sum up" as is traditionally done by a coroner sitting alone, the family was left with hearing the jury return a finding as to identity, date and place and manner and cause of death - a process which took minutes. It is fair to say that the finding returned by the jury mirrored the view of the State Coroner, though had the State Coroner been sitting alone he would have given a lengthy summing-up, quite harshly criticising aspects of the policing in terms of the police operation itself, and the policing which led to the commencement of the operation in the first place.

Further, in the Coroner's view the jury was quite incapable of making recommendations and chose not to, leaving him to finalise recommendations to the NSW Police.

A practical problem in this particular case is that the police operation which led to the death involved many police and the Officer-in-Charge, properly in the Coroner's view, took perhaps fifty ERISP Records of Interview, which in many instances ran to over 100 pages. In order to properly lead that evidence to a jury, a second barrister had to be retained to assist the coroner by reducing those ERISPS to statement form so that Counsel Assisting could lead the evidence viva voce - it being utterly confusing to the jury to have to read volume upon volume of the brief of evidence. Those statements were contested by many of the witnesses and had to be adjusted "at the courtroom door" as it were.

The sheer size of the brief, led to a decision that the case could not be heard at the nearest court house - Gundagai. Tumut Court did not have jury facilities. Wagga Wagga court was fully booked for most weeks of the year and so could not be utilised. The court houses at Yass and Cootamundra were unavailable. Finally Temora was chosen.

Again, the size of the inquest in terms of witnesses led to a decision by the State Coroner to require the jury to sit from 9.30 am to 4.30 pm, four days per week. This was stressful, not only for the jury, but for counsel at the bar table and the coroner with staff. As it was, the case finished on the final day, the Coroner threatening to sit all weekend if necessary.

In those circumstances the NSW State Coroner, in a submission to the Attorney General recommended that juries be abolished or, in the alternative, that the State Coroner gains a discretion to overrule the family/association.

The Police Operation.

J.H. was shot by a member of the NSW Police Force in **the execution of his duty during a protracted siege in a paddock** in Southern NSW. The State Coroner ruled that there was insufficient evidence against a known person, within the meaning of Section 19, Coroners Act 1980, to terminate the inquest and refer the matter to the Director of Public Prosecutions.

As the jury was the sole judge of the facts of the matter and had to return an appropriate finding, it is inappropriate now for the Coroner to criticise or, for that matter, endorse aspects of the operation which culminated in J.H.'s death, so far as this Annual Report is concerned.

As stated, the State Coroner was of the opinion that the jury returned a verdict entirely consistent with the evidence before it.

Formal Finding: (by the jury)

That J.H. died on 24th February, 2001 at 6.03 pm, at Adjungbilly via Tumut, of a gunshot would to the neck inflicted then and there by Senior Constable B.P., a member of the New South Wales Police Force, acting in the execution of his duty. As to whether there is evidence that the police operation was deficient in any respects (being deficiencies, which in a real sense contributed to the death of J.H.) we are unable to decide.

Recommendations (by the NSW State Coroner.)

1) **That consideration should be given to establishing procedures to ensure, that in appropriate cases, forward command posts are provided with on site intelligence capability.**

2) **That protocols should be established which set out the responsible officer for properly informing relatives of a person that has been killed or wounded by police. This should be done by an appropriate senior officer where circumstances permit.**

545/01 **Male aged 75 years died on 23 December 2001 at Long Bay Gaol, Malabar. Finding handed down on 1 May 2002 at Glebe by Carl Milovanovich, Deputy State Coroner.**

The deceased was 75 years of age with a history of cardiac disease. He was serving a long sentence for murder with a release date in 2008 followed by 5 years on Parole.

On the day of his death he appeared in good spirits, had spoken to a Welfare Officer regarding superannuation and was being walked back to his cell when he complained of not feeling well and fell to the ground.

Post mortem reports indicated the deceased died from natural causes. There were no suspicious circumstances.

Formal Finding:

That L.S. died on 23 December 2001 at the Special Needs Unit, 13th Wing, Long Bay Gaol, Malabar from Ischaemic Heart Disease.

555/2001 **Male aged 59 years died on 31 May 2001at Liverpool Hospital, Liverpool. Finding handed down on 16 July 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.**

The deceased was a male caucasian aged 59 years. He was not in good health, had been depressed and was on a number of medications. He was also despondent due to having lost his employment. On the date of his death he had consumed a considerable quantity of alcohol (Toxicology results showed 0.239mls/100) and became argumentative with his wife and children. He went to a bedroom and produced a sawn off .22 calibre rifle and threatened to take his life.

The family called Police and they arrived and set up a perimeter. While in the process of ensuring the safety of other residents a shot was heard. The family witnessed the deceased to place the rifle to his right temple and pull the trigger. Police then entered the home, secured the firearm and the deceased was rushed to hospital where he eventually died. As the deceased shot himself while the Police were outside his home it was treated as a death in a Police Operation.

Finding:

That RCV died on the 31st May, 2001, at Liverpool Hospital, Liverpool in the State of NSW from a gun shot wound to the head, self inflicted with the intention of taking his own life.

626/01 Male aged 19 years died between 15 and 16 June 2001 at Metropolitan Remand Centre, Silverwater. Finding handed down on 3 July 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.

Facts: The deceased had a history of drug abuse and a criminal history. He came into custody following bail being refused after being charged with the Breach of an Apprehended Violence order. He was bail refused on the 14th June, 2001 and transported to the Reception Centre at Silverwater. He was assessed as requiring protection and because of his drug abuse was placed in an observation cell with another inmate. The following day (15th June) he was seen by a registered nurse and was considered to be no longer at risk and was classified as being suitable to be placed in a general cell either alone or with another inmate. The change in his status was notified on his medical file and the Senior Correctional Officer changed his status and he was to be moved from the observation cell to a one out cell later in the day. In the meantime (while still in the observation cell) the deceased had a further interview with welfare officers and phone calls were made on his behalf. Following this interview the deceased became very distressed and the nursing staff decided to re-classify the inmate as being at risk and completed the mandatory notifications. A registered nurse sent mandatory notifications via fax machine and an oral notification was given to the correctional officers directly responsible for the deceased. It was apparent that at approximately 6.00pm he had been moved from the observation cell to the one out cell, however, no action was taken to reverse his cell placement when the last "at risk" notification was communicated. There was clearly a breakdown in the administrative procedures and the deceased remained in the one out cell overnight, when he should have been placed in the observation cell. Sometime during the night the deceased used a sheet which he attached to a bolt which was holding a picture frame to form and ligature and took his own life.

Finding: I find that RH died between 8pm on the 15th June, 2001 and 6.00 am on the 16th June, 2001, in Cell 72 at the Metropolitan Remand & Reception Centre, Silverwater, in the State of NSW, from hanging, self inflicted with the intention of taking his own life.

Recommendations:

That the transcript of the evidence and a copy of the Brief of evidence be forwarded to the Commissioner for Corrective Services with a recommendation that the procedures for the notification and action upon Mandatory Medical Notifications be reviewed having regard to the circumstances of this death.

764 of 2001 **Male aged 38 years died on 16 March, 2001 at San Remo, NSW. Finding handed down on 22 January, 2002 at Glebe by John Abernethy NSW State Coroner.**

R.T., a 38 year old Caucasian male was serving a sentence of Six Months Imprisonment by way of Home Detention.

R.T. died at his place of residence and his treating medical practitioner issued a Death Certificate which gave the cause of death as:

"liver failure due to Hepatitis C / Ethanol abuse."

Police officers attended the home and processed the matter as a coronial death. The Form "P.79A" (Report of Death to a Coroner) was generated. Because of the unusual nature of the R.T.'s custody, the matter was not initially identified as a Death in Custody within the Meaning of Section 13A, Coroners Act 1980. Accordingly, instead of a post mortem examination being ordered a Death Certificate was issued by the deceased's treating medical practitioner.

After hearing evidence the NSW State Coroner accepted that the deceased died of natural causes. He was satisfied that he had been suffering a long term, irreversible terminal illness which was in its final stages.

In fact, R.T. had recently returned home from hospital. At the hospital his "bracelet" had been removed and his gaolers, the Department of Corrective Services, because of the gravity of his condition, elected not to replace it on his return home.

The family of R.T. and other interested parties raised no issues in relation to this death in custody.

The State Coroner, on being satisfied of the cause of death, and the explanation for the lack of a post-mortem examination, could fine none either.

Formal Finding:

That R.T., a prisoner on home detention, died on 16 March, 2001 at San Remo of a natural cause, to wit, liver failure due to Hepatitis C / Ethanol abuse.

773/01 **Male aged 79 years died on 30 April 2001 at Prince of Wales Hospital, Randwick. Finding handed down on 16 August 2002 at Glebe by Jacqueline Milledge, Senior Deputy State Coroner.**

Overview

The deceased was a 79 year old inmate of the Long Bay Correctional facility.

He had been sentenced to a 7 year term on 14 June 2000. He had a long history of medical problems including 5 heart by-pass operations.

At 7.25am on 29 April, the deceased was released from his cell for a shower at the shower block. FB was permitted to shower alone, before the other inmates were released as he was embarrassed by scarring to his body.

His shower usually lasted no more than 5 minutes. On this day 15 minutes had passed without him emerging from the shower block. Correctional Officers were concerned and went to the shower area where they found FB slumped on the floor, partially undressed. He had not yet showered.

CPR was commenced immediately, the paramedics arriving at 8.23am.The deceased responded to treatment breathing unassisted . He was transferred to the Prince of Wales Hospital at 8.45am where tests revealed FB was 'brain dead'.

Issues

The Coroner was satisfied that there were no suspicious circumstances and that the death was a 'natural cause' death.

In perusing the Correctional Health files on the deceased, the Coroner was also satisfied that his medical treatment whilst in prison was timely and appropriate.

The only issue of concern, and it had no effect on the finding of 'cause and manner of death,' was the scene of his demise was not treated as a 'crime scene'. As all deaths in custody require a mandatory inquest it is imperative that all death scenes be preserved as 'crime scenes' for the purpose of a thorough investigation.

Formal Finding

FB died on 30 April, 2001, at the Prince of Wales Hospital, Randwick. The cause of death is Ischaemic Heart Disease due to Coronary Atherosclerosis.

Recommendations

That the Commissioner for Corrective Services ensure that all areas where inmates are found deceased or in critical circumstances where their death is likely to result are preserved as 'crime scenes'.

That the Commissioner for Police ensure that Crime Scene Officers attend in all situations where inmates and other persons in custodial situations (pursuant to section 13A of the Coroner's Act) are found deceased or in critical circumstances where their death is likely to result.

774/01 **Male aged 20 years died 24 July 2001 at St George Hospital. Finding handed down on 1 July 2002 at Lithgow by Carl Milovanovich, Deputy State Coroner.**

Facts. The deceased was a 20 year old male who came into conflict with the law when still a juvenile and had spent periods serving sentences in juvenile detention facilities. On the 23/4/2001 the deceased was sentenced to a 12 month period of imprisonment with a minimum term of 6 months. Due to the fact that he had whilst serving a sentence as a juvenile escaped from custody his classification was determined as E.2 and accordingly he was transferred to the Lithgow Correctional Centre on the 26th June, 2001. On the 13th July,

2001 the deceased was observed behaving in an unusual manner and he was referred to the correctional centre clinic where he became threatening towards one of the nurses. It was determined that he was at risk and was placed in a safe cell for 3 days. He was also disciplined by the Governor for the threats he had made. He pleaded guilty to that offence and was ordered to serve 3 days confined to his cell. It was decided that as he was at risk he would serve his three days confinement concurrently with the period that he was to be held in the safe cell. After three days in the safe cell he was transferred to a one out segregation cell (17/7/2001). On the 19/7/2001 he was spoken to at 8.30am and when his cell was checked again at 9.40am he was found hanging from a bed sheet attached to bars at the rear door. He was cut down immediately and CPR was commenced, a heart beat was detected and he was rushed to Lithgow Base Hospital and then airlifted to St.George Public Hospital in a critical condition. He died on the 24th July, 2001.

Finding: That AC died on the 24th July, 2001, at the St.George Public Hospital, Kogarah, in the State of NSW, from Hypoxic Encephalopathy and pneumonia due to hanging, self inflicted, with the intention of taking his own life.

779/01 **Male aged 30 years died on 26 July 2001 at Villawood Detention Centre. Finding handed down on 17 June 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.**

Circumstances of death: The deceased entered Australia on 23/4/2001 on a tourist visa. At the time he had a return ticket to South Africa and sufficient funds to be deemed a bona fide tourist. It is apparent that he came to Australia to seek work and was in fact working in a pie shop in Bondi contrary to his visa. The deceased was in the belief that if he left Australia before his visa expired and then re-entered he may have a greater chance of extending his visa. He left Australia on 21st July, 2001 and flew to New Zealand. He re-entered Australia on the 25th July, 2001. A routine bag search and interview determined that the deceased had documents in his possession (references etc) that were indicative of him re-entering Australia for the purpose of seeking employment. He was questioned and it was determined to cancel his visa. He indicated that he would agree to return to South Africa. He was detained pursuant to Section 217 of the Migration Act as he agreed to be deported within 72 hours. He was taken to the Villawood Detention Centre, Villawood where he was assessed as not being a risk and was placed in room 5B Darling Block which was for detainees who are considered not to be at risk. He was found at 5.25pm on 26/7/2001 hanging from a belt which had been tied around a pipe above his head. The deceased left a suicide note.

Finding: That AG died on the 26th July, 2001 at the Villawood Detention Centre, Villawood in the State of New South Wales from hanging, self inflicted, with the intention of taking his own life.

792/01 **Male aged 43 years died on 3 May 2001 at Goulburn Corrrectional Centre. Finding handed down on 22 January 2002 at Goulburn by Carl Milovanovich, Deputy State Coroner.**

The deceased was serving a sentence at Goulburn Correctional Centre and was due for release in February 2007. He was in the general prison section and shared a cell with another inmate. The deceased had a history of ill health. He went to bed on the evening of 3 May 2001 and his cell mate heard him get up and go the toilet during the night.

In the morning the prison staff had difficulty waking both prisoners and entered the cell. His cell mate was still asleep and the deceased was found in bed deceased.

The deceased died of natural causes and there were no suspicious circumstances.

Formal Finding:

That M.J. died between approximately 1530 hours on 2 May 2001 and 0615 hours on 3 May 2001 at Goulburn Correctional Centre from Acute Myocardial Infarction.

825/01 **Male aged 39 years died on 8 May 2001 at Bathurst Correctional Centre. Finding handed down on 8 May 2002 at Bathurst by Jacqueline Milledge, Senior Deputy State Coroner.**

Overview

DW was a 39 year old aboriginal male serving a 10 year sentence for 'aggravated Sexual Assault'. His term of imprisonment was to expire on 6 April 2004.

At 6.10pm the evening of his death, DW had been involved in a physical altercation with other inmates. According to many witnesses, the deceased was the aggressor and initiated the confrontation.

Prison Officers heard the commotion and ordered the inmates to return to their cells. The deceased and his victim were taken to the clinic for treatment, the deceased declining any attention. He denied any involvement in any physical confrontation and stated he was not injured. The deceased had no signs of injury and asked the correctional officer if he could return to his cell for 'lock down'.

At 7.05 pm, DW did not answer the evening muster and was found laying on his bed, unresponsive. CPR was immediately commenced with Ambulance Officers attending to continue resuscitation attempts. He did not respond.

Issue

Was any other person responsible for his demise, given he was involved in a physical confrontation?

Conclusion

The Coroner was satisfied that no other person was responsible for the death of DW. Any confrontation with the other prisoner was started by the

deceased and anything that followed was simply 'self defence'. Witnesses stated that during the assault on the other prisoner, the deceased had to stop from time to time to catch his breath.

The police investigation was extremely thorough and detailed, and the Coroner was satisfied that the death was properly investigated.

The deceased had a past history of heart problems including a heart attack in 1996. Whilst he had significant heart disease, the deceased had refused a cardiac by pass procedure and indeed any other treatment.

Formal Finding.

That DW died on 8 May 2001 in X Wing, Cell 64, Bathurst Correctional Facility, whist an inmate. He died of natural causes being Atherosclerotic Coronary Artery Disease.

935/01 **Male aged 26 years died on 7 September 2001 at Westmead Hospital. Finding handed down on 25 November 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.**

Circumstances of death:

The deceased migrated to Australia in 1992, was educated to the School Certificate level, he was married with an infant son. He developed a heroin addiction and subsequently was sentenced to 18 months Periodic Detention for Supply a Prohibited Drug. This Sentence was converted to full time imprisonment in May, 2001.

Upon admission he was assessed, placed on the Methadone Program and his Medical File indicates that he had no known allergies.

On the 4/9/2001 the deceased visited the clinic at Silverwater Prison complaining of an irritated throat and was dispensed 4 aspirin and advised to gargle. A short time later he re-presented complaining that he could not speak and felt shocking. At this point he was not referred to a Doctor (although one was present) and was told by a Registered Nurse to continue gargling. He left the clinic and some short time later was seen in a distressed state and brought back to the clinic where he collapsed.

He was taken immediately into the clinic and the Doctor and Nursing Staff diagnosed that he was suffering from severe respiratory problems. The deceased was given oxygen however a clear airway could not be achieved and the inmate continued to be in severe distress. The Doctor considered that it was essential to perform an emergency tracheotomy. Ambulance had been called. The Tracheotomy may not have been successful due to a number of factors, that included the severe swelling of the deceased's neck, the lack of an appropriate scalpel and handle and that lack of an appropriate tracheotomy tube as a catheter was used to improvise. The Ambulance attended shortly after and intubated the deceased. He had suffered a heart attack and vital signs had been restored and he was transferred to Westmead Hospital.

His condition did not improve at Westmead Hospital and he died on the 7th September, 2001.

In his findings the Coroner made comment in regard to the need to keep accurate clinical notes and the fact that the deceased should have been referred to the Doctor when he presented on the 2nd occasion. The Coroner also commented on the fact that if clinics are to maintain some emergency equipment, eg scalpels etc, that their location and accessibility be known to all medical and nursing staff.

Finding.

That TB died on the 7th September, 2001, at Westmead Hospital, Westmead in the State of NSW from Hypoxic Encephalopathy (Clinical) due to or following Anaphylaxis to Aspirin.

975/01 **Male aged 34 years died on 1 June 2001 at Berrima Correctional Centre. Finding handed down on 2 July 2002 at Bowral by Jacqueline Milledge, Senior Deputy State Coroner.**

The deceased was a 34 year old inmate with a lengthy criminal history for offences of violence including sexual assault. He was considered a violent man capable of stand over tactics with other prisoners.

Despite his disposition to violence, he behaved well in Berrima and there were no major issues with his care. He did however, have a history of multiple drug use.

A previous attempt at suicide by hanging occurred in 1995.

Prior to his incarceration in Berrima, he had been assessed in March 2001 by the Risk Assessment Intervention Team at the MRRC when he told them "I wish I could die right now". He requested, and received a transfer.

On 28 May police interviewed the deceased over an alleged sexual assault of a fifteen year old girl who was a family member. After making admissions to police, he was charged.

As a result of being charged, his prison classification altered. He could no longer remain at Berrima as it was a 'B' classification prison and EJM was required to be held in a maximum security facility, 'A' classification.

Five days prior to his death, he was secured and segregated due to his change in status. He became withdrawn and stopped eating the prepared meals. Evidence suggested he continued to buy food at the 'buy ups' and was eating fruit.

Prison officers, who had known him for a number of years during the periods of his incarceration, believed he was not at risk. He did not impress as depressed or suicidal.

His mother had given police the information that led to him being charged with the fresh matters, and as a result of his behaviour his family withdrew their support. It is thought that the deceased was extremely embarrassed by his actions and found it difficult to deal with the family.

At 7am on 1 June, his breakfast was delivered. At 12.04pm when his lunch was delivered, the door to his cell could not be opened. The officer and sweeper pushed at the door to dislodge the obstruction, and on entering the cell they found the deceased hanging, his body being the obstruction to the doorway.

In examining the body post mortem, a 10 mm diameter abrasion with a trickle of blood was found on his forehead. Whilst the deceased mother was concerned that this may have been a significant injury before death, the Forensic Pathologist confirmed that the injury was occasioned 'post mortem' as a result of the door being forced open against the deceased's body.

The Coroner was satisfied that no other person was involved in the demise of EJM.

The Coroner found that the prison authorities had acted responsibly in dealing with the deceased. She was satisfied that the deceased's change of mood was noticed and addressed by correctional officers. They spoke to him about his feelings to gauge the likelihood of self harm and he assured them he was coping. In hindsight, their assessment was incorrect, however, they gave him timely and appropriate attention.

A Stanley knife and a pair of scissors were found in his cell. These had been used by the deceased in his craft work prior to his increased classification. It was obvious that the items had been used to cut material into a noose. The Coroner found that these items should have been removed from his possession the moment he was classified 'maximum security'.

Finding:

EJM died on 1 June, 2001, Cell 56, Berrima Correctional Centre. The cause of death is suicide by hanging.

1077 of 2001

Male aged 19 years died 8 June 2001 at John Hunter Hospital, Newcastle. Finding handed down on 3 December 2002 at Toronto by John Abernethy, NSW State Coroner.

The deceased (N.C.) died from injuries received when, as a passenger, the motor vehicle in which he was being conveyed, left the roadway and came into collision with a tree. The driver of the vehicle was charged with an indictable offence. In those circumstances the inquest was terminated under the provisions of section 19 of the Coroners Act 1980.

1105/01

Male aged 33 years died on 25 October 2001 at Pheasant's Nest. Finding handed down on 22 November 2002 at Moss Vale by Carl Milovanovich, Deputy State Coroner.

Facts: The deceased was a married man with a three year old daughter, he was estranged from his wife. He met his wife in 1990 and they married in 1994. Prior to his marriage the deceased had had a number of suicide attempts which continued after his marriage and his separation from his wife. On prior occasions he had attempted to cut his writs, take an overdose, shoot himself and attempt to jump from the Pheasants Nest Bridge. He had been diagnosed

with severe depression, he had been admitted into a hospital under the Mental Health Act on a number of occasions and he was a very heavy drinker. It is apparent that the deceased had little insight into his illness and was non-compliant with his medication. Notwithstanding his depression he held down a regular job and was considered affable and generous by many of his friends. On the 25th October, 2001, an Inspector of Police was travelling along the Hume Highway towards Camden when he noticed a vehicle approaching him from behind at a very fast rate. The vehicle which was being driven by the deceased overtook the Police Officer at approximately 160 kph. The Police Inspector activated the emergency lights and sirens and attempted to pull the driver over. It is apparent from the evidence that the deceased ignored the Police presence and continued to maintain his speed until reaching a point before the Pheasants Nest Bridge when he reduced his speed and eventually stopped in the middle of the bridge in the break down lane.

The Police Inspector exited from his vehicle but did not approach the deceased who at this stage had also exited his vehicle and was standing in front of it. The deceased had a conversation with the Police Officer during which he indicated his intention to jump off the bridge. Police called for back up and two further uniformed Police arrived, however, within seconds of the second Police vehicle arriving the deceased jumped over the bridge.

The Inquest heard that the deceased had on a prior occasion threatened to jump from the very same bridge but on that occasion was physically restrained by the Police.

The death was treated as a death in custody (Police Operation) and all the necessary protocols had been implemented and followed. There were no adverse findings made by the Coroner in regard to the role of the Police. The Coroner returned a finding of suicide.

Finding.

That RY died on the 25th October, 2001, at Pheasants Nest Bridge, Pheasants Nest, in the State of NSW from multiple injuries occasioned there and then when he jumped from the Pheasants Nest Bridge with the intention of taking his own life.

1203 of 2001

Male aged 30 years died on 21 November, 2001 at Nepean River, Pheasants Nest Bridge, Pheasants Nest. Finding handed down on 29th November, 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.

G.W. was an unmarried male who had worked as a male prostitute and for a number of escort agencies. He resided in Queensland but often travelled overseas with clients and prior to his death had been living in Melbourne for some months. The deceased suffered from the deformity of having "club feet" and was very self conscious about it. There was a reported history of a prior suicide attempt approximately 2 years prior to his death and it appears that the deceased had become increasingly depressed in regard to his future, his financial situation and a failed business venture.

A few days prior to his death he met a male person in Melbourne with whom sexual intercourse took place. The deceased maintained in his "suicide letter" that the encounter was consensual, however, it appears that the other person made a complaint to Police in Victoria that he had been raped and that the deceased had indicated that he had the HIV virus. This resulted in the Victorian Police commencing a Police Investigation and a conversation took place over the telephone between the deceased and investigating Police. The deceased was also questioned by the Victorian Health Commission in regard to his HIV status.

The deceased became more depressed and was fearful that he would be arrested and possibly be subjected to a HIV test. He had a phobia in regard to needles. The deceased was a moderate drinker of alcohol and was not a drug user. Some two days prior to his death he spoke to a Solicitor in Sydney who advised him that he was not under arrest and was at liberty to travel back to New South Wales. It appears that the deceased packed his vehicle with his belongings and phoned a friend in Queensland advising that he was going to find a building to jump from. It appears that the deceased travelled from Victoria to the area of Pheasant's Nest near Camden and spent some period of between 24 to 48 hours in this area, drinking alcohol and writing a very long letter in which he indicated an intention to jump from the bridge. During the period before his death he made no contact with any person, although he did have a mobile phone in his possession.

Motorists on the Freeway had seen the vehicle parked on the bridge and had reported the matter to Police, it was also reported that a person was seen near the vehicle on the Bridge looking over the railing. Police issued a radio dispatch on the basis that a person may be in need of welfare and three Police vehicles responded. The first vehicle on the scene was driven by a sole occupant female Police Officer. The first officer on the scene parked her vehicle and approached the vehicle but could not see the deceased. At about the same time a second Police Vehicle arrived and it was at this point that the first officer on the scene noticed the deceased getting out of a sliding door which was on the nearside of the vehicle. The deceased indicated to the Police Officer that he intended to jump and before the Police Officer could entertain any meaningful dialogue the deceased jumped over the bridge and landed some 70 metres below in the gorge of the Nepean River.

The matter was treated as a death in a Police Operation. All necessary protocols had been followed. The incident was witnessed by an independent witness. The Coroner found that the Police action could not be criticised and in fact the first officer at the scene had attempted to grab the deceased placing her own safety at risk.

Formal Finding:

That G.W. died on the 21 November, 2001, at the Nepean River, Pheasant's Nest Bridge, Pheasant's Nest from Multiple Injuries when he jumped from the Pheasant's Nest Bridge with the intention of taking his own life.

1249 of 2001

Male Aged 43 years died on 6 December, 2001 at John Moroney Correctional Centre, Windsor. Finding handed down on 16 December, 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.

C.P. did not suffer from any major medical problems, however, on the 8th September, 2001, he presented to the Corrections Clinic at John Moroney Correction Centre, Windsor, complaining that he had experienced sharp chest pains for the last 3 days. The deceased was conveyed to Hawkesbury Hospital and an ECG and other tests excluded Ischaemic Cardiac disease and pulmonary embolism. He was discharged on the 8th September and was reviewed by a Doctor on the 11th September, 2001. On the 11/9/2001 he still complained of some chest discomfort. The Doctor diagnosed that he was suffering from non cardiac chest pains, muscoloskeletal pains and left side costochondritis (inflammation of the Costal cartilage).

There were no further consultations or notes in the prisoner's medical file that would indicate that he complained of any further discomfort until the day of his death, being the 6th December, 2001. On this day the deceased had been exercising with a fellow inmate when he complained of chest pains and presented at the clinic stating that he had a burning sensation in his chest.

The registered nurse on duty prescribed 20mls of Gastrogel and was told that if the pain continued to return to the Clinic. The deceased went back to his room and did not answer the muster at 7.30pm. A fellow prisoner was asked to check on him and found him deceased at 7.30 pm.

The post mortem report indicated that the deceased had died from Acute Myocardial Ischaemia and it was also noted at post mortem that the deceased had an extremely narrow right coronary artery.

The family of the deceased raised a number of issues in regard to the care and treatment of the Prisoner and the fact that with his medical history and earlier presentation that he should have been more closely examined on the 6th December, 2001. The Coroner did not disagree with this submission and commented that a closer examination of the deceased on the 6th December, 2001, together with a detailed examination of his medical file may have resulted in a decision to transfer the prisoner to a hospital immediately.

Formal Finding:

That C.P. died on the 6 December, 2001, at the John Moroney Correctional Centre, Windsor from Acute Myocardial Ischaemia due to Coronary Atherosclerosis and Small Right Coronary Artery.

1356 of 2001

Male aged 56 years died on 1 August 2001 at the Prince of Wales Hospital Correctional Unit, Randwick. Finding handed down on 1 November 2002 at Glebe by John Abernethy NSW State Coroner.

J.M was a 56 year old Caucasian male, a sentenced prisoner, who died on 1st August 2001 in the Prince of Wales Correctional Unit, Randwick. He died of a natural cause - consequences of adenocarcinoma of the lung.

The Coroner was satisfied that he was being adequately treated prior to his death and that, after collapsing suddenly he was appropriately treated by staff of the Corrections Health Service. Treatment at the Prince of Wales Hospital, too, was appropriate.

No issue arose in relation to the death.

Formal Finding:

That J.M. died on 1 August 2001 at Prince of Wales Hospital Correctional Unit, Randwick of a natural cause, to wit, consequences of adenocarcinoma of the lung.

1858 of 2001

Male aged 61 years died on 15 October 2001 at Goulburn Correctional Centre, Goulburn. Finding handed down on 18 November 2002 at Goulburn by John Abernethy NSW State Coroner.

R.H. was located in his cell, of the Goulburn Correctional Centre, North Goulburn, by correctional officers at 6.20 am on 15th October 2001. He was lying on his bed and had been deceased for some time.

Police investigated the matter thoroughly, securing and examining the cell. There were no signs of foul play and the cell call alarm was found to be in working order. Located on a table in the cell was a notepad with writings speaking of illness and hinting at an intention to commit suicide. The prisoner (R.H.) did not notify either correctional or corrections health staff as to the full extent of his physical problems.

It was found at post mortem that R.H. died of combined drug (Venlafaxine, paracetamol, codeine) intoxication. A large number of pill fragments were found in the stomach of R.H. There was evidence of leukaemia.

The State Coroner accepted the opinion of investigators that the deceased had probably stockpiled medications. R.H. would have either stockpiled his own and/or obtained medication from other inmates or visitors. At the time of his death he was being prescribed Venlafaxine (Efflexor); paracetamol was given in batches of four tablets as needed by prisoners.

The Coroner was satisfied that there was no issue of "safe custody" in this case. He noted:

> *"Whilst it is of concern that prisoners can either stockpile their own medications or obtain medications from others, be they other prisoners or visitors, the paracetamol was not a script medication and could be given in batches of about four by a registered nurse when requested. The venlafaxine was a script medication for depression, properly prescribed, and the prisoner had been taking the drug for most of the year. I doubt that the Department of Corrective Services could be expected to do more than it does to police such matters. At present it conducts full gaol 'lockdowns' at least monthly and regular cell and prisoner searches for contraband."*

Both the Nursing Unit Manager, an experienced registered nurse, and a Senior Assistant Superintendent of the prison gave evidence confirming that should what appear to be excess medications located during search or 'lockdown', the medications are taken to the clinic and checked against the medical file of the prisoner. When necessary that prisoner is then supervised when taking his medication, as is done with the drug Methadone.

The State Coroner said:

> *"Prescription drug suicides are extremely rare in our prisons. I have never heard of a prisoner using paracetamol to assist his own suicide. In those circumstances I am satisfied that this death could not reasonably have been avoided and that the systems in place, by way of safe custody, to minimise the risk of such an event, are adequate.*
>
> *This prisoner was facing a very long sentence for a major extortion. He was depressed and in fact, quite ill. The dosage and his writings before death are sufficient, in my view, to enable the presumption against suicide to be rebutted. I am satisfied that he took his own life."*

Formal Finding:

That R.H. died on or about 15th October 2001 at Goulburn Correctional Centre, Goulburn, of combined drug intoxication (paracetamol/ venlafaxine), such drugs being ingested with the intention of taking his own life.

2230/01 **Male aged 19 years died on an unknown date near Bathurst. Finding handed down on 24 July 2002 at Glebe by John Abernethy, State Coroner.**

The deceased, SE, was an escaped inmate from Bathurst Correctional Centre. A known person was charged with the deceased's murder. In those circumstances the inquest was terminated under the provisions of section 19 of the Coroners Act, 1980.

29/02 **Male aged 23 years died on 4 January 2002 at Parklea. Finding handed down on 24 December 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.**

The deceased, AB, was an inmate at Parklea Gaol when he Was stabbed. A known person has been charged with an Indictable offence which resulted in the death of the deceased.

In those circumstances the inquest was terminated under Section 19 of the Coroners Act, 1980.

59/02 **Male aged 30 years died on 13 January 2002 at Liverpool Hospital. Finding handed down on 14 November 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.**

Inquest Summary: The deceased was a Vietnamese national who came into Australia on a student Visa in June, 1997, that Visa was not renewed in March,

2000 and she did not leave the country. She came into Custody on 4/7/2001 as a detainee under the Migration Act and was placed at Villawood Detention Centre. On the 29th August, 2001 she was taken to Banks House and admitted as a mentally ill person. She escaped from that Hospital on 1/9/2001 and remained at large until arrested for a minor shop lifting matter on 11/12/2001 and was returned to Villawood Detention Centre. On the 12/12/2001 she was seen climbing over a railing and it was believed with the intention of jumping and causing self harm. She was scheduled back to Banks House and appeared before a Magistrate under the Mental Health Act on two occasions until her discharge on the 8/1/2002. On her discharge it was considered by the hospital Psychiatrist that she was no longer at risk of self harm.

She was returned to Villawood and a High Risk Assessment Team determined that she should be placed in an observation room on 2 minute observations. This was done for a short period of time and then the High Risk Assessment Team decided that her observations could be reduced to every 15 minutes.

Within a very short time of the 15 minute observation routine being commenced the deceased ran from her room to the very same point where she had previously been stopped from jumping over the rail. On this occasion Detention Staff chased her and called out to her to stop, however, she placed her feet over the railing and either fell or jumped backwards, hitting her head on the ground (concrete) some 3.3 metres below. She was taken to hospital but died on the 13th January, 2002 from Head Injuries.

The Coroner was satisfied that all aspects of her detention, care and treatment at Villawood Detention Centre were appropriate. The Coroner did make some comments in regard to the appropriateness of her assessment by the Hospital Psychiatrist by the use of a telephone interpreter service which resulted in the decision to discharge her. Notwithstanding that comment there was also abundant evidence to suggest that her condition at Banks House was improving and accordingly no adverse comment could be made by the Coroner in regard to her care and treatment at Banks House whilst detained there.

This was a matter that came under the provisions of Section 13A of the Coroners Act as the deceased was a detainee under Commonwealth Legislation.

Finding:

That Thi Hang Le died on the 13th January, 2002, at Liverpool Hospital, Liverpool in the State of NSW from a Head Injury, whether self inflicted with the intention of taking her own life or by accidental fall, the evidence adduced does not allow me to say.

86/02 Male aged 41 years died on 17 January 2002 at Fairfield. Finding handed down on 18 September 21002 at Westmead by Carl Milovanovich, Deputy State Coroner.

Inquest Summary: The deceased was a native of El Salvador. He was previously married with 2 children and a more recent marriage resulted in his wife being deported back to the USA. In recent years he had a history of depression, alcoholism and suicidal thoughts. He was well known to Police

in his local area as being a person who would regularly threaten suicide and had on a number of occasions requested that the Police shoot him. He was regularly scheduled by Police under the provisions of the Mental Health Act and usually discharged within days after admission. His suicidal tendencies usually subsided within days and invariably coincided with his abstinence from alcohol.

On the day of his death he approached 3 Police Officers and demanded that he be taken to hospital as a result of a minor injury to his finger. The Police suggested he attend a local Medical Centre. Within minutes he made two "000" calls to the Ambulance Service asking that they come and pick up his body at Fairfield Railway Station. One Ambulance arrived but could not find him. Between the arrival of the first and second Ambulance he had climbed onto the outside of the overhead railway bridge and was seen in this position holding a bottle of beer. Members of the public alerted Police who rushed to the Station, but within seconds the deceased had jumped onto the roof of a stationary train. Rail staff immediately took action to cut the power supply, however, the deceased grabbed live wires and died on the roof of the train from an electrical injury.

As Police had spoken to him earlier and were actually present when he jumped onto the roof of the train, the matter was treated as a death in a Police Operation and all the appropriate protocols were followed.

Finding.

That Milton RC died on the 17th January, 2002, at the Fairfield Railway Station, Fairfield in the State of New South Wales from an Electrical Injury.

97 of 2002

Male aged 34 years died 15 January, 2002 at Canberra Hospital, Canberra. Finding handed down 21 November 2002 at Tumut by John Abernethy, NSW State Coroner.

M.H. was managing "The Elms" Motel, Tumut at the time of his death. On the night of 14 January 2002, in Simpson Street, Tumut he shot himself in the head in front of officers of the NSW Police who had just then located him and who intended to detain him according to law. He died the next day in the Canberra Hospital of a gunshot wound to the head. The deceased was heavily affected by Methamphetamine and Amphetamine at the time of his death.

The deceased M.H. had had a history of mental illness, characterised by depression and drug/alcohol dependency. He had been hospitalised a number of times in the years prior to his death following attempts at suicide or self-harm.

The NSW State Coroner was satisfied that the police involved at the time that M.H. took his own life, acted appropriately at all relevant times and that there were no issues requiring canvassing in relation to the police operation which ended when the deceased took his own life.

The matter was thoroughly and competently investigated for the coroner by an independent, experienced criminal investigator.

The family of the deceased were satisfied that the police involved acted appropriately and with propriety at all relevant times.

The family raised the issue of care and treatment in the NSW Health System with the State Coroner. In essence, the Coroner found that the deceased had been hospitalised on a number of occasions for florid attempts at self-harm or suicide. On some of those occasions he either discharged himself or was discharged shortly after admission. He had, after all committed suicide. After reviewing several medical files that were in the brief of evidence the Coroner elected to refer the matter to the NSW Health Department's Mental Health Sentinent Events Review Committee for that Committee's consideration.

Formal Finding:

That M.H. died on 15 January 2002 at Canberra of a gunshot wound to the head, self-inflicted at Tumut on 14 January 2002, with the intention of taking his own life.

98/02 **Male aged 47 years died on 22 January 2002 at Echo Point, Katoomba. Finding handed down on 4 July 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.**

Facts: The deceased had a history of alcohol abuse and may have been depressed after attending a wedding on the 19th January, 2002, the bride being a young woman who it was believed the deceased was infatuated with. The deceased phoned friends on the 21st January, 2002, on his mobile phone to say that he was at Echo Point, Katoomba and intended to take his own life. Police at Katoomba were contacted and dispatched a Police vehicle. When Police arrived the deceased could not immediately be identified due to the number of sightseers and tourists, however, it would appear that the deceased became aware of the Police presence and climbed over the safety fence and dived into the Jamieson Valley. Police got no closer than approximately 3 metres and Police and other witnesses have indicated that the deceased dropped a bottle of beer and jumped over the safety fence before Police or anybody else could intervene. The matter was treated as a critical incident (Death in a Police Operation) and all appropriate protocols were followed. The family of the deceased expressed to the Coroner at the Inquest their appreciation for the compassion and manner of the Police investigation. The deceased had a blood alcohol level of 0.235gms/100 mil at the time of his death.

Finding.

That PA died on the 21st January, 2002, at Echo Point, Katoomba in the State of NSW from multiple injuries, sustained when he jumped from the Lookout with the intention of taking his own life.

149/02 **Male aged 33 years died on 11 February 2002 at Glenmore Park. Finding handed down on 27 August 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.**

Inquest Summary: The deceased was a male Caucasian aged 33 years, living in a defacto relationship with 2 children. Eight years prior to his death the deceased experienced a tragic event in which his mother was the subject of a murder/suicide. Following this event he enrolled in a Pistol Club and purchased a 0.357 Pistol for which he was fully licensed. The deceased worked as a seaman, often six weeks at sea and six weeks on shore. Shortly before his death his relationship with his defacto had become strained and this was further exacerbated when he became aware that she had been having an affair with a man that she had met prior to the defacto relationship with the deceased and that this affair had been on going for over 8 years. One of the deceased's children was also involved in a sexual assault in which the child was the victim. The deceased also had developed a regular drinking habit and was often intoxicated when on shore leave. On the day of his death he confronted his defacto and her lover, he threatened her lover and produced the pistol firing a number of shots at them in a moving motor vehicle. Police where informed and surrounded the house. Negotiators had been called in, however, before they arrived a muffled shot was heard. A mechanical robot with video confirmed that the deceased appeared to be deceased with a firearm near him. Police removed the children from the home and eventually entered to find the deceased with a fatal gun shot wound to the head. The matter was correctly treated as a death in a police operation due to the presence of the Police at the time of death.

All appropriate Police protocols had been followed, including breath testing and weapons checks. The Coroner found that there were no suspicious circumstances and that the deceased had taken his own life due perhaps to his state of depression and his high level of intoxication. At the time of death his had a blood alcohol reading of 0.245.

Finding.

That FV died on the 11th February, 2002, at 17 Winna Place, Glenmore Park in the State of NSW from a Gun Shot Wound to the Head, self inflicted with the intention of taking his own life.

165/02 **Male aged 66 years died on 30 January 2002 at Condell Park. Finding handed down on 4 June 2002 at Glebe by John Abernethy, State Coroner.**

The deceased, AN, was a pedestrian when he was struck by a vehicle which was being pursued by police. The driver of the vehicle has been charged with an indictable offence. In those circumstances the inquest was terminated under the provisions of section 19 of the Coroners Act, 1980.

269/02 **Female aged 17 years died on 19 March 2002 at Ingleburn. Finding handed down on 27 September 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.**

Circumstances of death: The deceased, SM, was a passenger in a vehicle that struck a tree during the course of a police pursuit. A known person has been charged with an indictable offence which resulted in the death of the deceased. In those circumstances the inquest was terminated under section 19 of the Coroners Act, 1980.

306/02 **Male aged 34 years died on 30 March 2002 at Metropolitan Remand and Reception Centre, Silverwater. Finding handed down on 16 May 2002 at Westmead by Carl Milovanovich, Deputy State Coroner.**

Circumstances of death: The deceased, AP, was an inmate of the Silverwater MRRC when he was assaulted. A known person has been charged with an indictable offence which resulted in the death of the deceased. In those circumstances the inquest was terminated under section 19 of the Coroners Act 1980.

590/02 **Male aged 26 years died on 21 January 2001 at Grafton Correctional Centre. Finding handed down on 22 August 2002 at Grafton by Carl Milovanovich, Deputy State Coroner.**

Inquest Summary: The deceased was sentenced to 2 months imprisonment on the 14/1/2001 with a release date of 13/3/2001. He had numerous incarcerations going back to when he was a juvenile and also had an E classification for an escape when in a juvenile detention centre. On the day that he was sentenced to 2 months imprisonment he was also charged with a serious indictable offence, "Robbery whilst armed with an Offensive Implement" The deceased had indicated that he intended to plead guilty and that he was expecting a sentence of at least 5 years. All the appropriate custody assessments had been made by Police and Correctional Staff. It was never determined, nor was there any suggestion that he was a person at risk of self harm. In all his assessments with Prison Officers, Welfare and nursing staff and in his discussions with the Psychologist he was future positive with his only immediate concerns being his property and seeing his child. He spoke to his mother on the day before his death and indicated that he was leaving Grafton for good tomorrow. His mother interpreted that comment that he was being transferred. The deceased and his cell mate had a conversation in the evening prior to his death in which he stated that he was thinking of hanging himself. His cell mate stated that he did not think he was serious, felt he had cheered him up and did not report that conversation to any person in authority. About 7am the next morning his cell mate woke to find the deceased hanging by a ligature made from a torn sheet. The ligature had been tied to the top rail of the double bunk. It was determined that the deceased had been dead for a number of hours when he was found shortly after 7.00 am.

The Inquest did not reveal any shortcomings in the reception and assessment process, nor did the Inquest come to the view that there was any evidence, material or information available to Correctional Staff that may have resulted in either placement in a safe cell or a different classification.

The Inquest did note, however, that in respect of the 911 tool it was not being carried on the person of the Senior Wing Officer and that it had to be obtained from the Office. While this fact had no bearing on this Inquest as the deceased had clearly been deceased for a number of hours the Coroner did express concern that the 911 Tool be always in the possession of the senior wing officer. It was also noted in this Inquest that while the knock up button system worked effectively, as in a prior Inquest (Tamworth 3/6/2002) the

electronic time recording device was not recording the correct time the knock up button was pressed. In this case it was out by one hour, apparently due to not being changed over from daylight savings time.

Finding:

That the deceased, MD, died on the 21st January, 2001, at the Grafton Correctional Centre, Grafton, in the State of NSW from hanging, self inflicted, with the intention of taking his own life.

591/02 Male aged 20 years died on 14 November 2001 at Lismore. Finding handed down on 25 July 2002 at Grafton by Carl Milovanovich, Deputy State Coroner.

Inquest Summary: DR died at Lismore Base Hospital on the 14th November, 2001, following a suicide attempt whilst in inmate of the Grafton Correctional Centre. The deceased had been held in custody on numerous occasions whilst a juvenile and since attaining the age of 18 years had 5 periods of incarceration, the last period commencing on 3rd September, 2001, when he was charged with a number of serious indictable offences on which bail had been refused.

On re-entering the Grafton Correctional Centre on 3/9/2001 his medical and case management files where accessed and he was classified as an A2 unsentenced prisoner. There were no prior notations on his file to indicate that he was at risk of self harm, the only relevant notation was over 12 months prior when he was placed in a safe cell after threatening self harm. The records of that incident showed that the prisoner had later indicated to medical staff that he was not serious and only made the statement so that he could be moved from his cell at the time.

From the 3/9/2001 until 10/11/2001 the prisoner remained at Grafton except for a short period when he was moved to and then returned from the Metropolitan Remand Centre. He was received back into Grafton on 4/11/2001 and placed in a two out cell with another Aboriginal Prisoner. On the 10/11/2001 he was involved in a fight and was dealt with for disciplinary matters by the Superintendent, his punishment being three days confined to his cell. Co-incidentally on the same day his cell mate was moved to another cell following a request for transfer. This effectively left the deceased in a one out cell for the period of his punishment. The punishment meant that he would be confined to his cell for 23 hours of the day and allowed out for exercise for 1 hour. The evidence before the Coroner suggests that a number of other prisoners approached Correctional Staff with a view of getting the deceased moved to a cell called the "mission cell" (up to 4 Aboriginal males sharing this cell). This request was refused as the prisoner was serving a period of confinement. There was no evidence adduced before the Inquest that the deceased approached any person seeking that he be moved from the one-out cell. The deceased was visited on each day of his confinement by a registered nurse from the medical clinic. On each occasion the prisoner was reported to be well and no record or notation appears of any concern for his wellbeing. On the 11/11/2001 he was spoken to by Correctional staff in the morning and stated he was fine. He saw a nurse at about 11.20am and was

fine and showed some of his art work to her. He was also spoken to again by Correctional staff at about 1.00pm and 1.10pm (this was the period when the other prisoners had been released from their cells). At approximately 1.18pm he was found hanging in his cell from a ligature made from torn sheets. Immediate response and CPR managed to stabilise a heart beat and the prisoner was transferred first to Grafton and then Lismore Base Hospital in a critical condition. He subsequently passed away on the 14/11/2001. During the Inquest there was no evidence to suggest that the prisoner was not properly classified and there was no evidence that he may have been at risk of self harm.

Finding.

That DR died on 14 November 2001 at Lismore Base Hospital from the combined effects of Hypoxic Brain Damage and Multi organ failure, consequent upon hanging, self inflicted on 12 November 2001, whilst an inmate of the Grafton Correctional Centre, whether with the intention of taking his own life or otherwise, the evidence adduced does not allow me to say.

Recommendations:

1. **That action be taken to screen the obvious hanging points (bars across windows/vents) as recommended in the Report of the Royal Commission into Aboriginal Deaths in Custody.**

2. **While the Royal Commission into Aboriginal Deaths in Custody did not make specific recommendations regarding young Aboriginal males in Corrective Services Custody (the reference being to Police Cells) the recommendation that young Aboriginal males should not be placed in a one out cell should be followed wherever possible. In this particular case as the deceased had been confined to his cell for 3 days as punishment the need to re-assess his cell placement was even more imperative.**

661/02 **Male aged 57 years died on 18 September 2000 at Rutherford. Finding handed down on 18 September 2002 at East Maitland by John Abernethy, State Coroner.**

Circumstances of Death.

The deceased, a 57-year-old Caucasian male had been separated from his wife for many years, after a very short marriage, which ended in domestic violence. He inherited real estate at Salisbury, near Dungog and used to run cattle. He went there mainly on weekends but much less often over the last 12 months of his life.

During the week the deceased lived at the family home at Rutherford. His parents died in 1990 and 1991 and since the death of his mother he became more and more reclusive.

He was the holder of a current Shooter's Licence and was the Registered Owner of two rifles.

The deceased had no substantial criminal record. In 1999, the cousin of the deceased reported a concern for his welfare to police. Police forced entry to the home and the deceased was found with two black eyes. He seemed vague but was left in the care of his family.

On Monday, 7th August 2000 his next-door neighbour became concerned about what she felt was psychotic behaviour by the deceased. He went to her back door and asked for rags and cigarettes. He had a cut foot wrapped in a plastic bag and said that he had had an accident with a tomahawk. It is likely he deliberately inflicted injuries to his foot with a tomahawk including the severing of his left toe. He spoke of the "big mates wanting clean rags and cigarettes". He said his "mates" weren't in the house but "would be back".

Police and ambulance officers arrived and spoke to the deceased. They formed the view, after assessment, that there was insufficient evidence of mental illness within the meaning of *Section 24, Mental Health Act 1990* to have him taken to a hospital for treatment.

The neighbour, however, was still concerned and the following day went to the Maitland Police Station where she spoke to a sergeant of police. The COPS entry was not activated so that the police officer did not look at the entry made by police who attended the day before. He explained, instead, that there was little police could do and the neighbour should contact "Mental Health" and explain all to them.

The neighbour did that. She spoke to a Registered Nurse attached to the Hunter Valley Mental Health Service who told her "somebody would look into it". According to the nurse who gave evidence, the neighbour was quite vague about her concerns.

The neighbour was concerned though and that same afternoon contacted the half sister-in-law of the deceased.

On Wednesday, 9th August the half sister-in-law and a friend went to Maitland Police Station and spoke with another officer, also a sergeant of police. The registered nurse had also contacted the police officer first seen by the neighbour on 9th August. She told him of the conversation she had had with the neighbour the day before.

On 10th August the half sister-in-law told her daughter who worked for the Health Department. The daughter (niece of the deceased) contacted the Mental Health Team and spoke with a Clinical Psychologist. The matter was treated as a "referral" and on Friday 11th August the Mental Health Team together with police attended the house to make an assessment. There was no answer to their doorknock and the telephone had been disconnected.

Specialist police, including State Protection Support Unit police and police negotiators were called in and finally on 12th August, elements entered the house and found that the deceased had taken his own life by shooting himself in the head.

Issues.

The initial police call-out.

The State Coroner was satisfied, on hearing the evidence of police, ambulance officers and others, that the two police and two ambulance officers who initially attended the home, formed a bona fide view that there were insufficient indicia of mental illness to enable them, validly, to take the deceased to hospital pursuant to Section 24, *Mental Health Act 1990.*

One police officer was impressive in the witness box and clearly gave full consideration to the proper operation of Section 24. He found the deceased to be:

> *"... obviously upset with Police for possibly a number of reasons. Although upset he retained a consistent line of thought and conversation. His replies were rational, lucid and concise. The house ..... was well kept, clean and tidy. ..... was dressed and seated during the whole time ..... and made no threats toward anyone, nor did he state that he had any intention of harming himself. He did not rant and rave but rather continued to insist that police leave. He did raise his voice but appeared to be in control of his emotions. He certainly did not appear to be suffering from delusions or paranoia or other mental illness. I formed the opinion that I had no power or reason to remain on his premises ..... ."*

The four were consensual about the lack of reason to intervene in terms of the relevant legislation. Police generated an appropriate COPS entry. A medical practitioner who reviewed the case was also of the view that, based on the way the deceased presented, police were justified in taking no action.

The dealings of the concerned neighbour with a sergeant of police on 8th August.

The State Coroner found that the sergeant of police should have activated the COPS entry made the day before whilst speaking to the concerned neighbour. Had he done so he would have been in a better position to consider her request for help. In evidence he conceded that it probably would have made no difference to the advice he gave. He should also have activated the COPS entry when telephoned by the registered nurse.

The dealings of the concerned neighbour with the registered nurse.

The registered nurse made a contemporaneous written note of her conversation with the neighbour. The Coroner found that in those circumstances it is likely to be substantially true. In essence the nurse was also of the opinion that there was insufficient reason to treat the matter as a "referral". She did however contact the first sergeant of police to discuss the matter and in order to determine whether contact had been made at all, as that was not clear from speaking to the neighbour. She indicated that there was a good relationship between local police and mental health workers.

The matter was treated by the Unit, on her recommendation, as an "await contact" case.

She indicated that had the COPS entry been read over to her she would have discussed its contents with the consultant psychiatrist. She maintained that the "self-harm" issues were not raised with her by the neighbour.

The State Coroner, on balance, felt that the neighbour may not have mentioned the self-harm, but wondered why she made the call at all. He felt there may have been a problem of expression over the telephone. He found both the neighbour and the nurse to be strong, believable witnesses and generally witnesses of truth.

The half sister-in-law's dealings with the second sergeant of police.

The half sister-in-law was treated courteously and the matter was discussed privately and at some length. He felt that the deceased would have to do more before police could act. He suggested contact with the medical practitioner of the deceased.

The State Coroner found it unlikely that the police officer activated the COPS entry.

The niece's dealings with the Hunter Valley Mental Health Unit.

By speaking, finally, to a person employed by the Health Department, contact was made with an appropriate health professional. He became convinced that action needed to be taken and implemented appropriate action by way of "referral".

The Police and Health Department involvement in attending the premises.

Local protocols were implemented and the matter was actioned appropriately. Unfortunately because of intelligence as to possession of firearms police had to act cautiously. It took some time, therefore to enter the house. It is likely that death had occurred prior to the police and Mental Health Team first attending the premises.

Conclusion.

The inquest enabled findings of facts to be made. It was concerned with the examination of a particular death in order to satisfy the legitimate concerns of family, friends and the wider community.

The State Coroner made muted criticisms where necessary though he found it difficult to criticise the NSW Health Department at all.

He found that the deceased presented to police, quite firmly as not mentally ill.

The Coroner was satisfied that the interaction between the NSW Health Department and the NSW Police in relation to mental illness issues, at all levels, but particularly at the local level, is improving, and that educative processes are now taking place. He said, inter alia:

"The MOU between the Services has been supplemented with schematic diagrams, and efforts are being made at the local level for personnel to roll sleeves up and get to know each other in order to maximise the partnership envisaged between those leading the two services in this area. As NSW State Coroner I have made coronial Recommendations in relation to the matter (eg: Ali HAMIE - 2002). The Senior Deputy State Coroner has also (eg: CARROLL - Police operation at Orange - 2001). It is heartening indeed to see the priority accorded by both Services to these mental health issues. To my mind, if Community Mental Health resources are limited - the assistance of local police will always be sought. Conversely, it is in the best interest of the NSW Police Service to have an effective partnership with the NSW Health Department, and for that matter the NSW Ambulance Service - so much more is achievable, it is as simple as that.

The new form "T2: Telephone Contact and Action" appears to be vastly superior to its predecessor the old "Intake Form". Inter alia, it prompts the person filling it out where necessary; it clarifies the purpose of the call; it gives the "Crisis Triage Rating Scale"; it gives an "urgency of response of call; and it forces a detailing of the action initiated and where an action plan is made, requires a brief summary of it.

This man's death was undeniably a real tragedy. From it, the family, I hope, can take some comfort that the authorities charged with dealing with mental health in our community are constantly reviewing their processes in order to minimise critical incidents in the area of community mental health and policing."

Because of previous recommendations the State Coroner saw no reason to make Recommendation pursuant to Section 22A, Coroners Act 1980 on this occasion."

Formal Finding.

That AE died on or about 9th August 2000 at Rutherford by gunshot wound to the head, self-inflicted with the intention of taking his own life.

698/02 **Male aged 35 years died on 29 April 2002 at Grafton Correctional Centre. Finding handed down on 12 August 2002 at Ballina by Jacqueline Milledge, Senior Deputy State Coroner. Background**

SG was a 35 year old remand prisoner. He was arrested for robbery of a hairdresser inMurwillumbah on 20 April 2002. When interviewed by police he admitted the offence as well as other robberies in Queensland. The Queensland Police intended to seek his extradition at the end of his sentence in NSW.

He was heroin dependent and committed offences to support his habit. Since 1990 he had served several terms of imprisonment.

On admission to the Correctional Centre, SG gave no indication of suicide or self harm. He was however, referred for drug and alcohol counselling.

Previous periods of incarceration saw him behave as a model prisoner, popular with both staff and inmates. He did not present to anyone as someone who would self harm.

Circumstances prior to his death

On the Sunday before his suicide, SG told a correctional officer that he had "stuffed up" and was probably looking at a 12 to 13 year sentence.

At 10.30pm that same night, he was taken to the clinic for an injection to stop him vomiting. He was also suffering stomach cramps due to his 'withdrawal'. He was allowed to have a hot shower as that relieved the pain.

After returning to his cell, he rang for assistance at 2.45am, again requesting a shower to relieve the pain. That shower lasted 1 hour.

SG's cellmate stated the deceased had written a letter to his girlfriend that evening and started to cry. The cellmate said that whilst he settled down, he was still suffering severe 'withdrawal'.

The cellmate awoke early the next morning to find the deceased hanging from the window by a bed sheet.

Reasons for suicide

The deceased believed he was facing an extremely lengthy prison sentence both in NSW and Queensland. He was also in an extremely fragile state going through heroin withdrawal.

Issues

The Coroner was satisfied that the Correctional Officers had dealt with the deceased in a proper and timely manner.

On admission to the facility he was assessed as 'heroin dependent' and was placed on a withdrawal program with drug and alcohol counselling.

There was no prior indication the deceased was depressed enough to self harm.

On the night of his death, he received immediate attention each time he used the 'knock up' button, officers having taken him to the clinic and showers on each request.

Formal Finding

I find that SG died 29 April, 2002, at Grafton Correctional Centre, Grafton. The cause of death is hanging. The deceased intentionally took his own life.

769/02 **Female aged 16 years died on 29 July 2002 at Ashcroft. Finding handed down at Westmead on 27 August 2002 by Carl Milovanovich, Deputy State Coroner.**

The deceased, SM, was a passenger in a vehicle involved in a police pursuit. A known person has been charged with an indictable offence which resulted

in the death of the deceased. In those circumstances the inquest was terminated under the provisions of section 19 of the Coroners Act 1980.

776/02 **Male aged 48 years died on 29 August 2001 at Arding. Finding handed down on 20 August 2002 at Port Macquarie by Carl Milovanovich, Deputy State Coroner.**

The deceased was married with children and in the months leading to his death had become depressed and his marriage was deteriorating. The deceased had consulted a Doctor regarding his depression, however, in the weeks before his death he became more depressed and often made diary notes about his feelings and the thought of taking his own life. He had told his Doctor that he was considering suicide. On the day of his death the deceased contacted the Police and told the officer that he had made up his mind to take his own life. Police attempted to keep the deceased on the phone in order to dispatch a vehicle, however, upon arrival the Police found that the deceased had shot himself in the chest with .22 calibre rifle. No suspicious circumstances, diary and suicide note located. Death treated as a death in a Police Operation.

Findings:

That the deceased, DG, died on the 29th August, 2001, at "Barrackee" Arding Rd, Arding, in the State of NSW from a gunshot wound to the chest, self inflicted with the intention of taking his own life.

Recommendations:

That the Department of Health be informed of the provisions of Section 79 of the Firearms Act, 1996, which states inter alia;

"(1) If a registered medical practitioner, or other health practitioner of a class prescribed by the regulations, is of the opinion that a patient, is an unsuitable person to be in possession of a firearm

(a) because of the patient's mental condition, or

(b) because the practitioner thinks that the patient might attempt suicide or would be a threat to public safety, if in possession of a firearm, nothing prevents the practitioner from informing the Commissioner of that opinion.

(2) This section has effect despite any duty of confidentiality, and any action by a practitioner in accordance with this section does not give rise to any criminal or civil action or remedy."

and that the Department of Health remind all relevant Practitioners of the above provisions.