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CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of [redacted] ("MF")
Hearing dates:	13-15 September 2021
Date of findings:	23 September 2021
Place of findings:	Coroners Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Self-inflicted death, Safe Driving Policy, "urgent duty driving", use of lights and sirens
File Number:	2016/290240
Representation:	**Counsel Assisting**: Mr M Dalla-Pozza instructed by Ms A Doyle, Solicitor, Crown Solicitor's Office **Commissioner of Police:** Mr R Hood, instructed by Mr S Robinson, Office of the General Counsel, NSW Police Force
Findings:	The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are: ***Identity*** The person who died was [redacted] ***Date of death*** He died on 27 September 2016. ***Place of death***

	He died on Fairey Road, South Windsor NSW ***Cause of death*** He died of blunt force injuries. ***Manner of death*** He died as a result of a motor vehicle collision with a tree. His death was intentionally self-inflicted.
Non Publication Orders:	The non-publication orders made in this matter are set out in Annexure A.

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Introduction

1. This inquest concerns the tragic death of [redacted], whom I shall refer to in these findings as "MF"

2. MF's death came after a struggle with depression and substance use issues. Events escalated on 27 September 2016, after police were contacted in relation to a report of violent behaviour in a domestic setting. MF was well affected by amphetamines when he left the premises at which his partner was staying in his partner's car. MF subsequently stopped by the side of a nearby road where a sympathetic member of the community, spotting a rope looped through the back windows of the vehicle, sensed he needed help and tried to calm him. On returning to his truck on the pretext of getting MF a cigar, this man made a surreptitious call to police for assistance. Tragically, a short time later it appears that on seeing a police vehicle approach, MF sped off and intentionally crashed his vehicle into a tree. Given the circumstances it is likely that he was concerned that police were arriving to arrest him. The Police found MF almost immediately and although resuscitation was commenced, MF had suffered very significant injuries and could not be saved.

3. The events before the collision were extremely distressing for his family, but they do not sum up his life or worth as a person. His family gave the Court some insight into his personality, his struggles and his passions.

4. His partner, [redacted] ("JA"), told the Court that she and his children continue to feel his loss every day. She described his central position in their lives. Losing a loved one in tragic circumstances is always traumatic and difficult. In JA's case, however, that pain must have been compounded by the fact that when she first received notice of MF's death she was at Windsor Police station making a statement in which she disclosed very serious acts of personal violence committed by MF against her earlier that day. It is appropriate to record the distress and anguish this terrible state of affairs must have caused JA. For this reason, I wish to sincerely thank her for her presence at the inquest and for the generous and gracious approach she took to these proceedings. JA experienced at first hand the results of MF's trauma and uncontrolled drug use. She nevertheless had the grace to acknowledge the love they also shared.

5. MF's foster family also assisted the Court in understanding the complexities of his personality. Despite some years of minimal contact, they had reconnected with MF and tried so very hard to assist him with the internal demons he faced. [redacted] ("BB"), MF's foster brother, spoke

of happy childhood memories and reiterated the family's unconditional support. He also undertook to communicate the essence of these proceedings to MF's biological family who could not attend.

6. MF is greatly missed by all those who loved him. JA wrote eloquently of the profound effect MF's death continues to have on the lives of their children. I wish to express my sincere condolences to her and to MF's children for their profound pain and loss.

The role of the coroner and the scope of the inquest

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

8. In this case there was no dispute in relation to the identity of the deceased or to the date, place or medical cause of death. However, the manner or circumstances of MF's death required significant investigation.

9. This inquest was a mandatory inquest. MF's death occurred prior to relevant amendments to s. 23 of the current *Coroner's Act 2009.* At the time of MF's death an inquest was mandatory if the death occurred "in the course of a police operation." I am satisfied that a police operation was underway at the time of death and I note NSW Police's investigation was carried out pursuant to critical incident guidelines.

10. A list of issues was prepared before the proceedings commenced. In addition to the statutory findings pursuant to s. 81 of the *Coroners Act* 2009, the listed issues were:

    - Whether MF's death was intentionally self-inflicted and/or precipitated by a mental health episode;

    - Whether the manner of driving by NSW Police Force Officers, both to the report concerning MF in his car, and in response to MF driving away from them, was appropriate and in accordance with the applicable policies and procedures;

[1] Section 81 *Coroners Act* 2009 (NSW).
[2] Section 82 *Coroners Act* 2009 (NSW).

- The appropriateness of the medical treatment MF received for his depression, mental health and substance abuse issues by Nepean Hospital and Dr Tan.

The evidence

11. The inquest proceeded some five years after MF's death. This occurred for a number of reasons including delay caused by the determination of an interlocutory application and associated proceedings in the Supreme Court of NSW. COVID 19 meant that the hearing was conducted via audio and video link. The Court is aware that delay can cause additional stress on a family and acknowledges the difficulties inherent in conducting proceedings in a virtual courtroom.

12. The Court took evidence and submissions over three days. Three involved officers gave oral evidence, as well as the member of the public who tried to assist MF on the day. The Court also heard from Sergeant Hyrmak, who was formerly an Acting Sergeant in the Traffic Policy Section of the Traffic & Highway Patrol Command, and who had some expertise in relation to interpreting the NSW Police Force's Safe Driving Policy. In addition, the Court received extensive documentary material. This material included witness statements, medical records and CCTV and audio recordings.

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

Background

14. Counsel Assisting's opening set out a brief chronology of the undisputed facts and I rely heavily on that summary which I regard as an accurate record of events.

15. MF was 46 years of age at the time of his death. He was an Aboriginal man who had been taken from his family at a young age. The Court is unaware of the background involved in his removal from his birth family but accepts it is likely to have caused considerable grief. While MF developed a strong and loving relationship with his foster family, the effects of early trauma can be profound and ongoing.

16. MF was fostered to the [redacted] ("B") family when he was around two years of age. He became part of a loving and close family of nine siblings. BB told the Court that the B family loved MF unconditionally and that he fitted in well in the family, enjoying soccer, motorcycle riding and go kart racing.

17. MF reconnected with his biological family at around 14 years of age after his mother reached out through a foster care organisation. The Bs supported MF's decision to make a connection with his birth family and have remained in contact with that family. BB told the Court that as a teenager MF left their family to explore life and that at one point spent time with his birth family and with friends in Brewarrina.

18. The Bs remained in MF's life and at crucial moments were there to give him support and assistance. MF was a skilled racer and BB assisted him at one point to get employment at the Hawkesbury indoor kart centre. It was here that MF met and formed a relationship with JA.

19. In the early years of the relationship there were some drug problems but the couple had three children and eventually settled into running egg farms in the Hawkesbury area. Unfortunately at some point things deteriorated and MF commenced using amphetamines, specifically the drug ice. As time went by MF's drug use escalated and there was significant turmoil and repeated incidents of domestic violence.

20. It is clear from what is before me that MF loved his children greatly, even during these years when he struggled to care for them as he may have wished.

21. There is considerable evidence to indicate that the relationship between MF and JA was, especially in the early days, close and loving. However, as his addiction to ice developed the relationship was also characterised by episodes of significant violence. I accept JA's evidence that the violence was ongoing and that many instances were never reported to NSW Police. Eventually police took out an ADVO against MF on JA's behalf. That order was in force at the time of MF's death.

22. At the time of his death, MF was in crisis. His General Practitioner, Dr Tan, reports that when he first saw MF (in the period between 2010-2011) he presented as a loving husband and hard worker. Dr Tan described MF as a "respectful man" who was "always courteous and friendly" and as a "responsible father". However, when Dr Tan next saw MF (in 2016, after a gap of many years), he saw a changed man. MF told Dr Tan that he was depressed and homeless and that he was addicted to ice.

23. Prior to seeing Dr Tan in 2016, MF had been admitted to Nepean Hospital to treat his drug dependency issues. This ultimately, does not appear to have been effective to allow MF to break his addiction to ice nor does treatment appear to have helped MF understand the underlying issues that plagued him. Substance use issues can be chronic and recurring. Many attempts are sometimes needed to understand deep seated causes and triggers.

24. MF was again admitted as a voluntary patient to Nepean Hospital in 2016. On 1 September 2016 he was again discharged. This, of course, was only a matter of weeks before his death. Again, it appears that this admission was not effective in breaking the cycle of problematic drug use or helping MF gain greater insight into the triggers for his behaviour.

Events leading up to MF's death

25. On the day of MF's death, Constable Goldsmith and Senior Constable Taydler had been called to the premises where JA was staying to respond to an allegation that MF had breached the ADVO made for JA's protection. They were attached to the vehicle, Hawkesbury 16. MF was not present when police attended, and no action was taken at that time.

26. JA reports that, at a later point on that day, MF again attended the address. He seriously assaulted her during a prolonged episode of violence. MF then took JA and their daughter for a drive at which time he repeatedly said: "I'm going to run this car into a tree". He also said, "I don't want… [his daughter] in the car when I do it". He eventually let JA and their daughter out of the car at JA's mother's premises and drove off.

27. At this time a broadcast ("the first radio broadcast") was made over police radio for police to attend the premises where JA was staying. Hawkesbury 16 (with Senior Constable Taydler as the driver and Constable Goldsmith as the passenger) responded to that call and expedited to that job under lights and sirens. The VKG records that they were responding in a "Code Red" capacity to that job.

28. The first radio broadcast was also acknowledged by Hawkesbury 15. Senior Constable Galea was the driver and his partner was Senior Constable Cole. They proceeded "Code Red" to the job (again, under lights and sirens).

29. Whilst both Hawkesbury 15 and 16 were en route to the address where JA was staying, a further radio broadcast was made over the police system (the "second radio broadcast"). The substance of that broadcast was that a man had been seen in a car with a rope attached to him at a location in Fairey Road. That location was only a couple of hundred metres from the address where JA had been staying.

30. The southern end of Fairey Road is a partially paved and partially gravel or dirt road. It terminates in a dead end. All officers were well acquainted with the area.

31. Perhaps unsurprisingly, responding police treated what was communicated over the second radio broadcast as a job involving a potentially suicidal person. Accordingly, both Hawkesbury 15 and Hawkesbury 16 decided to divert to that location. I accept this was the right decision.

32. There was some conflicting evidence about the exact routes each vehicle took, however it appears that Hawkesbury 16 turned on to Fairey Road and proceeded south closer towards where that road terminates in a dead end. At a different intersection further north, Hawkesbury 15 also turned onto Fairey Road and proceeded to follow behind Hawkesbury 16 which had emerged onto Fairey Road in front of them.

33. The Court heard evidence that Hawkesbury 16 deactivated its lights and sirens because they believed that they were responding to a potentially suicidal person and were concerned, in the words of one of the involved officers, to avoid “inflaming” that situation. Hawkesbury 15 was further back from the car in question but similarly deactivated their siren, leaving the lights on to warn other potential road users of their presence.

34. Before the police arrived, Mr Maher, the member of the public who had made the second report to police, engaged with the man in the vehicle, a Nissan Pulsar, which was parked to the left-hand side of the road. Upon seeing the rope dangling outside of the Pulsar, Mr Maher had adduced, correctly, that its occupant, now known to us as MF, was contemplating suicide.

35. The Court had the opportunity to hear directly from Mr Maher. He explained that he immediately knew something was wrong and had a fair idea that the driver was suicidal. It appears that he was able to quickly assess what was happening and that he planned to establish rapport with the driver in an attempt to buy time until he could arrange for the police to come. In my view, he acted with extraordinary sensitivity, discretion and skill. He was immediately focussed on trying to prevent MF from taking his own life. He first tried to engage MF in conversation, offering him a cigar. Under the pretext of retrieving the cigar from his vehicle, Mr Maher then surreptitiously called 000, the action which prompted the second radio broadcast. Mr Maher then re-engaged MF in conversation. Mr Maher directed the conversation to topics such as MF’s family. He was able to keep MF engaged in conversation until police arrived in Fairey Road.

36. It appears clear that, at some point, MF saw a police vehicle or vehicles on Fairey Road behind where he was parked and, after he did, he accelerated away at some considerable speed.

37. Mr Maher says that, prior to this point in time, the keys to the Pulsar were not in its ignition. Upon noticing the police, MF took the keys from his pocket and went to insert them in the ignition. In an attempt to stop MF from doing so, Mr Maher covered the ignition with his thumb,

but MF was able to force it away, by bending it backwards. MF then inserted the key in the ignition and the Pulsar drove off, running over Mr Maher's foot in the process (although, fortunately, not occasioning him any harm, due to the steel capped boots Mr Maher was wearing). Again, it seems appropriate to acknowledge Mr Maher's bravery at this point.

38. Hawkesbury 16 was the first vehicle to arrive at the location where the Pulsar was parked. There were discrepancies in the evidence as to how close this vehicle got to the Pulsar. The distances given in oral evidence ranged from around 100 metres, on the account Senior Constable Goldsmith, to around 15-30 metres, or as close as ten metres, on the account of Mr Maher.

39. Estimating distance can be a difficult task at the best of times. Mr Maher, of course, was encountering a difficult and stressful situation. He was only peripherally focussed on police and, at relevant times, was engaged in a struggle with MF with his head through the window of that vehicle, which must have impeded his view. Further, it may be noted that, in his statement, Mr Maher placed the Pulsar between 50-100 metres south of the intersection with Berger Road, and that, in his call to Police, he placed the Pulsar about 100 metres south of that intersection.

40. While police may be more used to estimating distance, they too were in a stressful situation. They were moving at speed and focussed on assisting the driver of the Pulsar. The whole episode happened very quickly, and Hawkesbury 15 was well behind Hawkesbury 16 when the Pulsar took off.

41. Counsel assisting submitted that it is not possible or indeed necessary to make a precise finding of the distance between Hawkesbury 16 and the Pulsar at its closest point before the Pulsar drove away. I accept that view.

42. What is certain is that only the briefest period of time elapsed between Hawkesbury 16 arriving in close proximity to the Pulsar and MF driving off. At most, it is possible Hawkesbury 16 may have come to a momentary pause, although the preponderance of the evidence suggests that even this may not have occurred. Therefore, even if Hawkesbury 16 did come to within 10-15 metres of the Pulsar, there was not enough time for either Senior Constable Taydler or Constable Goldsmith to have done anything to aid Mr Maher. They knew nothing of the rapport Mr Maher was establishing with MF nor did they have any time to form a plan to assist.

43. It is important to note at this stage that neither police vehicle appears to have ever reached great speed, particularly after the point at which they deactivated some or all of their warning devices. Senior Constable Goldsmith who was the passenger in the lead vehicle, Hawkesbury 16, stated that when responding Code Red they would likely have exceeded the speed limit

and overtaken other vehicles. He stated that they slowed as they reached Fairey Road and that there were fewer cars in that area. Senior Constable Galea, who was the driver of Hawkesbury 15 stated that they did not speed after the siren was deactivated and later the dirt road conditions meant they needed to slow down to some degree. Sergeant Cole, who was the passenger in that vehicle recalled they were initially travelling around the speed limit "maybe slightly higher", but they slowed when they saw Hawkesbury 16 emerge in front of them on Fairey Road.

44. After MF drove off, Constable Goldsmith informed police radio "this vehicle has taken off on us. We are not in pursuit. We are going to follow as the road is a dead end".

45. By the time Hawkesbury 15 arrived on the scene, both MF and Hawkesbury 16 had already begun to drive off, travelling further south down Fairey Road. The Court was initially concerned about the reason Hawkesbury 15 had used its siren to make a short "whelp" noise at the location where Mr Maher had been engaging with MF in the Pulsar, and the effect that hearing that noise may have had on MF. However, at the conclusion of oral evidence, I was satisfied that Hawkesbury 15 had not indicated a direction to stop and had used the siren very briefly as a safety warning to Mr Maher who was still adjacent to the road. Further, I was satisfied that this took place after MF had already left the vicinity.

46. The Pulsar accelerated away proceeding down Fairey Road. Before Fairey Road terminates in a dead end it forks to the left. Immediately behind where the road forks is a tree with which the Pulsar collided. All the indications are that MF made no attempt to apply the brakes before impact.

47. I note that the collision is captured on CCTV footage obtained from a sewerage treatment plant located in Fairey Road. It is clear from this footage that the police vehicles were somewhat behind the Pulsar and were driving considerably slower than it. In particular, a period of 27 seconds elapses between the point in time in which the collision is depicted and when the first of the two police vehicles comes into view. The footage shows MF's car hitting the tree without slowing.

48. The evidence suggests that after the collision, each of the responding officers took appropriate steps to attempt to remove MF from the wreckage and to deliver him aid. These steps included cutting the rope, which by this time was observed to, in fact, be two ropes, both of which were affixed to MF's neck. Upon the ropes being cut, MF took a faint breath. Police promptly called for an ambulance. It is appropriate to record that the circumstances confronting police must have been extremely traumatising and illustrate just how difficult the jobs that first responders are routinely asked to perform can be.

49. Dr Haden from Care Flight then attended the scene. MF had died by this time and Dr Haden completed the life extinct form at 14:48.

50. While these events were occurring, JA's friend arrived and took her to Windsor Police Station, where police took a statement from her, and took photographs of her injuries. As previously noted, this process was ongoing at the time of MF's death.

51. An autopsy was conducted on 28 September 2016. MF's injuries were significant and included multiple fractures including to his skull. A subarachnoid haemorrhage involving the brain, transection of the aorta and a large amount of blood in the left chest cavity indicated his immediate injuries were wholly incompatible with life. Toxicological analysis detected amphetamines, cannabinoids, and the anti-depressant medication citalopram.

Was MF's death intentionally self-inflicted?

52. A finding that a death is intentionally self-inflicted should never be made lightly. There must be clear and cogent evidence in relation to intention.[3]

53. On reviewing all the evidence before me I am satisfied to the requisite standard that MF's death was intentionally self-inflicted. He had previously indicated suicidal thoughts and was being treated for depression. While he was clearly affected by amphetamines[4], his conversation with Mr Maher indicates that he had not lost capacity to make decisions or to reason. In fact he told Mr Maher that he "felt like doing himself in" and that if the police arrived he was "out of here". He had earlier in the day threatened suicide by driving and had ropes around his neck. The objective evidence provided by the CCTV footage indicates that he made no attempt to stop as he drove at high speed into the tree. Subsequent examination of the vehicle did not reveal anything to suggest there was a mechanical fault.

54. There is poignant evidence that MF had previously felt suicidal and had survived. On this occasion, despite the efforts of Mr Maher, he took action. Tragically there are times when decisions such as this are made impulsively or in moments of despair that could ultimately pass. Mr Maher tried his hardest to delay any action by MF and for that he has my thanks and admiration.

[3] The proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard (*Briginshaw* v *Briginshaw* 60 CLR 336)
[4] The objective evidence of the toxicology results confirms this.

Did MF receive appropriate assistance for his mental health and drug and alcohol issues?

55. Given the connection between MF's behaviour on the day of his death and his history of intertwined depression and amphetamine use, the Court was keen to understand whether MF was provided with the assistance he needed to deal with these issues. As I have stated, Dr Tan identified his use of ice as a significant factor in his mental health decline in the last years of his life.

56. With respect to the treatment provided by Dr Tan he provided a statement to the Court and a copy of MF's medical record. As stated above, MF returned to Dr Tan's medical practice after an absence of some years on 27 July 2016. On that occasion, MF advised Dr Tan that he had just finished rehab and was in great despair, feeling suicidal and depressed. Dr Tan prescribed MF the anti-depressant Lexapro, and in an act of kindness provided MF with the money to obtain this medication. MF again attended Dr Tan's practice on 15 August 2016, where he expressed similar feelings to those he was experiencing at the time of the previous visit, and Dr Tan increased MF's dosage of Lexapro.

57. MF's last visit to Dr Tan occurred on 9 September 2016. He informed Dr Tan that he had been released from rehab a few days earlier but was still feeling very depressed. He informed Dr Tan he had ceased taking his Lexapro and Dr Tan wrote him another script for the anti-depressant.

58. A statement was obtained from Dr Anthony Korner, the Consultant in Charge at Nepean Hospital. Dr Korner was responsible for MF's admission to that facility in September and October 2015. Dr Korner explained that the discharge plan prepared for MF at that time involved MF being followed up by the Acute Care Team (Mental Health) and by the Drug and Alcohol team. Dr Korner states that MF was given information about the available programs to assist him to deal with his drug dependency issues and that the social worker may also have assisted him with telephoning the providers of such programs prior to his discharge. Dr Korner notes that there was some uncertainty as to when a place in these programs might become available. He explains that, as at September 2015, MF appeared motivated to pursue admission into such a program.

59. A statement was obtained by Dr Rajneesh Singh, who was also involved in the admission for MF in 2015 at Nepean Hospital. Dr Singh suggests that, prior to his discharge, accommodation for MF had been secured and that MF was provided with detailed psychoeducation relating to his diagnosis and with information as to the support available to him in the community.

60. A statement was obtained from Registered Nurse Siphathisiwe Sibanda. Nurse Sibanda was also involved in MF's 2015 admission at Nepean Hospital. Nurse Sibanda states that there

were plans to allow MF to be provided with a telephone to allow him to contact rehabilitation services. The services proposed to be made available to MF in the community included community outpatient services and individual and group counselling to help him achieve abstinence. These options were ultimately declined as MF wished to pursue other drug and alcohol rehabilitation options. A list of drug and alcohol rehabilitation options was provided to MF and he was advised to make contact with those services.

61. In relation to MF's more recent admission to Nepean Hospital, in October 2016, the Court received a statement from Dr Fisher, who was in charge of the relevant inpatient ward at the time of MF's admission. Dr Fisher explains that MF was treated as a priority patient due to his Aboriginal heritage. The history MF gave was that he had last used 36 hours previously which meant that, at the time he presented, he was not in active or physical withdrawal. Dr Fisher explained that MF was not physiologically dependent on methamphetamine and had previously demonstrated capacity to remain abstinent. Her plan was to admit MF for a week in order to break the ritual involved in his use of methamphetamine.

62. Dr Fisher further explained that, by the time of his discharge, MF was given contact details for community organisations to support him with his drug dependency issues. These referrals could not be arranged to coincide with his discharge from his hospital due to a number of matters including: waiting lists; MF's ineligibility with number of providers as a result of having an upcoming court case; because he did not have a criminal record check (Dr Fisher understood that certain of those organisations would not accept persons with particular criminal histories); and, financial constraints. Accordingly, there were limited options. Dr Fisher explained that the only community drug and alcohol treatment service Nepean Hospital had the capacity to influence was an organisation called We Help Ourselves ("WHOS"). An assessment with that service was done whilst MF was in inpatient.

63. Dr Fisher stated that Nepean Hospital did help MF find accommodation through their Aboriginal Liaison Officer, Mr Jamie Bellwood. Whilst he was an inpatient, Mr Bellwood supplied MF brochures and information regarding his options for drug rehabilitation after discharge. Mr Bellwood attempted to get MF into the Orana Aboriginal Rehabilitation Centre and worked with the Marrin Weejalli Aboriginal Corporation to secure this outcome.

64. Mr Bellwood formed the view, however, that MF was not interested in completing rehabilitation as he was committed to returning to the farm to be with his wife and children. Mr Bellwood explains that he could not force MF to attend rehabilitation against his will and expressed the opinion that he did as much as he could to help MF.

65. Mr Brown, the Aboriginal Mental Health Worker employed at Nepean Hospital also provided a statement. Although his recall is imperfect, Mr Brown explained that he would have assisted MF to arrange for the admission into rehabilitation facilities. While this was more the role of a social worker he would have assisted if he could and, in particular, he would have arranged for any assessments into such facilities to be conducted if he were asked to. However, he was of the impression that MF seemed comfortable and wished to follow up on the referral process himself.

66. A report and information in the form of Wellnet records was obtained by the Court. The only report made to the NSW Health Child Wellbeing Unit concerning MF's children occurred on 23 September 2015. Contact had been made to the unit out of concerns arising from MF's mental health following a suicide attempt. No action was taken at that time because MF was voluntarily seeking treatment and there was another carer.

67. Ms Etter, the manager of WHOS, provided a statement and documentation setting out the eligibility requirements for participating in the drug and alcohol rehabilitation program that service provides. WHOS did not have a policy requiring a court outcome prior to an assessment being conducted, and there was no initial admission fee for entry into the program it offered. Ms Etter did not say whether MF was assessed for eligibility with that service.

68. Mr Coyte, the CEO of rehabilitation service provider, the Glen, provided a statement. He noted that the Marrin Weejalli Aboriginal Corporation had made an online application on MF's behalf for a referral to that service on 31 August 2016. Staff from the Glen attempted to make phone contact with MF on 22 September 2016 to complete his assessment, however, the phone rang out. While the Glen charges a fee for the program, the service never rejects a client on the grounds that they cannot afford to pay the fee; rather they accept the client and help her or him to get Centrelink benefits to cover that fee. Mr Coyte explained that there is often a waiting list. The service will admit clients who have court proceedings pending but does not accept clients who have a history of particular types of offending (malicious wounding assault, robbery, sexual or indecent assault, arson, murder or manslaughter).

69. Mr Bennett, the CEO of Orana Aboriginal Corporation, provided a statement. He notes that MF had been referred to that service by the Marrin Weejali Aboriginal Corporation and had completed a phone assessment on 22 September 2016. MF was accepted and placed on the waiting list pending bed availability. At that time, the waiting list was 6-8 weeks. Significantly, Mr Bennett advised that, had MF been assessed as requiring immediate assistance, he could have been given priority over the other applicants in the waiting list. However, this was not done

as MF had provided only minimal information in support of his application. Mr Bennett advised that while Orana charge a fee, they do not refuse entry to anyone unable to pay on arrival.

70. Mr Jeffries, the CEO of the Weigelli Centre Aboriginal Corporation, advised that there is always a waiting list for the services provided by that centre. Sometimes a prospective client's admission is deferred if a court date is near to see what the outcome is. The cost of admission is 75% of a client's Centrelink and rent assistance benefits and clients are not required to pay any money up front. A person convicted of serious violence, arson, sex offence charges or who has been released from custody is not eligible for the programs provided by that service.

71. Major Gavin Watts of the Salvation Army provided a statement in relation to the services available to be provided by the Dooralong Transformation Centre. The only criterion for admission is that participants must be willing on their own volition to be an active participant in the program. Major Watts stated that the waiting list in September 2016 would likely have been around 4-6 weeks.

72. Ms Babineau, the CEO of Odyssey House, stated that there are some circumstances where a prospective client to that facility may not be admitted. To be eligible for admission, the person must be mentally stable, well enough to do the program and would need to want admission. Waiting lists are rarely needed. Ms Babineau said Odyssey House would not defer assessment of a potential client due to upcoming court dates but that the organisation may defer admission if court is within 6 weeks as the organisation did not have the means to transport a person to and from court. There is an admission fee, but the service is generally able to access brokerage to assist if a person is not able to pay upfront.

73. Significantly, it appears that the Marrin Weejali Aboriginal Corporation had been providing MF with a significant degree of support throughout 2016, and had been actively involved in assisting him with the process of securing a referral to these service providers after his discharge from Nepean Hospital in 2016. Ms Bonham, a team leader at that Corporation notes that the support provided to MF throughout 2016 included: individual counselling; the provision of Narcotics and Alcoholics Anonymous meetings; and, the referral to other support groups and services (including Nepean Hospital detox unit, WHOS, the Glen, Odyssey House, William Booth and Orana Haven). Ms Bonham notes that there were no available beds at those facilities at the relevant time resulting in MF having to wait "indefinitely" for a bed to become available.

74. In summary, the evidence appears to show that appropriate steps were taken to refer MF to support for his mental health and drug and alcohol issues, both after his 2015 and his 2016 admissions. Individual service providers and indeed Dr Tan appear to have acted

conscientiously and appropriately. However, once again this Court cannot help but observe that the perennial resourcing issues in this sector mean that lengthy waiting lists affect a patient's ability to get adequate treatment at the moment of crisis. Unfortunately, the lack of residential rehabilitation beds in NSW means that patients may be left unsupported at a critical time in their care.

75. While the Court accepts Dr Fisher's opinion that at the time of MF's discharge, he was not physically dependent on methylamphetamine, he was clearly in need of ongoing support. One worker has expressed the opinion that MF may not have been sufficiently motivated to engage in treatment at that time. However, in my view it is difficult to say this with any degree of certainty given that MF was not offered a bed forthwith. Instead, he was advised that he would be placed on a waiting list. In my view the ongoing shortage of residential places in rehabilitation for those struggling with amphetamine or ice addiction remains a very significant problem in the community.

76. The B family raised this issue as a particular concern and it is one I share. This Court reviews numerous deaths each year where the lack of immediate access to drug and alcohol treatment is an issue. The problem has not been solved by successive governments. I intend to send a copy of these findings to the Minister of Health for his information and review.

77. MF was provided with some support for his substance use issues and he was prescribed an anti-depressant medication by Dr Tan. The Court accepts that it may not have been possible to further treat whatever underlying mental health issues MF may have had while he was using significant amounts of ice. MF needed long term support to understand and properly unpack the complex reasons behind his substance use. His suicidal feelings, his depression and his amphetamine use were interconnected and needed to be addressed in a safe and culturally appropriate environment.

Was the response of the NSW Police on 27 September 2016 appropriate and in accordance with the NSW Safe Driving Policy (SDP)?

78. The Court needed to consider whether the police involved were well guided, supported by, and compliant with, the NSW Police Force's Safe Driving Policy (SDP). Sergeant Hyrmak formerly of the Traffic Policy Section of the Traffic & Highway Patrol Command was called to give expert evidence and assist in this regard. Sergeant Hyrmak analysed the police actions within the context of the relevant policy framework.

79. It is important to note that all four involved officers stated that they were never "in pursuit" of MF. In oral evidence officers from each car stated that they considered themselves to be involved in "urgent duty driving" pursuant to the SDP. This is entirely consistent with Senior Constable Goldsmith's call to VKG.

80. Having heard all the evidence I accept Sergeant Hrymak's analysis of events and his opinion that neither car was "in pursuit" of MF for the purposes of the SDP. While both police vehicles followed MF's vehicle down Fairey Road, there was no relevant communication by police indicating for him to stop.

81. Sergeant Hrymak's evidence as to the type of matters that could be regarded as a direction to stop was clear and consistent and I accept that, even if the evidence as to the shortest distance between the Pulsar and Hawkesbury 16 is accepted, there was no indication that Hawkesbury 16 took action which should properly be construed as a direction to stop.

82. Counsel assisting also submitted that Sergeant Hrymak's opinion that the police were engaged in "urgent duty driving", even after the point at which they had de-activated some or all of the warning devices ought to be accepted. I note that no submission to the contrary was made by Mr Hood.

83. Part 6 of the SDP which was in force at the time of MF's death deals with "urgent duty driving" which is defined as "duty which has become pressing or demanding prompt action".[5] Urgent duty driving is governed by rules which are distinct from those governing police pursuits. Prior to engaging in urgent duty driving police should take into account the potential danger to other road users. A number of other factors required to be taken into account are set out including weather and road conditions, traffic density (including vehicles and pedestrians), the time of day (including specific factors such as school zones or road works). The distance to be covered and the driver's level of certification should also be considered. Part 8, specifically clause 8-2 makes it clear that when undertaking an urgent duty response or driving "code red" warning devices are to be activated.

84. Sergeant Hrymak pointed out that cl. 8-2 of the SDP[6] mandating "warning devices", required police to have sirens **and** lights activated at all times when "driving urgent duty".[7] The version of the SDP presently in force contains an identical requirement.

[5] A similar definition is contained in the current version of the SDP at Part 8
[6] All references relate to the SDP in force at the time of MF's death being version 8.2.
[7] See also cl. 6-3.

85. The Court understands the officers' decisions to deactivate warning devices in these unusual circumstances. The circumstances involved responding to an incident in which there was a significant potential for imminent self-harm. I accept the police evidence that heralding their arrival could have frightened or "spooked" a person in crisis. While using these devices offers some protection to other road users, in a quiet area, faced with someone anxious to avoid the police, but also possibly suicidal, it appears to make sense to turn them off. The police were in marked police vehicles so they could hardly approach unnoticed, but there was little to be gained by using a police siren in these circumstances. I accept that the involved officers had some regard to the risks involved and took into account appropriate factors such as their speed, the road surface and the number of other vehicles in the vicinity. Counsel assisting submitted that while the deactivation of the warning devices constituted a technical breach of the SDP, it was not something which should greatly concern the Court in these particular circumstances or prompt criticism of the officers involved. I accept that view.

86. Counsel Assisting took the Court to policy equivalents to the SDP in the Federal and Queensland jurisdictions. Both policies provide police who are driving urgent duty with the discretion to turn off lights and sirens in particular circumstances. These policies are intended, it is presumed, to reflect particular operational exigencies which police may from time to time encounter and to provide police with some degree of operational flexibility. These exigencies could include, as Sergeant Hrymak observed, responding to an incident concerning an apparently suicidal person.

Is there a need for recommendations in this matter?

87. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

88. The Court carefully considered whether it is appropriate to make a recommendation in relation to the requirement to have lights and sirens activated when engaged in urgent duty driving. It may be observed that the appropriate wording of such a condition is a matter of some complexity. While it may seem sensible to allow some level of operational discretion in an appropriate case, the limits of that discretion need to be very carefully considered. Lights and sirens should ordinarily be activated whenever an officer is undertaking a course of urgent driving. The exceptions to that rule of practice should be very clear and carefully controlled. There is the potential for extreme danger if a police vehicle is permitted to undertake "urgent duty driving", and thus have the capacity to disobey certain road rules, without activating its

warning devices. The situations where this may be appropriate are likely to be extremely rare. I am not confident that the limited evidence before me about the particular facts surrounding MF's death is adequate to allow me to suggest where the limits of that discretion should lie.

89. I was heartened to hear that Sergeant Hrymak has raised the issue himself in the context of a review being undertaken by NSW Police of the SDP. Sergeant Hrymak advised that he tabled the issue of an amendment to the relevant provision and I understand that such an amendment is being given serious consideration. Given the issue is already under consideration by NSW Police it does not seem necessary for the Court to make any recommendation in this regard and I decline to do so. However, I intend to send a copy of these findings to the NSW Police Force's Traffic & Highway Patrol Command to assist in their ongoing review.

Findings

90. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was [redacted]

Date of death

He died on 27 September 2016.

Place of death

He died on Fairey Road, South Windsor NSW.

Cause of death

He died of blunt force injuries.

Manner of death

He died as a result of a motor vehicle collision with a tree. His death was intentionally self-inflicted.

Conclusion

91. I offer my sincere thanks to counsel assisting, Michael Dalla-Pozza and his instructing solicitor Amber Doyle for their hard work and enormous commitment in the preparation and conduct of this inquest.

92. I acknowledge the difficulties faced by officers responding to tragedies such as this and thank them for their service.

93. Finally, once again I offer my sincere condolences to MF's families. While I understand that they have been somewhat separated, I see that they are united in their love for MF. I acknowledge that the pain of losing a loved one in these circumstances is profound and that their grief is ongoing.

94. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
23 September 2021
NSW State Coroner's Court, Lidcombe

Annexure A: Schedule of Non-Publication Orders

Orders made on 22 April 2021

Pursuant to s. 74(1)(b) of the *Coroners Act 2009*, the following information contained in the brief of evidence tendered in the proceedings not be published:

1. In relation to the NSWPF Safe Driving Policy version 8.2 – July 2016 (Tab 52)
    a. Pages 18 – 19 , cl. 5-1-4 to cl. 5-1-8 up to and including the end of the first full paragraph after the dot point;
    b. Page 19, cl. 5-4-2 line from “the” up to and including “riding”;
    c. Page 19, cl. 5-4-4;
    d. Page 22, cl. 7-1-6;
    e. Page 23, 7-2-4;
    f. Pages 24 – 25, cl. 7-5-1, bullet points 6, 9, 10 and 15;
    g. Page 28, cl. 7-6-3;
    h. Page 28, cl. 7-6-8;
    i. Page 28, cl. 7-6-9;
    j. Page 34, fourth paragraph of the definition of “Terminate”; and,
    k. Page 37, eleventh line under “C”.

2. In relation to the NSWPF Safe Driving Policy version 9.2 – June 2019 (Tab 53)
    a. Page 12, cl. 5-1-4 to cl. 5-1-8 up to and including the end of the first full paragraph after the dot point;
    b. Page 13, cl. 5-4-2, line 3 to the third word on line 4;
    c. Page 13, cl. 5-4-4;
    d. Page 14, cl. 7-1-5;
    e. Page 15, cl. 7-2-4;
    f. Page 16, cl. 7-5-1, bullet points 6, 9, 10 and 15;
    g. Page 18, cl. 7-6-3;
    h. Page 19, cl. 7-6-8; and,
    i. Page 19, cl. 7-6-9.

3. In relation to the report of A/Sergeant N Hrymak (Tab 30A)
    a. Paragraph 15, line one, the words between “a” and “fully”;
    b. Paragraph 15, line two, the words between “a” and “vehicle”;
    c. Paragraph 15, the extracted portion of cl. 5-1-8 of the Safe Driving Policy;
    d. Paragraph 17, line one, the words between “a” and “fully”;
    e. Paragraph 17, line two, the words between “a” and “vehicle”; and,

f. Paragraph 17, the extracted portion of cl. 5-1-8 of the Safe Driving Policy.

Orders made on 13 September 2021

1. Pursuant to s. 75 of the *Coroners Act 2009* there be no publication of any matter that identifies [redacted] or any of his relatives.

2. Pursuant to s. 74(1)(b) of the *Coroners Act 2009* there be no publication of Exhibit 1 being the medical evidence relating to Rachel Ryman (nee Taylder).