CORONERS COURT

NEW SOUTH WALES

Inquest:	**Inquest into the death of Officer A**
Hearing dates:	14-18 September; 26-30 October; 27 November 2015
Date of findings:	18 December 2015
Place of findings:	State Coroner's Court - Glebe
Findings of:	Deputy State Coroner HCB Dillon

Catchwords:	**Coroners – Cause and manner of death** – Self-inflicted death – Police officer on duty – Nature and cause of mental condition – Whether management and treatment of psychological injury appropriate – Whether decision to move officer managed appropriately – Whether relationships between officer and other officers contributed to her death – Whether search for officer conducted appropriately
File number:	[redacted]
Representation:	Mr I Bourke SC with Mr J Harris (Counsel Assisting) instructed by Ms N Malhotra, Crown Solicitor's Office Ms J Needham SC with Mr D Mallon instructed by Ms S Reid, Henry Davis York (Commissioner of Police and NSW Police Force) Ms P Lowson instructed by Mr K Madden, Walter Madden Jenkins (Officer A's husband ("F") and family) Mr G Doherty instructed by Mr G Willis, Criminal Defence Lawyers (Officer B) Mr S Beckett instructed by Mr J Hall, Carroll & O'Dea (Officer C) Mr D Nagle instructed by Mr D Longhurst, McNally L Staff (Officer D) Mr C Jackson instructed by Mr J Kamaris, Avant (Dr E) Mr D Sibtain instructed by Ms L Mullins (News Ltd) & Mr G McAvaney (ABC)
Findings:	I find that Officer A died on duty as a police officer on 3 July 2013 by hanging herself in the [State Forest], New South Wales while suffering from a work-related Major Depressive Disorder and Post-Traumatic Stress Disorder.

Recommendations:	I make the following recommendations to the **Minister and Commissioner of Police:** 1. That the Commissioner revise relevant policies and procedures, including the Injury Management Standard Operating Procedures, to require that any known act that has been identified as an act of suicide or attempted suicide by an officer of the NSW Police Force is (i) reported to the Region Commander or equivalent officer within 24 hours of the incident coming to notice; (ii) that that officer then ensures that a P902 report form is submitted as soon as practicable; and (iii) that the incident is then subject to a safety investigation in accordance with the procedures encapsulated in the P901/P902 process. 2. That the P901/P902 process in respect of suicides and attempted suicides should include investigation not only of the incident itself but also, if the injured officer has suffered from a pre-existing injury, should result in an urgent reassessment of the case including diagnosis, treatment and ongoing management of the injured officer. 3. That, in relation to attempted suicides and other serious psychological injuries, consideration be given to obviating the risk of conflict of interest by having the investigation carried out by an independent officer, such as an officer from another specialist unit or command, rather than by the injured officer's supervisor. 4. That assessments by Police Medical Officers and police psychologists of officers suffering psychological injuries should ordinarily include, when reasonably practicable, consultation with the officers' treating clinicians to ensure that the PMO and psychologist (a) obtain a full understanding of the officers' histories; (b) undertake risk assessments on a fully informed basis; and (c) provide advice to commanders and injury managers that is based on the best available information. In cases where the reason for the assessment is that supervisors or commanders are concerned for the officer's safety from self-harm, consultation with the treating clinicians should be considered a priority for the purposes of assessment.

Recommendations: (continued)	5. That where Injury Management Advisers or treating clinicians have difficulties engaging officers suffering psychological injuries in appropriate treatment programs, consideration be given to holding regular case conferences with relevant staff including supervisors, IMAs, and clinicians to assess progress, identify problems and to investigate possible solutions. Such a process might also include engaging with spouses, partners, welfare officers, support persons and others as the case may be. 6. That urgent consideration be given by the NSW Police Force both to amending the Conflict of Interests Policy (see next recommendation) and to ensuring that all senior officers are educated in the fundamental principles concerning conflicts of interest and in recognising and resolving potential conflicts. 7. That the NSW Police Force 'Procedures for Managing Conflicts of Interest' be amended so as to add the words "or other ongoing intimate" after the word "domestic" on pages 12 (final dot point) and 24 (fourth paragraph), and to add the words "or other persons in an ongoing intimate relationship" after the word "spouses" on page 24 (fourth paragraph). 8. That the Commissioner take steps to provide further training and instruction regarding the operation of the 'Procedures for Managing Conflicts of Interest' (in the amended form as suggested above) so as to raise awareness of the requirement to identify, and manage, the potential conflict of interest which may arise where a domestic or other intimate relationship exists between two police officers. 9. That in decision-making meetings in which an injured officer might want or require support because his or her interests are at stake, a support person who is independent of the supervisor or commander making the relevant decisions, and who is specifically nominated by the officer, and who is willing to act in the role, ought to be made available at those meetings if reasonably practicable. .

Recommendations: **(continued)**	10. That consideration be given to amending the Critical Incident Guidelines to remove the distinction between incidents in which officers use their service weapons to attempt or commit suicide and those in which other lethal methods are used on the basis that the implement is means to a common end.
Non-publication orders:	Pursuant to s75(5) Coroners Act 2009 I direct that there be no publication of any report of these proceedings pending further order by myself or the State Coroner. I direct that the application to lift or vary the non-publication orders be further adjourned to 19 February 2016 for decision in chambers and that interested parties serve upon each other, and file, any supplementary submissions they wish to make by close of business on 5 February 2016 and that any further responses to such supplementary submissions be filed in the Registry by close of business 15 February 2016.

Variation of non-publication orders:	Note that on **19 February 2016** the non-publication orders above were varied as follows: (i) That a redacted version of my findings and recommendations, with my redacted reasons for decision, be made available by the Registrar of the Coroners Court for publication by the applicants and any other persons after 2pm on 19 February 2016. (Annexure A). (ii) That, pending any further order by me or the State Coroner: a. there be no publication of any other reports of the proceedings or of my findings, recommendations or reasons for decision; b. there be no publication of any material relating to this inquest that identifies or tends to identify any current or former NSW police officer or employee of the NSW Police Force who has been referred to in the findings or reasons for decision (Annexure A); c. there be no publication of any transcripts of the proceedings, exhibits, statements or any materials gathered during the course of the coronial investigation whether or not included in the coronial brief tendered during the proceedings; d. there be no publication of any of the submissions made on behalf of interested parties or Counsel Assisting in respect of this application; e. there be no publication of any report identifying any of the individual persons named in this decision; f. there be no publication of any material in the Coroners Court file concerning the case.

Note:	This decision has been amended to correct typographical errors.

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REASONS FOR DECISION

Introduction

1. Officer A died on 3 July 2013. Her death was self-inflicted and came about while she was suffering a Major Depressive Illness and was also suffering symptoms of Post-Traumatic Stress Disorder. She left behind her a shocked and devastated family – her devoted husband, F, also a police officer, and their two young children. It was also very evident during the inquest that her death has had an enormous and very saddening effect on many of her friends and colleagues in the NSW Police Force.

2. Because she died while on duty, her death was considered to have taken place in the course of a 'police operation'. In such circumstances, the Coroners Act requires that an inquest be held by a senior coroner: s 23.

3. The deaths of police officers on duty always raise serious questions of public interest. Police services are important public institutions and the protection of their officers from undue risk and harm is a major responsibility of senior police management and our society more generally. Officer A 's case has raised questions concerning the way in which her illness was managed and whether improvements can or should be made to the police injury management system to reduce risk of self-harm by police officers suffering psychological injuries in future.

The role of the coroner and the function of an inquest

4. An inquest is not a trial but an independent judicial inquiry, a fact-finding exercise. Although hard questions may be put to witnesses, and cross-examination may touch tender nerves, this is done not to prove or disprove a case but with the intention of testing the evidence so that the relevant facts can be determined. This court does not adjudicate a contest between parties on questions of guilt or innocence, or rights and liabilities. If those issues arise, they may be decided in other jurisdictions.

5. The Coroners Act requires me to identify the person whose death is the subject of the inquest, the date and place of death and the immediate cause of death. None of these matters are controversial. I am also required to consider the 'manner' or circumstances of the death. It is this issue, and the questions related to it, on which this inquest has mainly focused.

6. A coroner may also make recommendations relating to the death if it appears necessary or desirable to do so. I propose to make a number of recommendations.

Officer A

7. Inquests are not detached technical exercises merely concerned with technical or policy issues. They have at the heart of them sad human stories. Before proceeding to deal with the technical issues, I should start by outlining something of Officer A's history and personality, and how she was known by her husband and her friends.

8. Officer A was born in [year] and joined the NSW Police Force (NSWPF) after school. She graduated from the Police Academy in [year] In [year], she met F , also a police officer, while they were both stationed at [a Sydney] Police Station. They married in [year].

9. In [year], Officer A resigned from the NSWPF, and took up a job as an investigator with a private company. [redacted]

10. In [year], Officer A rejoined the NSWPF, and was stationed at [a Sydney police station]. In [year], F also rejoined the NSWPF. It was in early 2007 that Officer A seems first to have sought treatment for psychological issues. In March 2007 she was diagnosed as suffering major depression, with acute anxiety, severe insomnia and panic attacks. A significant contributing factor to this 2007 episode seems to have been the stress of commuting from [her place of duty to the family home], compounded by advice that she was unlikely to be transferred closer to home.

11. Officer A's depression led to her having periods of time off work in [redacted] 2007, and on [redacted], she suffered a severe relapse of major depression. In about [redacted] Officer A was transferred to [redacted] on compassionate grounds. On [redacted] 2007, Officer A suffered another major setback when she received significant injuries [redacted].

12. In common with most police officers, Officer A attended the scenes of some very disturbing incidents in the course of her police work. It was in about late 2009 that Officer A started having significant problems with sleeping. She was particularly affected by [a number of fatalities].

13. Despite suffering the effects of her mental conditions, Officer A's motivation and determination to work were very striking and unusual aspects of her character. She was a strong-minded, hard-working, intelligent woman who was very determined to do her work as well as she possibly could, even at personal cost. Her husband F described a woman with 'a passion for policing', who would 'run towards danger when others were running away from it.' She saw policing as a noble vocation.

14. She had a life outside the police force. [redacted]

15. Before the illness that finally overcame her struck hard, Officer A was a highly regarded officer known for her energy, enthusiasm and sense of humour. It is important, when considering her death, to be reminded of how full of life she was before she became sick.

The issues

16. This inquest has considered the following issues:

(i) The nature of A 's mental condition;

(ii) The cause of A 's mental condition;

(iii) The appropriateness of police management of A 's mental condition and return to work in the period preceding her death;

(iv) The appropriateness of medical treatment received by A in the period preceding her death;

(v) The appropriateness of the review of A by police medical officers on 2 July 2013 and of recommendations made following that review;

(vi) The appropriateness of actions of police in reaching and carrying out a decision to transfer A on or about 3 July 2013;

(vii) Whether A was involved in a relationship of an intimate nature with Officer B or Officer C or any other officer of the NSW Police Force. Whether any such relationship(s) adversely affected As 's mental condition, or police management of her mental condition and return to work in the period preceding her death;

(viii) The appropriateness of actions by police to locate A after she left [the police station at which she had a meeting with representatives of management] on the morning of 3 July 2013.

17. Before considering them, however, it is necessary to understand the factual background, which is largely uncontroversial.

Background and summary of events

18. Officer A was an officer working in [a police station]. Her substantive position was in [a unit at that station]. In [redacted] 2012, she attempted suicide at work by taking an

overdose of prescription medication. Following this incident, she was placed on sick leave.

19. On 3 July 2013, she attended a meeting at the station at which a plan for her return to work was presented to her. It involved an immediate transfer to [another] police station in [a] Local Area Command that she did not wish to accept. She left the meeting in tears, apparently unhappy with the plan that senior management had developed for her. She drove to a hardware store, bought a rope, then drove to [a State Forest] where she hanged herself. A welfare alert was raised and a search started for her. Later in the day she was found by searching police. Unfortunately, she was beyond resuscitation.

20. Although the meeting at [the station] was the trigger for this calamity, what caused Officer A's death was a much more complex set of factors. To understand them, we need to look more closely at her history over the years leading up to July 2013.

Officer A's mental health history

21. As noted above, Officer A suffered depression in 2007 and was significantly traumatised by incidents that occurred in 2009 and 2010. In 2010, she continued to consult with doctors and a psychologist and was prescribed anti-depressants. It was in 2010 also that Officer A commenced drinking quantities of wine at night in order to help her sleep.

22. In [redacted] 2010, Officer A was promoted to Sergeant and took up [a] position [in a unit at a police Station]. The [unit] was headed at that time by Officer B. As Manager, he was directly responsible for three other staff in that unit: Officer A, the Executive Officer [redacted] and [redacted]. When Officer A joined the unit, the [redacted] position was vacant. This vacancy became a source of tension for Officer A over time.

23. Officer A continued [in her position] in the [unit] during 2011. Although she carried a heavy workload, it appears that Officer A coped reasonably well in her job during 2011, and had mostly good relationships with her co-workers. Although she spoke of immense stress from her workload and from reading some of the distressing 'SITREPS' which some of her work involved, she does not appear to have reported any major psychological problems during 2011.

24. However, things changed for the worse in 2012. Although she had temporarily relieved Officer B as Manager during January 2011 without obvious or reported difficulties, when she did so again in January 2012 it was a stressful experience for her. This was in part because no-one filled Officer A's own job. It seems that she attempted to keep on top of both the Manager's job and her own simultaneously.

25. In the period following Officer B's return from leave at the end of January 2012, one of Officer A's co-workers observed that '*the unit dynamics had changed considerably*' and, in particular, that there was a notable degree of conflict between Officer A and Officer B.

26. Officer A was working extremely long hours in 2012, and took a number of periods of sick leave during the year. She was also drinking substantial quantities of alcohol at night, and having trouble sleeping. This all came to a head on [redacted] 2012, when Officer A broke down and told her husband of recurrent thoughts of traumatic incidents she had attended as a general duties police officer. On [redacted] 2012, a P902 'Incident Notification Form' was submitted to the NSWPF by Officer A's husband, F . The purpose of that form was to inform the employer and workers compensation insurer of a workplace injury, and to set in train an investigation into the cause of the injury.

27. In the section which asked 'How did the incident or near miss occur?' F recorded: *Stressful work environment, at* [redacted] *office. PTSD from* [redacted] *in 2009. The pressure at work has caused the victim to re-live these incidents'.* Subsequently, Officer A was certified by doctors as 'Unfit' for work, and remained off work for about two months. She returned to work on [redacted] 2012.

28. In a report dated [redacted] 2012, a psychiatrist commissioned by the police insurer Employers Mutual Ltd concluded that Officer A was suffering a '*Major Depressive Episode and Post Traumatic Stress Disorder*' and that these psychiatric conditions were a result of her exposure to traumatic incidents at work as a police officer, most notably the [fatalities in 2009 and in 2010.]

29. It is apparent that after her return to work on [redacted] 2012, Officer A was experiencing stress from the workload associated with her job, and working long hours. This led to several email exchanges between Officer A and Officer B in relation to her hours and various outstanding tasks that she was trying to manage. He ultimately insisted that she not work overtime without his permission.

30. Officer A's condition, however, continued to deteriorate culminating, on 23 November 2012, in a suicide attempt. She took a large quantity of tablets in the attempt. She was discovered, unconscious, in the locked office of one of her co-workers in the [unit]. She was admitted to hospital, and remained under medical treatment or assessment until her discharge on [redacted] 2012.

31. A P902 'Incident Notification Form' was not submitted by the employer in relation to this overdose on [redacted] 2012. The incident was treated by the employer – apparently on the advice of the insurer -- as a 'recurrence' of Officer A's earlier psychological injury. The basis of that advice and who gave it is unclear. This later became a very sore point with Officer A.

32. Officer A remained off work until [redacted] 2013 when she returned on a graduated Return to Work plan. However, after a verbal disagreement with a supervisor that day, she again went on sick leave until [redacted] 2013 when she returned on another graduated Return to Work plan.

33. The incident on [redacted] 2013 was, viewed objectively, a minor one but it led to an intense reaction from Officer A, symptomatic of her fragile state of mind. Her RTW plan had specified that she would work in the [unit] where she was given a task to do with firearms as her duty for the day. At some point during the day, however, she left her desk in the [unit] t and went around to [her previous unit] where she offered assistance to Sergeant P who was working temporarily in Officer A's position in that unit. Inspector M, who was the [unit] Manager asked what she was doing in the unit. He knew that she had been posted to [another] Unit and some of Officer A's history. Officer A reacted furiously, stormed out of the office, went home and later sent a message to Officer D who was managing the [other] Unit that she would not be coming in to work.

34. The 'Police Blue Ribbon Insurance Scheme', which applied to officers such as Officer A, provided for a period of up to 270 days (about nine months) during which she could remain off work, but on full pay, and without the need to resort to using recreation leave as sick leave. During 2013, Officer A was seeing a psychiatrist and a psychologist for ongoing counselling and treatment. However, the effectiveness of this counselling and treatment was limited, largely, or at least in part, by Officer A's reluctance to engage with it.

Events of late June & early July 2013

35. A number of events took place in late June and early July 2013 that appear to have had cumulatively adverse effects on Officer A.

36. On or about 24 June 2013, Officer A and her husband learned that her wage 'top up' period of 270 days had come to an end nine days earlier. Her salary was going to reduce by 25 per cent. This came as a shock to Officer A and her husband F, as they had been told that they would be given about 30 days' notice of when the '270-day' full 'top up' period would expire. The failure to give Officer A proper notice of the expiry of the 270-day period was an oversight by NSWPF staff responsible for administering the Income Protection scheme, and an apology for this mistake was sent to Officer A by email.

37. This oversight, however, unfortunately coincided with the announcement of improvements to the benefits payable under the PBRI Scheme but for which she was ineligible. A form letter announcing those improvements was received by Officer A at around this time exacerbated her distress and sense of grievance.

38. In late June 2013 Officer A's treating psychiatrist, Dr E, told Officer A that he may refer her to a different psychiatrist for treatment because of the lack of progress they were making. He felt that a working therapeutic relationship had not developed between them.

39. Another event that assumed significance for Officer A in late June 2013 was that she became aware of and concerned about some correspondence she believed had been sent to her treating psychiatrist by her NSWPF Injury Management Advisor. Officer A by then

had a poor relationship with the Injury Management Advisors and she became quite fixated on this issue, demanding that a copy of the correspondence be given to her. That correspondence is discussed further below but the upshot was that on 1 July 2013 a heated telephone conversation between Officer A and her Injury Management Advisor, Ms G in relation to her request for a copy of this correspondence took place. This conversation was very upsetting both for Officer A and Ms G.

40. As a result of the acrimony between them, the difficulties in managing Officer A's return to work, and the tensions that had developed in [the Office] as a consequence, a meeting involving Officer A's supervisor, the Regional Commander, and various Injury Management staff was convened following the phone call. It was decided to arrange for a Police Medical Officer and a Police Psychologist to assess Officer A's fitness for work. Apart from the fact that Officer A's volatility was stressful for others in the office, those managing her had become concerned that the pattern of behaviour that had culminated in her suicide attempt the previous November was repeating itself. They believed she may be at risk of self-harm.

41. Officer A and her husband F were informed of the proposed Police Medical Officer assessment that evening, and it was agreed that Officer A would be driven to the assessment by her husband F who would support her.

42. On the morning of 2 July 2013, however, Officer A told F that she did not want him to accompany her to the assessment. She drove herself to Sydney. When F informed Officer A's supervisors of this development, they made arrangements to drive F to Sydney so that he could provide support to his wife.

43. Officer A was assessed by the PMO and psychologist as fit for restricted duties. It was also recommended that she work at a different location for a period of three to six months, with a review after three months.

44. The Region Commander endorsed this recommendation, and directed Officer A's supervisor, Chief Inspector J and another Chief Inspector to inform Officer A. He also directed that the change of work location take place immediately. The plan was that following the meeting she would be driven to [another police station] to commence her duties there.

45. On 3 July 2013, Officer A arrived for work at about 8am. It seems that one of the first things she did was to complete a P902 Incident Notification Form in relation to her overdose seven months earlier. In the section describing the nature of the injury, she wrote , '*Attempted suicide at workplace by taking an overdose of prescription medication due to the mismanagement of psychological injury by staff attached to* [redacted].'

46. At around 8.40am, Officer A was spoken to by her supervisor, Chief Inspector J and by a representative of the Region Commander, Chief Inspector T. Neither her husband F nor a

support person, independent of the Regional Command and specifically chosen by her to accompany her to the meeting, was present.

47. In that meeting she was told of the recommendations of the PMO assessment and of the Region Commander's decision that she be transferred that same day to commence work at another police station. She became upset at this news, and said she was 'going off sick'. Although efforts were made by Officer A's supervisor to drive her home, or to have her husband pick her up, Officer A insisted on driving herself. She left in her car sometime before 9.30am that morning.

48. Officer A's husband F was informed of the outcome of the meeting and that Officer A was expected to be driving home. However, Officer A did not go home, and at about 10.15am that morning she visited a Bunnings Hardware store where she bought a length of rope, and some other items. F became aware of this fact by checking bank records and by then attending and speaking to staff at the Bunnings store. He eventually spoke with Officer A by telephone. His fears that she was considering self-harm were confirmed: he immediately understood that she intended to take her own life. He desperately sought to dissuade her but had the devastating experience of being unable to do so.

49. In the meantime, police in the region at this time were attempting to locate Officer A by means of tracking her mobile telephone. These efforts were carried out promptly and effectively and Officer A's location was determined to be in [a State Forest]. Tragically, however, when police located Officer A she was no longer alive. Toxicology testing later indicated that Officer A had also consumed a quantity of tranquiliser and anti-depressant drugs before hanging herself.

50. I now turn to consider the issues that Officer A's death has raised.

Officer A's mental condition

51. The medical and psychiatric evidence all demonstrates that Officer A was suffering from a Major Depressive Disorder with symptoms of Post-Traumatic Stress Disorder. Her history and all the medical and psychiatric evidence points to this diagnosis. There is no controversy about this issue.

The causes of Officer A's mental condition

52. Analysing the causes of Officer A's condition is a much more complicated exercise. During the inquest, one independent expert, psychiatrist Dr BB, suggested that the causes of Officer A's depression are open to speculation. On the other hand, another independent expert, psychiatrist Dr CC expressed the opinion that Officer A's depression was linked to her employment with the Police Force. Both psychiatrists agreed that a number of matters may have contributed to the development and persistence of Officer A's mental condition.

Personality

53. A person's inherent personality traits are always a factor in their mental health. One of Officer A's personal attributes that made her a very capable officer was that she had a very high work ethic bordering on perfectionism. Officer A's work ethic and sense of professionalism seems to have been so intense that she gave work priority over many other issues, including her own health. Paradoxically, the intensity of her professionalism seems to have contributed to her illness. She was hard on herself and her judgments of others whom she perceived to be less professional in their attitudes could be harsh. This may have undercut the support that she would otherwise have received.

54. This very driven element of Officer A's personality was described by her treating psychiatrist, Dr E in his report of 20 January 2013, when he wrote:

> *'…Although not by nature harsh, Officer A seems to have grown that way towards herself and anyone or anything that reminds her of what she sees as her own unacceptable failings. Officer A does not view herself as legitimately injured – she views herself as weak. Officer A is much more concerned about her career than she is about her health…(and) her own survival. If Officer A makes another suicide attempt the next one will be driven by [1] a sense of shame at weakness and [2] anger at herself for having stupidly ruined her career…* '

55. As a result of this very rigorous and exacting attitude, and her general personality, Officer A could be very a challenging and outspoken personality, unafraid to express her views bluntly to her superiors and others. This made her at times a difficult person to live with, work with, or supervise. While Officer A's inherent personality traits were important in this respect, some of these difficulties were created, or exacerbated, by workplace psychological injuries, by her management within the workplace and, more generally, police culture. More than one witness described Officer A as a perfectionist, and it appears that she held herself to impossibly high standards.

56. Dr E wrote in a report of 17 February 2013 that Officer A had 'a low tolerance for being sick, seeing doctors, taking sickies and [had] the idea that people rort the system by pleading sick'. In Dr E's view, which I endorse, this attitude does Officer A some credit. Indeed, it was the notoriety of the 'rorting' of the workers' compensation system by some police officers that ultimately led to the changes in the system that disadvantaged Officer A. Regrettably, however, Officer A applied these views just as, or even more, stringently to herself, viewing her own condition not as an illness but as a 'weakness' which she could deal with using willpower. As a consequence, she did not readily seek support from others, and was not comfortable discussing emotional or psychological problems. This adversely affected her ability to engage with those treating her.

57. Dr E considered whether Officer A had a personality disorder but ruled this out on the basis that she had been high-functioning and successful at work in the past. The

independent psychiatrists agreed. Dr E did, however, consider that a degree of 'personality decompensation' (ie, regression of relatively normal personality function to a disordered state, under pressure of intervening psychiatric disorder and other stressors) had arisen, exacerbating Officer A's condition and her presentation.

Occupational effects

58. There is strong evidence that Officer A's depression was linked to her employment. In November 2012, Dr H, a [local] psychiatrist, concluded that Officer A's Major Depressive Episode and Post Traumatic Stress Disorder were a result of her exposure to traumatic events in the course of duty, and her claim in this respect was accepted by her employer.

59. What is more difficult to determine is whether the problems later (i.e. post August 2012) experienced at work by Officer A were a cause of her continuing depression or a consequence of it. Perhaps they were both. An analysis of the coincidence in timing between Officer A's depressive symptoms and events in the workplace is perhaps instructive:

- The onset of Officer A's depression in February 2007 was at a time when she was suffering stress due to long hours commuting from [work to home], and the demands of also trying to manage her children and household. Police work, especially for a person of Officer A's temperament, is inherently demanding. Adding several hours of travel to lengthy police shifts must have been exhausting. The risk of adverse health effects of long hours are well-known and can include depression.[1]

- Officer A attempted to return to work in [redacted]2007 but on the very day she returned she became very upset and again went off sick when her supervisor refused to allow her to work without seeing a medical certificate. She later returned to work following a transfer to [a more convenient] police station on compassionate grounds in [redacted] 2007.

- Officer A became depressed again in [redacted] 2010 after witnessing traumatic events in the course of her duties.

- Officer A relieved in Officer B's role, which she found stressful, during January 2012. Following an argument with him at work near the end of January 2012 she attended her GP with symptoms of depression.

- On [redacted] 2012 Officer A attended her GP with depression and reported 'pressure at work'. This appears to have coincided with stress about her workload and conflict relating to her desire that Ms U continue to act in the [redacted] role.

[1] See, for example, Safework Australia *Guide for Managing The Risk of Fatigue at Work* (2013)

- Officer A's attempted suicide occurred when she was trying unsuccessfully to return to work, was not coping and was involved in some conflict in the workplace.

60. The events that precipitated Officer A's suicide also involved conflict and problems in the workplace. It is difficult to conclude that any one or more of these work-associated incidents were *the* cause of Officer A's initial or ongoing depression. It seems more likely that these incidents were at times a contributor to that depression and at other times (and perhaps at the same time) an outward manifestation of it.

Other possible contributory factors

61. Officer A was [injured] in [redacted] 2007 and suffered serious injuries, [redacted]. Dr CC thought that these injuries may also have played a role in the development of her depression. This is given further support by the evidence of at least one witness who said that Officer A often suffered from pain, associated with her injuries. Chronic pain is well-known to be associated with depression.

62. Officer A reported drinking up to a bottle of wine a day from 2010. This was almost certainly an attempt on her part at self-medication. Both experts agreed that this may have had an impact on Officer A's condition. Dr BB placed more emphasis on alcohol than Dr CC. In his opinion, Officer A experienced alcohol dependency, which is supported by some other assessments. Although alcohol is believed to assist a person to go to sleep, it has a disturbing effect on the quality of that sleep.[2] Further, alcohol is a depressant agent in itself. It is not an anti-depressant medication. To what extent alcohol use affected Officer A's depression is difficult to say but it was not the primary cause of her depression. Rather, she overused alcohol in response to her condition.

63. Dr BB noted that there may have been be a genetic component in Officer A's condition. Women are more likely to suffer from depression than men.

64. How management issues and her relationships with Officer B and Officer C may have affected her condition will be considered separately.

Management of Officer A's condition and return to work

65. It is in respect of the way Officer A was managed by the NSWPF, especially in relation to her suicide attempt in [redacted] 2012 and her return to work in 2013, that her family have expressed their gravest concerns and strongest criticisms. In summary, the systemic criticisms made by counsel for the family were as follows:

[2] See, for example, Dr Karl Doghramji, *The Effects of Alcohol on Sleep h*ttp://www.medscape.org/viewarticle/497982

- Police management failed Officer A in several respects related to staffing and workload issues, investigation of her suicide attempt, the management of her psychological injury or injuries, her return to work plans, and salary advice.

- While the decision to have Officer A reviewed by a PMO was appropriate, the execution of the plan was not and was deficient in several ways;

- The medical care given to Officer A was deficient in a number of respects;

- In making the decision to move Officer A, and in carrying out that decision, Assistant Commissioner N failed to discharge his responsibilities to Officer A; and

- Officer B had an inappropriate relationship with Officer A that compromised his ability to manage her appropriately.

66. In answer, the NSWPF submitted that it acted carefully and with genuine respect for Officer A and her well-being, and with every intention of helping her recover. It also submitted that it acted appropriately both in what it decided to do and how it carried out those decisions. It says that Officer A's death was not predicted or predictable.

General management issues

(i) Workload

67. Counsel for the family argued that the [unit] was inadequately staffed and that the understaffing of the unit had contributed to Officer A's stress, thereby exacerbating her depression and PTSD. The NSWPF disputes this contention.

68. I am not in a position to resolve this issue. I do not doubt that Officer A's perception was that she was, at least at times, overwhelmed with work. But subjective perception may not coincide with a more objective institutional assessment. Much depends on the expectations of both the organisation and the individual. As far as I am able to tell, no one in [her] Command ever criticised Officer A for laziness, incompetence, lack of attention to detail, or indecisiveness. Nor is there any evidence before me that she was creating an unacceptable backlog or failing to meet KPIs (if there were any). She appears to have ruthlessly applied to herself a much higher standard than the organisation or her supervisors did.

69. Presumably the [unit] Manager and other middle managers were consulted about these sorts of issues. It may be that the support she was provided was indeed insufficient for her to maintain a high level of productivity in her own particular position and that she therefore took on work that would otherwise have been delegated. If so, she was effectively doing her own job and someone else's.

70. However, if she was therefore working much harder than some others in the office, it does not necessarily follow that the unit was understaffed. If police senior management

had other staffing priorities and were prepared to accept a lower standard of productivity and output from the [unit] than Officer A was, that was a matter for them.

71. Concerning Officer A, the practical issue was more complex and psychological: how to stop her working so hard. In my view, it is likely that many of the staffing issues that exercised Officer A so much were a symptom of her condition rather than a significant cause of the decline in her condition. Her perfectionism and other aspects of her mental condition, such as insomnia, led her to work long hours of unpaid overtime, regardless of strict directions and exhortations not to do so.

(ii) Failure to investigate suicide attempt appropriately

72. A second management issue that Officer A's family raised was the failure by anyone in management to initiate a formal P902 investigation into Officer A's suicide attempt. The general approach taken at the time was that, because Officer A had a pre-existing psychological injury, it was unnecessary to investigate *this* incident. On the day she died, Officer A filed a P902 report, alleging among other things, that her psychological injury resulting in the suicide attempt had been caused or exacerbated by the Injury Management Team.

73. In the period immediately following Officer A's attempted suicide there was discussion about the issue:

- [A] Health and Safety Coordinator, Ms Y, believed that a P902 should have been filed, and she emailed Officer B on 4 December 2012 asking him to lodge a P902. Officer B said he would do so later that day. He then spoke with Inspector K who directed him to Ms L [an Injury Management Adviser].

- According to Officer B, Ms L advised that a P902 was not required as there was already an open injury file. Ms L gave evidence that she did not recall this conversation, but accepted it was possible it took place.

- Officer B said that he accepted Ms L's advice because she was the 'expert' in injury management.

- Ms Y said she also spoke with Inspector K about the matter, who told her she had been in touch with Ms G and the insurer to confirm the injury was being treated as a recurrence and a P902 need not be submitted.

- Although Inspector K said she did not recall this conversation, she did not dispute it.

74. Officer A raised the issue of the P902 not being submitted on a number of occasions:

- On 3 May 2013 Officer A told the insurer she wanted to file a P902 and that the attempted suicide was as a result of poor injury management. Chief Inspector J

spoke with Officer A on 8 May 2013, explaining the process and offering assistance including a discussion with the Region Commander. However, according to Chief Inspector J, Officer A told him that it was 'in the past' and that she did not wish to pursue the matter by submitting the P902.

- It seems however, that Officer A was not genuinely satisfied with this situation. On 13 May 2013, she asked Chief Inspector J whether there was any investigation of the 23 November 2012 suicide attempt. According to Chief Inspector J, he spoke with Inspector K and Ms G about the matter, and then told Officer A on 16 May 2013 that they were not aware of any such investigation.

- The issue was still a live one on 23 May 2013, when Ms G noted in an email that Officer A had expressed concern that there would be 'repercussions' if she (Officer A) submitted a P902. Some support for this view is perhaps given by the fact that Ms G recorded in that same email that if a P902 was submitted, then she would immediately withdraw from Officer A's case. She apparently did not speak to Officer A about the issue however. Chief Inspector J stated that he discussed the issue of an investigation with Officer A again on 29 May 2013, when she said that her previous discussion had resolved the issue, and she did not require further information.

- However, this seems to be contradicted by the fact that on the morning of her death, Officer A submitted a P902 in relation to her [redacted] 2012 attempted suicide, in which she alleged 'mismanagement of psychological injury' by staff attached to [her region].

75. Ms G believed that Officer A wanted to file a P902 in order to gain a further nine months of 'top up' pay. However, while this was probably one of Officer A's motivations, it appears that she was also concerned about whether there had been an investigation into the circumstances of her attempted suicide and whether the matter had been reported to WorkCover.

76. None of the witnesses could identify any disadvantage in submitting a P902. In oral evidence, it was acknowledged (by Ms L, Inspector K and Assistant Commissioner V) that on reflection, the preferable course of action would have been to file a P902.

77. Clearly, those involved in Officer A's injury management (especially Ms G) had good reason to resist a P902 being filed if it was going to allege that it was the actions of the Injury Management Team which caused or contributed to the suicide attempt. This was effectively acknowledged by Ms G in her confidential email to Dr E on 3 June 2013, where she stated *'…I would not submit a notification on her behalf, alleging myself, L or her supervisor at the time, as the cause of her attempted suicide'.* This comment demonstrates a clear conflict of interest in relation to Ms G – her stated reason for refusing to file a P902 being her concern that the P902 would allege that the suicide attempt was linked to mismanagement by Injury Management staff and others

(including Ms G herself).

78. A clearer conflict of interest is difficult to imagine, and it is surprising that Ms G did not seem to accept this when she gave evidence in the inquest. This underlines the importance of there being a mandatory requirement for a P902 (or similar) notification in all cases of self-harm or self-harm attempts.

79. I doubt that the decision not to file a P902 was because of a conscious wish to avoid an investigation or was any part of an attempted 'cover-up'. The Injury Management staff were well aware that Officer A or F could have themselves filed a P902 at any stage, so a 'cover-up' would have been futile. It appears likely that Officer A was reluctant to do so because she didn't want to 'rock the boat' and was concerned about repercussions.

80. The relevant policy relating to the submission of a P902 (and other issues) was being revised at the time of Officer A's attempted suicide, including the *Guidelines for the Injury Management of all NSWPF Employees* and the *Injury Management Standard Operating Procedures* ('SOPs'). While the SOPS were not officially issued until June 2013, various Injury Management witnesses agreed that they were being applied 'in spirit' from late 2012.

81. The SOPs had the following effect:

- a new injury should be reported on form P902;
- a 'recurrence of injury' should be reported on a recurrence of injury form;
- if a 'frank incident' has caused a recurrence this should be reported as a new incident via a P902.

82. Neither the Guidelines nor a previous version of the SOPs made the distinction between a new injury and a recurrence. The reference to this distinction suggests staff were aware of the new definitions at the time of Officer A's attempted suicide. And, in event (as already noted) the June 2013 SOPS were being applied in spirit from late 2012.

83. The SOPs state that a P902 form can be filed by any Police employee. It is required to be filed by the injured officer or his or her supervisor within 24 hours. The consequences of filing a P902 are that, first, the command, the insurer, injury management and the health and safety coordinator are all automatically notified of the injury; and, second, a P901 safety investigation is commenced, usually completed by the supervisor. The P902 is also part of the injury reporting process that prompts the manager or commander to consider obligations to notify WorkCover pursuant to the *Work Health and Safety Act 2011*.

84. Because a P902 was not submitted, no P901 safety investigation was commenced. As a result, no investigation was ever conducted into the circumstances of Officer A's attempted suicide until after her death.

85. It is extraordinary that no P902 form was filed, and that no investigation was ever conducted into Officer A's suicide attempt. As several witnesses agreed, a suicide attempt by an officer (especially where it occurs in the workplace) is clearly a most serious event. Short of an actual death, it is indeed difficult to envisage a more serious event. As several witnesses also agreed, one of the purposes of a P902 is to trigger an investigation, and an investigation into such a serious event would ordinarily be desirable (if not imperative).

86. In Officer A's case the very point of conducting an investigation would have been to find out why, despite being managed over a period of years for her pre-existing injury, she had taken such a drastic, life-threatening step *at that time*. What had been the trigger? What had changed in her situation? Had something gone wrong in her treatment? Had some significant feature of her illness been missed or misdiagnosed?

87. These questions needed to be investigated. Yet without further ado the pre-existing injury was presumed to be the root cause of her action. No one involved in Officer A's injury management satisfactorily explained why. Nor did anyone who gave evidence at the inquest take responsibility for this oversight. Nevertheless, virtually everyone who gave evidence on this topic conceded, at least with the benefit of hindsight, that an investigation should have been carried out. This was also conceded by the NSWPF.

88. The lodging of a P902 and the conduct of an investigation was not only desirable from the perspective of 'good staff management', but it might also (as more than one police witness agreed) have resulted in Officer A's suicide attempt being treated as a new injury. If it had been so treated, then this would have meant that the 'clock' would have re-started, and Officer A would have had another nine-month period within which to return to work without suffering a pay 'drop down'.

89. No satisfactory explanation has been given for the failure to lodge a P902, and the failure to conduct an investigation into Officer A's suicide attempt. While it is not necessary to single out any particular individual for criticism, this was a significant systems failure. Additionally, no notification was made to WorkCover until 7 June 2013, after Inspector K attended training on the subject and raised the issue with Superintendent W.

(iii) Officer A and the Injury Management Advisers

90. The management of Officer A's condition and return to work was complex. It is unusual for an officer to return to work after attempting suicide. Although neither Dr CC nor Dr BB were critical of police management of Officer A's mental illness, there are some aspects of the process that were problematic.

91. The Injury Management Unit had a primary role in Officer A's return to work, being responsible for her case management, with the goal of assisting her return to pre-injury duties. The electronic case management system ('OLIMS') notes show that staff spent

considerable effort trying to manage Officer A's return to work. Ms G, the Senior Injury Management Adviser ('SIMA') stated that Officer A's case took up more of her time than any other.

92. Officer A developed antagonism toward her initial IMA Ms L because she was not happy with the way her return to work had been handled, ostensibly because Dr X 's report was not provided to her treating doctors but also because rapport between Officer A and Ms L had been poor.

93. Because of this, and also because Officer A's case was becoming increasingly complex, in February 2013 Ms G took over case management. Ms G met with Officer A and F in their home and discussed Officer A's plans to return to work in detail. At that time, Ms G made enquiries with Dr E and drew up a proposed return to work plan.

94. However, following Officer A's abortive attempt to return to work on 15 March 2013, the relationship between Officer A and Ms G began to deteriorate. Officer A blamed Ms G for this failure and 'vented' her anger at her.

95. In my view, Officer A's criticism of Ms G at that time was not justified. The nub of Officer A's complaint was apparently that Ms G had not written into the return to work plan that Officer A was not to carry out any work in the [unit]. However, this was hardly a valid criticism. The return to work plan contemplated that Officer A would carry out particular work in a different section of the [command] office, (not the [unit in which she had been working]), which, by implication, meant that she was not expected to carry out work associated with [that unit]. (The question of the RTW plan is discussed in more detail below at [107]ff.)

96. Officer A's reaction when approached by Inspector M on 15 March 2013 (who politely asked if she should be in the [unit]) was very disproportionate to the significance of the issue. A proper response would have been for Officer A to have immediately complied with Inspector M's request, and left the [unit] to carry out her assigned duties as set out in the return to work plan. But her irrational response to Inspector M, and her complaint against Ms G, are yet further symptoms of her illness, and of her fragility.

97. From May 2013 Officer A stopped responding to emails from Ms G.

98. On 1 June 2013 and 3 June 2013 there was a frank email exchange between Dr E and Ms G in which they described the difficulties they had had or were having with Officer A. These communications were intended to be kept confidential between them. In Dr E's view this sort of exchange was an appropriate way of sharing experiences and it was necessary or desirable to do so as part of the attempts to manage Officer A effectively. He also felt he had a role in providing support to Ms G.

99. Ms G stated in her email of 3 June 2013 that Officer A left a suicide note which talked about an affair, and that the suicide attempt and the discovery of the affair were 'timely'.

In evidence Ms G accepted that her basis for speculating about the suicide note, which she had not seen, was not well-founded. She also accepted that it was inappropriate to have provided information that could have been relevant to Officer A's treatment in a confidential way. Ms G said in evidence that she no longer engages in such confidential communication with doctors and she has also advised other injury management staff to record all relevant information in OLIMS.

100. A further deterioration in the relationship occurred after Ms G sent Dr E an email on 18 June 2013 in which she stated, wrongly, that Officer A intended to change treatment providers. Officer A learned about some of the contents of this email from Dr E's receptionist and made repeated requests to see it.

101. Officer A contacted Ms G about this email on 1 July 2013. There was conflict in the evidence about the manner in which both Officer A and Ms G conducted themselves during this call. There is little doubt that Ms G was upset by the conversation (as was Officer A), and stated in evidence that she had broken down in tears when she had spoken with Inspector K afterwards. This event, when reported to Assistant Commissioner N, directly precipitated the decision to have Officer A assessed by the Police Medical Officer (PMO) and to consider moving Officer A from the [command] office.

102. Officer A was a forceful personality who held herself to high standards and expected others to do the same. Some staff said that they felt like they were 'walking on eggshells' around her after her attempted suicide. Some other staff also experienced conflict with Officer A, notably Inspector M on 15 March 2013 and Chief Inspector J on 17 June 2013. It is highly probable that Officer A's forceful personality and the effects of her mental condition contributed markedly to the breakdown in relationships with Ms L and Ms G.

103. Given the deterioration in the relationship with Officer A, it might have been appropriate for Ms G to have considered allocating another Injury Management Advisor (IMA) to take over Officer A's case. Ms G said that she did not do this because she believed there was no-one more experienced than herself who could manage the case, and because in any event, Officer A was gradually returning to work and relevant information could be obtained from the doctors.

104. Given the history of conflict with (the previous IMA) L, and with several other staff, it seems unlikely that such a change would have led to a sustained improvement in Officer A's management.

105. The email by Ms G to Dr E on 3 June 2013 raises a number of issues of concern. Firstly, the confidential nature of this email exchange seems to have led to Ms G feeling free to inform Dr E of matters that (if the email had not been confidential or if it had been recorded on OLIMS) she would likely not have raised, or not raised in that way. In particular, Ms G offered her own opinion questioning the diagnosis of PTSD. She also

saw fit to raise her belief in there being some connection between Officer A's suicide attempt and an 'affair' which was referred to in a suicide note. This suggestion (of a suicide note making reference to an affair) was, as is now known, completely untrue. The source of this rumour about the contents of the suicide note remains unclear. However, the falsity of this suggestion underlines the danger associated with 'confidential' exchanges of this kind – which may have the potential in some cases to adversely affect an officer's treatment.

106. As a result of this experience, Ms G has revised the injury management practices which apply in the [command] office. Communications with treating practitioners can no longer be treated as confidential. (Presumably this does not exclude formal case conferences and the like.)

(iv) The Return to Work plan

107. It was argued by counsel for the family that either Officer A's Return to Work (RTW) plan in March 2013 should have specified that she was not permitted to perform the duties of her substantive position, or there should have been no issue with her assisting Sergeant P with the work.

108. It was also submitted that Officer A should either have been treated like a 'normal' officer, and been permitted to assist Sergeant P, who was standing in for her in the [unit], or have been placed in a 'special' category identified in the RTW plan.

109. Inspector M gave evidence that had he had access to the RTW plan, he would have worded it differently to make it more precise. This may be so. But he made that concession with hindsight and during a cross-examination in which it was being implied that his conduct had in some fashion contributed to Officer A's downward spiral.

110. When considered objectively, the RTW plan set out, in positive form, a series of goals, parameters and activities that were intended to assist Officer A's recovery. It did not expressly prohibit her from visiting or working in the [unit]. It specified that her duties were in [another unit].

111. It would have been unreasonable, in my view, for the plan to have specified all the duties that Officer A was *not* permitted to carry out. Taken to a logical extreme, they could have included everything from the duties of the Commissioner to those of the security guards at the Police Academy. In any event, a list of prohibitions, short or long, might be counter-productive. A plan that is intended to give an officer returning to work a positive program to look forward to might be implicitly undermined by a list of otiose prohibitions and warnings, especially if they are designed primarily to protect management from potential criticism of this nature, rather than to help the injured officer.

112. In my view, Officer A's plan implied that the [unit] was not regarded by senior police

management and the injury management staff as a suitable work environment for her. The fact that she had been highly stressed while working in the unit, and had attempted suicide in one of its offices, was a solid foundation for such a view. Whatever else may be said about those managing Officer A at this time, there appears to be no doubt that they had her best interests and her welfare at heart when they made their various decisions.

113. An officer on a RTW plan is, almost by definition, still at risk and is, therefore, in a 'special category'. His or her risk must be carefully considered by supervisors and managed. Had Officer A been allowed, despite the RTW, to work part-time in the [unit] and had a relapse or made another suicide attempt, any criticism of her supervisors for failing to prevent her from returning to a toxic environment would have been abundantly justified.

114. For welfare reasons, it made sense to direct Officer A not to spend time in [another unit] away from her other duties. Her reaction – again, symptomatic of her fragile condition – was highly disproportionate to the objective significance of Inspector M's intervention which, in my view, was reasonable in the circumstances.

115. From a general management perspective, it also appears to have been reasonable. If an officer has duties in a particular unit, it is reasonable for management to expect the officer to carry out those duties, not others that he or she would prefer to carry out at the time. I accept, of course, that police officers assist one another in their general duties but I would not expect that officers in specialist units are free to wander about lending a hand in other units without supervision or direction. That would make management impossible. Nevertheless, whether it was spelled out in the RTW plan or otherwise, in hindsight it may have been prudent for those managing Officer A to explain why she was being moved and why they did not wish her to work in the [unit] at that time.

(v) Compartmentalisation of Officer A's care

116. The 'compartmentalisation' of different aspects of Officer A's care within the police force was criticised by counsel for the family as 'having deleteriously affected the capacity of individuals to discharge their responsibilities for Officer A's care, particularly upon and after her return to work in 2013'.

117. There may be some force in this argument, although perhaps not as much as counsel suggests. Indeed, one of her strongest criticisms of Ms G and Dr E was that they conferred and exchanged views about managing and treating Officer A and the difficulties they were having. The 'silos', as Ms Lowson put it, were not quite as impermeable and separate as the argument implied. Ironically, a formal example of the capacity of the injury management system to allow cross-referencing by the various involved parties is the conference on 2 July at which the decision was made to move her from the Regional office to Charlestown.

118. There is, however, a degree of compartmentalisation in the system. This is a necessary consequence of the confidentiality of therapeutic relationships between patients and their treating clinicians. Without that protection for patients, psychologically injured police officers could not be treated appropriately or adequately.

(vi) Salary advice

119. The NSWPF has conceded that Officer A did not receive timely advice about the reduction in her salary. There is no doubt that this was a very important issue for her and the administrative error caused her considerable distress. As has been noted above at [33], this exacerbated her condition.

Whether intimate relationships contributed to Officer A's death

120. One of the many unfortunate aspects of this case is that while Officer A was suffering from her condition, she had a brief affair with Officer C. There is some evidence in the form of email messages and the like that raises a suspicion that she may also have had an intimate relationship with Officer B and possibly with Officer D. Ordinarily, these private matters would be irrelevant in a coronial investigation like this. As I stated during the hearing, this is not a court of morals. The issue became relevant, however, because of the possibility that these relationships may have contributed directly or indirectly to Officer A's death. It is also relevant because there may have been a conflict or conflicts of interest that affected the ways in which Officer A's psychological injuries were managed.

121. Both B and D were Officer A's direct supervisors, although Officer D was only for a few hours. Officer C was neither her direct supervisor nor was he in a direct line of command over her. Officer A and Officer C had met as junior police officers working at [a Sydney] Police Station many years before and had remained friends.

Officer B

122. During the investigation of Officer A's death, a large quantity of material consisting of emails, text messages and 'chat' messages between Officer B and Officer A was discovered. Given the nature of this case and the issues to be resolved, it is neither necessary nor, in my view, appropriate to outline more than a few details of these communications.

123. In summary, from about April until December 2011 Officer A and Officer B exchanged a large volume of email, instant chat and text messages. Officer A also communicated with Officer B via her second phone in 2012. The content of these messages is not known. Over time these messages became increasingly sexually suggestive. Each person initiated a thread of these messages at various times (although Officer A was more often the initiating party). While some messages might be characterised as office 'banter', it is apparent that many were much more intimate. Officer B gave evidence that he was

aware that Officer A found these messages gratifying, that she was attracted to him and that she was interested in having a physical relationship.

124. Physical contact occurred between them on 21 June 2011 (although Officer B claims that he was 'groped' without his consent on this occasion). There is no direct evidence that physical contact occurred at any other time. After this event, Officer B continued to exchange suggestive messages with Officer A. The sexual content appears to have ceased after Officer A relieved in his position in January 2012 and following an argument about her conduct at work on 31 January 2012.

125. In his evidence and the submissions made on his behalf, Officer B sought to convey the impression that he had not reciprocated Officer A's feelings or behaviours in any significant way. He claimed that on some occasions he had been engaging in ordinary office 'banter' or , on other occasions, to have been humouring her as some form of (misguided) management technique.

126. I find this evidence implausible. When read together, the messages of various types strongly suggest that, for a period, Officer A and Officer B had a mutually flirtatious relationship. Whether Officer B felt as attracted to Officer A as she apparently was to him is not to the point – his response was to encourage and stimulate the dalliance, not to dampen it down. His evidence that he had been affronted by Officer A's behaviour but had exercised his discretion not to report it did not ring true.

127. I accept that a person who has been 'groped' in the workplace by a colleague may not report it. There are many reasons why he or she may make this decision, not least, if the victim likes that person and is willing to forgive him or her, the embarrassment that it might cause the offending colleague or both parties. But Officer B's communications with Officer A afterwards were hardly discouraging of further advances and were, in that context, both flirtatious and inconsistent with his evidence at the inquest. Indeed, it does Officer B little credit that he accepts very little responsibility for the situation and entirely blames Officer A who, conveniently for him, cannot answer.

128. Whether there was a physical relationship between Officer A and Officer B is not clear. It is unnecessary for me to make any positive finding about that. What is clear, however, because of the potential or actual conflict of interest that inevitably arose as a result, is that the type of relationship that developed between them was inappropriate for a supervisor and a subordinate colleague working in the same unit in the same organisation.

129. At some point around December 2011 or January 2012, the records indicate that the flirtatious relationship was abandoned by Officer B. Why he did so, and the reason why he chose to do so at that time, he has not been explained. In any event, Officer B appears to have realised that the way he had been communicating with Officer A was inappropriate from a managerial and professional point of view. As a man who valued his wife and marriage, he may also have had moral qualms about conducting himself in

such a way. Certainly, it seemed apparent during the inquest that he cares very much about his wife and family and is remorseful for his conduct.

130. The effect, especially the long-term effect, on Officer A of Officer B distancing himself from her is difficult to gauge. Although some of the messages she sent him suggest that she accepted the new situation quite stoically, it would be hard for anyone to continue to work happily or enthusiastically in such circumstances. It is evident from her messages to him that Officer A felt rejected and disappointed by Officer B. In the circumstances she probably felt professionally isolated as a result.

Inspector Officer D

131. A series of suggestive and flirtatious email messages that had passed between Officer A and Officer D over a period of 19 days in August 2011 was discovered by the investigators late in the investigation. In many respects they were similar to messages exchanged between Officer A and Officer B during 2011. At the time Officer D had no formal supervisory responsibilities in respect of Officer A but he was superior to her in rank and working in the same building. He later supervised her for a day and acted as her welfare officer for a period from December 2012.

132. What prompted the exchange of emails, which were full of double entendre and sexual innuendo, is not known. Officer D was too ill to attend the inquest. There is, however, no evidence that it led to a physical affair between the two officers. Nor is there any evidence that this short period of inappropriate messaging adversely affected Officer A's mental state.

133. The relevance of this exchange is threefold: first, it lends support to Officer B's claims that there was a general culture of ribald or risqué 'banter' in the office at the time.

134. Second, if that is correct, the inference that might otherwise be available that B and Officer A were having an affair at that time cannot be drawn with any confidence.

135. Third, if there was a general culture of such sexualised 'banter' in the [command] office at the time, it ought to be a concern to senior police management. Of course, the investigators in this case did not conduct an audit of all emails, text messages and 'chat' passing between officers and civilian staff in the office at the time, so how common this kind of 'banter' was at the time (or is now) is impossible to say. But the numerous scandals that have beset the Australian Defence Force over the years should be a warning to police forces of the dangers of allowing professional standards to be set by the lowest common denominators in a unit. As Lieutenant-General David Morrison, then Chief of Army, stated during the Army's 'Jedi Council' scandal, 'The standard you walk past, is the standard you accept. That goes for all of us, but especially those, who by their rank, have a leadership role.'[3]

[3] http://www.theguardian.com/world/video/2013/jun/13/australia-army-chief-women-video

136. Dr E, Officer A's psychiatrist at the time of her death, proffered the opinion that office affairs are much more common among police officers than in the general population. If that is so, it may need a psychological anthropologist[4] to explain this phenomenon and its effects on police officers. Whatever the explanation, if affairs result in poor workplace cultures, that in turn undermines professional relationships, corrodes discipline and morale in a hierarchical organisation and can lead not only to loss of mutual respect between supervisors and subordinates but, as the ADF's scandals have shown, to conflicts of interest, abuse of position and authority, and even to criminal offences, including sexual assaults.

137. Officer B's difficulty in asserting his managerial authority and properly taking responsibility his in respect of Officer A from January or February 2012 is probably attributable in large part to his failure to keep his relationship with Officer A entirely on a professional level.

Officer C

138. It seems more than a coincidence that, after the apparent breakdown of her relationship (whatever it was) with Officer B, Officer A had a brief affair with Officer C, who was an old friend. After a small number of meetings, Officer A terminated the relationship. There appears to have been no acrimony about this on either part.

139. Although it may have been another symptom of her deep unhappiness, the brief affair does not appear to have caused any great distress to Officer A at the time. It is much more difficult to discern to what extent it played on her mind over the following months. Officer C was not only Officer A's old friend but he was a friend of F 's too. The complexities of such a relationship, as well as feelings of anxiety and guilt, must have affected Officer A.

140. Officer C was strongly criticised by counsel for the family. She contended that the relationship had created a potential conflict of interest and, in any event, [because he was a senior officer] was improper and not in accordance with the values espoused by the NSW Police Force as an organisation. Officer C was not Officer A's supervisor, nor was he in a position directly to influence how she was being managed or would be managed. In this sense, there was no conflict of interest that could arise. There is no evidence or even suggestion that he misused his position to cut across lines of command to benefit or disadvantage Officer A.

141. The Coroners Court is not a military 'honour court' or a disciplinary tribunal. Because

[4] Psychological anthropology is an interdisciplinary subfield of anthropology that studies the interaction of cultural and mental processes. This subfield tends to focus on ways in which humans' development and enculturation within a particular cultural group—with its own history, language, practices, and conceptual categories—shape processes of human cognition, emotion, perception, motivation, and mental health. It also examines how the understanding of cognition, emotion, motivation, and similar psychological processes inform or constrain our models of cultural and social processes: see https://en.wikipedia.org/wiki/Psychological_anthropology accessed 14 December 2015.

they fall outside the scope of this inquest, it is, in my view, inappropriate for me to comment further on the personal and moral issues that the relationship between Officer A and Officer C raises. I note, however, that the rupture in his friendship with Officer C has caused F sadness and disappointment.

Medical and psychological treatment

142. Her medical records show that Officer A was treated in 2007 for adjustment disorder, anxiety and depression. She had rejoined the Police Force but been posted to [a Sydney police station] while her husband F was posted to [a regional police station]. She was apparently informed that there was little likelihood of a posting to [her husband's] area. Interestingly, at this time she was willing to engage with and receive treatment from her GP, Dr Z and a psychologist Ms AA.

143. This inquest, however, has largely concentrated on the medical and psychological care she received following her suicide attempt in November 2012. Counsel for the family argued strongly that this care was deficient in several respects. In particular, she was critical of Dr E, who was Officer A's treating psychiatrist, Dr Q, her treating psychologist, the Police Medical Officer, Dr R, who reviewed her on 2 July, and Ms S, the psychologist who reviewed her on 2 July.

144. In relation to Dr E, the main criticisms made were that he had been slow to recognise that he was not making progress in engaging Officer A, that he had been 'somewhat arrogant' in presuming that no one else could treat her, and that he had divulged aspects of his care of Officer A to Ms G in an inappropriate manner.

145. Dr E explained that the exchange with Ms G had been similar to those he might have with a junior member of a clinical treating team. He said that treating patients with mental health issues could be difficult and that psychiatrists were trained to support members of the treating team. He said that he had been trying to provide Ms G with support by letting her know he understood how she was feeling and allowing her to vent her feelings. His comments had been made strictly confidentially to Ms G to assist both of them sort out their feelings and to obviate them distorting the relationship with Officer A. In the exchange, both of them vented feelings about the problems they had been experiencing in seeking to treat or manage concerning Officer A. Provided that such discussions do not contaminate or prejudice the treatment of the patient, this approach seems appropriate and reasonable.

146. Indeed this criticism of Dr E seems somewhat inconsistent with the argument that there should not be 'silos' of care for injured police officers. While there are ethical limits on what can be disclosed by a clinician about a patient's confidences, it is obviously appropriate for those involved in a rehabilitation or return to work program to discuss their mutual issues concerning patients with a view to solving any problems that may be arising in the course of the program.

147. In contrast with her attitude in 2007 when she engaged with her therapists, in 2012 Officer A seems to have been determined to resist their attempts to engage with her. She expressed contempt for weakness in others and seems to have been determined to show no weakness in herself to anyone. Why her attitude towards herself had by 2012 become so remorseless is impossible to say. But a clue may be found in tensions within police culture between those who (notoriously) seek to 'rort' the workers' compensation system and those who have too much professional pride to do so. She was very much of the 'proud' school.

148. Dr E was not slow to recognise that he was making little headway with Officer A. But he also recognised the primary impediment to progress was that Officer A did not appear to want to engage in the process. She did not want to undergo therapy. She wanted to get back to her full duties without further ado. In my view, it was not arrogance that led Dr E to keep trying with Officer A, it was the sense that she was unlikely to engage with anyone involved in her return to work program. That was demonstrably the case – she did not engage with him, with Dr Q or with Ms G. Dr E was unable to think of anyone to whom he could refer Officer A and, in any event, if he did so, that person would have had to start all over again. It seems highly unlikely that Officer A would have been content to do that.

149. Dr Q first saw Officer A on 5 December 2012. He did not feel he established good rapport and perceived a number of 'red flags', including her disappointment at having survived her suicide attempt, her strong motivation to return to work and her resistance to being helped. He felt there could be aspects of her condition that were beyond the range of his specialty, including possible personality problems. As a result he referred Officer A to Dr E and asked him to see her sooner rather than later. Dr Q saw Officer A on three further occasions in 2013, when he began to introduce strategies for coping with stress, and for developing resilience.

150. Dr Q finally saw Officer A on 24 June 2013. At that appointment Dr Q reported that Officer A had variable mood, and that she had also made a veiled threat that if it doesn't all work out she will do it again (attempt suicide). However, he did not assess her as at particular risk of suicide. At that appointment, Officer A was talking about enrolling in a PTSD clinic at Westmead Hospital and had booked a future appointment. This indicated a reasonably positive outlook on Officer A's part, suggesting that she could see a better future ahead of her. Dr Q's assessment and approach was reasonable, appropriate and directed to Officer A's best interests.

151. Dr E described Officer A as a uniquely difficult patient for him and said that his impression was that others found her to be difficult also. Ms G gave evidence that she spent more time on Officer A's case than on any other. Ms G took over the case from Ms L because she felt that Officer A's case was so complex it needed her experience as Senior Injury Management Adviser to manage it. There can be little doubt that all those charged with treating and managing Officer A's condition and return to work program did their best to help her and to find solutions to the problems. Both the independent

experts who reviewed the case, Drs BB and CC, considered that the care and treatment the clinicians provided Officer A were appropriate and reasonable. I agree with that assessment.

Review by police medical officers on 2 July 2013

152. The review by the Police Medical Officer, Dr R, and Ms S is a classic demonstration of the unpredictability of suicide. But it was also a flawed process. In particular, Dr R came to a view, which he expressed to Officer N and others managing Officer A, that her suicide attempt may not have been genuine. And he did so without specialist qualifications in psychiatry and without conferring with Dr E or Dr Q who had a much better understanding of Officer A's history and complex psychology than he did. His impression came from her 'matter of fact' demeanour when giving her account of the suicide attempt and his doubts were also reinforced by what he called a lack of 'corroboration'.

153. This was a curious state of affairs. Dr R knew that Officer A had been referred by people who were much more familiar with her and her history than he was. He also knew or should have known that she had been referred for assessment due to concerns they held that she was at risk because she was repeating behaviours that had preceded her suicide attempt in November 2012. He agreed in his evidence that it is better to err on the side of caution before expressing the kinds of view that cast doubt on the previously accepted understanding. But he did not adequately explain why he had not applied the precautionary principle of assuming, until proven otherwise, that the November incident had been a genuine attempt or why, if his doubts about the genuineness of the attempt were strong, he did not consult Dr E or Dr Q or both for their views.

154. His justification for not doing so, namely that Officer A was not being returned to full duties, was both lame and irrelevant. On all the evidence available both then and now, Officer A's suicide attempt was genuine. His impression about that was wrong and it led him to underestimate the risk. While his assessment at the time he saw Officer A was that she was *then* unlikely to harm herself, and this may have been accurate *at that moment*, because he discounted the November attempt, the advice he gave to Officer N implied that Officer A's risk level was lower than it actually was. It is well known that a previous suicide attempt is a significant risk factor and, in the circumstances, it should not have been under-rated. The consequence was that Dr R's advice to the Region commander was considerably more reassuring than it ought to have been.

155. This is not to suggest that Dr R caused or was responsible for Officer A's death. Her decision appears to have been relatively spontaneous, and made at or shortly after the meeting on the morning of 3 July. But Dr R's assessment of Officer A was flawed and contributed to the failure of a process intended to protect Officer A.

156. Ms S, on the other hand, thought that Officer A's attempt had been genuine and she

proceeded on that assumption. She applied the MMPI test[5], a rigorous, but not infallible, personality test. It indicated that Officer A was truthful in claiming to be reasonably positive in her outlook. She also interviewed Officer A at some length. This supported the test results. Ms S's view was that Officer A, at the time of the assessment, had no current suicidal ideation or plans and had 'turned a corner'. Her overall impression was that Officer A's outlook was positive.

157. Significantly, during the interview, Ms S asked Officer A what she would do if she was required to move from her current location for work. at which point Officer A had tears in her eyes and said, 'I just wouldn't go to work - I'd go off sick'. Ms S said Officer A appeared to be genuine when she said this. Ms S did not explore this response further other than to discuss with Officer A who would be an appropriate person to whom she could raise her concerns about moving locations. In this context, Ms S asked about her then supervisor, Officer J, and Officer A said something like, 'He's all right'.

158. Officer A's comment to Ms S about what she would do if she was relocated did not of itself indicate any intention to self-harm. The independent experts were divided about the appropriate response. Dr CC thought that the comments should have been explored further, whereas Dr BB was not critical of Ms S and noted that the comment could be viewed in a positive way (as being counter-indicative of suicidality). These views are not mutually exclusive and are probably both right.

159. One of the acknowledged problems of risk-assessment is that suicide is virtually impossible to predict accurately, even for patients assessed as being in the 'high-risk' category in psychiatric units according to standard risk assessment tests and by way of clinical examination. Only a small proportion of patients assessed as being in the high-risk category commit suicide.[6] And some patients assessed as being in the low-risk category do commit suicide.[7]

160. Clinical assessments of this nature are essentially slices in time. Of course, they are coloured by a patient's history but they have very limited value as predictors of suicide. Some suicides are impulsive acts. In other cases, the suicide may be planned but the victim conceals his or her intentions from family members and clinicians. On 2 July 2013, at the time that she saw Dr R and Ms S, it may have been true that Officer A was not ruminating about or planning her suicide.

161. I make no criticism, express or implied of Ms S, who appears to have conducted a careful and thorough assessment. Nevertheless, in hindsight, it would have been better for Ms S

[5].Minnesota Multiphasic Personality Inventory (MMPI) is the most widely used and researched standardized psychometric test of adult personality and psychopathology. Psychologists and other mental health professionals use various versions of the MMPI to help develop treatment plans; assist with differential diagnosis; help answer legal questions (forensic psychology); screen job candidates during the personnel selection process; or as part of a therapeutic assessment procedure.

[6] See, for example, M. Large, G.Smith, S.Sharma, O.Nielssn, S.Singh 'Systemic review and meta-analysis of the clinical factors associated with suicide of psychiatric in-patients' *Acta Psychiatrica Scandanivica*2011: 124: 18-29.

[7] See M. Large, S. Sharma, E. Cannon, C. Ryan, O. Nielssen 'Risk factors for suicide within one year of discharge from psychiatric hospital: a systematic meta-analysis' *Aust NZ J Psychiatry*. 2011 Aug; 45(8):619-28.

to have advised the Region Commander, Officer N, or those advising him, of Officer A's remark about going off sick if she were moved. This would have given the [region] a chance to prepare an appropriate response, such as advising F, seeking his presence and help in letting Officer A down as gently as possible or providing her with some other effective means of support.

The meeting on 3 July 2013

162. In my view, Officer N's decision to move Officer A out of the Northern Region office was reasonable and considered. Objectively assessed, the plan to move her temporarily to [another police station] was both pragmatic and compassionate. Relationships between Officer A and a number of people in the office, notably with the SIMA, Ms G, were poor. Some people in the office felt that they were 'walking on eggshells' because of her volatility. As Dr E put it, the situation had become 'untenable'. For the good of everyone, this needed to be addressed by the Region Commander..

163. Although Officer A was unable to recognise it, the environment was toxic for her and for others. Moving to [another police station], away from people, including 'bosses', whom she did not like, would have provided her with a new start, doing real and meaningful work with a supportive team. The move was not a planned as a permanent one but as a circuit breaker to be reviewed in three months' time.

164. The immediate execution of the plan, however, although well-intentioned, was not well thought through. It was entirely predictable, and indeed *was* predicted by Officer A, that she would be resistant to any proposal to move her out of the [the police station in which she was working]. It was almost inevitable that she would feel slighted, isolated and alienated if the decision to move her was taken. That she would react angrily and emotionally was a racing certainty. It was therefore imperative that she go to the meeting feeling that she had someone on her side, someone whom she could trust to understand her point of view and to put it to police management.

165. Although she had nominated Officer J as a person to whom she could talk if the question of a transfer or move was raised, to appoint him as one of the two representatives of the [Region Commander] was a mistake. The intention, of course, was to demonstrate that management cared about her and was trying to help her recover. And, to be fair, this was no mere demonstration; the concern for her was genuine. But Officer J could not simultaneously act as her support person *and* one of the delegates of the [Region Commander] without a conflict of interest arising.

166. Had F been invited to be present at the meeting and to support Officer A it is possible that she would not have felt so bereft or have taken such a drastic course. A decision had been taken by the group managing Officer A, however, that he would be her *domestic* support person and that someone else - in this case Officer J - would be called in as her support person for the meeting.

167. Although I believe both senior officers behaved compassionately and kindly towards Officer A, they could not sugar what for her was a very bitter pill. As far as she was concerned that morning, she was being expelled from the group to which she wanted desperately to belong. Hence she needed someone to whom she could turn in the crisis and who would be an advocate for her. But that morning she clearly felt she had no one. Even Officer J, in whom she had previously expressed some confidence, appeared to be against her.

168. An obvious lesson to be learned from this terrible experience is that in such delicate situations conflicts of interest, real or perceived, must be avoided, and that support persons must be exactly that.

The search for Officer A

169. No criticism can be made of the efforts by police to find Officer A. Indeed, F appears to me to have exercised his detective skills in consummate fashion in working out Officer A's movements and intentions. Sadly, those skills and the police ability to triangulate Officer A's telephone calls were not enough to save her.

Lessons learned

170. Several lessons can be learned from this case:

171. First, attempted suicides or acts of self-harm or attempted self-harm by police officers should *always* be investigated. They should *never* be presumed to be a recurrence of a pre-existing injury. If an officer has a pre-existing psychological injury that is being managed one of the primary questions for investigation is whether or not the incident or attempt is a frank injury or a recurrence.

172. Second, even if the attempt flows from a pre-existing injury, investigation of the circumstances should prompt an immediate reassessment of the case including the diagnosis, treatment and ongoing management of the officer.

173. Third, assessments by PMOs and police psychologists of officers suffering psychological injuries should ordinarily include, when reasonably practicable, consultation with the officers' treating clinicians to ensure that the PMO and psychologist (a) obtain a full understanding of the officers' histories; (b) undertake risk assessments on a fully informed basis; and (c) provide advice to commanders and injury managers that is based on the best available information. In cases such as this where the reason for the assessment is that supervisors or commanders are concerned for the officer's safety from self-harm, consultation with the treating clinicians should be considered a priority for the purposes of assessment.

174. Fourth, where IMAs or treating clinicians have difficulties engaging officers suffering psychological injuries in appropriate treatment programs, consideration ought to be

given to holding regular case conferences with relevant staff including supervisors, IMAs, and clinicians, to assess progress, identify problems and to investigate possible solutions. Such a process might also include engaging with spouses, welfare officers and support persons, as the case may be.

175. Fifth, conflicts of interest arose in Officer A's case in at least three ways: Officer B's overly familiar relationship with Officer A gave rise to a potential conflict in managing the [unit]; Ms G was conflicted in relation to the P902 report concerning Officer A's suicide attempt; and Officer J was placed in the invidious position of being both the messenger with the bad news and the support person at the meeting on 3 July. Although there is a Conflict of Interest policy that is meant to guide the actions of police officers, there appears to be a surprisingly widespread ignorance both of the rules but, more significantly, of the underlying principles and rationale for the rules within the organisation. If this case is any indicator, even some senior officers do not appear to be able to recognise even obvious examples of potential or actual conflict of interest. This is not to criticise individuals – if my impression is correct, it is an indication of a flaw in the culture of the organisation. If that is the case, the implications for the management of the Police Force are profound.

176. Sixth, at present, when a P901 investigation is carried out, it is frequently and perhaps usually carried out by the officer's supervisor. In some cases, however, such as this one, there is potential for conflict of interest to arise. An officer's supervisor(s) may have contributed directly or indirectly to causing the injury. At least in relation to serious injuries, especially psychological injuries, consideration ought be given to obviating that risk by having the investigation carried out by a more independent officer, such as an officer from another specialist unit or command.

177. Seventh, in meetings (and other situations) in which an injured officer might want or require support because his or her interests are at stake, a support person who is independent of the supervisor or commander making the relevant decisions, and who is specifically nominated by the officer, and who is willing to act in the role, ought to be made available at those meetings if reasonably practicable. This would be protective both for the officer concerned and the commander.

178. Eighth, it is perhaps unsurprising that Dr E has observed affairs within the Police Force to be very common. It is a close-knit community. Many of its members are young. The job is at times stressful, exciting, challenging and even dangerous. Police officers rely heavily on those with whom they work and form close relationships as a result. They work shifts. They see and do things that few others in the community understand or ever observe. They understand one another's experiences and therefore many police officers marry or partner with other officers. But, as I have observed above, affairs can be deleterious to the organisation. In my view, the Police Force may need to consider its own culture to ensure that officers are not placed in positions of conflict, are not psychologically harmed and that professional relationships are properly maintained for the good of the organisation and the community more generally.

179. Ninth, there does not appear to be a satisfactory rationale in the Critical Incident Guidelines for distinguishing between the use of service weapons to attempt or commit suicide and other lethal methods. If the intention is the same and the outcome is the same, the means seem to be a detail rather than an essential element.

180. Tenth, the income protection schemes for NSW police officers operate in different ways and may, in some respects, be unfair or disadvantageous to certain groups of officers. F has suggested a recommendation under the Coroners Act that the scheme be reviewed by an independent person. While income protection issues were a concern of Officer A's, the inquest did not explore the scheme in detail. The NSWPF submitted that because the Police Blue Ribbon Insurance Scheme is not owned by it but by the insurers it is not in a position to review the terms of the agreement. In my view, the Police Association is much better placed than a coroner both to understand the scheme and to consider how it should be reviewed.

181. A number of other suggestions for recommendations to the Minister for Police and Commissioner were circulated by Counsel Assisting and counsel for the family. I have considered them all as well as the responses by the NSWPF. The recommendations I propose to make are based on the lessons I have referred to above.

Conclusions

182. Officer A 's death was unutterably sad. She was only 43 and should have been in the prime of her life. She left behind two beautiful children and a devoted husband who are grief-stricken not only by what happened to Officer A but by how her life fell apart. The sense of loss is compounded by a sense that perhaps there might have been a different outcome. The great English writer Samuel Johnson, thinking about grief and loss wrote:

> *But for [grief] there is no remedy provided by nature; it is often occasioned by accidents irreparable, and dwells upon objects that have lost or changed their existence; it requires what it cannot hope, that the laws of the universe should be repealed; that the dead should return, or the past should be recalled.*

183. This seems to capture precisely the feelings of so many who knew Officer A and who have participated in this inquest all of whom wish in their hearts that 'the laws of the universe should be repealed' and that Officer A would return.

184. Officer A was afflicted with a mental condition that cannot be attributed to a single causative factor. Indeed it would be surprising if things were that simple. Her Major Depression (with elements of PTSD) resulted from a combination of factors.

185. First of all, she was a person who was more prone to the condition than others, by reason of her personality, her perfectionism, and her inability to engage help from others. Secondly, she worked in an occupation which exposed her to events that would be traumatic and depressing to even the hardiest individuals. And thirdly, she ended up

in a workplace where there was always work to be done, and constant pressure (partly self- imposed) to complete it in a timely manner. At the same time, Officer A was trying her best to manage (with her husband) the demands of raising young children. On top of all this, there is evidence that Officer A was, during 2011 and 2012, engaging in some type of intimate relationship with at least two other officers – and was perhaps experiencing stress and guilt associated with this.

186. However, it is also likely that Officer A's mental condition was in large part brought about and exacerbated by her employment with the NSW Police Force. This conclusion is supported in particular by the opinions of Officer A's treating practitioners, in particular Dr E, who (somewhat presciently) said in his report of 20 January 2013 that – *'Officer A is much more concerned about her career than she is about her health. Officer A is more concerned about her career than she is about her own survival'.*

187. F movingly described how much Officer A loved policing and how important being a police officer, a fully-functioning officer, was to her. She was difficult to manage partly because of her personality but also because she refused to behave like an invalid or disabled person. He also described how she preferred to run towards danger when others were running from it. She was very strong in some ways but also very vulnerable.

188. Although, in my view, there is no such thing as 'closure' after such a tragedy, F and his children may take some comfort from the fact that their concerns have been listened to and some lessons have been learned from Officer A's life and death that may help reduce the risk of harm for other police officers.

189. Finally, I hope that he, [and his children] will accept the sincere and respectful condolences that the coronial team and I offer them.

Findings s81 Coroners Act 2009

190. I find that Officer A died on duty as a police officer on 3 July 2013 as a result of external neck compression due to self-inflicted hanging in the [State Forest], New South Wales while suffering from a work-related Major Depressive Disorder and Post-Traumatic Stress Disorder.

Recommendations s82 Coroners Act 2009

191. I make the following recommendations to the Minister and Commissioner of Police:

(i) That the Commissioner revise relevant policies and procedures, including the Injury Management Standard Operating Procedures, to require that any known act that has been identified as an act of suicide or attempted suicide by an officer of the NSW Police Force is (i) reported to the Region Commander or equivalent officer within 24 hours of the incident coming to notice; (ii) that that officer then

ensures that a P902 report form is submitted as soon as practicable; and (iii) that the incident is then subject to a safety investigation in accordance with the procedures encapsulated in the P901/P902 process.

(ii) That the P901/P902 process in respect of suicides and attempted suicides should include investigation not only of the incident itself but also, if the injured officer has suffered from a pre-existing injury, should result in an urgent reassessment of the case including diagnosis, treatment and ongoing management of the injured officer.

(iii) That, in relation to attempted suicides and other serious psychological injuries, consideration be given to obviating the risk of conflict of interest by having the investigation carried out by an independent officer, such as an officer from another specialist unit or command, rather than by the injured officer's supervisor.

(iv) That assessments by Police Medical Officers and police psychologists of officers suffering psychological injuries should ordinarily include, when reasonably practicable, consultation with the officers' treating clinicians to ensure that the PMO and psychologist (a) obtain a full understanding of the officers' histories; (b) undertake risk assessments on a fully informed basis; and (c) provide advice to commanders and injury managers that is based on the best available information. In cases where the reason for the assessment is that supervisors or commanders are concerned for the officer's safety from self-harm, consultation with the treating clinicians should be considered a priority for the purposes of assessment.

(v) That where Injury Management Advisers or treating clinicians have difficulties engaging officers suffering psychological injuries in appropriate treatment programs, consideration be given to holding regular case conferences with relevant staff including supervisors, IMAs, and clinicians to assess progress, identify problems and to investigate possible solutions. Such a process might also include engaging with spouses, partners, welfare officers, support persons and others as the case may be.

(vi) That urgent consideration be given by the NSW Police Force both to amending the Conflict of Interests Policy (see next recommendation) and to ensuring that all senior officers are educated in the fundamental principles concerning conflicts of interest and in recognising and resolving potential conflicts.

(vii) That the NSW Police Force 'Procedures for Managing Conflicts of Interest' be amended so as to add the words "or other ongoing intimate" after the word "domestic" on pages 12 (final dot point) and 24 (fourth paragraph), and to add the words "or other persons in an ongoing intimate relationship" after the word "spouses" on page 24 (fourth paragraph).

(viii) That the Commissioner take steps to provide further training and instruction regarding the operation of the 'Procedures for Managing Conflicts of Interest' (in the amended form as suggested above) so as to raise awareness of the requirement to identify, and manage, the potential conflict of interest which may arise where a domestic or other intimate relationship exists between two police officers.

(ix) That in decision-making meetings in which an injured officer might want or require support because his or her interests are at stake, a support person who is independent of the supervisor or commander making the relevant decisions, and who is specifically nominated by the officer, and who is willing to act in the role, ought to be made available at those meetings if reasonably practicable.

(x) That consideration be given to amending the Critical Incident Guidelines to remove the distinction between incidents in which officers use their service weapons to attempt or commit suicide and those in which other lethal methods are used on the basis that the implement is a means to a common end.

Magistrate Hugh Dillon
Deputy State Coroner
18 December 2015