**CORONERS COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Rebecca Maher |
| **Hearing dates:** | 4 to 15 March 2019 |
| **Date of findings:** | **5 July 2019** |
| **Place of findings:** | NSW Coroners Court, Lidcombe |
| **Findings of:** | **Acting State Coroner, Magistrate Teresa O'Sullivan** |
| **Catchwords:** | CORONIAL LAW – Aboriginal death in police custody – intoxicated persons – Custody Notification System ("CNS") – Part 16 *Law Enforcement (Powers and Responsibilities) Act 2002* ("LEPRA") |
| **File number:** | 2016/218940 |
| **Representation:** | (1) Counsel Assisting<br>Mr David Buchanan SC of counsel and Ms Frith Way Solicitor Advocate of the NSW Crown Solicitor's Office, instructed by Ms Alana McCarthy and Ms Clare Skinner of the NSW Crown Solicitor's Office<br>(2) Next of kin<br>Mr William de Mars of counsel, instructed by Ms Helen Cooper of Legal Aid<br>(3) NSW Commissioner of Police<br>Mr Michael Spartalis of counsel, instructed by Mr Nicholas Regener of Makinson d'Apice Lawyers<br>(4) Senior Constable Laurie Coleman and Senior Constable Ron Nichols<br>Mr Paul Madden of counsel, instructed by Mr Greg Willis, Criminal Defence Lawyer<br>(5) Sergeant Nathan Brooks and A/Sergeant Greg Hosie<br>Mr Stephen Wilkinson of counsel, instructed by Mr Ken Madden and Ms Susan McTegg of Walter Madden Jenkins |

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| | (6) Senior Constable Elizabeth South and Sergeant Jonathan Cassidy<br><br>Mr Brett Eurell of counsel, instructed by Ms Nadia Baker of Carroll & O'Dea Lawyers<br><br>(7) Dr Gunendra Weerabaddana<br><br>Ms Kim Burke of counsel, instructed by Ms Chandrika Darroch of Meridian Lawyers<br><br>(8) Mr Keith Gael<br><br>Mr David Lloyd of counsel, instructed by Mr John Simpson of Clinch Long Woodbridge |
| **Non publication order:** | Pursuant to ss. 74 and 65 of the *Coroners Act 2009*:<br><br>1. There shall be no publication of and no access to the CCTV footage from Maitland police station, which includes Exhibit 5, Exhibit 6 and Tab 35 of Exhibit 1;<br>2. There shall be no publication of or access to the material that appears at Tabs 37 to 39 of Exhibit 1;<br>3. There shall be no publication of and no access to Exhibit 2;<br>4. There shall be no publication of DT's name or anything to identify him including evidence of his physical appearance; and<br>5. There shall be no publication of the names JB and PW or anything to identify them. |

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| **Findings:** | The *Coroners Act 2009* in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Rebecca Maher.<br><br>**Identity of deceased:**<br>The deceased person was Rebecca Maher.<br><br>**Date of death:**<br>Rebecca died on 19 July 2016.<br><br>**Place of death:**<br>Rebecca died in a cell at Maitland police station.<br><br>**Cause of death:**<br>Respiratory depression after loss of consciousness caused by mixed drug toxicity and possibly aspiration of vomit.<br><br>**Manner of death:**<br>Rebecca's death occurred accidentally while she was detained by officers of the NSW Police Force ("NSWPF") as an intoxicated person, medical attention not having been sought on her behalf. |
| **Recommendations:** | To the Attorney General of NSW and Commonwealth Minister for Aboriginal Affairs:<br><br>1. That the Attorney General consider amending the Law Enforcement (Powers and Responsibilities) legislation to ensure that an Aboriginal person detained under Part 16 of LEPRA as intoxicated is provided with the same access to the Aboriginal Legal Service CNS as an Aboriginal person held in custody under Part 9 of LEPRA, and that the duty of police to put an Aboriginal person in custody in touch with the CNS is extended to Aboriginal persons detained under Part 16; and<br><br>2. That the Commonwealth Minister for Aboriginal Affairs continue to work with the NSW government on funding options and on potential improvements to the Aboriginal Legal Service CNS model to enable it to provide its service to Aboriginal persons detained under Part 16 of LEPRA.<br><br>To the Commissioner of Police, NSWPF:<br><br>1. That the NSWPF consider improvements to its education and training of police officers to provide clear and understandable information as to the |

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| | nature of infectious diseases and associated risks.<br>2. That the NSWPF consider improvements to its education and training of police officers as to circumstances which call for persons detained as intoxicated to be searched, in particular circumstances where the person may be intoxicated with prescription drugs and might have such drugs on them when detained.<br>3. That the NSWPF consider the implementation of a requirement that all police officers who perform duty as custody manager at police stations undertake the Safe Custody Course, which would include education and training as to:<br>a. The duty in respect of a person detained under Part 16 of LEPRA to make all reasonable efforts to identify and locate a "responsible person"; and<br>b. Content of the NSWPF poster entitled "*Safe Custody: Medical Risks*" including that, when managing a person detained as intoxicated, it is dangerous and inappropriate to take the approach that the person will or can "*sleep it off*".<br>4. That the NSWPF consider modification to the Custody Management System to require the custody manager:<br>a. when making entries for inspections to record, where the detainee is intoxicated, (1) what occurred when the custody manager attempted to rouse the detainee, and (2) the custody manager's assessment of the detainee's level of consciousness; and<br>b. to record the efforts they have made to identify and locate a "*responsible person*", including consulting previous Custody Management Records.<br>5. That the NSWPF continue to review the circumstances of the death of Rebecca Maher at Maitland police station as a case study in training of police officers who are to undertake the duties of a custody manager. |

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*These are the findings of an inquest into the death of Rebecca Maher.*

# Introduction

1. Rebecca Maher was born on 4 May 1980 and was a proud Wiradjuri woman. She was 36 years old when she died sometime before 6:00am on 19 July 2016 in a cell at Maitland police station. Her family have confirmed that they would like me to refer to her as Rebecca.

2. I acknowledge the Aboriginal custodians of the land on which this Court sits and pay my respects to the elders past, present and emerging.

3. Rebecca died after she was detained by officers of the NSW Police Force ("NSWPF") at Cessnock just after midnight on 19 July 2016 as an intoxicated person, pursuant to the provisions of Part 16 of the *Law Enforcement (Powers and Responsibilities) Act 2002* ("LEPRA"). An autopsy report dated 25 October 2016 records the direct cause of death as "*mixed drug toxicity*", noting high levels of Alprazolam and Methadone detected in Rebecca's system, the combination of which could lead to respiratory depression and failure. Cannabis and non-toxic levels of other benzodiazepine drugs/metabolites and Mirtazapine (an anti-depressant) were also detected.

4. As Rebecca died while she was in police custody, an inquest is required to be held pursuant to ss. 23 and 27(1)(b) of the *Coroners Act 2009* ("the Act").

## *The nature of an inquest*

5. The role of a Coroner, as set out in s. 81 of the Act, is to make findings as to the:

    (a) identity of the deceased;

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

    (c) physical or medical cause of death; and

    (d) manner of death, in other words, the circumstances surrounding the death.

6. There was no controversy at the inquest about Rebecca's identity, or about the date and place of her death. The focus of the inquest was therefore the cause and manner of Rebecca's death, in particular, the circumstances leading up to her detention as an intoxicated person, what occurred during that detention and the appropriateness of police action while Rebecca was detained.

7. A secondary purpose of an inquest is to determine whether it is necessary or desirable to make any recommendations in relation to any matter connected with the death, including in relation to matters of public health and safety.[1]

8. In preparing these findings, I have been greatly assisted by the Statement of Uncontested Facts agreed upon by the parties in advance of the inquest, as well as the submissions of Counsel Assisting. I have also been assisted by submissions prepared on behalf of each of the interested parties.

# The Facts

## *Background*

### Personal circumstances

9. Rebecca lived in Raymond Terrace, NSW since she was a teenager. At the time of her death, her residential address was 22 Windsor Street, Raymond Terrace. She had lived there on and off for a number of years. From around mid-2015, Rebecca lived at that residence with her partner, Kieren Jordan.

10. Rebecca was the daughter of Debbie Small, who is also from the Wiradjuri group from Mudgee area. Rebecca had three brothers, Justin, Aaron and Chris. Rebecca also had four children: Kaine, Joshua, Mia and Beau. Although Rebecca's children were not living with her at the time of her death, it is clear to me that she was always a part their lives and loved them very much.

11. Debbie, Kaine, Justin, Justin's partner Aretta, Kaine's girlfriend Candus and her mother Barbara all attended the hearing of the inquest, as did Beau's foster parents, Natalie and Aaron. On the final day of the inquest, Natalie read to the Court a moving statement prepared by Debbie and Kaine, which spoke about Rebecca's kind and caring nature throughout her life towards all people that she

[1] Section 82 *Coroners Act 2009*.

met. It also spoke about Rebecca's love of her family and her determination to overcome the very significant challenges that she faced. Their attendance at the inquest is a testament to the love that they had for Rebecca and I thank them for their dignity and contribution throughout the inquest.

## Rebecca's history with police and medical history

12. Rebecca had a lengthy history of dealings with police, which commenced in 1995 when she was a juvenile. At the time of her death, Rebecca was on bail for larceny charges from 18 May 2016 and was reporting daily to Raymond Terrace police station.

13. Rebecca also had a lengthy history of using illicit and prescription drugs from the age of 15 or 16. In November 2000, records show Rebecca reported "*constant*" use of opiates and five accidental overdoses. From at least November 2000, Rebecca was prescribed Methadone by the Hunter/Newcastle Methadone Program ("Pharmacotherapy Service"). Rebecca continued to regularly consume Methadone on prescription until the time of her death, dispensed either by the Pharmacotherapy Service or, while in gaol, by Justice Health.

14. Rebecca's medical history indicates that she did not consume alcohol often and, when she did, rarely in large quantities. She did regularly smoke large amounts of cigarettes. In November 2000, Rebecca reported being prescribed various medications for "*asthma/bronchitis*" and continued to regularly report issues with those conditions.

15. Medical records indicate that, between 2000 and 2013, Rebecca tested positive to Hepatitis C. However, despite NSWPF records to the contrary, Rebecca never tested positive to HIV. Rebecca's autopsy report confirmed that she had antibodies to Hepatitis C but was HIV negative.

16. In 2001, Rebecca reported using benzodiazepines to manage symptoms of heroin withdrawal. Over time, Rebecca reported increasing consumption of benzodiazepines, both prescribed and obtained on the street. From 2008 to early 2015, Rebecca was regularly prescribed Alprazolam (Xanax) and other benzodiazepines. For much of this period, she was also on the Methadone program.

17. Starting in about July 2011, Rebecca reportedly started "*doctor-shopping*" (as described in relevant records) to obtain benzodiazepines. Medical records indicate that on three, possibly four, occasions, Rebecca was informed of the risk of overdose if she took benzodiazepines while on Methadone. In January 2016, Rebecca reported being hospitalised for "*accidental overdose*" in relation to heroin twice and in relation to benzodiazepines once.

18. In January 2016, Rebecca was released from gaol and commenced the Methadone program at the Pharmacotherapy Service. From February to June 2016, Rebecca was prescribed Methadone maintenance therapy of 150mg (30mls) daily, and took this dose most days.

19. In March and May 2016, urine screening of Rebecca indicated the presence of only drugs she was prescribed, Methadone and Mirtazapine. However, Rebecca's last urine screening on 1 June 2016 indicated the presence of Methadone, two benzodiazepines (Oxazepam and Clonazepam) and Olanzapine (a drug used mainly to treat schizophrenia and other mental disorders). Pharmaceutical Benefit Scheme ("PBS") records for Rebecca indicate that she was not obtaining those drugs from prescriptions filled in her name.

20. On 14 July 2016, Rebecca saw her GP in Newcastle, Dr Julia Gan, and reported feeling unwell. Dr Gan diagnosed Rebecca with asthma, acute bronchitis, anxiety disorder and a need to stop smoking. Dr Gan prescribed Symbicort, Ventolin and Klacid (antibiotics) for the asthma and bronchitis, Axit 30mg (Mirtazapine) for chronic anxiety and depression, and Nicotinell patches.

## *Events preceding Rebecca's detention*

### Sunday, 17 July 2016

21. On the morning of 17 July 2016, Rebecca had a 150mg (30ml) dose of Methadone at the Pharmacotherapy Service.

22. Around this time, Rebecca and Kieren exchanged text messages that appear to indicate they ended their relationship. Rebecca subsequently began a relationship with DT and spent time with him that day.[2]

23. On the evening of 17 July 2016, Rebecca and DT checked into a motel in Mayfield. There was evidence before the inquest that, at that time, Rebecca was quite agitated and appeared to be under the influence of a drug but did not smell like she had been drinking alcohol.

## Monday, 18 July 2016

24. At 8:05am on 18 July 2016, Rebecca had a 150mg (30ml) dose of Methadone at the Pharmacotherapy Service. Rebecca also sent text messages and made phone calls that morning, which, Counsel Assisting submitted, indicate that Rebecca was trying to purchase prescription drugs.

25. Rebecca and DT then travelled by public transport from Newcastle to Maitland, and from Maitland to Cessnock.

26. In Cessnock, Rebecca and DT each had a consultation with a GP, Dr Gunendra Weerabaddana, at Hunter Valley Medical Practice.

27. Dr Weerabaddana prescribed Rebecca one Alprazolam 2mg tablet twice a day. Alprazolam is a drug used to treat anxiety and associated disorders. Dr Weerabaddana's prescription authorised the dispensing of 50 tablets. At the time of prescribing, Alprazolam was a "*drug of addiction*" under Schedule 8, *Poisons and Therapeutic Goods Act 1966*.

28. Separately, Dr Weerabaddana gave DT a prescription for Sildenafil (Viagra). DT had previously consulted with Dr Weerabaddana and had been prescribed Alprazolam (2mg x 50 tablets) on 16 June 2016 and 8 July 2016.

29. At 5:20pm, Rebecca and DT had their prescriptions filled at Priceline Pharmacy in Cessnock. Pharmacist Keith Gael dispensed Alprazolam to Rebecca and Verafil (Viagra) to DT. In a statement provided to investigating police, Mr Gael said that he "*noticed that [Rebecca] was unsteady on her feet and that she*

[2] Non-publication order in respect of DT's identity, and in respect of any material which may tend to identify him, made on 4.3.19.

*appeared to be under the effect of a substance and that she was not functioning normally*". He did not detect alcohol on her.

30. Shortly after Rebecca's death, DT told investigating police that Rebecca opened the bottle of Alprazolam straight away after leaving the pharmacy, which suggests that Rebecca had Alprazolam there and then. There is some question as to the weight to be given to DT's evidence, in light of his extensive history of drug abuse and pre-existing brain damage. However, DT's account in this regard is consistent with evidence of a pharmacy employee and with Rebecca having been dependent on Alprazolam and needing to alleviate withdrawal symptoms.

31. At about 6:00pm, Rebecca and DT went to Cessnock police station where, on the suggestion of an officer there, Rebecca called Raymond Terrace police station to inform them that she would report on bail at Cessnock.

32. DT told investigating police that he and Rebecca then went to a house and consumed crystal methamphetamine ("ice") and alcohol. DT also gave oral evidence about this at the inquest, Again, there is a question about how much weight should be given to this evidence. Given there was no ice or alcohol detected in Rebecca's post-mortem blood sample, it is likely that DT was confusing a memory from an earlier occasion or alternatively that he and Rebecca consumed something that he thought was ice but was something else.

33. At about 9:00pm that evening, Rebecca and DT were seen on South Street in Cessnock. Rebecca asked the passenger of a passing car for money and a lift to Raymond Terrace, and also asked where she was. The passenger described Rebecca as *"…very pale in the face and she was slurring her speech and she was not coherent. She was awkward on her feet and in her movements in general."* She formed the view that Rebecca "*was very much under the influence of something. Whether it was alcohol or drugs or both*".

## *Events of 19 July 2016*

### Sergeant Brooks sees Rebecca and DT

34. Late at night on 18 July 2016, Sergeant Nathan Brooks ("Sgt Brooks") from Cessnock police station was patrolling Cessnock by himself in a police vehicle.

Around midnight, he responded to a police radio broadcast of two to four males running into traffic on Wollombi Road near a Seven Eleven service station. When he arrived at the scene, Sgt Brooks drove around for a while looking for those persons.

35. When Sgt Brooks pulled over across the road from the Seven Eleven, he was approached by the driver of a nearby car who informed him that a girl wearing a pink jumper (presumably Rebecca, who was wearing a pink or orange coloured jumper at the time) had jumped out in front of his car.

36. Sgt Brooks drove around again and saw Rebecca. Sgt Brooks immediately formed the opinion that Rebecca was intoxicated on the basis that "*[s]he was unsteady on her feet and staggered as she walked*". DT was with Rebecca and it appeared he was trying to get her to sit down.

37. DT told investigating police and gave evidence at the inquest to the effect that, when they saw police, they "*freaked out*" and he gave Rebecca a pill bottle containing Alprazolam tablets. According to DT, Rebecca indicated that she would hide her bottle of Alprazolam and his bottle in her vagina. He told the inquest that while he believed that was what Rebecca then did, he did not actually see it happen and did not recall whether Rebecca said she had done this.

38. Sgt Brooks spoke with Rebecca and DT. He then briefly lost sight of them, before seeing what he described in an interview with investigating police as Rebecca "*staggering in the middle of [Wollombi Road] trying to cross the road. A vehicle was forced to slow right down and manoeuvre around her*." Sgt Brooks approached Rebecca and DT again.

## Rebecca is detained as an intoxicated person

39. Sgt Brooks asked Rebecca and DT for identification. DT handed Sgt Brooks his wallet, and Rebecca eventually gave her name and her home address of 22 Windsor Street, Raymond Terrace.

40. Sgt Brooks then conducted Central Name Index ("CNI") checks on Rebecca and DT. The radio despatcher told Sgt Brooks that Rebecca had failed to report on

bail that day. In response to this (incorrect) information, Sgt Brooks called for a caged vehicle so that he could arrest Rebecca.

41. In addition, the radio despatcher stated that Rebecca may be an illicit drug user and that "*she is HIV and Hep C positive and may inflict self-injury*". This information was recorded against Rebecca's CNI number in the NSWPF database. As noted above, while Rebecca did have antibodies to Hepatitis C, she was HIV negative.

42. A short time later, a police vehicle staffed by Senior Constable Luke Marks ("SC Marks") and Constable Robert Brown, and a police van staffed by Senior Constable Laurie Coleman ("SC Coleman") and Senior Constable Elizabeth South ("SC South") arrived at Wollombi Road. SC Marks informed Sgt Brooks that Rebecca had reported on bail at Cessnock police station.

43. A number of officers present at Wollombi Road gave evidence that, at this time, Rebecca alternated between appearing to fall asleep and being responsive. Rebecca was described as slurring her speech and being unsteady on her feet. At times she would stand up and on at least one occasion reportedly attempted to cross the road. It is clear to me that each of the officers formed the view that Rebecca appeared to be seriously intoxicated. Although the officers were unsure of the cause of Rebecca's intoxication, each surmised it to be alcohol or drugs or a combination of the two.

44. In an interview with investigating police, Sgt Brooks said that DT told him they had been drinking alcohol but denied using anything else. SC South gave a similar account of this conversation during her interview with investigating police. However, in his oral evidence at the inquest, Sgt Brooks said that both DT and Rebecca indicated they had taken drugs earlier that day.

45. Sgt Brooks decided that SC South and SC Coleman should take Rebecca to Maitland police station to be detained there as an intoxicated person pursuant to s. 206(4) of LEPRA. This provision allows a police officer to take an intoxicated person to an authorised place of detention and detain them there if a responsible person cannot be found to take care of the intoxicated person. There was evidence before the inquest that Sgt Brooks nominated Maitland police station as

opposed to the closer Cessnock police station because Maitland had the benefit of a 24 hour custody manager.

46. Sgt Brooks told the inquest that, in reaching his decision to detain Rebecca as an intoxicated person, he considered releasing Rebecca into DT's care but did not consider him to be a responsible person, as DT was himself intoxicated and had been unable to stop Rebecca from walking out onto the road. Sgt Brooks said that he did not attempt to have Rebecca taken to her Raymond Terrace home address because he doubted that she lived at that address and assumed there would be no responsible person there. Rebecca had also indicated she was not going anywhere without DT.

47. At the request of SC South, Rebecca, guided by SC South and SC Coleman, walked to the van and got into the rear of the caged section.

## Police do not search Rebecca at Cessnock

48. Section 208 in Part 16 of LEPRA authorises police to search a person detained as an intoxicated person and to remove any personal belongings found on them.

49. Sgt Brooks stated that he asked Rebecca and DT whether they had anything in their pockets at the same time he asked for their identification. Sgt Brooks said that DT turned out his pockets but he could not recall whether Rebecca did. He did recall that Rebecca pulled earphones out of her pocket, although no earphones were found in Rebecca's property or clothing after her death.

50. SC South gave evidence at the inquest that she had originally intended to conduct an ordinary search of Rebecca. However, while SC South was escorting Rebecca to the van, Sgt Brooks said something to SC South which caused her to immediately stop touching Rebecca. Rebecca continued walking to the back of the van. SC South conducted no ordinary search of Rebecca at Cessnock and nor did any other officer.

51. Sgt Brooks and SC South gave conflicting evidence as to what Sgt Brooks said to SC South while she was escorting Rebecca to the van. SC South told investigating police that Sgt Brooks said to her, "*Did you hear the warnings? … She's got AIDS. Don't search her, just put her in the back of the truck*." SC South

told the inquest, "*Sergeant Brooks said something along the lines of 'Just put her in the back of the truck', I from that assumed that he said not to worry about searching her, although I had made my own decision not to search her at that time*". By contrast, Sgt Brooks said he warned SC South that Rebecca had "*HIV and Hep C just be careful*" but denied directing SC South not to search Rebecca. He said that, as a matter of general practice, he does not give directions to escorting police about searches.

52. SC South and SC Coleman also gave conflicting evidence as to whether SC South asked Rebecca whether she had anything in her pockets. While SC South gave evidence that she performed no more than a "*visual search*" of Rebecca and could not see that she had any pockets, SC Coleman told the Court he heard SC South ask Rebecca whether she had anything in her pockets.

53. Counsel Assisting submitted that, where there were conflicting factual accounts between SC South and Sgt Brooks and/or SC Coleman, SC South's evidence should be preferred. This was on the basis that she generally presented as a credible witness, who was prepared to make some admissions against her own interests and gave a more nuanced account of events. By contrast, and as will be explored further below, both Sgt Brooks and SC Coleman gave evidence that was not, on occasion, credible. For the reasons submitted by Counsel Assisting, I do accept the evidence of SC South where it conflicts with the evidence of Sgt Brooks and SC Coleman.

54. It is clear to me from SC South's evidence that the dominant reason for not searching Rebecca at Cessnock was a perceived health risk of contracting HIV or Hepatitis C from Rebecca. SC South consistently expressed concern that, when she spoke, Rebecca was "*projectile splattering*" such that she thought she might be exposed to an infectious disease. SC South told the inquest that, even if she wore a mask, her eyes would still have been exposed. She said that she was particularly concerned given that, at the time of detaining Rebecca, she thought she might be pregnant. Her evidence was that the only way to avoid the risk of being struck by body fluids from Rebecca would have been to forcibly search her involving two officers, one using their arm to hold Rebecca's head so that it faced away from the officers.

55. There was also evidence from SC South and Acting Sergeant Greg Hosie ("A/Sgt Hosie") that Rebecca smelled quite strongly as if she had not showered for a few days. As will be explored further below, this may have been relevant to the level of care she received when she reached Maitland police station.

## Rebecca and DT enter the van

56. There was evidence before the inquest that DT picked up a bag from where he and Rebecca had been sitting and, with the consent of police, got into the back of the police van and sat with Rebecca.

57. SC Coleman and Sgt Brooks gave inconsistent descriptions of the bag collected by DT. Sgt Brooks described a leopard print handbag. This matches the appearance of the handbag that police obtained from DT after Rebecca's death, which contained belongings of both Rebecca and DT. By contrast, SC Coleman described the bag as a reusable shopping bag. He denied seeing a leopard print handbag, but said it was possible that that bag was inside the shopping bag. Counsel Assisting has submitted that this inconsistency does not need to be resolved and I agree.

58. The evidence was that, at some point around this time, SC South conveyed Sgt Brooks' warning about Rebecca to SC Coleman, although SC Coleman could remember only the reference to HIV.

## Rebecca is transported to Maitland police station

59. SC South and SC Coleman drove Rebecca and DT to Maitland. The trip took between 20 and 30 minutes.

60. SC South and SC Coleman both gave evidence of hearing Rebecca and DT either arguing or speaking in "*elevated voices*" during the trip. This is consistent with what DT told investigating police. DT said that, during the journey, he asked Rebecca to give him back his bottle of tablets but she refused to do so.

61. During the journey, SC Coleman telephoned Maitland police station and spoke to the custody manager A/Sgt Hosie. SC Coleman told A/Sgt Hosie that they were conveying to the police station an intoxicated person in a dishevelled state who was HIV positive.

62. SC South and SC Coleman dropped DT near Maitland railway station and arranged for DT to take Rebecca's bag with him. SC Coleman told the Court that this was because he wished to avoid preparing paperwork caused by entering the bag into police custody. SC South suggested that an additional reason was "*because of the AIDS and all*"; that is, to avoid contracting an infectious disease by handling the bag or its contents.

## Rebecca arrives at Maitland police station

63. CCTV footage indicates that the police van transporting Rebecca arrived at Maitland police station at 1:24am. At 1:25:10am, Rebecca exited the van, stumbling as she did so. She was wearing a pink or orange coloured jumper, three quarter length black pants and shoes.

64. Rebecca walked through the doorway to the charge room at the end of the van dock corridor, followed by SC South and SC Coleman. At 1:25:26am, Rebecca can be seen to stumble and was held up by SC Coleman.

## 1:25am – Rebecca is taken to cell 4

65. At 1:25:39am, Rebecca followed SC Coleman down the van dock corridor to cell 4. The inside of cell 4 was visible to persons in the corridor outside. There were also CCTV cameras in the corridor and one in cell 4. Monitors in the charge room showed the feed from the CCTV cameras.

66. SC Coleman opened the door to cell 4 and Rebecca entered it. CCTV footage shows Rebecca staggering and falling forward before she pushed herself up and sat on the bench in the cell. SC South and A/Sgt Hosie were standing at or just outside the doorway of cell 4 at this time.

67. At 1:26:05am, Rebecca removed her shoes at SC South's request, and SC South kicked them out of the cell. SC South threw two blankets onto the floor in the cell. Rebecca pulled the mattress from the wall it was leaning against and spread a blanket out on the mattress. SC South then left the cell.

## Warnings, search and opportunity to contact responsible person

68. At some stage, SC Coleman informed A/Sgt Hosie that Rebecca's CNI check contained a warning as to a risk of self-harm. By this stage, A/Sgt Hosie was also aware of the warning about HIV and Hepatitis C. A whiteboard in the charge room was used to provide information to oncoming police about persons kept in the cells. On that whiteboard, A/Sgt Hosie recorded that Rebecca was being detained as intoxicated and made a notation of "*HIV*" and "*Hepatitis C*". He did not record any other information, including the warning about Rebecca's risk of self-harm, her level of intoxication, or his inability to complete a risk assessment of Rebecca.

69. A/Sgt Hosie stated in his oral evidence that he did not know why he did not record any further information. He denied that he had been more concerned for the welfare of police than he had for the welfare of Rebecca. However, Counsel Assisting has submitted that this is the only rational inference available. In response, A/Sgt Hosie submitted through his counsel that his actions (in the context of his subjective belief that he was only dealing with an intoxicated person who was "*sleeping it off*" and appeared "*normal*") did not rise to the only inference asserted by Counsel Assisting. In my view it was most likely a combination of both.

70. It is clear that Rebecca was not searched while at Maitland police station. Both A/Sgt Hosie and SC South provided an account of a conversation where SC South told A/Sgt Hosie that she had not searched Rebecca due to her concerns about contracting an infectious disease, and SC Hosie agreed that it was not necessary in the circumstances.

71. It is also clear that A/Sgt Hosie did not make attempts to give Rebecca an opportunity to contact a "*responsible person*" after she arrived at Maitland police station, as required under s. 207(2)(a) of LEPRA. A/Sgt Hosie told the inquest that he was not aware of his obligation, as a custody manager, to do so and did not think of making any enquiries.

### 1:26am – Rebecca asks for food and uses toilet

72. At around 1:26am, Rebecca asked SC South and then A/Sgt Hosie for some food. SC South responded to the effect that Rebecca would not be fed because

she would not be detained for that long. When asked about this at the inquest, SC South stated that the reason she said this was because it was past the cut-off time for provision of a meal. SC South said she was unaware that there was a specific provision of Part 16 LEPRA as to the need to provide intoxicated persons with food and other sustenance appropriate to the person's needs.

73. The two officers then left the cell and locked Rebecca in. CCTV footage shows Rebecca staggering over to look through the perspex door.

74. At 1:27am, Rebecca walked over to the toilet. She could not walk in a straight line. The CCTV footage from the camera in cell 4 is limited because the area of the toilet is permanently blacked out for privacy reasons. What can be seen is that Rebecca discarded a piece of toilet paper, dropped the toilet paper roll and struggled to pull up her pants.

75. The piece of toilet paper Rebecca discarded was discussed by police, who were watching Rebecca on the CCTV monitor in the charge room, as having "*blood on it*". In the police investigation following Rebecca's death, that piece of toilet paper was reported to have on it what appeared to be a bloodstain.

### 1:29am – Rebecca sits on mattress and slumps forward

76. CCTV footage shows that, at 1:29am, Rebecca spread one of the blankets out on the mattress then sat down. She rolled up the left leg of her pants.

77. The quality of the CCTV footage is not good enough to be certain as to exactly what Rebecca did at this point. Counsel Assisting submits that it is possible that Rebecca either retrieved or secured in position a pill bottle. However, on behalf of Rebecca's family, Mr de Mars submitted that I could comfortably conclude that Rebecca did not, at this point, place a pill bottle in the rolled up left leg of her pants, because she would have had to have such a bottle in her hands prior and the CCTV footage show that her hands are empty. The location of the pill bottles is explored in more detail below.

78. What is clear is that Rebecca sat up on the bed when A/Sgt Hosie came to the door shortly afterwards. They had a conversation through the door, and A/Sgt Hosie returned to the charge room. Rebecca started to slowly slump forward

before sitting back upright again. At 1:30am, Rebecca leaned forward, lost her balance and appeared to touch the toilet paper on the floor.

79. At 1:32am, Rebecca, still sitting on the mattress, leant forward with her arms hanging on the floor and appeared unable to hold herself up before she sat back with her elbows on her knees. She repeated this behaviour a couple more times.

80. At 1:33am, Rebecca looked as if she was going to fall over onto the floor. In the charge room, A/Sgt Hosie and SC South watched Rebecca on the CCTV monitor. SC South then left the charge room and walked to cell 4. SC South gave evidence that her concern at this point was that Rebecca might fall over and hurt her head, not that she might be losing consciousness.

81. SC South appeared to speak to Rebecca through the cell door without getting a response. SC South then kicked the cell door and Rebecca sat up. SC South told Rebecca to lie down on the mattress and returned to the charge room.

### 1:34am – Rebecca lies down on mattress

82. At 1:34.30am, Rebecca stood up, leant on the mattress and lay down on her right side with her back to the cell CCTV camera. Her right arm was stretched out above her head and her knees were tucked up slightly with her left arm in front of her. Rebecca did not change her position before she died.

83. Counsel Assisting submitted that the evidence shows that police officers who saw Rebecca on the CCTV monitor screen in the charge room had concerns about her health. SC South gave evidence that she either mentioned to A/Sgt Hosie, or else simply thought to herself, that it looked like Rebecca may have been dead. This was within the hour or so that SC South and SC Coleman remained at the police station after delivering Rebecca.

84. By 1:34:30am, SC South had returned to the charge room after speaking to Rebecca through the cell door. On more than one occasion, particularly in the early part of Rebecca's detention, A/Sgt Hosie used the zoom function on the CCTV camera for cell 4 to get a close-up view of Rebecca lying on the mattress.

85. When talking to police investigators on 19 July 2016, SC South said she thought that A/Sgt Hosie had responded to her drawing attention to the fact that Rebecca

had not moved and looked as if she may be dead by saying, "*No, I can see her chest rising*". However, in her evidence at the inquest, she said she raised it with SC Coleman.

86. On the CCTV footage, SC South can be seen to have a series of exchanges with A/Sgt Hosie at around 1:33am. From the gestures made by SC South during the conversation, it appears that at least part of the discussion concerned the reasons she did not conduct a search of Rebecca. SC South is visible in the charge room thereafter, from 1:48:36am to 1:55:10am, and then again from 2:04am to 2:21am, during which periods both A/Sgt Hosie and SC Coleman were also present.

## 1:55am – Custody Management Record

87. At around 1:55am, A/Sgt Hosie entered data in the NSWPF computerised custody management record ("CMR") for Rebecca.

88. There was evidence before the inquest that each CMR has a number of components, including the detained person's details, a brief assessment, a visual assessment, a vulnerability assessment, a questionnaire, and other "*actions*", which relevantly include details of inspections. The visual assessment, vulnerability assessment and questionnaire are all "*mandatory actions*", which means that, in theory, they must be completed before the CMR can be finalised. However, the inquest heard evidence that it is possible for a custody manager to defer completing the mandatory actions until the point at which the prisoner or detainee was to be released. Each topic or question in the mandatory actions included a section for the custody manager to enter comments.

89. The NSWPF Custody Management System ("CMS") indicates that A/Sgt Hosie listed the address for Rebecca as her home address of 22 Windsor Street, Raymond Terrace. Against "*ATSI Status – Aboriginal/Torres Strait Islander*", the word "*refused*" appears. The inquest heard evidence that the only options which A/Sgt Hosie could select were "*Yes*", "*No*" and "*Refused*".

90. The digital record for Detained Person's Details shows that in the field for Next of Kin, the word "*incoherant* [sic]" appears. This does not appear in the printed copy tendered as part of the inquest. A/Sgt Hosie told the inquest that he did not write

the word "*incoherant*" in Rebecca's CMR, and that it may have been entered by SC Coleman when he completed the Field Arrest Report. However, there was no field for "*Next of Kin*" in the Field Arrest Report. Further, in the vulnerability assessment section of the CMR, A/Sgt Hosie entered "*Unable to obtain this information due to her intoxicated state*".

91. A/Sgt Hosie told the Court that, although there were other NSWPF databases he could consult to try to find records of Rebecca's next of kin or someone who could look after Rebecca, he did not give this any consideration. A/Sgt Hosie did not think of making an inquiry as to whether there was anyone at Rebecca's home address who could take care of her that night.

92. In the visual assessment section, against the topic "*Illness*", A/Sgt Hosie entered the comment, "*Appears to be seriously effected [sic] by intoxicating liquor or drug*". Although scars on Rebecca's left wrist were found on autopsy, A/Sgt Hosie responded to the question, "*Does the person have scars or injuries that suggest previous attempts at self-harm"* with the response *"No".* To the question, "*Does the person appear irrational*", A/Sgt Hosie responded "*No*". In a comment at the end, A/Sgt Hosie wrote, "*Appears to be seriously effected [sic] by intoxicating liquor or drug, seen to be very unsteady on feet*"

93. In the vulnerability assessment section, A/Sgt Hosie answered four of the six questions "*Not Known"*, including the question "*Is this person Aboriginal or Torres Strait Islander*". As noted above, in the comments for this section, A/Sgt Hosie wrote, "*Unable to obtain this information due to her intoxicated state*".

94. The inquest heard evidence that the questionnaire in particular is part of a risk assessment process, and is meant to be completed by asking the detainee questions. In this case, the questionnaire, which includes questions in relation to a detainee's health and mental condition, was completed by A/Sgt Hosie without attempting to ask Rebecca any of the questions in it. His evidence was that he did not ask Rebecca any questions because of her level of intoxication.

95. Counsel Assisting submitted that the requirement to complete the mandatory actions indicate that they are essential to the proper assessment of whether the detainee was in need of medical care. An inability to complete them due to the

detainee's condition would necessarily indicate that the detainee was so incapacitated that police were unable to assess whether the detainee was fit to be kept in detention. A/Sgt Hosie's failure to complete the mandatory actions, particularly the questionnaire, was indicative that Rebecca was in a state where she should not have been kept in police detention but instead taken to a hospital.

96. I accept Counsel Assisting's submissions.

## 3:00am – Sgt Brooks visits Maitland police station

97. At around 3.00am, Sgt Brooks arrived at Maitland police station. He spoke with A/Sgt Hosie in the charge room. CCTV footage shows A/Sgt Hosie appearing to mimic Rebecca slumping forward during this conversation. When he was shown this footage at the inquest, Sgt Brooks told the inquest he could not remember "*at all*" what he talked about with A/Sgt Hosie at that point.

98. Both officers spent a substantial amount of time looking at the CCTV monitor. At about 3:10am, Sgt Brooks conducted a visual inspection of Rebecca from the van dock corridor through the perspex into cell 4. He did not attempt to rouse her. He later said, "*I could see that she was lying on her right side and her stomach was rising and falling*." Counsel for Sgt Brooks submitted that Sgt Brooks observed no abnormal breathing pattern and had no concerns with respect to Rebecca's breathing. He did, however, concede that Sgt Brooks had no medical training with respect to types of breathing patterns that should cause a Custody Manager concern.

99. Sgt Brooks spent further time in the charge room, mainly speaking with A/g Sgt Hosie. Sgt Brooks was not prepared to speculate in his evidence at the inquest as to the likely topics of conversation with A/Sgt Hosie, and continually responded that he had no recollection of what they talked about.

100. Counsel Assisting submits, and I accept, that given Sgt Brooks' seniority and experience, and what can be seen in the CCTV footage of the time that he spent with A/Sgt Hosie in the charge room discussing Rebecca, I can be reasonably satisfied that A/Sgt Hosie and Sgt Brooks spent time discussing the general topic of Rebecca's initial detention and her health, including her infection status and the concerns which had earlier been discussed about Rebecca's breathing.

101. This conclusion is supported by evidence from SC South that she heard SC Coleman say that A/Sgt Hosie had a conversation with Sgt Brooks, in which Sgt Brooks stated that they had to watch Rebecca because her breathing was shallow. Although Sgt Brooks said in his oral evidence that "*there was definitely no discussion*" about Rebecca's health, I note my earlier comments about the credibility of this witness as compared to SC South. I have also taken into account the gestures that Sgt Brooks can be seen to make in the CCTV footage.

102. Commencing at about 4:43am, Sgt Brooks made entries in police records relating to the events involving Rebecca and DT at Cessnock. Counsel Assisting notes that both sets of entries recorded that Rebecca and DT were "*searched with nothing found*". However, as noted above, Sgt Brooks gave evidence at the inquest that he did not conduct an ordinary search but simply asked Rebecca and DT to turn out their pockets. His evidence was that he had left the searching of Rebecca up to the escorting officers.

103. I find these two COPS entries to be misleading. They leave the reader with the impression that Rebecca and DT had been searched and nothing was found. A more accurate entry would have been that the pair were asked to turn out their pockets and nothing of interest was seen or seized. On behalf of the family, Mr de Mars submitted that the COPS entries are even more particular in suggesting that a substantive search of Rebecca and DT had been conducted, and that the nature of the entry clearly misrepresents what had occurred. I accept this submission.

## Checks conducted on Rebecca

104. The CMR for Rebecca also comprises a series of additional actions for Inspection. The time and date for each such entry is automatically recorded by the CMS and each entry contains a comment.

105. The evidence shows, however, that many of the inspection entries made by A/ Sgt Hosie do not correspond with him physically going to cell 4. Similarly, on a number of occasions where CCTV footage shows that he did go to cell 4 and look into the cell, it is not recorded in Rebecca's CMR. Accordingly, the CMR is not a reliable record of what A/g Sgt Hosie did by way of inspection of Rebecca.

106. On a number of occasions whilst he was in the charge room, A/Sgt Hosie can be seen to look at the image of Rebecca on the CCTV monitor. A/Sgt Hosie explained to the Court that a number of his inspections of Rebecca were carried out this way. It should also be noted that A/Sgt Hosie relied on the CCTV monitor to conduct inspections of the two other detainees in custody at Maitland police station at the time. However, inspecting prisoners or detainees by looking at them on a CCTV monitor is contrary to the instruction, set out twice, in the Code of Practice for CRIME, to conduct inspections in person.

107. The CCTV shows that A/Sgt Hosie also conducted six visual checks, which involved him looking through the perspex door into cell 4 from the corridor. During these checks, the lights in the cell were off in Rebecca's cell. They remained off until 5:55:46am. The only source of light was a fluorescent-style night light in the ceiling of the van corridor, outside the cell.

108. At no point between 1.27am and 5:51am did A/Sgt Hosie or any other officer enter Rebecca's cell and attempt to physically rouse Rebecca to check on her breathing and consciousness level.

109. Counsel Assisting submitted that there is more than one possible reason why police did not enter Rebecca's cell to physically check on her wellbeing, including:

(a) A smell emanating from the cell. Although A/Sgt Hosie denied that this was a reason, the CCTV footage shows him conducting his inspections more than once while covering his mouth and nose with his arm and elbow, seemingly to guard against an unpleasant smell;

(b) Lack of knowledge/training. A/Sgt Hosie said he had not been trained to physically attempt to rouse an apparently sleeping intoxicated person to check their level of consciousness. Sgt Brooks and SC Coleman also gave evidence that they were unaware of this requirement; and

(c) Lack of concern for Rebecca's welfare relative to concern for welfare of police. Examples of this attitude include: the failure to

search Rebecca for fear of contracting an infectious disease; the failure to note on the whiteboard the warnings about Rebecca's risk of self-harm; A/Sgt Hosie's conduct in the charge room in which he mimicked Rebecca's stumbling in the police station as the behaviour of a chimpanzee; and a prevailing sentiment in relation to Rebecca's level of intoxication, which seems to have been to simply "*let her sleep it off*" (that is, to simply accommodate Rebecca and not to care for her).

110. Counsel for A/Sgt Hosie submitted that the primary reason for police not entering Rebecca's cell was because of their "*collective subjective belief that she was not in danger*". However, Rebecca's family have submitted that, in light of what can be seen on the CCTV footage and other evidence, it is difficult to escape the conclusion that "*distaste*" for the physical state Rebecca was in was a significant factor in the manner in which police dealt with her. I respectfully agree with this submission.

## Concerns about Rebecca's breathing

111. There is evidence to suggest that, from what could be seen on the CCTV monitor of Rebecca lying on the bench on cell 4, police had concerns about her manner of breathing during the first half of her detention.

112. CCTV footage from the charge room shows several officers, particularly A/Sgt Hosie, spending a relatively long time studying the footage from cell 4. The only movement which was apparent on the monitors, and which therefore could have been the subject of discussion or concern, was a rise and fall in the area of Rebecca's waist and lower back.

113. The CCTV footage shows that after checking on Rebecca, A/Sgt Hosie had a conversation with A/Sgt Jonathan Cassidy in which he appears to be demonstrating the manner of Rebecca breathing. He can be seen holding his two hands at the left side of his lower torso and making a pushing in movement. A/Sgt Hosie then zoomed in on the monitor screen, and the pair watched Rebecca's breathing on the monitor intently and for an extended period of time.

114. A/Sgt Cassidy gave evidence that A/Sgt Hosie was expressing concerns about Rebecca due to her breathing, and zoomed in on the monitor. After observing Rebecca on the monitor, A/Sgt Cassidy gave evidence that he was of the view that "*it appeared as though her breathing wasn't normal. You could clearly see her stomach suck in in a sharp motion and was slow to push out*." A/Sgt Hosie denied that A/Sgt Cassidy had said anything to him about Rebecca's manner of breathing. His evidence was that, if A/Sgt Cassidy had said any such thing to him, he would have called an ambulance.

115. A/Sgt Hosie told the inquest that he either mentioned to another officer, possibly SC Coleman, or thought to himself that he was considering getting Rebecca checked over by an ambulance. However, he said that it was "*just a general consideration because of her intoxicated, dirty state*" and not for a specific reason. He also said it may have been because he had "*noticed the deep breaths*" although he had thought that was "*was just part of her being intoxicated*". SC Coleman said that he raised with A/Sgt Hosie the subject of calling an ambulance, however, A/Sgt Hosie maintained that it was he who raised it.

116. SC Coleman also gave evidence that he said to A/Sgt Hosie he wouldn't like Rebecca to vomit or choke on her vomit. A/Sgt Hosie denied any recollection of this comment.

117. Counsel Assisting submitted that a conclusion can be drawn that, at a relatively early stage in Rebecca's detention, A/Sgts Cassidy and Hosie and SC Coleman all had concerns about Rebecca's breathing being abnormal and consideration was given by SC Coleman and/or A/g Sgt Hosie to calling an ambulance. Counsel Assisting further submitted that it reflects poorly on the credit of A/Sgt Hosie that, after being taken to CCTV footage of his apparent conversations with A/Sgt Cassidy and SC Coleman about Rebecca's breathing, during which he made gestures on his torso and his stared intently at the CCTV monitor for extended periods, he did not concede that it is likely he expressed concern to any officer about Rebecca's breathing. I accept these submissions.

## 5.40am – final recorded inspection of Rebecca

118. At 5:30.00am, A/Sgt Hosie looked up at the CCTV monitor and then left the charge room in the direction of the muster room. At 5:35.18am, A/Sgt Hosie returned to the charge room and thereafter he moved back and forth from the charge room in the direction of the muster room and back again.

119. A/Sgt Hosie's final recorded inspection in the CMR is at 5:40am and is accompanied by the comment "*Sighted, sleeping in cell, nil issues*". In this entry, the inspection frequency was also changed from 30 minutes to 60 minutes. While A/Sgt Hosie denied making that change manually, Counsel Assisting submitted that the evidence in relation to the functions of the CMR, which should be accepted, is that the change could only be made manually.

120. Counsel Assisting submitted that the CCTV footage appears to show that the last movement of Rebecca's waist or lower back was at 5:22:05am. He submitted that it should therefore be concluded that A/Sgt Hosie's final inspection of Rebecca was not only conducted by CCTV monitor, but also that it was not even an attempt at an inspection. By that time, according to what can be seen on the CCTV footage, the movements of Rebecca's waist or lower back had long ceased. Despite this, by 5:40am, A/Sgt Hosie was apparently satisfied that Rebecca did not need close monitoring and, by changing the inspection frequency to 60 minutes, signalled as much to the oncoming custody manager.

121. Counsel Assisting submitted, and I agree, that it should be concluded that, at least by 5:40am, despite the entries he was making in the CMS, A/Sgt Hosie was not making serious attempts to monitor or inspect Rebecca.

122. CCTV footage shows that, at 5:51am, A/Sgt Hosie looked at the CCTV monitor in the charge room and then walked down to cell 4. A/Sgt Hosie looked through the perspex at Rebecca and moved his head closer. He knocked on the perspex a number of times. Rebecca did not respond.

123. At 5:52:32, A/Sgt Hosie walked away in the direction of the muster room and, shortly after, returned to cell 4 with A/Sgt Cassidy.

### 5:52am – Police enter cell 4

124. At 5:52.41am, A/Sgt Hosie entered cell 4. He did not touch Rebecca at this stage. A/Sgt Hosie then left the cell and returned at 5:53.14am wearing gloves. A/Sgt Hosie entered the cell and then left again for a brief time. He re-entered the cell again at 5:53.26am. A/Sgt Hosie called out to Rebecca but she did not respond. He touched Rebecca on the shoulder. A/Sgt Cassidy entered the cell.

125. Both A/Sgts Hosie and Cassidy later said that Rebecca's skin looked purple or blue. A/Sgt Cassidy also saw what appeared to be vomit on the blanket and around Rebecca's mouth and nose. A/Sgt Hosie described seeing phlegm in that position.

126. A/Sgt Hosie shook Rebecca with two hands but she did not respond. He is reported as saying to other officers that Rebecca was not breathing. By this stage, a third officer, SC Nichols, was standing outside the cell.

127. At 5.54am, A/Sgts Hosie and Cassidy ran out of the cell. A/Sgt Hosie returned with a defibrillator, although he did not know how to use it. He was shortly followed by several other officers including Inspector Craig Reid ("Insp Reid"), A/Sgt Cassidy and Constables Nicky Taggart and Ryder. At the same time, SC Nichols called "000" from the charge room.

128. It should be noted that it took more than two minutes after A/Sgt Hosie observed from his final visual inspection that he could no longer detect any movement of Rebecca's torso before he actually came into physical contact with Rebecca. Although this may not sound like much time, the reality is that Rebecca was not breathing and it was a situation that required far more urgency than is apparent from A/Sgt Hosie's actions visible on the CCTV footage. When asked to explain this delay, A/Sgt Hosie's response was "*I don't know how to explain that*".

## 5:55am – Police attempt to resuscitate Rebecca

129. At 5:54.53am, Insp Reid entered the cell and put on gloves. He checked Rebecca's pulse and looked for any rise and fall of her chest but found no activity. Insp Reid, assisted by other officers, rolled Rebecca onto her back and commenced CPR at 5:55.42am. Insp Reid told investigating police that he smelt vomit and he and other police officers saw what they thought was vomit or yellow

mucus on and around Rebecca's head. At about 6am a defibrillator was used on Rebecca but indicated no shockable rhythm of the heart.

130. At 6:02.27am, paramedics arrived in the cell and took over attempts at resuscitating Rebecca. However, the evidence of attending paramedics was that there was no electrical current in Rebecca's heart. The paramedics reported "*large amounts of vomit material and fluid regurgitated with each compression*" during CPR, and also noticed dry vomit on and around Rebecca's head and clothes.

131. At 6:07.29am, paramedics ceased administering CPR to Rebecca and she was pronounced dead.

### 8:18am – crime scene investigation

132. At about 8:18am, Detective Senior Constable Sven Gerber and Senior Constable DT Costelloe arrived at Maitland police station to conduct a crime scene investigation. During the course of that investigation, DSC Gerber observed that there was visible fluid around Rebecca's mouth, nose and neck areas and on her hands, which he believed to be vomit. He also noticed that there was red coloured staining on toilet paper sitting on the floor of the cell.

133. DSC Gerber found two chemist's pill bottles inside the left leg of Rebecca's pants, one with a red cap and one with a white cap. He also found one Alprazolam tablet on Rebecca's back in the area where her bra strap had been.

134. I am satisfied on the evidence that the bottle with the red cap was the bottle of tablets given by DT to Rebecca at Wollombi Road. When found, this bottle was bloodstained and contained nine Alprazolam tablets and one Clonazepam tablet. I am also satisfied that the bottle with the white cap was the bottle that had been dispensed to Rebecca by Mr Gael at Priceline Pharmacy, Cessnock. When found, this bottle was not bloodstained and contained 19 whole and two half Alprazolam tablets plus two Clonazepam tablets.

### 12:20pm – notification of death to Rebecca's mother

135. At around 12:20pm, at Raymond Terrace, an acting sergeant and a leading senior constable personally advised Debbie of her daughter's death. This was

more than six hours after Rebecca had been found dead, although it appears that the officers could not initially locate Debbie.

136. Counsel Assisting submitted the overall delay in notifying Debbie of her daughter's death and the fact that Debbie was not notified by a commissioned officer, as required by the NSWPF Handbook, is a matter of concern. No evidence was given at the inquest to explain this delay.

137. Further, in the death message conveyed for forwarding to Debbie, Raymond Terrace police were told Rebecca had been "*subject to regular checks by the custody manager*" and accordingly told Debbie that "*Throughout the night Rebecca was regularly checked as per our guidelines*". This information was not only wrong but obscured a material factor contributing to Rebecca's death.

## *Cause of death*

138. The weight of the expert evidence was that the levels of Alprazolam and Methadone detected in Rebecca's blood sample were both in the toxic and potentially fatal range for each of those two drugs, and that the combination of those substances could also be fatal.

139. As noted above, the autopsy report records the direct cause of death as "*mixed drug toxicity*". It notes, "*this mix of drugs could act synergistically causing significant sedative/respiratory depression leading to fatal respiratory failure*". The weight of the expert evidence at the inquest, and the written submissions of the parties, supported this finding.

140. The autopsy report further records the presence of cannabis and non-toxic levels of other benzodiazepine drugs/metabolites and Mirtazapine in Rebecca's system, which may have contributed to Rebecca's overall sedation.

141. I also note the evidence of Dr John Vinen, expert in emergency medicine, who identified the conditions leading to Rebecca's death as:

(a) decreased level of consciousness;
(b) leading to respiratory depression/possibly partially obstructed airway;
(c) followed by aspiration of gastric contents; and

(d) followed by death.

142. The autopsy report raised the question of whether vomitus material found in Rebecca's airways had implications for the cause of death or whether it occurred as a result of CPR. However, it appears from the evidence of several police officers involved in resuscitation attempts that vomitus was present around Rebecca's face before police attempted CPR. The autopsy report does not express a firm conclusion on this issue, but notes that heavily sedated individuals are at a significant risk of aspirating vomit. This was also noted by Dr Vinen, who opined that aspiration of vomitus contributed to Rebecca's death and may have been a major factor in her death.

143. On behalf of Rebecca's family, Mr de Mars submitted that the cause of death be recorded as "r*espiratory depression after loss of consciousness caused by mixed drug toxicity and possibly aspiration of vomit*". This was supported by Counsel Assisting. Although aspects of this submission were contested by other parties, I am satisfied that it is a fair summary of cause of death.

## Issues explored at the inquest

144. A list of issues was circulated to the interested parties in advance of the inquest outlining the areas of interest for the inquest. The issues can be broadly categorised as follows:

(a) The circumstances by which Rebecca obtained and consumed prescription drugs on 18 July 2016;
(b) The circumstances and appropriateness of Rebecca's detention and requirements of the relevant legislation;
(c) The appropriateness of police actions once Rebecca was detained; and
(d) The reason for the six hour delay in notifying Debbie of Rebecca's death.

145. I will deal with these issues in turn. I note that, in making findings, I have had regard to the principles established by *Brigenshaw v Brigenshaw*.[3]

## *The drugs*

### (a) Where did the drugs which Rebecca had consumed come from?

#### *Methadone*

146. As noted above, Rebecca was dosed by the Pharmacotherapy Service at Newcastle at 8.05am on 18 July 2016 with 150mg (30mls) of Methadone. I accept the evidence of Professor Alison Jones (toxicologist) and Dr Hester Wilson (GP) that this dose was within acceptable limits of clinical practice.

147. I also accept the evidence from Professor Jones, which Dr Wilson agreed with at the inquest, that the level of Methadone found in in Rebecca's blood post-mortem was indicative of her having consumed more Methadone than the 150mg dose she received on the morning of 18 July 2016. It is therefore likely that Rebecca obtained and consumed more Methadone on 18 July 2016 than her dose from the Pharmacotherapy Service earlier that day.

#### *Alprazolam*

148. On the afternoon of 18 July 2016, Rebecca was dispensed a bottle of 50 x 2mg Alprazolam tablets by Mr Gael at Priceline Pharmacy in Cessnock. That bottle was found in the course of the crime scene investigation in the left leg of Rebecca's pants just above the left knee. By that stage, the bottle had 19 whole and two half tablets left in it. I am unable to make a finding from the evidence as to what happened to the balance of 30 pills.

149. A second bottle containing nine tablets of Alprazolam and one tablet of Clonazepam was also found in Rebecca's left pant leg near the upper thigh. I am satisfied that this was the bottle DT gave to Rebecca when Sgt Brooks approached them. Although DT evidently formed the impression that Rebecca intended to place this bottle in her vagina, he did not see this occur and there is insufficient evidence for me to make a finding in this regard.

[3] (1938) 60 CLR 336 per Dixon J at 362. For a recent restatement, see *Re Day* [2017] HCA 2; 91 ALJR 262; 340 ALR 368 (Gordon J) at [15]-[19].

150. I accept Professor Jones' evidence that the concentration of Alprazolam in Rebecca's blood post-mortem indicates that she consumed Alprazolam tablets within the rough period of 9:00pm on 18 July 2016 and the time of her death between 5:20 and 5:50am on 19 July 2016. On the basis of this evidence, Counsel Assisting submitted that the possibility that Rebecca consumed Alprazolam shortly after going into police custody cannot be excluded.

151. It is not possible to make a finding as to whether Rebecca consumed a tablet or tablets while in the back of the police van which took her and DT to Maitland. Mr Madden (for SC Coleman) and Mr Eurell (for SC South) separately submitted that it was highly unlikely that DT or Rebecca took tablets while in the van. In making this submission, Mr Madden drew my attention to DT's evidence that he and Rebecca "*freaked out*" when they saw police and that he did not see pills or pill bottles in the van, as well as DT's history of being stopped and searched by police. However, both Counsel Assisting and Mr de Mars submitted that this possibility cannot be excluded and that, in the circumstances, there would have been opportunity for Rebecca to consume tablets undetected at that time.

152. It is also not possible to make a finding from the CCTV footage of Rebecca on the toilet in cell 4 whether she extracted a bottle from her vagina at that time or whether, either while sitting on the toilet or on the mattress, Rebecca consumed a tablet or tablets. On behalf of SC South, Mr Eurell submitted that there is no evidence that Rebecca ingested any drugs or substances after 12:45am or while in police custody. However, Counsel Assisting submitted that both possibilities cannot be excluded, and noted that Rebecca had at some stage apparently placed an Alprazolam tablet underneath the back strap of her bra – consistent with an intention to secrete it but have it available to her. Further, in reply submissions, Counsel Assisting submitted that it seems more probable than not that the pill bottle which had been dispensed to DT was secreted in Rebecca's left pants legging at the time she entered the observation cell. The location of the pill bottles is dealt with further below.

***Mirtazapine***

153. Dr Gan, Rebecca's GP, gave Rebecca a prescription for Mirtazapine on 14 July 2016. However, PBS records do not indicate that Mirtazapine was dispensed to Rebecca on that prescription.

154. Early in the morning of 18 July 2016, DT had Mirtazapine dispensed to him by a pharmacy in Wallsend on a prescription. Three Remeron (Mirtazapine) tablets were found in Rebecca's handbag. The expiry date and batch number on the foils for those tablets are the same as those on the empty Remeron box in DT's property.

155. I am therefore satisfied that, on 18 July 2016, Rebecca had access to Mirtazapine dispensed to DT this is the likely source of the Mirtazapine found in Rebecca's post-mortem blood sample.

## (b) Was it appropriate for Dr Weerabaddana to prescribe Alprazolam to Rebecca?

156. Dr Weerabaddana gave written and oral evidence in relation to his consultation with Rebecca on 18 July 2016.

157. The consultation on 18 July 2016 was Dr Weerabaddana's first consultation with Rebecca and took around 14 minutes. Rebecca gave a history of significant anxiety and panic attacks, and told Dr Weerabaddana that she was on Alprazolam and had no allergies. She also said that other medications did not work for her anxiety and that she was not suicidal.

158. Dr Weerabaddana's evidence was that he conducted a physical examination of Rebecca and did not find anything of concern. He did not remember seeing track marks on the cavity of Rebecca's left elbow suggestive of old injecting drug use but said it was possible that he did not examine her arms.

159. Dr Weerabaddana gave evidence that he explained to Rebecca the addictive and sedative nature of Alprazolam before prescribing 2mg twice a day, and giving her a script for 50 pills with no repeats. He then obtained a phone authority from the Department of Human Services to dispense the medication on the PBS.

160. Dr Weerabaddana told the Court that he obtained an authority from Rebecca so he could get a patient history from her regular GP before his second

consultation with Rebecca. Rebecca advised him that her regular practice was Raymond Terrace Family Practice but said that she could not recall her doctor's name. Dr Weerabaddana did not call Raymond Terrace Family Practice to find out the name of Rebecca's treating GP.

161. Dr Weerabaddana stated that he was prepared to prescribe Alprazolam to Rebecca without seeing her previous medical records because he was concerned about her getting withdrawal symptoms. He also relied on the fact that the Department of Human Services did not alert him to another recent script for Alprazolam when he sought the phone authority.

162. Dr Wilson gave evidence that, in her expert opinion, Dr Weerabaddana's prescribing of Alprozalam to Rebecca was not in accordance with professional practice for a GP. This opinion was based on the following factors:

(a) It was Dr Weerabaddana's first consultation with Rebecca;

(b) The diagnosis of anxiety and panic attacks given by Rebecca was not questioned or verified;

(c) There is no patient history to suggest a diagnosis of panic disorder was made. This may have been due to Dr Weerabaddana not appreciating the difference between panic attacks (symptoms) and a panic disorder (diagnosis);

(d) Rebecca exhibited many of the attributes that should have alerted a doctor that the patient was high risk: she was an unknown patient, asking for a specific psychoactive drug that is known to cause dependence and who stated that no other drugs had been effective; and

(e) Dr Weerabaddana had little understanding of the medical condition of dependency or addiction "*where individuals are not able to change their use despite harm*".

163. Dr Wilson gave evidence that, ideally, it would have been better for Dr Weerabaddana to direct Rebecca back to her usual doctor or take steps to corroborate information provided by Rebecca and/or obtain further relevant

information. Alternatively, Dr Weerabaddana could have prescribed a small amount of Alprazolam or liaised with Rebecca's local pharmacy to arrange staged and/or supervised supply.

164. As at July 2016, Alprazolam was a Schedule 8 drug under the Poisons and Therapeutic Goods legislation. Accordingly, Dr Weerabaddana would have required an authority from the Pharmaceutical Regulatory Unit at NSW Health to prescribe Alprazolam to Rebecca if, in his opinion, Rebecca was a drug dependent person.

165. When Dr Weerabaddana prescribed Alprazolam to Rebecca, he was not aware it was a Schedule 8 drug. He gave evidence that he was several years behind in his professional reading due to being busy with establishing his medical practice. Dr Weerabaddana conceded during his oral evidence that, in hindsight, and had he known of Rebecca being prescribed Methadone, he would not have prescribed Alprazolam. He stated that, in retrospect, he was "*overly naïve*" and is now more familiar with "*red flags*" which identify drug dependent persons.

166. Dr Weerabaddana gave evidence of the education programs he has done since July 2017 in relation to these issues. In her oral evidence, Dr Wilson acknowledged that the content of these courses addresses some of her areas of concerns about Dr Weerabaddana's prescribing of Alprazolam to Rebecca. Dr Weerabaddana also stated that he has not prescribed Alprazolam to anyone since around March 2017. He told the Court that he does not hesitate to contact previous doctors and other health care professionals "*to get further information from them regarding a patient to support my management and treatment of the patient*", and that he now takes a more holistic approach to the care of drug dependent patients.

167. I find that, in circumstances where there were signs to alert Dr Weerabaddana to the fact that Rebecca was a drug dependent person and he did not make any attempts to corroborate the information provided by Rebecca and/or obtain further information, his prescribing of Alprazolam to Rebecca in the absence of an authority was highly inappropriate.

***Is a referral necessary or desirable?***

168. Counsel Assisting has submitted that the evidence in the inquest warrants further investigation of Dr Weerabaddana's prescription of Alprazolam to Rebecca on 18 July 2016. He recommends that I give a transcript of the evidence to the Medical Council under s. 151A(2) of the *Health Practitioner Regulation National Law*.

169. In response, Ms Burke submitted, for Dr Weerabaddana, that this recommendation is unwarranted and seemingly punitive. Ms Burke submitted that the circumstances of the evidence referred to by Counsel Assisting does not account for the fact that Dr Weerabaddana's skill, experience and knowledge as a GP as at July 2016 did not provide him with the necessary "*red flags*" to suspect that Rebecca may be a drug dependent person, and that he now undertakes courses and a holistic approach in his practice. She also noted that, had Dr Weerabaddana called the doctor shopping hotline, that hotline would not have disclosed that Rebecca was a drug dependent or addicted person as she did not fit within the criteria

170. Ms Burke pointed to Dr Wilson's acknowledgement that it is possible for GPs to miss reading material or be unaware of the doctor shopping hotline, as well as her oral evidence of GPs' natural inclination to accept what a patient is telling them. She cited as significant Dr Wilson's evidence that Alprazolam and other prescribed restricted substances were known risks for patients and "*it is a skill that takes some time to learn as a doctor*".

171. However, this submission overlooks the fact that, when asked about the depth of her experience as compared to Dr Weerabaddana's, Dr Wilson acknowledged her particular expertise but stated, "*the reality is, if you are worried that someone is going to withdraw, then…it's part of the diagnosis of dependence. …They go together and it's not a highly specialist skill to be thinking that*". It also does not adequately address the fact that Dr Weerabaddana prescribed a Schedule 8 drug without knowing it was a Schedule 8 drug, nor his failure to contact Rebecca's claimed GP in Raymond Terrace before issuing a prescription.

172. Accordingly, I accept the submissions of Counsel Assisting and propose to give a transcript of the evidence to the Medical Council so that this matter can be investigated further.

### (c) Was it appropriate for the pharmacist, Mr Gael, to dispense Alprazolam to Rebecca?

173. As noted above, Mr Gael gave evidence that, when dispensing Alprazolam to Rebecca at around 5:20pm on 18 July 2016, he noticed that she was unstable on her feet, not functioning properly and apparently under the effect of a substance. One issue explored at the inquest was whether it was appropriate for Mr Gael to dispense a Schedule 8 medication to Rebecca in these circumstances.

174. Mr Gael gave evidence that, in hindsight, he considered that Rebecca's manner on 18 July 2016 was more likely due to her being "*anxious and requiring that particular medication to address her anxiety or panic*" than being intoxicated. However, he later conceded that his evidence that Rebecca was swaying on her feet was an indication of intoxication.

175. Mr Gael gave evidence that he would have verified the Alprazolam script supplied by Rebecca by his familiarity with Dr Weerabaddana's handwriting, and that, at 18 July 2016, he did not have any concerns about drugs of addiction prescribed by Dr Weerabaddana. However, he conceded that he "*probably*" had not exercised his independent judgment appropriately in dispensing Alprazolam to Rebecca, given she appeared intoxicated and was not previously known to him.

176. The inquest heard expert evidence from Mr Jonathan Feather, pharmacologist, to the effect that one action Mr Gael could have taken would have been to contact Dr Weerabaddana and confirm Ms Maher had a therapeutic need for the Alprazolam, and report that Rebecca appeared to be under the effect of a substance. At the inquest, Mr Feather was asked several questions about this conclusion by counsel for Mr Gael based on a series of 13 assumptions. Based on those assumptions, Mr Feather stated that the supply of Alprazolam to Rebecca on 18 July 2016 was probably warranted.

177. It appears to me that, in light of his observations of Rebecca's behaviour, it would have been prudent for Mr Gael to contact Dr Weerabaddana if practicable (noting that the exchange occurred around 5:20pm on a Monday). However, I agree with Counsel Assisting's submission that, on balance, and in light of Mr Feather's oral evidence at the inquest, Mr Gael's conduct on 18 July 2016

does not require further investigation. Based on his long experience as a pharmacist who regularly dispenses drugs of addiction, Mr Gael decided to dispense a legal prescription. The CCTV footage from the pharmacy shows that Rebecca's motor skills were impaired but she was able to take part in basic transactions such as paying for the medication.

### (d) Would the availability of real-time prescription monitoring in NSW have affected Rebecca's access to benzodiazepines during the period leading up to her death?

178. In her evidence, Dr Wilson expressed the view that a real-time prescription monitoring ("RTPM") service would be extremely useful for practitioners in NSW. This was also the evidence of Dr Weerabaddana. Dr Wilson noted that the Prescription Shopper Programme ("PSP") operated by the Department of Human Services identifies a limited range of patients, and that Rebecca probably would not have been identified by the PSP.

179. Counsel Assisting submitted that a RTPM would enable doctors to immediately get more information from a source other than the patient. Such a service would have readily identified that Rebecca was on a Methadone program and therefore a drug dependent person. This would have triggered the requirement for Dr Weerabaddana to obtain an authority from the Department of Human Service before prescribing Alprazolam to her.

180. The implementation of RTPM in NSW has been the subject of a number of coronial recommendations directed to NSW Health, most recently in March 2019.[4]

181. On 17 April 2019, a letter was sent to NSW Health requesting an update or submissions on behalf of NSW Health in relation to the implementation of RTPM in NSW, particularly in relation to the timing of the commencement of such a scheme. In a response dated 24 June 2019, NSW Health advised that it continues to support in principle the introduction of RTPM and is involved a national steering committee examining a potential funding model and technical

[4] See findings and recommendations of Deputy State Coroner Grahame in the Inquest into the deaths of DB, JD, DC, RG, AH &, AB, 1 March 2019; see further, findings in the Inquest into the death of Alissa Campbell, Inquest into the death of Paul Fennessy [2016] ACTCD 4 at [431] and Inquest into the deaths of Christopher Salib, Nathan Attard and Shamsad Akhta.

details for a National Data Exchange ("NDE"). The response notes that the architecture of the NDE requires clarity before NSW Health can determine the most effective and efficient approach in implementing any RTPM process. The response from NSW Health does not provide any dates or anticipated timeframes.

182. In light of recent recommendations made in other inquests, I do not propose to make a recommendation in this regard. However, I emphasise that Rebecca's death further highlights the desirability of RTPM being available to GPs. The present system is flawed and limits the information prescribers can obtain from sources other than the patient.

## *Circumstances of Rebecca's death*

### (a) Requirements of relevant legislation

#### *Detention as an intoxicated person*

183. As noted above, Part 16 of LEPRA sets out a series of requirements in relation to the detention of intoxicated persons (s. 206), detention of persons in authorised places of detention (s. 207) and searching of detained persons (s. 208). It includes the following requirements:

(a) an intoxicated person who is detained in a police station is required to be given a reasonable opportunity by the custody manager to contact a responsible person; and

(b) police detain an intoxicated person temporarily for the purpose of finding a responsible person willing to undertake the care of the person.

184. I note the following relevant definitions that appear at Part 16 s. 205:

> ***"'authorised place of detention'*** *means:*
> *(a) a police station,*
>
> *…*
>
> ***'intoxicated person'*** *means a person who appears to be seriously affected by alcohol or another drug or a combination of drugs.*

*…*

***'responsible person'** includes any person who is capable of taking care of an intoxicated person including:*

*(a) a friend or family member, or*

*(b) an official or member of staff of a government or non-government organisation or facility providing welfare or alcohol or other drug rehabilitation services.*"

185. As noted above, A/Sgt Hosie's evidence was that he was unaware that the power of detention was one that was to be exercised temporarily in order to find a responsible person.

186. Counsel Assisting and Mr de Mars submitted that there appeared to be consensus among SC South and A/Sgts Hosie and Cassidy that the power to detain an intoxicated person was to be exercised to allow the person to "*sleep it off*". In his written submissions for SC South and A/Sgt Cassidy, Mr Eurell submitted that this unfairly characterised the evidence, which was to the effect that, in the vast majority of cases, persons who have been detained under s. 206 of LEPRA are released after "*sleeping off*" the effects of alcohol. Mr Eurell submitted that it would be wrong to conflate experience with purpose.

187. I do not agree with Mr Eurell's submissions and am troubled by the apparently prevailing attitude in relation to allowing intoxicated persons to "*sleep it off*". I accept Counsel Assisting's submission that police involved in exercising powers which relate to the detention of people need to understand the express statutory purpose for the exercise of those powers, and what they should do to achieve that purpose.

***Rights of Aboriginal people as "vulnerable persons" under relevant legislation***

188. At the time of Rebecca's death, Division 3 of Part 3 of *Law Enforcement (Rights and Responsibilities) Regulation 2005* ("LEPR Regulation"; now in Part 3 of LEPR Regulation 2016) provided a scheme which ensured that, if a person fell into one of the categories of vulnerable persons as defined in the LEPR Regulation, they were to be put in touch with external assistance. The categories included (and still include) persons who are Aboriginal or Torres Strait Islanders.

189. This scheme is directed to people arrested under Part 9 of LEPRA for offences. The principal support for vulnerable persons is to have a support person or interpreter present when they are questioned or required to undertake an investigative procedure, and the custody manager has a duty to assist the person in exercising their rights as far as practicable, including any right to make a telephone call.

190. Further, pursuant to cl. 33 of the LEPR Regulation (now cl. 37), the custody manager has an obligation to immediately notify a representative of the Aboriginal Legal Service (NSW/ACT) Limited ("ALS") if an Aboriginal or Torres Strait Islander person is being detained in respect of an offence. However, the premise for this duty is that the person is being detained "*in respect of an offence*". It does not apply to people who are detained under Part 16 of LEPRA as intoxicated.

### (b) Should Rebecca have been detained as an intoxicated person or should some other measure/s have been taken and, if so, what other measure/s?

191. This issue requires consideration of whether Rebecca met the requirements for detention of an intoxicated person under Part 16 of LEPRA. These requirements are as follows:

> (a) That the person appears to be seriously affected by alcohol or another drug or a combination of drugs;
>
> (b) Was found in a public place; and
>
> (c) Was in need of physical protection because the person was intoxicated.

192. I am satisfied that each of these requirements was met in Rebecca's case when she was detained by Sgt Brooks shortly after midnight on 19 July 2016 at Wollombi Road, Cessnock. My reasons for this finding are set out above.

193. However, as noted above, Rebecca was only to be taken to and detained in an authorised place of detention (here, Maitland police station) if, relevantly:

(a) it was necessary to do so temporarily for the purpose of finding a responsible person; or

(b) a responsible person could not be found to take care of Rebecca or Rebecca was not willing to be released into the care of a responsible person and it was impracticable to take her home.

194. I accept Sgt Brooks' evidence as to why he did not consider DT to be a responsible person to take care of Rebecca. I also accept that, based on the information available to Sgt Brooks at the time, it was reasonable for Sgt Brooks to conclude that there was no responsible person at her address in Raymond Terrace into whose care she could be delivered.

195. However, through their counsel, Rebecca's family submitted that this was not a basis for Sgt Brooks foreclosing consideration of alternative options for Rebecca, and have requested a finding that Sgt Brooks could have made greater efforts to find a responsible person before detaining Rebecca at Maitland police station. In making this submission, Mr de Mars emphasised that, given her long history of police contact, an obvious source of information available to Sgt Brooks would have been Raymond Terrace police. This submission was supported by Counsel Assisting. I accept this submission.

196. Rebecca's detention as an intoxicated person continued through to the period of her detention at Maitland police station. Counsel Assisting submitted that, given Rebecca's state of intoxication, her behaviour upon her arrival, and the fact that she was unable to participate in the risk assessment because she was "*incoherent*", police should have made arrangements to transfer Rebecca to a hospital. Counsel Assisting supported a submission made on behalf of Rebecca's family that an ambulance should have been called at the point when A/Sgt Hosie determined that Rebecca was too intoxicated for him to administer the questionnaire, and by no later than the time when she was seated on the bench in cell 4 and slumping forwards.

197. The question of what point at which Rebecca should have been taken to hospital is explored further below. Separately, I note that, regardless of whether it was appropriate to detain Rebecca as an intoxicated person, this is intended to

be a temporary measure and A/Sgt Hosie had a duty under s. 206(4) of LEPRA to continue to try to find a responsible person to take care of Rebecca throughout the duration of her time in custody. There was no evidence before the inquest that A/Sgt Hosie made any effort to comply with s. 206(4), despite having access to databases that would have enabled him to identify and locate Debbie.

## (c) Are there alternatives to detaining intoxicated people at police stations?

198. The relevant aim of s. 206(3) and (4) in Part 16 of LEPRA is for intoxicated persons (who meet the criteria for detention) to be delivered into the care of a "*responsible person*", and to only detain such persons at a police station for so long as is necessary to find such a person. The definition of "*responsible person*" is set out above and includes a friend, family member or welfare facility.

199. There was no evidence before the inquest to indicate that there was a "*welfare facility*" into whose care Rebecca could have been delivered. Accordingly, if police did not identify a friend or family member as a responsible person, the detention of Rebecca would, as a matter of course, be at a police station.

200. There was no evidence to indicate that Rebecca's mother was not available to care for Rebecca on 18-19 July 2016. However, at no time at Wollombi Road or at Maitland police station did police ask Rebecca whether there was anyone who could take care of her. Apart from the questions asked of Rebecca by Sgt Brooks at Wollombi Road, there was no evidence of police attempts to identify or locate a responsible person into whose care she could be delivered.

201. All of the involved officers, but notably A/Sgt Hosie, had access to previous CMRs for Rebecca, through which they could have identified Debbie's contact details in a manual search. A/Sgt Hosie's evidence was that he did not consider next of kin, had never conducted a manual search of older CMRs and was not aware that he had an ongoing responsibility to try to identify a responsible person.

***Is a recommendation necessary or desirable?***

202. On behalf of Rebecca's family, Mr de Mars made submissions about alternatives to detaining intoxicated persons at police stations. He noted that the second reading speech for Part 16 of LEPRA anticipated that police and other local agencies would develop protocols to allow for the provision of services to intoxicated persons. Mr de Mars noted the absence of any evidence of relevant protocols in Rebecca's case and proposed that I make a recommendation to the effect that NSWPF review the existence of protocols developed for the purposes of Part 16 of LEPRA, with a view to reporting to the Minister for Police on the extent to which they appear to fill the role as envisaged in the second reading speech.

203. A similar proposition was made in submissions prepared on behalf of SC South and A/Sgt Cassidy. Mr Eurell also submitted that I make an additional recommendation to the following effect:

> *"That the New South Wales Government establishes, within each and every Police District, at least one public hospital as a proclaimed and authorised place of detention as contemplated within the meaning of s. 205 of [LEPRA]."*

204. In relation to the further recommendation proposed by Mr Eurell, Counsel Assisting submitted that, although it may have merit on its face, the question of using coercion to detain intoxicated persons under LEPRA in public hospitals was not canvassed during the inquest or raised with any witness, and therefore lacks an evidentiary basis. I agree with Counsel Assisting's submissions in this regard.

205. Counsel Assisting and the Commissioner both made submissions in response to the submission proposed by Mr de Mars.

206. The Commissioner submitted that, from July 2017, "*Safe Custody – Medical risks*" posters setting out the obligations of a custody manager, including in relation to seeking medical assistance, have been prominently displayed in custody areas. Further, the Commissioner noted Dr Vinen's evidence that the only alternative to detaining an intoxicated person at a police station is to take the person to a hospital or call for ambulance assistance. The Commissioner submitted that any review of the protocols developed for the purposes of Part 16

of LEPRA will not overcome the risks identified by Dr Vinen, and that the family's recommendation should be rejected.

207. Counsel Assisting submitted that while Mr de Mars' submission about the intention of enacting Part 16 of LEPRA is correct, in this case there was no evidence that there was a government or non-government organisation or facility providing welfare or alcohol or other drug rehabilitation services into whose care Rebecca could have been delivered.

208. Counsel Assisting proposed an alternative recommendation in relation to this issue. However, this issue was not canvassed in great detail at the inquest and I am not inclined to make a recommendation in this regard.

### (d) Should the Aboriginal Legal Service Custody Notification Service be extended to the detention of intoxicated Aboriginal people?

209. One matter explored during the inquest was whether the Custody Notification Service ("CNS") operated by the ALS, which was established as a result of recommendations arising from the Royal Commission into Aboriginal Deaths in Custody ("RCIADIC"), should be extended to the detention of Aboriginal or Torres Strait Islander persons detained as intoxicated persons.

210. As set out above, the obligation of police to notify the CNS only arises when an Aboriginal person is in custody for an offence. It does not arise if that person is detained as an intoxicated person under Part 16 of LEPRA. Therefore, on 19 July 2016, even if police had known Rebecca was Aboriginal, they had no statutory obligation to put Rebecca in touch with a lawyer or other person by reason of her being an Aboriginal person.

211. The CNS is clearly a necessary and valuable resource. The CNS is notified by police whenever an Aboriginal person comes into custody for an offence and an ALS solicitor is able to speak with the person arrested over the phone. Jeremy Styles, an ALS lawyer who has been deeply involved with the CNS since its inception, gave evidence at the inquest that the CNS performs an important welfare function in addition to its legal advice function. Based on his experience, Mr Styles indicated that if a CNS lawyer thought that an Aboriginal person required medical care and conveyed this message to police, police invariably

complied. However, Mr Styles also gave evidence that the caseload of the CNS already exceeds its resources, and it has not been funded or designed to assist Aboriginal persons detained as intoxicated persons.

***Is a recommendation necessary or desirable?***

212. I am satisfied that it is desirable to recommend that consideration be given to:

(a) amending LEPRA to ensure that an Aboriginal person detained under Part 16 of LEPRA as intoxicated is provided with the same access to the CNS as an Aboriginal person held in custody under Part 9 of LEPRA, and that the duty of police to put an Aboriginal person in custody in touch with the CNS is extended to Aboriginal persons detained under Part 16; and

(b) ensuring that the CNS is funded to enable it to provide its service to Aboriginal persons detained under Part 16 of LEPRA.

213. After the hearing of the inquest was complete, the Court received a letter from the Commonwealth Minister for Aboriginal Affairs advising that the Commonwealth "*is currently working with the NSW government on funding options after 31 June 2019 and on potential improvements to the CNS model to ensure it extends to protective custody*".

## (e) Why was Rebecca not identified as Aboriginal from her CNI entry? Is the process for identifying the Aboriginality of those detained by police in NSW appropriate and adequate?

214. It was accepted at the inquest that the officers involved in Rebecca's detention did not know she was Aboriginal. Counsel Assisting submitted that Rebecca was not identified as Aboriginal from her CNI entry for two reasons.

215. First, in her COPS profile, Rebecca was identified as "*Caucasian*". Second, at the time of her detention, there was no system to ensure that a reference to the fact that a person is Aboriginal or Torres Strait Islander in their COPS profile was also recorded in a person's CMR in the CMS.

216. In his initial investigation, the senior critical incident investigator reported that he was unaware that Rebecca was Aboriginal for some days after her death. As

a result, that officer recommended changes to NSWPF record systems, which have now been made. From October 2018, if a person is brought into custody and, importantly, has previously been recorded in the COPS system as being Aboriginal or Torres Strait Islander, the CMS suggests to the custody manager that that person is Aboriginal or Torres Strait Islander. The custody manager has an opportunity to ask the person to confirm this. If the person is intoxicated and cannot answer, the default answer is "*yes*". The result will be that a person in Rebecca's situation should be now automatically treated as an Aboriginal person in custody.

## *Actions of police once Rebecca was detained*

### (a) What searches of Rebecca should have been conducted? Were the reasons why Rebecca was not searched appropriate?

217. Police had the power, but not a duty, to conduct a search of a person detained as an intoxicated person under Part 16 of LEPRA. Both Counsel Assisting and Mr de Mars submitted that the general purpose of the search power under Part 16 was similar to the search power under Part 9 – specifically, to ensure the person in custody does not have anything which could be used to harm themselves or any other person. I accept this submission.

218. As I have set out above, it is clear that police did not conduct an intrusive search of Rebecca at either Wollombi Road in Cessnock or Maitland police station. They also did not conduct an ordinary search, beyond possibly asking Rebecca to turn out her pockets and conducting a visual inspection.

219. I have received different submissions as to the likely location of the pill bottles on Rebecca at the time that she arrived at Maitland police station. This is significant because it impacts the question of whether, had Rebecca been searched at that point or earlier, police would have located one or both of the pill bottles in her possession. Mr de Mars made compelling submissions that the evidence points to at least one of the pill bottles was located in Rebecca's clothing when she entered the observation cell, noting the completely clean state of the bottle containing Alprazolam ultimately located in her pants leg.

220. By contrast, Mr Eurell submitted that, prior to Rebecca entering the observation cell, both pill bottles were located in her vagina. Similarly, SC Coleman submitted, through his counsel, that the Court might find that Rebecca hid the bottles in her vagina and that this was the action of someone known to police. These submissions do not account for the fact that only one bottle located in Rebecca's pants appeared to be blood-stained.

221. Having considered the submissions, I am satisfied that it is likely at least one of the pill bottles was located in Rebecca's pants leg at the time she entered the observation cell at Maitland police station, such that, had a pat down search been conducted at that point, that bottle may well have been located. This in turn may have alerted police to the nature of her intoxication and need for medical assistance. It is certainly clear that, at the time Rebecca lay down on the mattress in cell 4, both pill bottles were in her pants leg, such that a search immediately prior to this point would have revealed them. This is around the same time as CCTV footage from the charge room shows SC South and A/Sgt Hosie having a discussion about the fact that Rebecca had not been searched.

222. Counsel Assisting submitted that three reasons emerged in the evidence as to why no search was conducted:

(a) fear of becoming infected with an infectious disease;

(b) a direct order by Sgt Brooks; and

(c) agreement by A/g Sgt Hosie with SC South not to search.

223. Counsel Assisting submitted that reason (a) above, particularly a fear of becoming infected with HIV or Hepatitis C, appeared to be the main reason police did not search Rebecca. He argued that fear of infection should not deter officers from performing an intrusive search where necessary or desirable. He noted that police policy and training includes information on the nil to low risk of occupational transmission of HIV and Hepatitis C. Further, all officers are provided with appropriate personal protective equipment to guard against the risk of contracting infection, and NSWPF Infectious Disease Prevention Guidelines teach police to use standard precautions. Counsel Assisting submitted that, therefore, as a matter of occupational risk, the fears which police had of risking

infection with HIV or Hepatitis C were not well-founded and therefore were not an appropriate reason to refrain from conducting a search of Rebecca. He emphasised that Rebecca was not, in fact, HIV positive.

224. SC South conceded, in submissions prepared on her behalf, that the risk of contracting HIV or Hepatitis C was one of a number of reasons why she did not search Rebecca. Her counsel submitted that other reasons included her perception that Sgt Brooks had determined that a search was unnecessary, her evaluation of the risks (including that Rebecca presented a low risk of self-harm, did not appear to have anything in her pockets and the potential for escalation if force was used), and the potential consequences for her pregnancy.

225. Through her counsel, SC South acknowledged that there was a low risk of becoming infected with HIV or Hepatitis C, but submitted that it would be wrong to conclude that there was no risk at all. Mr Eurell submitted that while the likelihood of infection from saliva alone was remote, this may be higher if a person is injured and there is exposed blood. He asserted that such matters become increasingly likely every time police decide to use force (including a search).

226. A number of officers gave evidence, which was picked up in submissions, that the reason they did not search Rebecca was due to the fact that she was being detained as an intoxicated person (as opposed to being under arrest) and/or the discretionary nature of the search power conferred by s. 208.

227. In submissions prepared on behalf of the Commissioner, Mr Spartalis accepted that, with the benefit of hindsight, it would have been best practice to search Rebecca. However, he emphasised that an officer charged with the discretion to search should exercise the discretion carefully.

228. Both Counsel Assisting and Mr de Mars submitted that the fact that a power is discretionary does not justify an omission to search where it is required or desirable in the circumstances, given that the main reason to conduct a search in these circumstances is to locate anything which could be used to harm the person searched or anyone else. As at July 2016, the NSWPF Handbook made clear that there are specific circumstances in which a search of an intoxicated

person can assist in ensuring their health and welfare while in custody. At the inquest, A/Sgt Hosie gave evidence that he was unaware of those provisions but accepted that the provisions suggested that Rebecca should have been searched. However, he said that he did not know whether, if he had known of the provisions, he would have insisted that Rebecca be searched.

229. Mr de Mars further submitted that it was fallacious for parties to somehow seek to distinguish the power to search persons detained as intoxicated from the power to search in relation to persons detained pursuant to Part 9 in relation to an offence, which is also not mandatory. He argued that, as a matter of police practice and procedure, it would be highly unusual and contrary to established practice not to search those going into police custody on either basis.

230. Counsel Assisting submitted that Rebecca's case illustrates that persons detained as intoxicated may have drugs on them that they may try to hide from police, which gives rise to the risk that they will then take such drugs while in police custody. He submitted that, in order guard against this risk, it is desirable that they be searched. Mr de Mars submitted that the reasons for searching a detainee go further than this, and that the identification of the quantity of a drug on a detainee is potentially a highly important piece of information for the police in relation to their assessment of the potential level and type of intoxication that may be involved. This may in turn have consequences for risk assessment and recourse to acquiring medical attention.

***Is a recommendation necessary or desirable?***

231. Counsel Assisting noted that the learnings for the risk of occupational transmission of Hepatitis C and HIV are not simple, and cited conflicting information in police policy and training that may result in confusion for police. Accordingly, he submitted that I should make a recommendation to the NSWPF that it improve its education and training of police officers to provide clear and understandable information as to the risk of infection associated with Hepatitis C and HIV from saliva and the use by police of barriers provided to them to reduce risk of contact from body fluids when searching a person.

232. In submissions on behalf of the Commissioner, Mr Spartalis noted that, while the Commissioner supports this recommendation, it also has to remain cognisant of its non-delegable duty to its employees and its mandatory obligations to its employees under the *Work Health and Safety Act 2011*. The Commissioner provided evidence of a current review of infectious diseases policies relating to custody to ensure that the policies adequately assist police to perform custody duties.

233. Counsel Assisting also submitted that I should recommend that NSWPF improve its education and training of police officers as to circumstances which call for persons detained as intoxicated to be searched, in particular circumstances where the person may be intoxicated with prescription drugs and might have such drugs on them when detained. In response, Mr Spartalis submitted that the Commissioner is in favour of training which highlights the necessity for a police officer to properly consider individual circumstances when exercising the discretion to search a person detained under Part 16 of LEPRA. He submitted that the NSWPF will continue to maintain and upgrade its training in response to any issues that arise, such as this inquest, and in response to any legislative changes that occur.

## (b) Were the observations made by Police of Rebecca in detention at Maitland police station adequate? If not, why not? How often and by what means should observations be conducted to ensure that an alarm can be raised if a person needs medical care?

***Requirements for checking on intoxicated detainees***

234. The requirements for checking on intoxicated detainees in the Code of Practice for CRIME (now merged into the NSWPF Handbook) make detailed provision as to what should be done to look after persons in custody who are:

(a) ***Affected by alcohol or drugs,*** including to:

i. Wake, speak to and assess the sobriety of the person at least every 30 minutes (or more frequently if necessary) during the first two to three hours of detention;

ii. Seek urgent medical help if the person cannot be roused or their level of intoxication or consciousness has not changed or is of concern;

iii. Do all assessments in person, not by video; and

iv. Immediately call for medical assistance or send the person to hospital if they are severely affected by alcohol or drugs.

(b) ***Sleeping,*** including to:

i. Check the person as often as possible;

ii. Rouse the person and observe their condition if they are snoring, particularly when they are affected by alcohol or drugs; and

iii. Only leave the person asleep if satisfied that they are breathing normally and without apparent distress.

(c) ***Unconscious,*** including to:

i. Check the person's condition and be alert to the following signs:

- cannot be roused
- no verbal response; incomprehensible response
- moaning but not speaking
- no eye opening in response to your requests
- no response to speech and simple requests.

235. The requirement to attempt to rouse the person was supported by Dr Vinen. Dr Vinen said that if a person did not respond to attempts to rouse or did not respond adequately (for example, with rational words like "*go away*" or "*stop hurting me*") but instead simply grunted slightly, then they should straight away be taken to a hospital.

***Adequacy of observations/inspections***

236. The evidence about the observations/inspections made of Rebecca at Maitland police station has been addressed above.

237. I accept the opinion of former Sergeant Piet, a custody management specialist with the NSWPF, that the manner in which A/Sgt Hosie conducted the inspections of Rebecca was not consistent with the requirements of the Code of Practice for CRIME. The expert evidence from Dr Vinen demonstrated the relationship between these inadequacies – and the failure to call an ambulance – and the chances of preventing death of a person in Rebecca's position.

238. Counsel Assisting submitted that, had A/Sgt Hosie conducted his inspections as was required, he would have found, at an early stage, that Rebecca was either unconscious or had very low level of consciousness and called an ambulance. In addition, Mr de Mars submitted, on behalf of the family, that Dr Vinen's evidence makes it plain that had efforts been made to properly observe Rebecca by way of attempts to rouse her, it would have been evident soon after she was lying down (and clearly the case by 2:00am, if not earlier) that her level of consciousness was problematic.

239. In relation to the appropriate frequency and manner of observations to ensure that necessary alarms can be raised, Counsel Assisting submitted that this question is answered by reference to what is observed of and/or known about the person. In this case, and as set out above, it is evident that Rebecca was so intoxicated that A/Sgt Hosie considered that he was unable to complete the questionnaire, an essential element of proper risk assessment. Counsel Assisting submitted that the critical factor is that the observations need to involve the custody manager physically entering the cell and attempting to rouse the detained person in order to determine whether it is safe to continue to have the person in custody.

240. A/Sgt Hosie gave evidence that he was not aware of the requirement to inspect intoxicated persons in person (as opposed to monitoring CCTV) and that he had not been trained to attempt to physically rouse an apparently sleeping

intoxicated person to check their level of consciousness. Sgt Brooks and SC Coleman were also unaware of this instruction.

241. Counsel Assisting submitted that the need for custody managers to understand the importance of conducting appropriate inspections is something which cannot be over-emphasised. Counsel for A/Sgt Hosie similarly made submissions of the importance of "*on the job*" education and training for custody managers on this issue. At the inquest, I had before me a "*Safe Custody – Medical Risks*" poster published by NSWPF and a Nemesis message sent to all police that highlighted the importance of custody managers making attempts to physically rouse intoxicated persons who appear to be asleep. I also received evidence about discrepancies between the intensive five-day Custody Managers Course, which deals in detail with safety issues, and the Custody Managers Workshop, which appears to train in little more than using CMS software. Counsel Assisting submitted that there can be no doubt that, the more custody managers who undertake the Custody Manager's Course, the greater the likelihood that intoxicated prisoners will be managed appropriately.

***Is a recommendation necessary or desirable?***

242. Counsel Assisting submitted that I should make three recommendations directed to NSWPF in relation to this issue.

243. First, that all police officers who perform duty as custody manager at police stations undertake the Safe Custody Course, which would include education and training as to:

(a) The duty in respect of a person detained under Part 16 of LEPRA to make all reasonable efforts to identify and locate a "*responsible person*"; and

(b) Content of the NSWPF poster entitled "*Safe Custody: Medical Risks*" including that, when managing a person detained as intoxicated, it is dangerous and inappropriate to take the approach that the person will or can "*sleep it off*".

244. In his submissions, Mr Spartalis indicated that the Commissioner supports this recommendation with respect to custody training generally rather than specifically to the "*Safe Custody Course*", subject to resources. Further, the NSWPF accepts that that all officers that conduct custody duties should undertake a form of safe custody training.

245. Secondly, that the CMS be modified to require the custody manager to record:

(a) when making entries for inspections where the detainee is intoxicated:

i. what occurred when the custody manager attempted to rouse the detainee, and

ii. the custody manager's assessment of the detainee's level of consciousness; and

(b) the efforts they have made to identify and locate a "*responsible person*", including consulting previous CMRs.

246. Mr Spartalis confirmed that the Commissioner supports this recommendation. He also noted the following initiatives undertaken by NSWPF in respect of these issues:

(a) Nemesis messages disseminated in February and March 2019 that reminded officers of their obligations to rouse, and undertake risk assessment of, intoxicated persons who appear to be sleeping;

(b) alteration of the CMS to record "*responsible person*" details, in addition to "*next of kin*";

(c) review and condensing of the safe custody course content to permit more officers to be trained; and

(d) introduction of a new NSWPF Learning Management System in January 2020 to enhance and increase the education available to officers.

247. Thirdly, that the circumstances of the death of Rebecca at Maitland police station be considered for use as a case study in training of police officers who are to undertake the duties of a custody manager. Mr Spartalis confirmed that the Commissioner supports this recommendation and resources have already been allocated to undertake the case study.

## (c) Can appropriate care be provided for those detained under the intoxicated persons' provisions at police stations? Should a nurse be involved or contactable when a person is in detention as an intoxicated person?

248. Although police officers may have greater basic first aid training than many people, they are not medically trained. Officers cannot be expected to provide medical care for people detained under Part 16 of LEPRA in a police station.

249. There was some evidence of police in other jurisdictions employing nursing resources to watch houses, either in person or over the phone. However, Counsel Assisting submitted that there are difficulties in implementing a similar scheme here, namely the high number of police stations in NSW and the concerns raised by Dr Vinen as to the efficacy of a telephone advice. As noted by Dr Vinen, a nurse in this situation cannot view the detained person and must depend on the police officer to provide an account as to the person's state. These uncertainties made Dr Vinen prefer that the person be taken to a doctor for assessment in a health care setting.

***Is a recommendation necessary or desirable?***

250. On the basis of Dr Vinen's evidence, which I accept, it does not appear desirable to make a recommendation in this regard.

251. I note the submission of Mr de Mars that the efficacy of a regular medical or nursing presence could be considered at larger watch house locations in NSW. On behalf of Rebecca's family, Mr de Mars also submitted that the difficulty of providing a nursing service at a location such as Maitland lends weight to the need for police to be more readily prepared to seek ambulance services or to transport detainees to hospital. Accordingly, he suggested that there may be a

place for the development of local area protocols between police and local area health and ambulance services.

252. This has not been canvassed with any relevant agency and, accordingly, I decline to make a recommendation in this regard.

### (d) Should an ambulance have been called before Rebecca died? If so, when should an ambulance have been called?

253. On the question of what the trigger point was for a person to be taken to hospital, Dr Vinen gave evidence of three basic indicators which occur before the point at which the person has lost consciousness, which are as follows:

(a) decreased level of consciousness, such that the person "*is either not responding… or responding inappropriately to stimulus, which may include pain*";

(b) being very unsteady on their feet, for example "*falling over, or sitting down and falling off, you know, chairs or benches or whatever*"; and

(c) having "*markedly slurred speech, or you know, they can't communicate with you*".

254. Dr Vinen was shown the CCTV footage of Rebecca's arrival at Maitland police station through to lying on the bench on the observation cell. After watching that footage, he said that, if a person had behaved that way in an emergency waiting room of a hospital, at a bare minimum they would have been put in a bed with side rails, placed under visual observation including testing their level of conscious, and hooked up to heart and blood oxygen monitors.

255. Dr Vinen said the safe thing to do with Rebecca would have been to have her transferred to an emergency department. What the emergency department of a hospital could provide which a police station could not was:

(a) airway management – ensuring an airway to ensure adequate ventilation and oxygenation, prevention of aspiration;

(b) oxygenation – maintaining oxygen levels within the required levels;

(c) ventilation-maintaining COR2R within the required limits; and

(d) administration of an opioid antidote. Naloxone, the antidote for opioid overdose, reverses all signs of opioid intoxication.

256. There was evidence before the Court that both Cessnock Hospital and Maitland Hospital had a 24 hour Emergency Department in operation on 18 and 19 July 2016.

257. Counsel Assisting submitted that it is open to me to conclude that:

(a) When she entered into custody, Rebecca was stumbling, had slurred speech and could not sit upright on the bench in the observation cell. Police should have concluded at that early stage that Rebecca was severely intoxicated;

(b) Rebecca's level of intoxication was so high that police were unable to perform the essential components of the risk assessment provided by the CMS to allow them to determine risks to her health;

(c) for an extended period of time during the first half of her detention, police had concerns about Rebecca's health, specifically her breathing;

(d) in light of the above, police should have caused Rebecca to be taken by ambulance to hospital for urgent medical assessment. If that had occurred, the expert evidence of Dr Vinen suggests that Rebecca would have survived; and

(e) the failure of police to organise for Rebecca to be transported to hospital for urgent medical assessment was in breach of applicable requirements of the Code of Practice for CRIME.

258. Counsel Assisting submitted that the ambulance should have been called no later than when Rebecca slumped forward with her arms hanging towards the

floor when seated on the bench on the observation cell. However, he noted that the criteria for calling an ambulance were satisfied when it was clear that Rebecca was stumbling and "*incoherent*". Rebecca was plainly severely intoxicated and, importantly, so much so that police were unable to complete the questionnaire in her CMR.

259. Counsel Assisting further submitted that it is arguable that if a person is relevantly incoherent, they should not be detained as intoxicated at a police station. Under s 207(2)(a) of LEPRA, such persons must be given a reasonable opportunity by the person in charge to contact a "*responsible person*". If, due to the person's level of intoxication, this function of the legislation cannot be achieved, then the person should not be detained at a police station and instead should be taken to a hospital. I accept and agree with these submissions.

### (e) Exploration of Back to Base Pulse Oximetry to ensure an alarm is raised if an intoxicated detainee's blood oxygen saturation drops.

260. This issue was raised before the hearing of the inquest because of a recommendation made in another inquest concerning this technology. That inquest involved a death in a psychiatric intensive care unit.[5]

261. Dr Vinen gave evidence as to the purpose and function of this technology, which can be used to detect suicide attempts by high dependency mental health inpatients in real-time. However, Dr Vinen pointed to a number of reasons why the technology might not be suitable in a non-health care setting like a police station and provided a lengthy list of requirements that would need to be met for back to base oximetry monitoring to be conducted for persons detained or held in custody in police stations.

262. I accept this evidence and am satisfied that this technology would not be practical for use in a police station.

### (f) SafeWork NSW referral

[5] See findings and recommendations of Deputy State Coroner Lee in the Inquest into the death of Ahlia Raftery.

263. Because of the potential for relevant work practices to remain systematically entrenched in the NSWPF, Rebecca's family have raised, through their counsel, a suggestion that I consider referring the circumstances of Rebeca's death to SafeWork NSW for investigation and review. Mr de Mars submitted that the evidence supports a concern that important aspects of the conduct of relevant police indicate there may be a widespread lack of understanding of officers' obligations.

264. Counsel Assisting submitted that these submissions have some force. By contrast, Mr Spartalis submitted on behalf of the Commissioner that there was no evidence before the inquest to suggest or find systematic failure, or to find that there is potential for police practices at one police station in relation to the exercise of the power under Part 16 of LEPRA for be systematically entrenched at all other Police Area Commands. Mr Spartalis argued that the submissions on behalf of the family in this regard should be rejected.

265. The submissions on behalf of Rebecca's family do not seek to trigger the institution of criminal proceedings under the *Work Health and Safety Act 2011*. Instead, noting the power of SafeWork NSW to seek enforceable undertakings, Mr de Mars' submissions propose that I forward a copy of these findings and the brief of evidence to SafeWork NSW so that it can determine whether any enforcement or other action in relation to NSWPF is warranted.

266. Both Counsel Assisting and Mr Spartalis submitted that this submission should be not accepted, as it would not be fair to NSWPF or the individual officers represented at the inquest for this issue to be raised at this late stage. Counsel Assisting noted that, given the broader public health issues involved, and noting that any person can do so as a matter of practice, I should not consider forwarding the papers to SafeWork NSW.

267. Mr Spartalis further submitted that, as issues arose for the NSWPF before and during the inquest, the NSWPF responded positively. With one exception, the Commissioner supports the recommendations for change proposed in Counsel Assisting's principal submissions. In other words, in considerable measure, the NSWPF accepts, supports or is in the process of implementing the

types of measures for change which would be likely to be the subject of enforceable undertakings flowing from any referral to SafeWork NSW.

268. I accept Mr Spartalis' submissions in this regard and decline to make a referral to Safework NSW or forward a copy of my findings.

### *Reason for the delay in notifying Rebecca's mother*

269. Counsel Assisting submitted that the management of notifying Debbie of Rebecca's death was in breach of NSWPF requirements and was disrespectful to Rebecca's family and to the memory of Rebecca herself.

270. In circumstances where the reason for the delay in notifying Rebecca's mother of her daughter's death is not known, I am unable to make findings in relation to this issue. However, I note my concerns about the manner in which this was handled and extend my condolences to Rebecca's family for any additional pain this may have caused.

## Conclusions

271. Before making my formal findings, I would like to once again acknowledge the dignity of Rebecca's extended family throughout the inquest process and thank them for their participation. It is clear to me that Rebecca was a cherished and much loved member of her family, who continues to be dearly missed.

272. I would also like to extend my thanks to my team for the enormous amount of work they have put into assisting me and to the Critical Investigation Team for their very thorough investigation and assistance at the inquest.

## Findings required by s. 81(1)

Pursuant to s. 81 of the Act, I make the following findings:

*Rebecca Maher died on 19 July 2016 in a cell at Maitland police station in NSW. Rebecca's death occurred accidentally while she was detained by officers of the NSWPF as an intoxicated person, medical attention not having been sought on her behalf. The medical cause of death was respiratory depression after loss of consciousness caused by mixed drug toxicity and possibly aspiration of vomit.*

## Recommendations

Pursuant to s 82 of the Act, I make the following recommendations:

*To the Attorney General of NSW and Commonwealth Minister for Aboriginal Affairs:*

1. *That the Attorney General consider amending the Law Enforcement (Powers and Responsibilities) legislation to ensure that an Aboriginal person detained under Part 16 of LEPRA as intoxicated is provided with the same access to the CNS as an Aboriginal person held in custody under Part 9 of LEPRA, and that the duty of police to put an Aboriginal person in custody in touch with the CNS is extended to Aboriginal persons detained under Part 16; and*

2. *That the Commonwealth Minister for Aboriginal Affairs continue to work with the NSW government on funding options and on potential improvements to the ALS CNS model to enable it to provide its service to Aboriginal persons detained under Part 16 of LEPRA.*

*To the Commissioner of Police, NSWPF:*

1. *That the NSWPF consider improvements to its education and training of police officers to provide clear and understandable information as to the nature of infectious diseases and associated risks.*

2. *That the NSWPF consider improvements to its education and training of police officers as to circumstances which call for persons detained as intoxicated to be searched, in particular circumstances where the person may be intoxicated with prescription drugs and might have such drugs on them when detained.*

3. *That the NSWPF consider the implementation of a requirement that all police officers who perform duty as custody manager at police stations undertake the Safe Custody Course, which would include education and training as to:*

    a. *The duty in respect of a person detained under Part 16 of LEPRA to make all reasonable efforts to identify and locate a "responsible person"; and*

b. *Content of the NSWPF poster entitled "Safe Custody: Medical Risks" including that, when managing a person detained as intoxicated, it is dangerous and inappropriate to take the approach that the person will or can "sleep it off".*

4. *That the NSWPF consider modification to the CMS to require the custody manager:*

    a. *when making entries for inspections to record, where the detainee is intoxicated, (1) what occurred when the custody manager attempted to rouse the detainee, and (2) the custody manager's assessment of the detainee's level of consciousness; and*

    b. *to record the efforts they have made to identify and locate a "responsible person", including consulting previous CMRs.*

5. *That the NSWPF continue to review the circumstances of the death of Rebecca Maher at Maitland police station as a case study in training of police officers who are to undertake the duties of a custody manager.*

I close this inquest.

**Teresa O'Sullivan**
Acting State Coroner
Lidcombe

**Date:** 5 July 2019