CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ian Fackender
Hearing dates:	16 December 2020; 8-12, 15-17 and 19 February 2021
Date of findings:	13 September 2022
Place of findings:	Coroners Court of NSW, Lidcombe
Findings of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – manner of death – death in the course of a police operation – police operation to enforce Community Treatment Order under *Mental Health Act 2007* – uninvited entry into premises to enforce Community Treatment Order – planning and risk assessment of same – discharge of Taser - discharge of firearm by police - community mental health care – schizophrenia - NSW Police Force – Western NSW Local Health District – Memorandum of Understanding between NSW Police, NSW Ambulance and NSW Health
File number:	2017/00264782

Representation:	1) Counsel assisting: Mr C Smith SC with Ms K Edwards of Counsel. Instructed by Mr J Herrington and Ms C Healey-Nash of the NSW Crown Solicitor's Office 2) Ian's mother, Ms S Slatcher (on behalf of his family): Mr I Nash of Counsel instructed by Mr D Evenden of the NSW Legal Aid Commission 3) The Commissioner of the NSW Police Force, the New South Wales Police Force ("NSWPF"), Constable K Tucker and Constable S Graham: Mr M Spartalis of Counsel instructed by Mr S Robinson of NSWPF Office of General Counsel 4) Senior Constable Rebecca Towns: Mr B Haverfield of Counsel instructed by Mr G Willis 5) Constable Darren Carter and Sergeant Marita Shoulders: Mr R Reitano of Counsel instructed by Mr D Longhurst of McNally Jones Staff Lawyers 6) Inspector Jodi Stewart: Mr B Eurell of Counsel instructed by Ms N Baker of Carrol & O'Dea Lawyers 7) Constable Benjamin Josh: Mr R Hood of Counsel instructed by Mr K Madden of Walter Madden Jenkins 8) The Western NSW Local Health District: Mr B Bradley of Counsel instructed by Mr L Sara of Hicksons Lawyers 9) Dr R Yasmin: Mr S Beckett of Counsel instructed by Mr R Li of Avant Lawyers 10) Dr M Patfield: Ms S Scott of Counsel instructed by Ms J Alderson of Minter Ellison 11) Registered Nurses Mooney, Day, Sturgeon and Ferrie: Ms K Doust of the NSW Nurses and Midwives Association

Findings:	**Identity of deceased**: The deceased person was Ian Fackender **Date of death**: He died on 30 August 2017 **Place of death**: He died at his home in View St, Kelso, Bathurst, New South Wales. **Manner of death:** He died from the effects of gunshot wounds after he was shot four times by a police officer. Mr Fackender had longstanding schizophrenia that was at least partially resistant to treatment. At the time he was shot, Mr Fackender was acutely psychotic. Mr Fackender was moving towards officers with a large sword when he was shot by the police officer, who acted in defence of himself and another police officer. **Cause of death:** The medical cause of the death was multiple gunshot wounds.
Recommendations	**To the NSW Police Force ("NSWPF"):** (1) Careful consideration is given to re-introducing the section from the *Memorandum of Understanding between NSW Health, Ambulance Service of NSW and NSWPF in respect of "Mental Health Emergency Response"* (July 2007) ("the 2007 MOU") on the "MARIA" guidelines into the current version of the MOU, or otherwise providing express guidance to officers within it, on assessing risk, specifically directed to police assisting in the execution of CTO breach orders. This guidance should take into account the limited availability of mental health services after hours and how information specific to a community treatment order ("CTO") patient may be obtained after hours. (2) If a risk assessment section is introduced to the MOU as above, consider how practical guidance can be given to general duties NSWPF officers as to how that section is to interact with the ANZPAA guidelines and the overarching search warrant procedures. (3) An experienced forensic psychiatrist be engaged as a matter of priority, i.e. within 6 months, to review the NSWPF Weapons and Tactics training curriculum and advise on how mental health considerations be effectively integrated into that training. (4) The Chifley Police Area Command ("PAC") introduce a system to ensure that officers with four-day MHIT

training are prioritized as responders to “mental health incidents”.

(5) The Chifley PAC introduce operational SOPs for the use of radio (if not already in existence) or reinforce the need for radio as the primary communication device between officers.

To NSW Health, NSW Ambulance and the NSW Police Force:

(1) The current (2018) Memorandum of Understanding between NSW Health, Ambulance Service of NSW and NSWPF in respect of “Mental Health Emergency Response” be comprehensively reviewed and revised so that:

(a) there is a section on CTOs and breach orders which provides clear guidance to all signatory parties as to:

(i) the required contents of a handover between NSW Health staff and NSW Police Force officers where police are requested to assist in a CTO breach order (see further below);

(ii) the agency which has responsibility for locating a person subject to a CTO breach order;

(iii) when an ambulance should usually be contacted, i.e. prior to or after locating a person;

(iv) the applicable legislative provisions and the NSW Police Force and NSW Health policies relevant to CTO breach orders including the relevant provisions of the *Mental Health Act 2007*, NSW Police Force policies on uninvited entry and other risk assessment policies and tools;

(v) the use of firearms at CTO breach order executions involving NSW Police;

(vi) the availability of mental health resources out of business hours; and

(vii) the use of PACER, MHIT trained officers and other resources when executing a CTO breach order.

(b) A section or appendix of the MOU be drafted on the handover or information exchange between police and mental health staff where police assistance is requested for a CTO breach. The section should outline appropriate practices including:

i. the handover to be arranged in advance and take place in a setting where patient confidentiality can be maintained;

ii. the exchange be performed (where practicable) by the case worker with carriage of the client or, if not practicable, by a person

with some knowledge or awareness of the client and their history;

iii. the police and case workers should have reference to a risk assessment tool or 'ready reckoner' of relevant considerations including:
    1. risk considerations, i.e. any history of self-harm, threats, impulsive or aggressive behaviour; any history of use of a weapon, the presence and nature of delusions, the level of compliance or cooperation at the time at which the operation will occur and known drugs and alcohol use;
    2. the personnel intended to attend at the scene;
    3. level of urgency and expected time frames for service of the notice/order, whether or not an afterhours approach should be attempted, and the number for the 1800 24/7 Mental Health Hotline;
    4. the particular profile of the patient including their condition, medication, perception of emergency services workers and likely attitude towards them, and techniques that may be effective for de-escalation; and
    5. resources for that patient including a photograph and contact details of helpful family or friends [the 'Contact MHS bubble' in Appendix B provides a helpful summary of relevant information];

iv. How documentation of that information exchange should take place and the method for ongoing communication between police and health workers including the contact details of a nominated person from NSW Health and NSW Police Force.

To NSW Health:

(1) That there be a review of the nature and layout of a "Breach Order" issued pursuant to s. 58 of the Mental Health Act to ensure that it provides relevant guidance including as to the relevant MOU.

(2) That consideration be given to the need for a review of the pro forma terms of a CTO Treatment Plan.

	To the NSW Attorney General: (1) Consideration be given to modifying the terms of s. 58 of the *Mental Health Act 2007* to provide for more flexible means of service where: (a) a non-complying patient is not contactable and reasonable attempts have been made to contact them and inform them of the need to comply with a CTO and the possible consequences of failure to comply; and (b) there is some clinical urgency/immediacy or issues of public safety that necessitate conveying the person for treatment quickly once they are located; and (c) police assistance is necessary to locate and transport the person. (2) For the avoidance of doubt, consideration of any reform should include how principles relating to the rights and dignity of mentally ill people and restraint as a last resort can be safeguarded if service requirements are modified or removed. (3) Consideration be given to removing the use of the word "apprehend" from the terms of s. 59 of the *Mental Health Act*.
Non-publication orders	**Annexure A** contains the details of non-publication orders made by the State Coroner and is available upon request from the Court Registry.

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Introduction

1. Ian Fackender (to be referred to in these findings as Ian, in accordance with his family's preference) died on 30 August 2017, aged 47, after he was shot by a police officer in the bedroom of his home in Kelso, Bathurst, NSW. Ian suffered from schizophrenia which was at least partially resistant to treatment.

The role of the Coroner

2. The inquest is a public examination of the circumstances of Ian's death. Unlike some other proceedings, the purpose of an inquest is not to blame or punish anyone for the death. The holding of an inquest does not itself suggest that any party is guilty of wrongdoing. Rather, the primary function of an inquest is to identify the circumstances in which a death has occurred.

3. The role of a Coroner, as set out in s. 81 of the *Coroners Act 2009* (NSW) ("the Act"), is to make findings as to the:

   - identity of the deceased;
   - the date and place of their death;
   - the physical or medical cause of their death; and
   - the manner of their death, in other words, the circumstances surrounding the death.

4. Pursuant to s. 27 of the Act, a Coroner is required to hold an inquest in circumstances where, as set out in s. 23(1)(c) of the Act, it appears that a person has died as a result of a police operation. In this case, Ian died as a result of a police operation conducted in his home on 30 August 2017.

5. Under s. 82 of the Act, a secondary purpose of an inquest is for the Coroner to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the person's death. That involves asking whether anything should or could be done to prevent a death in similar circumstances in future. These recommendations are made, usually to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest.

The purpose of a mandatory inquest

6. As described in Waller's Coronial Law & Practice in NSW (4th ed) at [23.7]:

> *"The purposes of a s.23 inquest are to fully examine the circumstances of any death in which Police … have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."*

Ian's life

7. Before I go on to discuss the circumstances of Ian's death, I would like to acknowledge evidence lovingly given by Ian's family about the person Ian was and about his life.

8. Ian was a father to seven children. He had a brother, Mark, and a sister, Bronwyn, and loving parents (his mother, Sue Slatcher, father, Peter Fackender, as well as his step-father Jeremy Slatcher, and Peter's partner, Mavis). His family members attended each day of the inquest.

9. Ian was born in the Illawarra. He was a quiet but happy child. In high school, he developed a lifelong interest in computers. He left school in Year 10 and met his future wife, Carol. He would go on to work in computer systems, including at Unisys. Ian was a devoted Christian.

10. Ian's family noticed he became increasingly withdrawn from around 1994. He was diagnosed with schizophrenia in 2002. From this point, Ian lived with a severe mental illness.

11. Ian was firmly supported by his family, and he was able to live with his mother and his stepfather near Orange, and at other times with his father and family in the Illawarra. A brief summary such as this is not apt to capture the person that Ian was, the enormous trauma that Ian experienced as a result of living with a mental illness, nor that of his family who cared for him so deeply and supported him throughout his life. It does not capture the enormous resilience that he and all his family demonstrated, either.

12. By all accounts, Ian was a profoundly warm and gentle soul. Ian's neighbours gave evidence of how helpful he was to them, and how he loved a chat and tending to the garden. I was grateful to hear Ian's mother, Ms Sue Slatcher, read a moving and beautifully written poem about her son.

13. Ian's sister, Bronwyn, paid tribute to her brother in a statement to the Court, noting that he was a gentle and loving person, brilliant with computers. She shared her memories of their childhood spent together and their bond as siblings.

14. Ian's father, Peter Fackender, kindly shared with me two videos about Ian, one a montage showing pictures of Ian from early childhood and throughout his life, and the other a song written and performed by Ian's brother.

15. I thank Ian's family for sharing this material with the Court, and for their participation in the inquest generally. The evidence of the inquest made plain that Ian was a warm and generous man, but also one who had suffered as a result of a debilitating mental health condition. Ian's family suffered with him, and their plight is the plight of so many other families who have loved ones who experience mental illness. The Court acknowledges Ian's life and contribution to the community and to all those around him; the love that his family showed him and he for them; and the terrible loss they have suffered upon his death.

The inquest

16. The inquest was heard in Bathurst from 8 to 19 February 2021. There was also a hearing on 16 December 2020 to take evidence from Constable Josh, who had not given an account of his involvement in the police operation that led to Ian's death until that time.

Issues at inquest

17. The issues that were considered at the inquest were as follows:

    1. *The manner and cause of Ian's death on 30 August 2017.*

    Issues relating to NSW Police Force officers

    2. *Whether Ian's death was preventable, having regard to:*

a. *The adequacy and appropriateness of planning (including risk assessment), decision-making and communication on 30 August 2017 before the second attendance of NSW Police Force ("NSWPF") officers at 41 View St, Kelso at or around 6:40pm;*
b. *The adequacy and appropriateness of planning (including risk assessment), decision-making and communication before NSWPF officers entered Ian's unit at 41 View St;*
c. *Whether Acting Sgt Rebecca Towns was appropriately supervised and supported by relevant senior NSWPF officers during the operation to enforce the Community Treatment Order ("CTO") on 30 August 2017;*
d. *Whether it was appropriate to enter Ian's unit on 30 August 2017;*
e. *Whether Constables Darren Carter and Benjamin Josh entered the unit contrary to the plan developed by Acting Sgt Towns and, if so, the adequacy and appropriateness of their planning (including risk assessment), decision-making and communication;*
f. *The appropriateness of the manner in which NSWPF officers entered the unit;*
g. *Whether an alternative course of action was open to Constable Josh, and was warranted, at the time he discharged his firearm towards Ian;*
h. *Whether, with the benefit of hindsight and reflection, any steps could have been taken by NSWPF officers on 30 August 2017 that may have led to a different outcome.*

Issues relating to potential recommendations directed to NSWPF

3. *Whether the applicable NSWPF policies and procedures were followed by the NSWPF officers present at 41 View Street.*
4. *Whether the NSWPF Critical Incident Guidelines were complied with on 30–31 August 2017.*
5. *Whether the Memorandum of Understanding between NSW Health, Ambulance Service of NSW and NSWPF in respect of "Mental Health Emergency Response" (July 2007) ("the MOU"), was adhered to on 30 August 2017.*
6. *Whether the events of 30 August 2017 reveal inadequacies or deficiencies in the above-mentioned policies such that recommendations pursuant to s. 82 of the Coroners Act 2009 are necessary or desirable with a particular focus on:*

a. *planning (including risk assessment), decision-making and communication when police are involved in the enforcement of a CTO Breach Order; and*
b. *the Police, Ambulance and Clinical Early Response ("PACER") program and other approaches to interactions between NSWPF and persons with a mental illness.*

7. *Whether the events of 30 August 2017 reveal inadequacies or deficiencies in training at the NSWPF relating to the issues and policies outlined above such that recommendations pursuant to s. 82 of the Coroners Act 2009 are necessary or desirable.*

Issues relating to Ian's mental health treatment and potential recommendations to the Western NSW LHD

8. *Was there inadequacy in the mental health care provided to Ian between 21 September 2016 and 30 August 2017 and, if so, did this cause or contribute to his death, with particular attention to:*

a. *the frequency and adequacy of clinical reviews and psychiatric reviews; and*
b. *the continuity of care provided to Mr Fackender in 2017.*

9. *Did any inadequacy in communication between Bathurst Community Mental Health Services ("BCMHS") and NSWPF on 30 August 2017 cause or contribute to Ian's death?*
10. *Whether the events of 30 August 2017 reveal inadequacies or deficiencies in BCMHS policies, practices or training such that recommendations pursuant to s. 82 of the Coroners Act 2009 are necessary or desirable, particularly with respect to awareness of the MOU and the information provided by BCMHS to NSWPF where their assistance is sought in enforcing CTO breach orders.*

The police investigation

18. Ian's death was declared a "critical incident" by the NSWPF. The investigation team was led by Detective Senior Sgt Mark Dukes, as the Senior Critical Incident Investigator. Detective Dukes conducted a great number of investigations and compiled a comprehensive brief of evidence. I commend him on the great efforts he went to during his investigation and during the hearing, along with the assistance of Detective Inspector Virginia Gorman.

19. The investigations included conducting directed interviews with police officers involved on the night of Ian's death. All of the involved officers gave directed interviews to the Critical Incident Investigation team, except Constable Josh, who declined to participate in a directed interview.

The factual evidence

20. Following careful review and consideration of the brief of evidence tendered at the hearing, as well as the oral evidence of the witnesses who appeared at the hearing, I make the following findings in relation to the evidence at inquest.

Background to the events of 30 August 2017

21. In August 2017, Ian was living alone in Unit 1 of 41 View St in Bathurst. He had moved to Bathurst in February 2016. He was happy in his apartment. He would have dinner regularly with his mother Sue, and one of his daughters would stay with him regularly in the front room. Ian's neighbours and his landlord described Ian as a good tenant and neighbour who was helpful around the unit block.

22. Ian was on the Disability Support Pension. Ian was also subject to the terms of a Community Treatment Order ("CTO"), an order which may be made by the Mental Health Review Tribunal ("MHRT") pursuant to Part 3 of the *Mental Health Act 2007* (NSW), prescribing conditions for the treatment of a person's mental health conditions.

23. Ian had first been placed on a CTO on 23 October 2015, when he lived in the Illawarra. A condition of the order was that Ian attend his community mental health service to receive a monthly "depot" injection of his anti-psychotic medication.

24. That CTO was not renewed and, in around April to May 2016, Ian stopped taking medication and his condition began to deteriorate. In June 2016, Ian came under the care of the Bathurst Community Mental Health Services (BCMHS), having previously been under the care of the community team in the Illawarra.

25. On 21 September 2016, Ian's condition had deteriorated to the point that he barricaded himself into his house, suffering from delusions. His mother reported that he had become withdrawn and he told her he was concerned that he was being chemically castrated at night. Two staff members of the BCMHS, Clinical Nurse Consultant Karen Richards and Russell Jones, attended Ian's unit on that day to assess him. Ian's mother, Sue Slatcher, also attended. Ian became

distressed that he might be sent to hospital and went into his bedroom. Ms Slatcher informed the BCMHS staff that Ian had a bow and arrow in his room, and they left the house. Ms Slatcher remained at the scene to help to calm Ian.

26. At this point Senior Constables Troy Johnson and Kylie Ellsmore of Bathurst Police Station attended Ian's house, having been called to the scene by the BCMHS staff. The officers talked to Ian through the screen door of the house, while Ms Richards assisted to negotiate. Although Ian appeared to calm down as a result of these discussions, he perceived at one point that people were laughing at him, and subsequently came out of the house holding the loaded bow and arrow.

27. As to what occurred subsequently, it was submitted by Ian's family that I should make a positive finding that Ian did not fire an arrow. It was submitted on behalf of the Local Health District, some of whose staff attended the incident, that the evidence did not permit such a determination to be made, although that I equally should not make a positive finding that Ian did fire an arrow.

28. The evidence before me is conflicting as to whether Ian ever fired an arrow at this point. No witnesses were called to give evidence at the hearing about the incident or to be cross-examined as to their recollection, and it was not relevant for the purposes of the hearing to do so. In those circumstances, I decline to make a finding as to whether Ian fired an arrow on 21 September 2016.

29. In what was no doubt a highly distressing situation for all involved, Ian moved towards his car and entered it, at which time he was Tasered and sprayed with capsicum spray by Senior Constables Ellsmore and Johnson. Ian was eventually restrained and transferred to Bloomfield Hospital at Orange, where he was admitted as a voluntary patient.

30. Following those events, Senior Constable Ellsmore made a record on the NSW Police "COPS" system that Ian had threatened the use of a weapon. The incident appears to have been the subject of general discussion by officers at Bathurst Police Station to the extent that it apparently became notorious. Almost all of the officers who gave evidence at the hearing stated they had knowledge of what became referred to in the inquest as the "bow and arrow incident."

31. Ian's admission to Bloomfield Hospital following the bow and arrow incident lasted around five weeks, after which he was discharged on a new CTO, dated 23 October 2016.

Care and treatment of Ian's mental health from October 2016 – 30 August 2017

32. At this point, I gratefully adopt the following factual summary prepared by Counsel Assisting of the evidence that was before the Court concerning Ian's mental health and the care he received over the next period. Except where noted below, the following facts were not in dispute at hearing.

33. Ian's CTO dated 23 October 2016 had a section headed "Ian Fackender's obligations" which read:

> *Ian Fackender must take the medication prescribed by Dr Martyn Patfield or delegate;*
>
> *Ian Fackender must attend reviews with Dr Martyn Patfield or delegate at least three monthly;*
>
> *Ian Fackender must meet with Kim Mooney or delegate at least fortnightly;*

The frequency, place, or timing of appointments between Ian and the case manager, and treating doctor or delegates may be changed by the case manager or treating doctor.

34. RN Kim Mooney officially became Ian's case manager in March 2017, although she had, in practice, been case managing him since October 2016. RN Mooney had been a registered nurse since 2013 and working at BCMHS since 2016. Ian's previous case manager, Ken Tuckey, became unwell in late 2016 and RN Mooney effectively inherited all of Mr Tuckey's clients as well as her own. RN Mooney was listed on Ian's October 2016 CTO as the "psychiatric case manager" and she organised his psychiatric review with Dr Patfield on 9 November 2016.

35. RN Mooney saw Ian approximately monthly when she administered his depot injection. She said that Ian needed a lot of prompting to receive his injections at first but progressively became more and more compliant. At each appointment, RN Mooney would undertake a mental state examination (which took about 30 minutes) and was vigilant for signs of limited insight, lingering delusional thoughts and any other evidence of deterioration.

36. Ian had a good rapport with RN Mooney and was compliant with his treatment while in her care. She took an interest in his hobbies and knew he liked computers, attending weekly roast dinners with his mother and listening to loud Christian music on his headphones (sometimes so loud that he couldn't hear the phone). Ian even brought one his daughters in to meet RN Mooney. RN Mooney spoke to Sue Slatcher approximately three times on the phone while she was managing Ian. RN Mooney described Ian as clean but consistently scruffy in presentation and recalled that he rarely wore shoes, even when it was very hot or very cold.

37. RN Mooney made much more detailed assessments and observations than were recorded in her notes and she stated in evidence that she regretted not taking better notes.

Review by Dr Patfield on 9 November 2016

38. On 9 November 2016, Dr Patfield reviewed Ian in a comprehensive psychiatric assessment. Dr Patfield described Ian as very gentle and cooperative man who was a little reserved. Ian accepted in the review that some of his views were delusional and misguided, but Dr Patfield suspected some lingering delusional thoughts. Dr Patfield decided to take Ian off his oral medication (10 mg of Abilify) as Ian was complaining of a sexual side effect. Dr Patfield wanted to address the side effect but also to show Ian, a patient with some history of non-compliance, that his concerns were being taken seriously and would be addressed if he raised them. Dr Patfield expected that Ian would be reviewed by a psychiatrist in about 4 months, that is, a month or two before his CTO was due for renewal.

39. Dr Patfield did not make a follow-up appointment to see how Ian responded to the medication change because he expected that he would be notified by the case worker of any negative side-effects. Dr Patfield actively wanted to know if Ian had experienced any effects as a result of the change in his medication.

Attempts to get Ian reviewed by a psychiatrist

40. On 22 November 2016, after his oral medication was removed on 9 November, Ian told RN Mooney that his Abilify did not seem as effective after three weeks. This was of clinical concern to RN Mooney. She made the following entry in the patient file:

Ian stated during appointment the Abilify seems to not be as effective after three weeks. It was negotiated with Ian for him to have another appointment with Dr Patfield to discuss his medication regime and maybe introducing some oral medication.

41. The negotiated appointment did not occur because RN Mooney was unable to have Ian seen by a psychiatrist. Dr Patfield did not find out about Ian's comments about his medication until after Ian's death. Dr Patfield agreed in his evidence that Ian's statement that his medication was not as effective after three weeks was a matter of concern given the potentially serious consequences if Ian's condition deteriorated.

42. RN Mooney repeatedly made unsuccessful attempts to have Ian reviewed by a psychiatrist. She wanted Ian to be psychiatrically reviewed, preferably by Dr Patfield, to raise Ian's comments about his medication and receive general reassurance about her management of Ian.

43. RN Mooney entered Ian's name into an appointment diary to see a psychiatrist. At that time, two psychiatrists attended BCMHS for a day each fortnight – in other words, the BCMHS had access to a psychiatrist one day a week. Patients' names were entered in pencil in an appointment diary for a "slot". There was a practice at BCMHS that if another patient had greater clinical need ("higher acuity"), their case worker would negotiate to take over another patient's pencilled-in appointment. These discussions usually occurred at morning meetings and were collaboratively resolved.

44. RN Mooney entered Ian's name in the diary at least three times but each time Ian's slot was ceded to a patient with higher acuity. In practice, this meant Ian's name in pencil was rubbed out of the diary and substituted with another name on at least three occasions. There was no other record of these substitutions in the patient file or in a master file. I pause here to note that the Western NSW Local Health District ("the LHD") stated in its submissions that an electronic data base has since been adopted which provides for better record keeping and improved access when triaging patient needs.

45. A multi-disciplinary team ("MDT") meeting headed by psychiatrist Dr Peter Jones took place every second Thursday at BCMHS and was an opportunity for caseworkers to raise concerns, such as being unable to secure an appointment with a psychiatrist. RN Mooney said she brought Ian's case to those meetings for discussion twice, but it did not lead to securing a psychiatrist's appointment for Ian. RN Mooney did not give an account of the discussions she had with the psychiatrist in those meetings and her ongoing attempts to have Ian seen by a psychiatrist were not recorded in Ian's case notes.

46. RN Mooney considered Ian to be generally stable but her desire to have Ian seen by a psychiatrist was consistent from November 2016 to April 2017. During that time, Dr Patfield and another psychiatrist went on extended leave. While locum services were secured and the psychiatrists held extra "make up" clinics, access to psychiatrists was more limited during that period. RN Mooney took no further steps to escalate Ian's case after the MDT meeting. She said she accepted the service was short-staffed in psychiatry and that other patients had greater clinical need.

47. Ian's sexual side effects were reported as resolved in December 2016 and between October 2016 and April 2017, RN Mooney noticed an improvement in Ian's mental state. She recalled that: "he started to engage a little bit better, his conversations were more free-flowing. His presentation seemed to have improved."

Review by Dr Yasmin on 6 April 2017

48. In April 2017 RN Mooney arranged for Ian to see Dr Rehana Yasmin, a Career Medical Officer (CMO), with experience as a psychiatry registrar, who worked at the Panorama Clinic in Bathurst, principally with voluntary psychiatric patients. Dr Yasmin had limited experience with CTOs and no background with Ian, but Ian's CTO was coming up for renewal and, as already detailed, RN Mooney had been unable to have Ian reviewed by any other psychiatrist since November 2016.

49. I note that Ian's family emphasised in their submissions that the predominant reason that Dr Yasmin saw Ian was for the renewal of his CTO. They note that Ian's consultation with Dr Yasmin was not the result of RN Mooney's efforts to have Ian psychiatrically reviewed but was simply a pre-requisite of renewing his CTO. This is reflected in the contemporaneous documentation of both RN Mooney and Dr Yasmin, as well as in Dr Yasmin's evidence about her understanding of the purpose of the consultation. I am satisfied that this was the primary purpose of the consultation with Dr Yasmin on 6 April 2017.

50. On 6 April 2016, RN Mooney spoke to Dr Yasmin about Ian for about 30 minutes and then observed Dr Yasmin review Ian for over an hour. She reported that Ian was calm and cooperative with logical and coherent thoughts and that he denied paranoia, delusions or thoughts of self-harm. Ian's insight and judgement appeared reasonable, but Dr Yasmin noted from Ian's case notes that his insight would fluctuate. RN Mooney said she told Dr Yasmin about the bow and arrow incident before Ian's review, but Dr Yasmin did not recall this, and it is not mentioned in Dr Yasmin's clinical notes. RN Mooney described Dr Yasmin's review as "very thorough".

51. Dr Yasmin recommended that Ian's CTO be extended despite apparently having some concerns about how often Ian had been seen by a psychiatrist during the term of the past CTO. She was surprised with the infrequency of his psychiatric reviews but assumed Ian would be reviewed by a psychiatrist every four to six weeks under the CTO going forward (because that had been her past experience). Dr Yasmin initially said she was not comfortable with Ian not yet seeing a psychiatrist in 2017 but later gave evidence that she was content with the existing arrangement for management and medication. Dr Yasmin was unable in her evidence to say clearly what the existing arrangement was under the CTO or if she was aware of it when she reviewed Ian.

52. Dr Yasmin could also not say if she turned her mind to Ian's clinical need for psychiatric review in the future, that is, how often Ian needed be reviewed by a psychiatrist, other than to say she would not have been concerned if Ian was psychiatrically reviewed every three months. Dr Yasmin considered Ian mentally stable at the time of the review.

53. On 26 April 2017, the MHRT extended Ian's CTO until 25 October 2017. Like his previous order, it required Ian to receive a depot injection every four weeks. Ian was also required to attend reviews with his psychiatrist, Dr Patfield, at least three monthly, and to meet with his caseworker, Kim Mooney, at least fortnightly.

54. In early May 2017, Ian reported to RN Mooney that he could feel his medication wearing off towards the end of his cycle and his thoughts "would start to range". Ian did however attend his next two appointments.

RN Day becomes Ian's case manager

55. On 27 July 2017 RN Mooney left BCMHS and RN Alison Day became Ian's case manager. There was scant evidence of any handover, and the legal representative for RNs Mooney, Day Sturgeon and Ferrie conceded that there was no formal

handover between RNs Mooney and Day. The LHD contended that there was a handover and relied on RN Day's evidence of a group meeting where RN Mooney performed a verbal handover in which she "went through all of the clients that she was handing over". RN Day believed the verbal handover of Ian's case would have taken around two minutes because "there [were] no immediate concerns raised" and it was a "routine handover". RN Day later spent about 30 minutes reviewing Ian's file. The adequacy of this handover will be considered further, below.

56. RN Day spoke to Ian on the phone on 27 July introducing herself as his new case worker and said he was pleasant and co-operative and knew he was due to attend in the next day for his depot injection. Ian told her he "feels like it's due" but denied psychotic symptoms. RN Day was not on duty on 28 July 2017 but Ian agreed to come in the following week so they could meet face to face. Ian attended on 28 July for his injection without further prompting and saw a nurse who had no previous experience with him. He was scruffy and shoeless as usual but apologised for his appearance and otherwise appeared stable. Ian did not attend the service again.

The deterioration in Ian's condition in July 2017

57. Ian began to deteriorate shortly after his injection on 28 July 2017. Ian's mother, Sue, said he normally improved after his injection but there was no noticeable improvement on this occasion. She recalled that Ian lost interest in his hobbies, was paranoid and mentally unstable and reported experiencing delusions about demons. Ian thought people were hiding in the bushes out the front of his house and they wanted to look into his eyes. He had particularly intense fears about emergency service sirens and police coming to arrest him and take him to gaol.

58. On 24 August 2017, six days before his death, Ian failed to attend his monthly depot injection as required by his CTO. Ian had in fact moved away from Kelso between 17 and 27 August 2017, staying at places including Bright in Victoria and southern New South Wales. Ian had a habit of visiting Bright when he was actively delusional.

59. Counsel for Ian's family submitted that despite RN Day's evidence that she attempted to contact Ian around this time, there was "no record of such contact". Counsel for the nurses relied on evidence that RN Day attempted to contact Ian on 23 August 2017 in advance of his appointment the next day and again on 24 August 2017, at which time she managed to contact Sue Slatcher, who said she would remind him to attend. I accept RN Day's evidence that she attempted to contact Ian on 23 and 24 August 2017 in relation to his depot treatment but that his phone was switched off.

60. RN Day did not become aware of Ian's deterioration or Sue Slatcher's concern about Ian until 28 August 2017, when she spoke to Ms Slatcher. RN Day regarded Sue Slatcher as a reliable and insightful source of information about Ian's condition. If RN Day had been aware of Ian's deterioration prior to this, she would have introduced more assertive care (including, potentially, a visit to Ian's home with police to assess him). Despite the earlier difficulty in getting Ian psychiatrically assessed, RN Day thought Ian could have been seen by a psychiatrist within a week in light of his history of rapid deterioration and the bow and arrow incident. Dr Patfield agreed in his evidence that Ms Slatcher's account of Ian's presentation indicated a need for an urgent psychiatric review.

61. On 29 August 2017, RN Day made a series of attempts to contact Ian by phone and left voicemail messages including a warning Ian that he might be in breach of his CTO. On the same day, RN Day met with the acting Director of Community

Services, Mr Derek Ferrie, and the Nursing Unit Manager (NUM) RN Sue Sturgeon. They discussed their concerns about Ian's mental state, his failure to attend the service, the deterioration observed by Ms Slatcher and the need to involve police in any attempt to locate and serve Ian. Mr Ferrie signed a breach order and breach notice. RN Day could not take the orders to the police station due to other commitments, so she gave them to RN Sue Sturgeon and asked her to take them to the police station and arrange for police to come with them to "*try and get Ian in*".

62. I pause to note that Ian's family submitted that I should find that the breach order was issued illegally, for several reasons including the fact that it was issued concurrently with the breach notice, contrary to the terms of subs. 58(3) and (4) of the *Mental Health Act*. This submission was dealt with at length by counsel for the LHD, which opposed a finding of illegality in relation to the breach notice and order. While Ian's family raised legitimate concerns about the way in which the breach notice and breach order were dealt with by the LHD, I am not persuaded that it is necessary for me to determine the legality or otherwise of the breach notice and breach order issued on 29 August 2017. I note however that the submissions made by Ian's family and the LHD raised important issues in relation to the appropriateness of the s. 58 procedure in cases where urgent intervention is required. The broader issues arising in relation to the procedure set out in s. 58 of the *Mental Health Act* will be dealt with further below.

63. Upon receiving the orders from RN Day, RN Sturgeon in turn asked community clinical psychologist, Sonja te Braak, to deliver the order to the police. She told Ms te Braak to tell the police that "Ian is very violent when he is mentally unwell" and that "we will be in touch". RN Sturgeon put an adhesive 'post-it' note on top of the folder containing the breach order saying, "NB: Alert, high-risk client".

64. RN Day and RN Sturgeon had previously attended homes with police to serve CTO breach notices or orders and assumed that the normal practice would occur. The normal practice was that police would locate the person and contact BCMHS, whereupon a caseworker and at least one other BCMHS worker would attend with police.

The actions of BCMHS staff on 30 August 2017

65. On 30 August 2017 Ms te Braak attended Bathurst Police Station in the morning and provided the CTO documentation (including the 'post-it' note) to desk officer Arna Martin and later to A/Sgt Towns who was walking past. Ms te Braak was transporting an assisting psychiatrist from the airport and he was waiting in the car. All the conversation took place at the front counter of the station. A/Sgt Towns told Ms te Braak that she had never seen a CTO breach notice before and wrote down RN Sturgeon's name and number as the contact person. The bow and arrow incident was briefly mentioned.

66. At some time in the mid-morning, A/Sgt Towns called RN Sturgeon, who explained that Ian would become delusional and isolated when unwell and that he had not been answering his phone.

67. At about 12.30pm, A/Sgt Towns attended BCMHS with Senior Constable Sarah Graham after they had accompanied another person to the Emergency Department at Bathurst Hospital. The officers spoke to RN Sturgeon and RN Day in person about Ian. They discussed Ian's delusions about demons and his paranoia about police and ambulance officers and vehicles. RN Sturgeon and RN Day said they were very worried about Ian as he had missed his depot injection and he could deteriorate rapidly when unwell. They said Ian could be violent when

he was unwell and explained they could not attend without police due to fears for their safety.

68. De-escalation approaches were not discussed and no concern about self-harm was expressed. RNs Sturgeon and Day provided Ian's mother's phone number to A/Sgt Towns so she could get more information about Ian and said that Ms Slatcher was a useful source of information. A/Sgt Towns was concerned to ensure that the CTO breach order was lawfully made and expressed confusion and concern (with some justification) during the meeting as to why the breach order and breach notice were to be served simultaneously.

69. RN Day and RN Sturgeon made it clear that they were prepared to go with police when they went to see Ian. Notably, the *Memorandum of Understanding – Mental Health Emergency Response between the NSWPF, NSW Health and NSW Ambulance* dated July 2007 ("the 2007 MOU"), a document which set out the roles of the police, mental health services and NSW Ambulance in attending to incidents involving people with a mental illness, was not mentioned at all despite A/Sgt Towns being open about her lack of experience in CTOs and her confusion about respective roles and responsibilities. No plan was expressed about what would occur if police located Ian.

70. At some time in the mid-afternoon, RN Day spoke to A/Sgt Towns on the phone and A/Sgt Towns asked when the BCMHS closed. RN Day advised that they closed at 5:00pm and asked the receptionist to contact RN Sturgeon if police called the office seeking assistance when she left for the day shortly after 4:00pm.

The police operation on 30 August 2017 to execute the CTO

71. As noted above, A/Sgt Towns had taken charge of attending to the breach notice that had been delivered to the police by the BCMHS. A/Sgt Towns' evidence to the Court was that she had never been involved in the execution of a CTO breach order before. A number of general uncertainties confronted her about the execution of the order. This included whether the police or BCMHS staff were responsible for locating Ian and where he should be taken (whether to Bathurst Hospital or the Mental Health Unit at Orange Hospital, Bloomfield House). A/Sgt Towns said that, at that time, she had only a basic understanding of the 2007 MOU, but not as it applied to CTOs.

72. A/Sgt Towns made a number of enquiries throughout the day about the nature of the CTO, which included initially trying to contact RN Day and then speaking to the police prosecutor supervisor, as well as the subsequent discussion with RN Day and RN Sturgeon described above. A/Sgt Towns also spoke to a series of senior officers, namely Sgt Spice, Inspector Cogdell, the Duty Officer, and finally to A/Inspector Jodi Stewart.

73. During their conversation, A/Inspector Stewart told A/Sgt Towns that it was the police's responsibility to locate a patient under a CTO and to get them to hospital. A/Sgt Towns mentioned to A/Insp Stewart that the man the subject of the CTO was involved in the "bow and arrow incident". A/Insp Stewart gave evidence she was familiar with that incident. A/Insp Stewart said she told A/Sgt Towns to "make sure everyone is aware of [Ian's] history", including telling other police who were to attend the job what Ian's history was and that he could be violent towards police. A/Insp Stewart told A/Sgt Towns to take both the police car crews that were available at the time. She told A/Sgt Towns to "Treat the job as you would any other mental health job." She did not remember whether she told A/Sgt Towns to involve an ambulance.

74. A/Sgt Towns reviewed information that police held about Ian on the COPS system, including warnings about his use of a weapon in the bow and arrow incident, and about resisting police.

75. A/Sgt Towns held a briefing with the officers assigned at that time to help execute the order, which consisted of Constables Sarah Archer, Sarah Graham and Darren Carter. It is unclear whether Constables Darren Josh and Jess Lodge were also present. The briefing occurred in the muster room of the station. A/Sgt Towns said she told the officers that they had to locate Ian and assist him to be taken to the hospital. She said that Ian was deteriorating mentally, and that there had been a previous incident where Ian had armed himself with a bow and arrow and "it got quite volatile and violent." A/Sgt Towns told the officers that the situation had the potential to escalate. She also told the officers about Ian's delusions, including that he believed he had demons in his stomach and that the demons could be police.

76. Constable Graham gave evidence that she recalled A/Sgt Towns also told the officers at the briefing that Ian was believed to have recently purchased a sword and that it was locked in his cupboard. The briefing lasted around three to four minutes, or possibly less. It does not appear on the basis of A/Sgt Towns' evidence that any of the discussion was devoted to the precise roles to be played by the officers at the scene if Ian was present.

First attendance by police at Ian's home

77. The group of six police officers then attended Ian's unit in three cars, arriving at around 2:49pm. A call was made enroute at 2.44pm by A/Sgt Towns to Ian's mother. A/Sgt Towns said information may have been conveyed at this point by Ms Slatcher about Ian having purchased a sword over the internet.

78. In the event, Ian did not appear to the officers to be home at this time, although other evidence suggests that he was. His car was not in the driveway. The officers knocked on Ian's door and also looked through the windows of the apartment. They told Ian's neighbour, Michael Parsons, to alert police if they saw Ian return. A message was also broadcast over police radio to keep a lookout for Ian's car. The officers left Ian's unit at 2:57pm.

79. After this, A/Sgt Towns undertook further actions when back at the station, including placing an alert on the COPS system, asking the Duty Operations Inspector for a triangulation on Ian's phone (which could not be authorised at that point), and making enquiries with Victorian police.

Ian is reported to police as having returned home

80. At 6:27pm, Mr Parsons called Bathurst Police Station to inform police that Ian had returned. This was relayed to A/Sgt Towns by Senior Constable Martin, who took Mr Parsons' call.

81. At that time, A/Sgt Towns was coming to the end of her shift as supervisor, and Sgt Marita Shoulders had arrived at the station and was preparing to commence hers. A/Sgt Towns said she was working towards a handover of Ian's CTO to Sgt Shoulders. The pair were both working in the supervisor's office.

82. The two officers had a conversation about Ian's CTO at this time which was the subject of some conflict in evidence.

83. A/Sgt Towns said she showed Sgt Shoulders the CTO and said words to the effect of: "I think this is that bloke that – this is the bloke that Tony [Johnson] and Kylie [Ellsmore] almost shot last year with the incident with the bow and arrow." A/Sgt Towns then asked "Okay, so what do we need to do?"

84. A/Sgt Towns gave evidence that Sgt Shoulders told her: “You need to go out and get [Ian] and you need to take him to the hospital.” A/Sgt Towns said she then asked if Sgt Shoulders was also going to attend. A/Sgt Towns told the Court that Sgt Shoulders said she would not attend as she had to attend to the paperwork at the station. A/Sgt Towns said in evidence that she then asked Sgt Shoulders several more times to attend, as she was concerned that the situation could be a volatile one, and Sgt Shoulders was the more experienced officer.

85. I pause to note here that Sgt Shoulders had completed the Mental Health Intervention Team (“MHIT”) training in 2008, which was a five-day course that included training on CTOs. She gave evidence that, as at August 2017, she had been involved in at least ten executions of CTO breach notices in her time as a police officer. She stated that she was aware of the 2007 MOU and carried a copy of it with her in her diary or on her person. She accepted in her evidence that, on the night of 30 August 2017, she was the most qualified person at the station as far as intervention with people with a mental illness was concerned.

86. According to A/Sgt Towns, Sgt Shoulders said “No, no I’ve got to take care of all of this”, meaning the paperwork and organisation of the station. A/Sgt Towns said that Sgt Shoulders said to her “No, no, just get the car crews, just head out there. He’s home, just head out there, you’re right.” Further, A/Sgt Towns said that Sgt Shoulders made reference to the fact that she was cold and did not want to go out. A/Sgt Towns said that she told Sgt Shoulders that she (Towns) was not very good at negotiating and asked about Sgt Shoulders’ negotiating skills.

87. Sgt Shoulders was also asked to give her recollection of this conversation. Her evidence was that she told A/Sgt Towns: “If you’ve been dealing with this all day, you are probably in the best position to make a judgment call on this and what we’re going to do with [Ian] so if you go out there and take all the crews out, I’ll be on standby on the phone and able to get you any resources or any assistance that you require”

88. Sgt Shoulders stated that those extra resources included the night shift crew, but also other resources if the situation “escalated”. This included the State Protection Support Unit (“SPSU”) and Tactical Operations Unit (“TOU”) as well as police negotiators.

89. Sgt Shoulders told the Court that she offered to go with A/Sgt Towns to the scene (A/Sgt Towns denied this) and put her jacket on in anticipation of doing so, but said that the two then decided mutually that it was better for Sgt Shoulders to stay in the police station. Sgt Shoulders’ evidence was that she thought A/Sgt Towns was happy with this position, and that A/Sgt Towns was not asking for help with the situation. She denied saying to A/Sgt Towns, “I’m not going out there. It’s too cold.” She denied that A/Sgt Towns asked her about her negotiating skills. Sgt Shoulders denied giving A/Sgt Towns any information about how a CTO breach notice worked.

90. Sgt Shoulders stated that she also told A/Sgt Towns: “If [Ian’s] there, make sure you call an ambulance so they can treat him and take him to hospital.” At a later point in her evidence, she said that she told A/Sgt Towns: “take an ambulance with you.” Sgt Shoulders did not subsequently arrange for the attendance of the ambulance herself.

91. A/Sgt Towns said she did not recall Sgt Shoulders mentioning anything about an ambulance being required. She said that if that had been said, she would have made those arrangements.

The police attend 41 View St for the second time

92. A/Sgt Towns, together with Constables Archer, Graham, Carter, Josh and Lodge then set off in three police cars to return to Ian's unit, arriving at 6.39pm. There was no briefing held before the officers departed as to what the plan was at this stage, or what the role of individual officers would be. A/Sgt Towns said that she had a discussion with Constable Archer in the car enroute, to the effect that she was "frustrated that [she had] asked [Sgt Shoulders] numerous times to come with us and she wouldn't come."

93. A/Sgt Towns said she had a further conversation with Ms Slatcher on the way to Ian's unit about obtaining the keys to it. A/Sgt Towns also spoke to Ms Slatcher about how Ian could be kept calm and spoken to in a non-confrontational way.

94. Upon the officers' arrival, Ian's car was in the driveway of the unit block. Constables Archer and Lodge remained at the front of the property. A/Sgt Towns attempted to raise Ian by knocking on his front door, but there was no response.

95. Constables Carter, Josh and Graham went around the side of the unit to look in the windows. They could not see Ian. They then moved to the back of the unit and looked through the window into Ian's bedroom.

96. In evidence, Constable Carter said he saw what appeared to be a lump on the bed, under a blanket, with hair sticking out. Constable Carter shone his torch through the window. He thought the figure was Ian. He told Constable Graham he thought he had seen something, and asked Constable Graham to also take a look. Constable Graham saw a lump in the bed covered by a blue doona. She could see some hair but not a face. She saw the doona rising and falling as if someone was breathing.

97. Constables Graham and Carter gave evidence that they both banged on the windows and called out to Ian. They saw no response. As a result of this knocking and banging, it appears that the blinds on the window closed partially and began to obscure the view into the room.

98. Constable Graham moved further around the back of the unit block and located a rear door which led to the laundry. Constable Graham said she turned on the light inside the laundry. She said she thought she might have then gone to inform A/Sgt Towns that the officers had seen Ian.

99. A/Sgt Towns went to the rear of the property and knocked and tapped at the window, calling out both loudly and gently to try to get the person in the room's attention. A/Sgt Towns said "Ian, it's the police, we're concerned for you." A/Sgt Towns shone a light into the window. She could see a figure with a doona over it.

The first phone call between A/Sgt Towns and Sgt Shoulders

100. At 6:49pm, A/Sgt Towns called Sgt Shoulders using her mobile phone. The call lasted 122 seconds. A/Sgt Towns stated that she made the call as she wanted some advice about what the next steps should be.

101. A/Sgt Towns told the Court that she told Sgt Shoulders that there was a figure inside the bedroom of the unit that she believed to be Ian and that Ian was not communicating with police. She then said to Sgt Shoulders words to the effect of "What should we do?"

102. A/Sgt Towns said she could not recall whether she mentioned the previous incident involving Ian using a bow and arrow, or whether Ian might have been in a possession of a sword during this call, although Sgt Shoulders' evidence suggests she had been made aware of this by around this time. A/Sgt Towns told the hearing that, in speaking to Sgt Shoulders, she was trying to gauge "whether this

was a high-risk situation or a siege or what the next step would be." She stated that she thought she had said to Sgt Shoulders: "We've got a bit of a siege situation here, I think". Constable Graham also recalled hearing A/Sgt Towns say the phrase "We possibly have a siege situation" around this time.

103. During this call, A/Sgt Towns said she either asked Sgt Shoulders or the station officer (who had initially answered A/Sgt Towns' call) to contact the keyholder of the premises, Century 21 Real Estate.

104. A/Sgt Towns gave evidence that, at this point, she thought the situation was a high-risk one, as she was concerned about Ian's previous behaviour involving the bow and arrow, and the potential for him to have access to weapons, including the potential for there to be a sword in the vicinity.

105. Sgt Shoulders gave evidence about her recollection of this conversation, which conflicted with that given by A/Sgt Towns in part. She said that A/Sgt Towns told her she believed someone was inside, and that "the blinds had moved." She said that A/Sgt Towns did not give her any other information. Sgt Shoulders said she told A/Sgt Towns: "Just keep communicating. Keep trying. I'll call Jodi Stewart and let her know." Sgt Shoulders could not recall whether she was told by A/Sgt Towns about Ian's purchase of a sword from eBay in this phone call or whether there was mention that the keys to the apartment were being obtained, although she did recall being told about those matters at some stage. She also could not remember if A/Sgt Towns made mention of Ian's mental health and delusions about demons in this call or the subsequent one. Sgt Shoulders denied that A/Sgt Towns had used the words "possible siege" when describing the situation to her on the phone.

The call from Sgt Shoulders to A/Inspector Stewart

106. At 6:53pm, Sgt Shoulders telephoned A/Inspector Jodi Stewart, whom she believed to be the on-call Duty Officer at the time and a trained negotiator. This call lasted 149 seconds. Sgt Shoulders said she rang A/Inspector Stewart to advise her that there was a "situation unfolding" and to say that she was "probably going to be needing some assistance at some point". Sgt Shoulders said she told A/Inspector Stewart on the call that she believed that a "possible siege" was unfolding

107. Sgt Shoulders said that she told A/Inspector Stewart that the "possible siege" involved the "guy from last time" and mentioned the bow and arrow incident. Sgt Shoulders said A/Inspector Stewart asked her if Ian was communicating and told her to make sure that there was one person engaging with Ian, but "not everyone". She said A/Inspector Stewart said to keep a line of communication going. Sgt Shoulders said she informed A/Insp Stewart that there was a keyholder on the way and that police had serious concerns for Ian.

108. Sgt Shoulders then said in evidence that she and A/Insp Stewart "both came to an agreement that, unless we're communicating and unless we can confirm he's in there, we may have to go in and see if he's in there and whether he's okay." She said that the words "We're gonna have to go in" were said by either one of the officers on the phone, and that there was agreement between the two of them during the phone call as to the need for entry to occur. She said the manner of entry was not further discussed, other than it would occur by use of the key that was being brought by the keyholder.

109. A/Insp Stewart was also asked about this call during her evidence. She said that Sgt Shoulders told her that there was a "possible potential situation going to occur." She said Sgt Shoulders referred to it as involving "the guy with the bow

and arrow", that police were at the scene, and that they had information that Ian "might" have purchased a sword on the internet. A/Insp Stewart denied that Sgt Shoulders used the word "siege" when describing the situation.

110. A/Inspector Stewart denied that the words "We've got to go in" were ever said in that conversation, or that there was any agreement as to that course of action. She said that such a plan would have been the "total opposite" of the advice that she gave over the phone. A/Insp Stewart said that the conversation was only about communicating with Ian, and not about entering the home. She said she would not have authorised entry into the home on the information she had available to her. She said that entry into the home would have invoked consideration of NSWPF policies applicable to uninvited entry. She denied that Sgt Shoulders mentioned anything about a key coming to the property, and that she only found out about a keyholder coming to the property in a subsequent text message from Sgt Shoulders (extracted below).

111. A/Insp Stewart said that she advised Sgt Shoulders to try to clarify the information to confirm whether a sword had been received and whether anyone knew whether Ian was in possession of it. She said that she also told Sgt Shoulders that one person should attempt to communicate with the person under the blanket (noting it was not confirmed that it was Ian). A/Insp Stewart suggested to Sgt Shoulders that the police also attempt to contact Ian by phone.

112. A/Insp Stewart said she believed it was more than likely that the person in the bedroom was Ian. She gave evidence that, at the end of the call, she had in mind that the scene at View St had been contained, and that it was important that there be further communication. She also stated that she did not consider the incident to be a high risk one at that stage, because of information that still needed to be clarified (presumably such as whether Ian had obtained the sword.)

113. A text message conversation then followed between Sgt Shoulders and A/Inspector Stewart, between 6.59pm and 7.08pm. The text message conversation included Sgt Shoulders writing at 6.59pm:

> *"Can see him hiding he won't communicate. [Have a] key holder going out"*

114. A/Inspector Stewart replied:

> *"Ok keep me informed. Jerry Cahill is on call tonight. Are you [on] scene?"*

115. Sgt Shoulders then wrote:

> *"Sorry roster had you. No all the cars are out. Bec towns is day shift supervisor out there."*

116. A/Inspector Stewart replied:

> *"It's all good"*

117. I note here that investigations revealed that there was a car in fact available to Sgt Shoulders at the time, contrary to what she told A/Inspector Stewart. Sgt Shoulders was asked about this in evidence, but said she was not aware of this at the time.

118. A/Insp Stewart said that, reflecting on the incident with the benefit of hindsight, she would have requested Sgt Shoulders to attend the scene at this point to make "as clear a risk assessment as possible" and that she would have also contacted A/Insp Cahill, the on-call inspector, herself. She said she would also have instructed Sgt Shoulders to contact A/Insp Cahill.

Second call between Sgt Shoulders and A/Sgt Towns

119. Sgt Shoulders rang A/Sgt Towns back at 6.55pm. The call lasted 76 seconds. There is again conflict in the evidence concerning the contents of this call.

120. Although A/Sgt Towns said she did not remember the contents of the call clearly, she said that what she gleaned from the conversation was that the officers at the scene needed to deal with the situation, that nobody else was coming to assist, including negotiators, and that it was a "simple mental health job" where the officers had concerns for the welfare of the person in the unit and needed to go into to assist him. A/Sgt Towns stated that Sgt Shoulders told her "We're going to have to go in." A/Sgt Towns was unsure whether Sgt Shoulders said the words "You're going to have to kick in the back door", or whether another officer at the scene said this to her around that time.

121. Sgt Shoulders, in her evidence about this second call, said that she passed on to A/Sgt Towns the substance of her conversation with A/Inspector Stewart. She said she told A/Sgt Towns to make sure to get one line of communication going. Sgt Shoulders agreed that she said "We're gonna have to go in" (although she was not sure if she used "we" or "you") but said in her evidence that she also included the caveat: "but I'm not there, I can't make the decision for you."

122. Sgt Shoulders stressed that she at no point told A/Sgt Towns what to do. She said that A/Sgt Towns read some of the CTO document out over the phone, and Sgt Shoulders explained to her "Yes, you have the power to enter. I can't tell you what to do. I'm not out there. You need to make your own decisions but I believe you may have to go in and see if he's in there."

123. In cross-examination by Mr Haverfield, Sgt Shoulders accepted that in her directed interview to investigating police in the wake of the incident, she told those investigators she had said to A/Sgt Towns simply "We're going to have to go in", without the additional qualifications noted above.

124. A/Sgt Towns said she was frustrated after this call. She said she felt she had been given advice to the effect that she "needed to harden up and deal with it." She stated: "I had in my head that somebody had said or that basically Jodi [A/Insp Stewart] had said 'Kick in the back door', so to me that nobody else was coming to assist, that we just need to deal with the situation, get the help and whether that meant kicking in the back door, then that's what needed to happen."

125. A/Sgt Towns further stated that she was frustrated that this advice was being given to her as she said, "there was no need to kick in the back door when I had the keys coming, so whoever gave me that advice wasn't aware of where we were up to." Nonetheless, A/Sgt Towns could not remember who had told her those words and said that it might have been Sgt Shoulders or Constable Tucker (although I note Constable Tucker did not arrive on scene until some 13 minutes after the call at 6.55pm).

126. A/Sgt Towns said she had a conversation with Constable Carter and Josh after the phone call with Sgt Shoulders, where she became frustrated and said that she had been told "We have to go in." She said she "indicated to the boys that, that yes, the bosses said we can go in."

127. Constable Josh gave evidence that A/Sgt Towns appeared unhappy at a point after he had seen her talking on the phone, and that she said words similar to: "We've just got to harden up and kick the door in." Constable Josh said he considered at this point that the police were "absolutely required to go into that room."

Arrival of the night shift officers at View St

128. At around 7:08pm, Senior Constable Ford, Constable Tucker and Probationary Constable Taylor arrived at Ian's unit, having driven from Bathurst Police Station. Constable Tucker gave evidence that she had arrived at the station to start her shift when was told by Sgt Shoulders that there was "a siege or possible siege mental health job out in View Street." She said Sgt Shoulders said to her "You can go out if you want" in a manner which Constable Tucker described as "blasé" – that is, not conveying that there was any particular urgency about the situation. She said Sgt Shoulders referred to the officers presently on site as a "shit crew".

129. In her evidence, Sgt Shoulders said she told the night-shift officers "Go out and see Bec. They're out at View Street. I don't know what's going on out there at the moment and they haven't got back to me." She said she told them that Ian was "the bow and arrow guy." She said that she gave the officers a direction to attend the scene (rather than only an invitation) and said they could take her car. She denied saying to Constable Tucker that the officers on the scene already were a "shit crew." She said she did not tell Constable Tucker "You're gonna have to kick the door in." She said that she did not think she described the situation to Constable Tucker as a "possible siege."

130. When Constable Tucker arrived on the scene, she said she was told by A/Sgt Towns that the officers already present had seen Ian, and that they believed he'd bought a sword on eBay, but "they thought it was locked in the cupboard in the bedroom." A/Sgt Towns said there was a key on the way from the real estate agent.

131. Constable Tucker said that A/Sgt Towns made a comment to the effect of, "I thought you were Shoulders in [Car 12]." Car 12 was the supervisor's car. Constable Tucker said that A/Sgt Towns appeared stressed and "frazzled".

132. In evidence, A/Sgt Towns stated that she had expected Sgt Shoulders to arrive with the nightshift officers, and was disappointed, frustrated and upset when she did not arrive.

133. At a time likely around 7.10pm, A/Sgt Towns knocked on the door of Ian's neighbour, told Mr Parsons that there was a "siege situation" and for him to stay away from the windows of his unit. Mr Parsons conveyed this to his girlfriend.

134. I note for completeness at this point that, back at the station at 7.12pm, Sgt Shoulders received a phone call from a member of the public who wished to complain about police actions in relation to the towing of his vehicle. This occupied Sgt Shoulders for 8 minutes and 40 seconds, which was for the vast remainder of the police operation unfolding at View St.

Ian's real estate agent brings over the key to Ian's unit

135. At around 7:16pm, Ms Leanne Hughes, a real estate agent, arrived with the keys to Ian's unit. She spoke to A/Sgt Towns at the front of Ian's unit. She provided A/Sgt Towns with a description of the layout of the unit, including that there was a door from Ian's bedroom that provided access to the laundry area. The layout was not drawn on paper but rather traced by A/Sgt Towns with her finger on the top of Ian's letterbox. A/Sgt Towns said she passed on the layout of the unit to Constables Carter, Josh and Graham collectively at the back of the unit. Constable Carter could not recall this.

136. Shortly after the attendance of the real estate agent, Constable Tucker told the Court that she had a conversation with A/Sgt Towns to the effect that officers should put on ballistic vests, given what was known about "the sword and the

incident with the bow and arrow." Constable Tucker and Probationary Constable Taylor searched the police cars at the property for the vests and retrieved three or four vests. They were handed to A/Sgt Towns, who took them to the back of the property.

137. At around 7:14 to 7:16pm, the unit's CCTV footage captured the officers donning ballistic vests.

138. A/Sgt Towns then asked Constable Tucker to come to the back of the unit to attempt to communicate with Ian. Constable Tucker said A/Sgt Towns then banged on the window and called out to Ian, saying "Ian, it's the police." Ian did not respond. Constable Tucker said that A/Sgt Towns then said she was "going to break the window and the guys were going to go in." Constable Tucker gave evidence that she took A/Sgt Towns' Taser at this point and moved over to join Constables Josh, Carter and Graham, who were near the laundry door.

139. Constable Carter stated that, after the officers had donned ballistic vests, he made a decision to "mark" the door leading to the laundry and Ian's bedroom and told Constables Josh and Graham that he was going to do so. He told those officers to arrange themselves on an angle behind him so that he would not trip if he had to back away.

140. Constable Josh gave evidence that he saw A/Sgt Towns arrive with a key, at which time he, Constable Carter, Constable Tucker and Constable Graham moved into the laundry.

Planning of police actions at this point

A/Sgt Towns' plan

141. A/Sgt Towns gave evidence that, by the time of the second phone call with Sgt Shoulders, she had become concerned for Ian's welfare and that he might harm himself. Her evidence was to the effect that she believed at this point that the police officers were required to enter Ian's bedroom because of the effect of the CTO. A/Sgt Towns said that she was putting various plans in place, but that:

> *"there was the potential we had to go in there. I was putting things in place to make it the safest I could, but we had an order. We needed to make sure that he hadn't harmed himself and we had an order that he needed help and that he needed to go to hospital."*

142. She stated in evidence: "We needed to apprehend him, yes."

143. A/Sgt Towns said that she wanted to move the window blind that was obscuring the view into the bedroom to see if she could confirm that Ian was "OK", to open lines of communication and to see what Ian was doing. She said that she thought she had begun to tell the officers present of this plan even before the second call with Sgt Shoulders. She said that she had at least communicated this idea to Constable Graham.

144. A/Sgt Towns said she went to the front of the unit to find an object to break the window, and spoke to Constable Archer, Constable Tucker and Constable Ford there about her idea of accessing the window and securing lines of communication and sight. She said that she "would have told" Constables Josh and Carter, who were at the back of the property, of the plan, although she did not recall doing so when giving evidence. She said she "thought I had told them."

145. As to her plan, A/Sgt Towns stated:

"My plan was to put the key in the door so that if access needed to be gained, we knew where the key was and nobody was fumbling around in their pockets to be able to find the key, and that I was going to go and smash the window. If, if something urgent was happening inside, the guys – I could guide the other crew in from the doorway, but I could also open the window, get a line of sight, make sure he wasn't standing at that doorway to ambush us as we entered."

146. A/Sgt Towns said that, upon breaking the window, she thought she would be in a position to guide the other police as to what they were to do. She said that she thought she would be able to do so either through Constable Graham, who was standing close to her, or because her communication with Ian would be audible to the others and that "they would be able to get the gist of what was happening." She said: "I'd be able to physically tell them where he was within the building, whether we needed to go in."

147. She said that she then, while at the back door of Ian's unit, told Constables Josh, Carter, Tucker and Graham:

"The key's in the door if we need to go in. I'm going to go over and smash the window and then that way I can see what's going on, and I can guide you if need be, if we need to go in."

148. A/Sgt Towns conceded that she did not say to the officers words to the effect of: "You're not to go in until you hear something further from me."

149. A/Sgt Towns said that she could see Constable Tucker "hovering" over his Taser, and Constable Josh "hovering" over his gun at this time. She said that the officers had arranged themselves at the back door, and to her mind that was to be able to react in case Ian came running out of the bedroom. She said she did not discuss with those officers what appointments would be held or used as part of her plan but she assumed that appointments might be used because of the way that the officers were "staged" outside the doorway.

150. A/Sgt Towns said she then went into the laundry and placed the key into the bedroom door. Upon doing so, Constable Carter said to her "You're not going in, we'll do that." A/Sgt Towns stated she then said, "Oh no, I'm going to go around and break the window and see what's going on." She conceded that she did not say to Constables Carter or Josh at this point that they were not to enter the bedroom until they had heard further from her.

Constable Carter's understanding of the plan

151. Constable Carter said he heard A/Sgt Towns say to him words to the effect of "We're allowed to go in." Constable Carter said he saw A/Sgt Towns place the keys in the door, but he said to her words to the effect of "Don't go in, Bec." He accepted that he might have said "You're not going in, leave that to us", meaning to him and Constable Josh. Constable Josh stated that he had a vague recollection of the words "leave it to us" being said by Constable Carter.

152. Constable Carter said he told A/Sgt Towns this because he and Constable Josh "had already spoken and formulated a plan." Constable Carter said he felt that he and Constable Josh were "better prepared to go in". He stated that he and Constable Josh, by that time, had formed the intention to enter Ian's bedroom. He said that when he saw A/Sgt Towns put the keys in the door, this created in his mind the idea that the police were to enter the unit, although A/Sgt Towns did not specifically tell them to do so. When A/Sgt Towns moved away from the door, Constable Carter gave evidence that he had a whispered conversation with Constable Josh to the effect that Constable Carter would use his Taser and

Constable Josh would use his gun "if need be". Constable Carter said he had his Taser out at this point. Constable Carter said the whispered discussion also included the plan that the officers would "reassess" the situation once they had entered through the door. Constable Carter said he did not discuss with Constable Josh at that stage what that reassessment would entail, or other important details as to what would happen next in the room, including if there was a violent confrontation. This was despite the fact that Constable Carter said he knew that Ian could be violent, that he could have a sword and that he had previously used a weapon in an incident with police.

153. Constable Carter accepted in his evidence that it was highly unlikely that his and Constable Josh's plan to enter the unit was communicated to anyone else beyond the two officers. Indeed, in his directed interview given after Ian's death, he positively stated the plan was not communicated beyond them.

154. Constable Carter also said that he did not hear A/Sgt Towns communicate her plan about breaking the window *first* before issuing the officers further directions. Constable Carter denied knowing anything of A/Sgt Towns' plan to break the window in order to gain better vision into the room.

155. At one point in his evidence, Constable Carter claimed he had later had a discussion (sometime after Ian's death), at a time he could not remember, and with a person he did not remember, in which he was told for the first time that A/Sgt Towns' plan was to smash the window before entry was gained. Constable Carter said he was "shocked" to hear this.

Constable Josh's understanding of the plan

156. In his evidence, Constable Josh firmly denied that there had been a whispered conversation between him and Constable Carter. He gave evidence that any conversation that had occurred between them was held openly. He said there would be "no point in making a plan without the supervisor being aware of it." He was adamant that A/Sgt Towns was aware of his and Constable Carter's plan to enter the bedroom, however, in cross-examination by Mr Haverfield, he could not point to a specific conversation where he had told A/Sgt Towns of the plan.

157. As to his understanding of the plan, Constable Josh said that he had given A/Sgt Towns his torch when he was in the laundry. He stated this was so that A/Sgt Towns could shine the torch through the window of the bedroom so that the others would not have to hold a torch when they entered. He denied hearing A/Sgt Towns say that she would try to break or crack the window or being privy to a plan to that effect.

158. Constable Josh stated that the intention was for the door to be opened and for the officers to go in. He said the event that would signal for him and Constable Carter to enter the bedroom was A/Sgt Towns being at the window and shining the torch through the window to provide some light with which to enter the bedroom. He said the precise moment of entry was a decision that he and Constable Carter made themselves. He said that he believed that all other officers present at the back of the property knew that they would open the door in the next few moments.

159. Constable Josh said that A/Sgt Towns had been privy to, and agreed with his discussions with Constable Carter, to the effect that Constable Carter would go into the room with his Taser drawn and that he, Constable Josh, would go in with his firearm drawn. He said that if "something were to happen", then Constable Carter would be able to use the Taser first and, if Ian became violent and the Taser did not work, then it would be Constable Josh's decision "to make the next tactical option", by which he meant the use of a firearm. When asked whether any

other “tactical options” were discussed, Constable Josh said there was no discussion of the use of OC spray, batons or manual physical force. He stated that he had his gun drawn because he knew there could be a situation of extreme violence.

160. In contrast to Constable Carter’s evidence, Constable Josh denied the plan included a “reassessment” of what would happen next once the door had been opened. He stated the plan was that, once the door had been opened, the officers were to enter the bedroom. He said this was because, in his mind, he had been directed to make entry into the house to apprehend Ian. He said, “It was just that I thought that that was our job, that was what we’ve been told to do, so that we had to go in and arrest him.”

161. In cross-examination by Mr Haverfield, Constable Josh denied that A/Sgt Towns had conveyed to him that she would give a direction for when the door was to be opened. He accepted he might not have heard A/Sgt Towns say this while he was discussing the plan with Constable Carter.

Constable Graham’s understanding of the plan

162. Constable Graham gave evidence that she heard A/Sgt Towns say: “I’m going to break the window and you guys are going to open the door.” It is unclear on her evidence whether Constables Josh and Carter were present when A/Sgt Towns said this to Constable Graham. Constable Graham said there was no discussion about the timing of entry into the bedroom or the roles the various officers would assume. She said she understood that the door was to be opened, but not necessarily that the officers would also then enter the room at that point.

Constable Tucker’s understanding of the plan

163. Constable Tucker said her understanding of the plan was that A/Sgt Towns was going to smash the window so that she could see in and communicate with Ian, which would also provide a “distraction so that the guys could go in.” Constable Tucker was not sure whether A/Sgt Towns had communicated this plan to any of the other officers present at the back of the unit. Constable Tucker herself did not speak to the other officers present as to the plan. She said she did not know what Constables Carter and Josh were supposed to do. She said she assumed a number of matters about what would happen next, including that Constables Josh and Carter would go in because “the boys in Bathurst always kind of go first.” She assumed Ian would be asked to show his hands, to lay on the ground and would be “arrested”.

Police entry into Ian’s room

164. A/Sgt Towns said that she went to stand at the bedroom window. From there, she could not see where Constables Josh or Carter were, nor what they were doing with their appointments.

165. She stated she started to bang on the window using her extendable baton. She banged at least three times, but the window did not break. The blind also did not move.

166. Constable Graham, who was standing in the laundry, said that as A/Sgt Towns banged on the window, the bedroom door was opened by either Constable Josh or Constable Carter. Constable Graham said she stepped out of the laundry at that point and told A/Sgt Towns “They’ve got the door open.” She said Constables Carter and Graham were still standing at the doorway of the bedroom at that time, but she then lost sight of them as she had left the laundry area. Constable Graham said she believed at that point that the police “were just going to try and

communicate with [Ian] and talk to him and negotiate with him to come to hospital with us."

167. A/Sgt Towns said she heard the words "We're in, we're in" and saw light from the laundry doorway inside the room. She stated the words were said by Constable Josh or Carter as they entered the bedroom.

168. A/Sgt Towns said that she had not expected the officers to enter the room at that point. She said that, to her mind, the banging or breaking of the window was not a trigger for the other officers to enter the bedroom. She said she had no expectations that the police would enter the bedroom until after she had seen what was going on inside and after she had seen where Ian was situated. She said that Constables Carter and Josh had not told her they were going to enter the bedroom. She said she had no line of sight to those officers at that point, as the window was still obscured.

169. Constable Josh said he had not heard A/Sgt Towns banging the window when the door was opened by Constable Carter. He said when the door was opened, there was torchlight already shining into the room. He assumed A/Sgt Towns was standing at the window but he had not heard her bang on the window. He conceded he might not have heard the banging, and said he was not listening for any, stating "I certainly wasn't aware of any plans regarding that so I wasn't paying attention to it." He said he had seen A/Sgt Towns standing at the window with his torch, holding it in an overhanded grip when he went into the laundry.

Events inside the bedroom

170. Upon entry, Constable Carter stated he turned on his Taser when he was just inside the door and took a step in. Records show that the Taser was armed at 7.20pm for 86 seconds. The Taser camera recorded events from this point, although the video footage is partially obscured. Constable Carter stated that this was because his fingers were placed partially over the camera on the Taser. Constable Carter said this was not a deliberate act on his part.

171. Once inside the bedroom, Constable Carter said, "show me your hands". There was some light in the room, and Constable Carter could see Ian's head. Ian's eyes were open. Constable Carter did not recall seeing Ian wearing headphones. Ian's left hand was visible. Constable Carter approached Ian's bed and pulled back the doona, at which time he saw Ian holding a sword in his right hand. Constable Carter said words to the effect of "He's got a sword."

172. Ian then stood up, whereupon Constable Carter discharged his Taser. This was approximately 29 seconds after the Taser was armed. Constable Carter said he did this so that Ian "wouldn't come and attack us." Ian appeared to fall backwards into the corner of the room. Constable Josh stated that, once in the room, he had re-holstered his firearm for a brief period as he intended to try to restrain Ian. This may have been after the Taser had been fired.

173. Constable Carter moved towards Ian, believing the Taser to have been effective. The Taser, however, had only made contact with Ian's clothing and the doona on the bed.

174. Ian stood up and moved very quickly around the foot of the bed towards the officers with the sword raised in his right hand. Constable Josh said at this point that he tripped as he attempted to create space between him and Ian. He stated he fell such that he was lying at a 45-degree angle from the horizontal, with his head positioned close to the doorway. He said he did not know what caused him to trip. He saw Ian move close to him with the sword raised. Constable Josh believed Ian was in a position where he could strike him with the sword. Constable

Josh at this point fired his gun at Ian. He described firing three shots, although the objective evidence showed that four bullets were fired. At the same time, Constable Carter dragged Constable Josh out of the bedroom through the door they had entered. This is depicted on the backyard CCTV footage at 7:22pm.

175. A/Sgt Towns and Constable Tucker then entered the room. Ian was handcuffed and the officers performed CPR upon him. An ambulance was called and arrived at the scene at 7.31pm. Ian was found to be in cardiac arrest. One of the ambulance officers attending said he could hear music coming from a pair of headphones in Ian's room. Loud music coming from the headphones was also heard by Acting Duty Operations Manager Melissa Parker, who arrived at the house at 8.11pm. Two further paramedics arrived at 7.34pm, and a Care Flight doctor arrived at 8.05pm from Orange. Tragically, medical interventions were unable to save Ian. He was declared deceased at 8.16pm.

Evidence at the hearing concerning NSWPF policies and procedures

Evidence of Senior Sgt William Watt

176. Senior Sgt William Watt is attached to the Weapons and Tactics Policy and review section of the NSWPF. Senior Sgt Watt and his colleague, Sgt Peter Davis, undertook a review of the police operation conducted on 30 August 2017 and considered the officers' compliance with NSWPF policies and procedures based on their expertise relating to weapons and tactics training. Sgt Davis was unavailable to give evidence at the hearing.

177. In his oral evidence, Senior Sgt Watt agreed that his expertise did not relate to conducting police operations. He also said his review of the police operation on 30 August 2017 did not extend to evaluating the various involved officers' compliance with policies and procedures as far as they related to search warrants or uninvited entries.

178. Senior Sgt Watt was taken in his evidence to NSWPF procedures and policies which govern use of force by officers, as well as planning and other actions when responding to situations, including risk assessment.

179. Senior Sgt Watt gave evidence of the need for police, when responding to situations, to undertake appropriate risk assessments, and to use good and clear communication. He stated that police are required to use de-escalation techniques at the scene before any entry is made, and to make an effective plan as to what will occur. Senior Sgt Watt said that ideally, were police to enter a room, all police officers directly involved would know if entry was going to occur, and they would know what their roles were with respect to the event playing out.

180. With respect to the operation, Senior Sgt Watt said he had based his opinion (that applicable policies had been followed by the officers) on the assumption that:

a. there was a plan to enter Ian's unit;
b. there was a dynamic risk assessment undertaken about the plan;
c. the plan to enter the unit was appropriate in all the circumstances;
d. the plan to enter was well-known to all at the scene;
e. the timing of the entry was known to all at the scene; and
f. A/Sgt Towns had good reason to have immediate concerns for Ian's mental and physical health.

181. Senior Sgt Watt expressed the view that there appeared to have been an absence of communication at the scene with regard to A/Sgt Towns' plan.

182. Senior Sgt Watt was also asked about training given to police officers about situations involving persons with a mental illness. He said that, between 2015 and 2018, no training in theory or reality-based scenarios involving police confronting a mentally ill person was provided to police officers. He stated this has since changed, commencing from mid-2018. Senior Sgt Watt outlined what training the NSWPF was considering in terms officers dealing with persons with a mental illness, including proposed consultation with a psychiatrist, Dr Kerri Eagle, which would help inform that training. Dr Eagle's evidence on this point suggested that that consultation was in its earliest stages. I will deal with this further when considering recommendations, below.

Evidence of Assistant Commissioner Crandell

183. Assistant Commissioner Crandell held the position of Commander of the Education and Training Command from August 2017 to July 2019. The Command included the Lessons Learned Unit, which was created to identify and progress remedial initiatives arising from coronial inquests and other investigations.

184. Assistant Commissioner Crandell gave evidence to the Court concerning NSWPF procedures and policies applicable to the execution of CTOs, both at the time of Ian's death and subsequently. The three applicable policies operating at the time of Ian's death were:

    1. The 2007 MOU, including Appendix A ("Multi-Agency Risk Information and Assistance ("MARIA") Guideline and Appendix B ("High Risk Situations");
    2. NSW Police Force Overarching Policy and Procedures for Search Warrants and other "Uninvited Entry and Search" Operations ("the Overarching Policy"); and
    3. NSW Police Force Standard Operating Procedures for the Execution of Search Warrants ("SWOPS")

185. The 2007 MOU has since been replaced by the 2018 version. I note with concern that the "MARIA" guidelines have been removed from the 2018 MOU and will return to this issue in my recommendations, below.

186. Assistant Commissioner Crandell stated that all the above listed documents are designed to assist police with risk assessment and other preparation of operations where police will perform an uninvited entry into premises. The policies are applicable not only to uninvited entry pursuant to search warrants but other operations requiring uninvited entry by police onto property, including CTOs. He said that the "Overarching Policy and Procedures for Search Warrants" document was revised in the wake of Ian's death to explicitly specify entry to premises pursuant to a community treatment order breach as an example of an uninvited entry.

187. Assistant Commissioner Crandell gave evidence that uninvited entry operations by police are ones that can expose police and members of the public at times to extreme risk. Use of the above documents enables police officers to determine a risk rating for a particular operation before an uninvited entry, allowing them greater situational awareness. Consultation of the documents can assist police to identify key facts that need to be considered during pre-planned operations, including whether to involve specialist police units.

188. After Ian's death, Assistant Commissioner Crandell also oversaw preparation of the Search Warrant Practice Note 22/19 ("Practice Note") in November 2019,

which considered operational aspects regarding entry by police pursuant to CTOs. This document was distributed by email among all police officers and commands. It was designed to make sure that police officers were aware of requirements for risk assessment and planning accompanying pre-planned and urgent uninvited entries pursuant to CTOs.

189. Since December 2019, the search warrant tool kit provided in the SWOPS has been augmented by the "CREWS" system, which is a web-based, electronic search warrant and uninvited entry risk assessment tool. An officer executing a CTO such as Ian's today would be required to use the tool to assess the risk and record that risk assessment before any uninvited entry was performed.

190. Various police officers who gave evidence at the inquest were asked about their familiarity with, and understanding of the MOU, the Overarching Policy and the SWOPS, the CREWS system and the 2019 Practice Note.

191. Their evidence in this regard suggested that there was neither widespread nor detailed knowledge within Bathurst Police Station about those policies, either at the time of Ian's death or at the time of the hearing. This was a matter which was accepted by counsel for the NSWPF in submissions.

192. The NSWPF has provided correspondence to the Court noting its intention to circulate and reinforce the 2018 MOU, Practice Note, SWOPS, CREWS system and the need for clear communication between officers during incidents, having regard to the NSWPF "Tactical Options Model". I shall return to this matter when dealing with recommendations, below.

Evidence regarding Ian's mental health treatment

Expert conclave of Dr Large and Dr Eagle concerning the care and treatment Ian received for his mental health

193. The Court heard evidence given concurrently by Professor Matthew Large, Senior Staff Specialist Psychiatrist at the Prince of Wales Hospital, and Dr Kerri Eagle, a consultant forensic psychiatrist.

194. Professor Large and Dr Eagle agreed that Ian had a severe form of schizophrenia, which featured recurrent relapses of acute psychosis in the context of non-compliance with treatment. He appeared to have limited insight into his need for treatment, and experienced residual positive symptoms of psychosis, suggesting treatment resistance.

195. Both doctors opined that there was a very high likelihood that Ian was experiencing an acute exacerbation of his illness in the period leading to 30 August 2017, with his thinking strongly influenced by his delusional beliefs.

196. The two doctors differed somewhat in their appraisal of the care that Ian received from the BCMHS, particularly with regard to the frequency of psychiatric review that he received. Professor Large drew attention to the burdens faced by public mental health services, generally, in providing care to a cohort of patients who are almost wholly complex. In his view, those realities affect the frequency with which psychiatric reviews can take place.

197. Notwithstanding, Professor Large was of the view that Ian received a good standard of mental health care from the BCMHS. Professor Large said that Ian had a committed treatment team that picked up early that Ian was becoming unwell and attempted to do something about it, although Professor Large accepted that RN Mooney should have been able to get Ian an appointment for a

psychiatric review in response to the concerns Ian had expressed about his medication.

198. Dr Eagle was of the view that Ian may have benefitted from more frequent review by a psychiatrist, particularly where he had raised concerns about his aripiprazole medication and his caseworker was concerned to seek the input of a psychiatrist about this. Dr Eagle expressed concern that those issues had not been well documented in Ian's notes and that Ian had not had that review. Dr Eagle considered Ian to be a particularly acute patient, stating:

> *"Mr Fackender was a high-risk patient that would've caused anxiety, potentially, for the service. The extent that they could feel that they couldn't even visit him at home, he was complex, medication had been changed, I don't think it unreasonable for a case manager, in fact, I think it was appropriate for a case manager that if she had any concerns about his treatment, that she had him reviewed by a psychiatrist or psychiatry registrar."*

199. Neither doctor was of the view that there were obvious signs of Ian's deterioration when he presented for his depot medication on 28 July 2017.

Executive evidence from the Western NSW LHD

200. Jason Crisp, the Director of Integrated Mental Health and Drug and Alcohol Services at the Western NSW Local Health District, gave evidence at the inquest about measures being adopted by the Western NSW LHD in response to the issues arising at the inquest.

201. Mr Crisp told the Court that, as a result of matters raised at the inquest, a protocol for information exchange between mental health caseworkers and police was being developed to assist when the help of police is sought by case workers when serving CTO breach notices. The protocol would be used in conjunction with the 2018 MOU to assist clinicians and police discuss details of a response to a CTO, such as the level of urgency required and the timing of attendance at the person's residence. He said conversations regarding this document between the LHD, NSW Ambulance and the NSWPF were ongoing at the time of the hearing.

202. Mr Crisp also detailed increases in resources within the BCMHS since Ian's death, including the employment of ten additional case workers within the LHD located across Bathurst, Cowra and Mudgee. The maximum caseload of any case manager was now 23. He said that consideration was being given to having a full-time psychiatrist employed by the LHD in Bathurst.

203. Mr Crisp also gave evidence of training that was given to staff to understand the obligations under s. 59 of the *Mental Health Act* concerning the CTO breach process. He detailed arrangements which had been put in place for Deputy Directors of Community Treatment to be appointed when the Director was on leave, to help resolve the legal ambiguities that were faced while the BCMHS Director was away.

204. Mr Crisp told the Court that the BCMHS had moved to electronic medical recordkeeping in which records of multidisciplinary meetings and morning meetings are now being kept.

Consideration of issues

205. Written submissions have been prepared on behalf of Counsel Assisting, Ian's family, and the other interested parties. I have considered all the submissions

carefully. I will proceed to make findings on issues contained in the issue list and others which arise in the parties' submissions.

Issues relating to the NSWPF

Whether an alternative course of action was open to Constable Josh, and was warranted, at the time he discharged his firearm towards Mr Fackender

206. As is evident from the above summary, once the police officers had entered Ian's room, the situation was such that there was a significant risk to both their safety and that of Ian.

207. Ian's family submitted that it is likely that Ian was not aware of the police presence at his house until the officers entered his room. Sue Slatcher and RN Mooney knew Ian to listen to loud Christian rock music, especially when he was significantly unwell. The Taser footage showed that Ian was lying in bed with headphones when police entered. After the shooting, paramedics who attended the scene recalled hearing music playing from the headphones lying on the bed. A subsequent examination of Ian's iPad found that it was playing music through his headphones throughout the relevant period. The volume was recorded as being at 100% at 7:30pm. I am satisfied that Ian was listening to loud music through headphones during the relevant period of time. I am unable to determine whether, as a result of this, he was aware or unaware of police outside his home. If Ian was aware of the police presence, this likely would have made him fearful and may have caused him to hide from police. If he was unaware, his surprise would have been even greater when Constables Carter and Josh entered his room. In either case, noting Ian's state of mind and his general paranoia about police, he no doubt would have been greatly alarmed and fearful when police opened the door to his bedroom, shone a Taser light in his eyes and ordered him to raise his hands.

208. Ian held specific fears in relation to police and mental health workers. He had previously told his mother that he experienced paranoia about police arresting him and taking him to gaol. He had at other times discussed his fear that he had demons in his stomach and the demons were police. Given Ian's state of mind on 30 August 2017, as well as his fears about police, I am satisfied that he was likely suffering from active delusions, although I am unable to make a finding as to their content. Ian's family also noted that Ian may not even have been aware, in the short time the officers were in his room, that they were police officers, given it was dark and Ian was wearing headphones. Given the uncertainty generally about what Ian saw and heard at that time, I am unable to form a concluded view about whether Ian knew the people in his room were police officers.

209. Ian's family further noted, and it is to be accepted, that Ian's first movement was away from police – he was on the far side of the bed to the officers and moved towards the furthest corner of the room to the right of the wardrobes. After Constable Carter unsuccessfully discharged his Taser, Ian then began advancing towards Constables Carter and Josh, holding the sword. I pause to note that, at the time Ian moved towards police with the sword, it is likely that he was acting under an honest belief that he was under attack and his life was in danger. While this belief may not have been objectively reasonable, in the sense that it was caused by his mental illness, his reaction was understandable and was driven by the delusions caused by his condition. I have no doubt that these actions were otherwise out of character for a usually gentle and non-violent person.

210. Constable Josh was regrettably unaware of many of the above matters in relation to Ian's state of mind. I observed Constable Josh's evidence and noted the

distress and palpable fear apparent in his account of the events in Ian's bedroom. He described being on the ground, with Ian moving towards him, swinging the sword. Constable Josh recalled that:

> *"… when he started to move the sword downwards I completely believed that the arc of that swing was going to strike me and it was going to strike me in the neck area, so he was at least that close…"*

211. While doubts have been raised by Ian's family in their submissions that Constable Josh was in fact within the arc of the sword swing at the time he discharged his firearm, this was a fast-moving and dangerous situation. I am satisfied that Constable Josh feared for his life and for the life of Constable Carter. His actions in discharging his weapon were warranted in the circumstances confronting him at that time. It is nonetheless deeply regrettable that Constable Josh found himself in such a situation and the circumstances and decisions that led to that point warrant close scrutiny.

Whether Ian's death was preventable

212. A dangerous situation was created by the circumstances of the police attendance at 41 View St. Every effort should be made to examine the circumstances of that night and how such a situation might be avoided in future. The issue of whether Ian's death was preventable requires consideration of several specific aspects of the police operation, which I will address in turn.

The adequacy and appropriateness of planning (including risk assessment), decision-making and communication on 30 August 2017 before the second attendance of NSWPF officers at 41 View St, Kelso at around 6:40pm

213. The evidence in this matter disclosed that the planning and communication prior to the second attendance at Ian's house was seriously deficient. While A/Sgt Towns did engage in information gathering, there was virtually no operational planning in relation to the execution of the CTO breach order. The only briefing was a discussion of less than five minutes which took place before the first attendance at Ian's house, several hours earlier. A/Sgt Towns accepted this but submitted that any criticism should be tempered by the limited assistance provided to her by senior officers. There is some force in that submission. It was evident from A/Sgt Towns' evidence and her conduct on the day that she was anxious to receive guidance from senior officers as she was unfamiliar with the relevant procedures. Such guidance was not forthcoming and could have greatly assisted in the planning and execution of the breach order.

214. It is troubling that both Sgt Shoulders and A/Sgt Towns accepted that earlier in the day, A/Sgt Towns said words to the effect of, "this is the bloke that Troy and Kylie *almost shot last year* with the incident with the bow and arrow." As noted by Counsel Assisting, common sense and logic would dictate that a high level of caution and planning would be warranted when embarking on a course so similar to one where police and health workers were threatened with a lethal weapon, police were injured and Ian was "almost shot".

215. In addition, the evidence disclosed that A/Sgt Towns' information gathering raised a number of highly relevant matters which should have influenced operational planning. This included: the risk posed by Ian's mental condition and his history of rapid deterioration; the bow and arrow incident less than one year earlier; the possibility that Ian possessed a sword; and his known reluctance to attend hospital for compliance with his CTO.

216. In light of the above matters, I am satisfied that enough information was available to A/Sgt Towns prior to attending Ian's house that, even accepting her limited experience with breach orders, she should have appreciated that careful risk assessment and communication were necessary.

217. Based on the information available to A/Sgt Towns, the following steps should have been taken:

Confirmation of whether Ian had a sword

218. Following Ian's death, the critical incident investigators established that Ian had obtained the sword at 2:33pm on 26 July 2016, more than one year prior to the events of 30 August 2017. Numerous officers gave evidence that they knew Ian had purchased a sword but thought that it might not have arrived yet. However, both Ms Slatcher and RN Day were aware that Ian had the sword and Ms Slatcher had informed police of that fact. Further enquiries should have been made to confirm that Ian possessed a sword and effort made to communicate that clearly to involved officers.

Consideration of who would attend the scene

219. Both RN Day and RN Sturgeon made it clear on 30 August that they were willing to go with police when they attended Ian's home to assist in bringing him to the hospital. They provided A/Sgt Towns with Sue Slatcher's contact details. Ms Slatcher was willing and able to be present when police attended and was a valuable resource in terms of her knowledge of Ian's condition and potential methods of de-escalation. Counsel Assisting submitted that it would also have been appropriate for Sgt Shoulders to attend in person. She had completed the four-day MHIT training and had been involved in at least ten previous CTO breach order executions. Sgt Shoulders gave evidence that she was familiar with the MOU and usually carried a copy in her diary or had one in her office. In contrast, A/Sgt Towns had no experience with CTOs and was on her second shift as Acting Sgt since returning from maternity leave.

220. There were differing accounts of the conversation at Bathurst Police Station in which it was determined that A/Sgt Towns would attend Ian's house and Sgt Shoulders would not, which I have outlined above. It is unnecessary to determine the precise content of that conversation and whether Sgt Shoulders refused or was merely reluctant to attend. The upshot of the conversation was that the more senior, more experienced, MHIT-trained officer did not attend.

221. In submissions the Commissioner acknowledged that Sgt Shoulders was MHIT trained, and the expectation would be that if a mental health issue arose, she would attend as a matter of best practice. The Commissioner ultimately submitted, however, that given A/Sgt Towns had been closely involved in the investigation earlier in the day, she was appropriately qualified to attend. I am unable to accept this submission. The evidence in terms of the officers' relative experience and training spoke for itself and no compelling reason was given as to why Sgt Shoulders could not have attended in person. I accept the submission of Counsel Assisting that Sgt Shoulders should have attended in person.

A briefing prior to the second departure, including an explanation of the relevant powers under the Mental Health Act

222. Counsel Assisting submitted that a briefing should have been conducted before the second departure, including, at a minimum, information about Ian's deteriorating mental health, his history of violence towards mental health workers, his reported possession of a sword and how those risks might be managed. The Commissioner accepted in her submissions that a briefing in respect of the

explanation of the execution of the CTO and police powers under the *Mental Health Act* should have occurred.

223. I find that, while some relevant information had been conveyed at an earlier briefing at around 2:30pm, it is not clear whether all the attending officers were present at the time. That briefing did not discuss what officers might do if Ian was located but was unwilling to go to the hospital with police. The briefing should also have explained the relevant powers under the *Mental Health Act* as well as the relevant aspects of the MOU and the MARIA guidelines. No doubt due to this lack of explanation, many of the attending officers had little knowledge of the relevant principles informing the execution of a CTO breach order, including the use of restraint as a last resort. Several officers referred to the purpose of the operation as being to "arrest" or "detain" Ian. Counsel Assisting emphasised the need for police to be aware of the steps outlined in the MOU and the expectation that police will use the least restrictive means possible.

224. It was accepted on behalf of the Commissioner that further training was required in this Police Area Command in relation to the obligations of police in respect of a CTO breach order and under the MOU. The Commissioner noted that improved communications would be considered as part of a revision of the 2018 MOU, which was noted by the Commissioner in her submissions to have been underway at that time.

An ambulance should have been notified to attend or be on standby

225. Counsel Assisting noted that the MOU provides for the use of an ambulance with a police escort even where a patient is a "serious risk to self/others" and states that the use of police vehicles should only occur "as a last resort". There was evidence in this inquest that there was a practice of calling an ambulance in CTO operations only after a person had been detained. Counsel Assisting submitted that it would be preferable to have an ambulance onsite from the commencement of the operation as paramedics can assist with clinical stabilisation, behavioural management and safe transport. Waiting for an ambulance carries a risk of escalation in finely balanced situations.

226. It was submitted on behalf of the Commissioner that having an ambulance in attendance would be impractical and would impose an undue burden on ambulance resources. I note however that there was no evidence that CTO operations are routinely protracted such that an ambulance would be detained for a long period of time. Given the clear risk of escalation and possible violence while waiting for an ambulance, it would in my view be preferable for an ambulance to be contacted to attend, or at least be on standby, before a CTO operation commences.

227. A factual issue arose in this inquest about whether Sgt Shoulders told A/Sgt Towns to take an ambulance with her. A/Sgt Towns did not recall any such instruction and stated emphatically that if it had been suggested to her, she would have done so. I accept the evidence of A/Sgt Towns on this issue. Her conduct throughout the operation and the subsequent inquiry demonstrated that she was eager to receive guidance and would almost certainly have acted on such an instruction. While I do not suggest dishonesty on the part of Sgt Shoulders, her account of their conversation changed at various times and was generally less reliable than that of A/Sgt Towns.

A plan should have been developed in the event that Ian was present but unwilling to attend hospital with the police officers

228. Counsel Assisting identified a range of steps that officers could have taken to establish a plan in the event that Ian was unwilling to come with them. This could

have included clarifying the internal layout of the property, the entry and exit points, light switches and the location of the key. It would also have been strongly desirable for police to leave the station with appropriate equipment such as torches, radios and ballistic vests. While I note the evidence of Assistant Commissioner Crandell, that officers would not be expected to undertake the level of planning required for an uninvited entry before establishing whether Ian was home and willing to come to hospital, this was clearly a possibility in the circumstances. There was a number of simple preparatory steps, as outlined above, which could have been taken prior to leaving the station to reduce the risk of escalation and the danger posed to Ian and the involved officers.

The adequacy and appropriateness of planning (including risk assessment), decision-making and communications before NSWPF officers entered Mr Fackender's unit

229. Much of the evidence at the hearing related to the shortcomings of the planning, communication and decision-making at the scene. Officers moved from the front to the back of the unit without any plan and there was no group briefing once it became apparent that Ian was inside but would not come out when asked. Officers communicated by text messages and mobile phone calls rather than a shared radio channel. There was little understanding of the internal layout of the unit.

230. It was in my view clearly necessary for a briefing to be conducted at 41 View St, following A/Sgt Towns' last phone call with Sgt Shoulders. The officers at the scene should have been informed in clear and concise terms of how entry was to be effected and what was expected of each officer. Sgt Watt gave clear evidence that this kind of information is necessary to maximise the chances of a safe resolution for everyone involved.

231. It was submitted on behalf of the Commissioner of Police that A/Sgt Towns did engage in risk assessment and continued to do so while at the premises. The Commissioner emphasised that officers are trained to conduct dynamic risk assessments, which do not need to be recorded. In written submissions, the Commissioner referred to *McIntosh v Webster* (1980) 43 FLR 112 at 123 where Connor J observed that:

> *"Arrests are frequently made in circumstances of excitement, turmoil and panic. I think it would be altogether unfair to the police force as a whole to sit back in the comparatively calm and leisurely atmosphere of the courtroom and there make minute retrospective criticisms of what an arresting constable might or might not have done or believed in the circumstances."*

232. I do not agree that the circumstances that attended the police's efforts to enforce Ian's CTO on 30 August 2017 were ones of "turmoil and panic." There was ample time throughout the day leading up to the police officers' second attendance at View St, and then at the house itself, for police to undertake a more comprehensive risk assessment.

233. Moreover, while it is to be accepted that risk assessments can be, and often are, performed dynamically, the more important issue in this inquest was the absence of any communication of any dynamic risk assessment and the lack of shared understanding between the officers at the scene. To the extent that A/Sgt Towns, or any other officers, were engaging in dynamic risk assessment, the lack of communication rendered this largely futile.

234. A further factual issue arose as to whether the incident would have been classified as "high risk" under the 2017 MOU or the ANZPAA guidelines. The Commissioner

emphasised in submissions that the incident was "routine" and not "high risk" and that, even given the likely presence of a sword and Ian's past history of threatening to use a weapon against police, there was no greater risk to the police officers than they face every day when entering a house in which residents have access to kitchen knives.

235. The High Risk Situation model in the July 2007 MOU states that:

> *"High Risk Situations are incidents where police judge that there is a real or impending violence or threat to an individual or the public. Examples relevant to this MOU include: sieges, any situation where a person is threatening to, or it is suspected they may, attempt to take their own life, threatening violence with possession of a weapon or any situation where it is believed that a trained negotiator would be of assistance to police*

236. As noted by Counsel Assisting, it is likely that the incident would not have been categorised as "high risk" pursuant to the ANZPAA guidelines until the officers entered the unit, whereupon it quickly became high risk. It was however readily foreseeable that the use of a weapon might occur. Counsel Assisting submitted that the relevant and applicable policies were those relating to uninvited entries as well as the MARIA guidelines, which are specifically directed to mental health incidents including CTO breach orders. Under those guidelines, the proposed entry was high risk and consideration should have been given to the allocation of specialist resources. I accept this submission and consider that in the circumstances, the situation should have been considered high risk and dealt with accordingly.

Whether A/Sgt Towns was appropriately supervised and supported by relevant senior NSWPF officers during the operation to enforce the CTO on 30 August 2017

237. Counsel Assisting and A/Sgt Towns both submitted that A/Sgt Towns did not receive adequate supervision and support from senior officers on 30 August 2017. This, it was submitted, was partially attributable to communication difficulties which meant that senior officers did not understand the true level of risk attending the operation, as well as the fact that no senior officers proactively offered assistance to A/Sgt Towns.

238. Throughout the day on 30 August 2017, A/Sgt Towns made appropriate enquiries about the relevant procedure for CTO breach orders. She received conflicting information and was at no stage directed to the MOU which set out the relevant matters and provided a contact number for assistance. This was a systemic failure related to inadequate training and information regarding the MOU at the Local Area Command ("LAC"). The Commissioner sought to address this shortcoming in correspondence to the Court, discussed further below.

239. In particular, Counsel Assisting submitted that once A/Sgt Towns was at 41 View St and had established that Ian was not responding to police, a higher level of support was required. By that time, A/Sgt Towns had formed the view that a siege or potential siege was unfolding. This had been communicated to Sgt Shoulders. Sgt Shoulders in turn told A/Insp Stewart that there was "a possible potential situation going to occur".

240. It was submitted on behalf of the Commissioner that Counsel Assisting's submissions were erroneously based on the assumption that the situation at View St (wherein Ian was likely to be in his bedroom but not responding to police), was a siege or potential siege, or otherwise a high-risk incident.. As discussed above, I am satisfied that once the decision was made to enter, the situation was indeed "high risk". Once senior officers became aware of the situation that Ian was not

responding (and, as discussed below, instructed A/Sgt Towns to enter the premises), A/Sgt Towns should have received a much higher level of support from senior officers. There was disagreement between the parties as to which officer(s) would have been best placed to offer that support.

241. A factual issue arose as to whether A/Insp Stewart agreed that entry should occur. A/Insp Stewart's evidence was that there was no discussion with Sgt Shoulders about a siege or potential siege, nor about entry (forcible or otherwise) and that self-harm was not mentioned. Her advice was to establish a single line of communication and contain and negotiate. She later informed Sgt Shoulders via text message that A/Insp Cahill was in fact the on-call duty officer. In contrast, Sgt Shoulders recalled that she and A/Insp Stewart came to a "mutual agreement" that "unless we're communicating and unless we can confirm he's in there, we may have to go in and see if he's in there and whether he's okay". A/Insp Stewart's account of this conversation is inherently more plausible. The conversation was short, less than three minutes. It is difficult to accept that she would have authorised a risky, uninvited entry in those circumstances. Additionally, the advice she recalled giving was in accordance with her training and her understanding of the situation. I accept A/Insp Stewart's account of this conversation, while noting that it is possible that Sgt Shoulders simply misapprehended the nature of the advice she received.

242. Counsel Assisting submitted that A/Insp Stewart would have been "well placed" to offer further support, and A/Insp Stewart conceded in her evidence that with the benefit of hindsight she would have requested that Sgt Shoulders attend in person, contacted A/Insp Cahill herself and would have told Sgt Shoulders to contact A/Insp Cahill. In written submissions however, A/Insp Stewart submitted that it would not have been appropriate for her to offer any additional support, given she was off duty while attending a social event at a licensed premises. I accept A/Insp Stewart's evidence as to the steps she should have taken and note that in the circumstances it may not have been appropriate for her to recall herself to duty. Sgt Shoulders was however in a significantly better position to assist A/Sgt Towns and could have sought and provided a much greater level of support than she did.

243. In terms of what was conveyed to A/Sgt Towns, Sgt Shoulders accepted that she said "we're gonna have to go in" and gave the impression that she and A/Insp Stewart had jointly decided that entry was necessary. She denied saying "you're gonna have to kick the door in", although it appears this was the "take-home message". This was the major turning point in the police operation that night. After that phone call, A/Sgt Towns and the other officers at the scene believed or assumed that they had been ordered to enter the premises and that senior officers had determined that no specialist assistance was required.

Whether it was appropriate to enter Mr Fackender's unit on 30 August 2017

244. Without laying blame on the officers at the scene, who believed they had been ordered to enter, I find, in accordance with the submissions of Counsel Assisting, that the decision to enter Ian's house was premature, unnecessary and created a dangerous situation for both Ian and the officers who entered.

245. It was submitted on behalf of the Commissioner that once A/Sgt Towns held concerns for Ian's welfare, entry was "inevitable". It was plain from A/Sgt Towns' evidence that she held genuine, if unjustified, fears that Ian was in imminent danger of self-harm. Together with her belief that senior officers had ordered her to enter, this was the principal reason she decided to effect entry. This belief did, however, create an unwarranted atmosphere of haste when there was, in fact, no

pressing need to enter. It was not pressing as the police officers had, effectively, contained the scene - there were officers positioned at the front and back entrances to the house. There was no evidence that Ian had hurt himself or was threatening self-harm, although he was not responding to police's attempts to communicate with him. Had a mental health worker or family member been present at the scene, they might have been able to better manage the situation.

246. Alternatively, if Sgt Shoulders or A/Insp Cahill had been present, they might have been able to recognise that the situation was contained and could have assisted to develop a better plan without initiating a premature uninvited entry. In the circumstances, while I accept A/Sgt Towns' evidence that she genuinely feared for Ian's safety and believed she had been ordered to enter, the fact remains that, objectively, there was no pressing need to enter the premises.

Whether Constables Carter and Josh entered the unit contrary to the plan developed by A/Sgt Towns and, if so, the adequacy and appropriateness of their planning (including risk assessment), decision-making and communication

247. As was apparent from the evidence at inquest, which I have summarised in detail in these findings, every officer at the scene had a different understanding of how, when and why the officers would enter. Although A/Sgt Towns was of the view that her plan had been communicated to Constable Josh, Carter, Tucker and Graham, this was evidently not the case. A/Sgt Towns accepted that her plan was vague and was not well-communicated to the officers present. I accept the evidence of Sgt Watt and Senior Sgt Davis that the use of radios or a group briefing would have been appropriate.

248. By the time A/Sgt Towns had explained her plan to some of the officers present, the officers had donned ballistic vests and the situation was considered volatile due to the risk of violence. Even accepting that the officers were engaged in dynamic risk assessment, it was necessary to consider and articulate a plan should the operation become dangerous.

249. A/Sgt Towns did not have a clear plan for communicating with the officers at the laundry door. When asked how she could communicate with Ian and the officers if they were all inside, A/Sgt Towns said that she had not thought that far ahead. As was accepted by A/Sgt Towns, it is clear that more thorough planning and communication was required once it was determined that entry was required.

250. As to how Constables Carter and Josh formed their plan, A/Sgt Towns recalled being surprised when they entered the room but accepted that she had not expressly told them to wait or given them a particular signal or order. It is possible that Constables Carter and Josh failed to understand that A/Sgt Towns had a plan and considered it was up to them to effect entry. Constable Carter's evidence in his directed interview was revealing in this respect. Constable Carter recalled that he told A/Sgt Towns that they would go in "because I felt better prepared and we, *I had a better plan than her* and I was, I was more suitable to do it." In cross-examination, Constable Carter said the following:

> *"Q. And why did you, if you use those words 'leave that to us', why did you say that?*
>
> *A. I just felt I was better prepared.*
>
> *…*
>
> *Q. Why did you think officer you were better prepared?*
>
> *A. Because myself and Ben Josh had already spoken and formulated a plan.*

Q. Between the two of you?

A. Correct.

Q. Communicated to no one else?

A. I can't recall if that was told to anyone else."

251. I am satisfied based on this evidence that Constables Carter and Josh decided to develop their own plan and did not communicate this to A/Sgt Towns. The situation was not one in which the senior officer had delegated responsibility for the manner of entry to the involved officers. However, Constable Carter appeared to have taken it upon himself to develop a plan without communicating it to A/Sgt Towns. The evidence of Sgt Watt was that this was contrary to best practice and that communication is essential to ensure entry is effected when the commander wishes. The decision of Constables Carter and Josh to develop their own plan created significant danger for both Ian and the officers present. There was no reason why their plan could not have been communicated to A/Sgt Towns. The officers were close in proximity and there was no pressing need to enter at the time they did. Any plan developed by Constables Carter and Josh should have been communicated to and approved by A/Sgt Towns.

The appropriateness of the manner in which NSWPF officers entered the unit

252. In addition to their complete lack of communication, the plan developed by Constables Carter and Josh was seriously flawed. The "plan" was whispered between them in the seconds before they opened the door. Constable Carter believed he said words to the effect of, "I've got taser, you've got gun. I'll open the door and we'll assess it from there". He accepted that no other officer would have heard that "plan" given they were whispering, although the level of detail involved in the plan was not such that any officer would have been greatly assisted by hearing it. A/Sgt Towns was surprised by their entry and did not have a line of sight or any way of directing the entry.

253. While Constable Josh gave a somewhat different account of the discussion prior to entry, his account of informing A/Sgt Towns and Constable Graham of the plan was inconsistent with the evidence of the other officers. Constable Josh did not give a directed interview after the incident and as such his first account was given almost three years after the relevant events. Thus, given Constable Carter's account was more contemporaneous, consistent with the other evidence and largely against interest, I accept his evidence on this point.

254. The deficiencies in the officers' approach are clear. While allowances can and must be made for "dynamic risk assessment" where no other options are available, the lack of communication, planning and risk assessment in this instance cannot be justified by the circumstances as the officers perceived them. Even accepting that the officers believed it was their duty to enter, there was no evidence that they could not have communicated their plan to their commanding officer and performed at least a preliminary risk assessment. Their failure to do so significantly increased the risk to Ian and to the officers involved.

255. Constable Carter's evidence was that the officers agreed to reassess after entering the unit. When cross-examined he said that the extent of the "reassessment" was to "give [Ian] a chance to comply with our directions" before pulling the blankets off his bed. The officers did not attempt to turn on a light or maintain a safe reactionary gap from Ian. Due to their lack of planning, they had no idea of the internal layout of the apartment or the location of the light switches. Their conduct in shining a light in Ian's face and shouting "police", while consistent with their training, would no doubt have terrified Ian given his entrenched fears

about police and his mental state at the time. Constables Carter and Josh had not spoken to Constables Graham and Tucker about how to co-ordinate the entry and the resulting pile-up of four officers at the door to Ian's room created further danger for the officers by obstructing the exit. Many, if not all, of these difficulties could have been resolved through clearer communication and risk assessment at the outset. There was ample time for planning and communication prior to entering Ian's unit and the failure to do so created unnecessary danger for Ian and the entering officers.

Whether, with the benefit of hindsight and reflection, any steps could have been taken by NSWPF officers on 30 August 2017 that may have led to a different outcome

256. The involved officers made a number of concessions in their evidence about steps that they would have taken with the benefit of hindsight and reflection. A/Insp Stewart stated that when she spoke to A/Sgt Towns at the station earlier in the day, she should have ensured that A/Sgt Towns and the other attending officers were briefed on their role and the applicable policies and procedures prior to attending Ian's residence. She also said that it would have been preferable for an ambulance to have been contacted prior to police arriving. A/Insp Stewart further stated that she would have requested that Sgt Shoulders attend the scene and would have contacted A/Insp Cahill herself as well as instructing Sgt Shoulders to contact A/Insp Cahill.

257. Constable Carter accepted that it would have been preferable for specialist resources such as the Tactical Operations Unit to attend and stated that with the benefit of hindsight he would have clarified with A/Sgt Towns whether specialist resources had been contacted. Constable Josh accepted that a more precise plan about how to enter and engage with Ian should have been developed and communicated to the other officers. Sgt Shoulders accepted that she was the most qualified person available to assist on the night and that there was nothing preventing her from attending on the night.

258. I accept all the concessions made by the involved officers and I have found, above, that there were many other steps which could have been taken to reduce the risk to Ian and the officers. Many of these were simple preparatory steps such as taking torches and radios, confirming the internal layout of the property and calling an ambulance prior to attending, as well as conducting a thorough briefing prior to leaving the station. Moreover, clearer communication with RNs Day and Sturgeon prior to attending Ian's house could have resulted in a daytime attendance with BCMHS staff present.

259. I have already found, above, that the decision to enter Ian's house was premature, unnecessary and created a dangerous situation for those involved. I am also satisfied that the senior officers could have provided much greater assistance to A/Sgt Towns to assist in her risk assessment, planning and decision-making. Sgt Shoulders was MHIT-trained and could have attended in person on the night. Additionally, a thorough risk assessment likely would have resulted in the allocation of specialist resources pursuant to the policies on uninvited entries and the MARIA guidelines. Finally, a further briefing should have been conducted once it was determined that entry was to be effected and Constables Carter and Josh should have communicated to the other officers any plan made between them. The lack of communication, planning and risk assessment was not justified in the circumstances and greatly increased the danger posed to Ian and the officers. Given the many steps that could have been taken to reduce the risk to Ian, I accept the submission made by Ian's family and by Counsel Assisting that Ian's death was "anything but inevitable" and accordingly find that Ian's death was preventable.

Issues relating to potential recommendations directed to the Commissioner of Police

Whether the applicable NSWPF policies and procedures were followed by the NSWPF officers present at 41 View St

260. In respect of policies and procedures generally, Sgt Watt provided a statement in which he opined that the officers did adhere to the relevant policies and procedures, although his statement did not take into account the policies on search warrants, uninvited entries or the MOU. I note that it was Assistant Commissioner Crandell's evidence that those policies were, in fact, applicable to the execution of Ian's CTO breach notice. In his oral evidence, Sgt Watt was a careful and helpful witness who made appropriate concessions. It did, however, become apparent from the evidence that the assumptions on which his opinion were based included that there was a plan to enter Ian's unit, that it had been communicated to the officers at the scene, that a dynamic risk assessment had been conducted and that there was good reason to fear for Ian's health.

261. I am thus unable to place any significant weight on his evidence on this particular issue given the assumptions on which his opinion was based. It became apparent from the evidence of the officers involved that there was no single plan to enter Ian's unit which was well-known to all at the scene and in respect of which a dynamic risk assessment had been undertaken. Given the assumptions underpinning Sgt Watt's report were not borne out in the evidence, I am not satisfied that the relevant policies and procedures were followed.

262. Sgt Watt's evidence more broadly was that best practice would involve proper planning, ongoing risk assessment and the maintenance of a safe reactionary gap. All of these aspects of practice were either lacking or seriously deficient in the operation at 41 View St, and to the extent that any planning or risk assessment was undertaken, it was unfortunately not adequately communicated.

Whether the Memorandum of Understanding between NSW Health, Ambulance Service of NSW and the NSWPF in respect of the "Mental Health Emergency Response" (dated July 2007) ("the MOU"), was adhered to on 30 August 2017

263. As discussed above, the MOU set out considerations relevant to high-risk procedures, which I am satisfied this operation became once the decision was made to enter. Regrettably, none of those considerations featured in the operational planning at the scene. This was largely because senior officers, in particular Sgt Shoulders, seriously underestimated the level of risk. As discussed above, had more information been sought and consideration given to the nature of the situation, it would have become apparent that uninvited entry was a high-risk procedure.

264. Additionally, as noted by Ian's family, the MARIA Guidelines in the 2007 MOU indicated that the CTO operation should have included the presence of mental health workers (because Ian was "uncooperative or unwilling to accept help/care") and likely also NSW Ambulance due to Ian's delusions and his history of aggressive behaviour. The lack of ambulance or mental health workers indicates that appropriate regard was not had to the terms of the MARIA Guidelines.

Whether the NSWPF Critical Incident Guidelines were complied with on 30-31 August 2017

265. The officers in charge of the critical incident investigation ("CII"), Detective Chief Inspector Mark Dukes and Detective Chief Inspector Virginia Gorman, worked hard to produce a comprehensive brief and to investigate any possible breach of

the Critical Incident Guidelines. There was apparent compliance, with one exception; the involved officers had discussed the incident with each other (and admitted to doing so in their evidence). This was not the fault of the CII team and the evidence did not reveal any obvious collusion. The lack of separation does however undermine the reliability of each officer's account and the perceived integrity of the evidence provided to this Court.

Proposed recommendations directed to the NSWPF

266. The following recommendations were proposed by Counsel Assisting in relation to the NSWPF:

> *"(1) Careful consideration is given to re-introducing the section from the 2007 MOU on the MARIA guidelines or otherwise providing express guidance to officers assessing risk specifically directed to police assisting in the execution of CTO breach orders. This guidance should take into account the limited availability of MH services after hours and how information specific to a CTO patient may be obtained after hours.*
>
> *(2) If a risk assessment section is introduced to the MOU as above, consider how practical guidance can be given to general duties NSW police officers as to how that section is to interact with the ANZPAA guidelines and the overarching search warrant procedures.*
>
> *(3) An experienced forensic psychiatrist be engaged as a matter of priority, i.e. within 6 months, to review the NSWPF Weapons and Tactic training curriculum and advise on how mental health considerations be effectively integrated into that training.*
>
> *(4) The Chifley PAC introduce a system to ensure that officers with four-day MHIT training are prioritized as responders to "mental health incidents".*
>
> *(5) The Chifley PAC introduce operational SOPs for the use of radio (if not already in existence) or reinforce the need for radio as the primary communication device between officers."*

267. The NSWPF did not support recommendation (1) on the basis that careful consideration had been given to the formulation of the 2018 MOU and it was determined not to include the MARIA Guidelines. It was further noted that the NSWPF commenced a joint review of the 2018 MOU in February 2021 and despite delays due to COVID-19 it was anticipated that the review would resume in early 2022. I am not ultimately satisfied that adequate consideration *was* given to the inclusion of the MARIA guidelines in the 2018 MOU; the reasons for its exclusion were not elaborated upon. I would thus propose that careful consideration be given to re-introducing those guidelines in a revised MOU.

268. The NSWPF supported recommendations (2) and (3) and indicated in correspondence that the NSWPF was in the process of engaging Dr Kerri Eagle (in relation to recommendation (3)). It does, however, appear that this consultation is in its earliest stages. This recommendation should be actioned as a matter of priority for the NSWPF.

269. The NSWPF accepted recommendations (4) and (5).

270. Ian's family submitted that a recommendation should be made to the NSWPF in relation to the referral of certain officers to the NSW Police Professional Standards Branch. The NSWPF noted in its closing submissions that the matter has already been referred to the Professional Standards Command for consideration as to

whether to conduct an investigation. I am thus satisfied that no recommendation is required in this respect.

Issues relating to Ian's mental health treatment and care

Was there inadequacy in the mental health care provided to Mr Fackender between 21 September 2016 and 30 August 2017 and, if so, did this cause or contribute to his death?

271. It was clear from the evidence at inquest that Ian's clinicians were dedicated, diligent and did their best to provide a high level of care to Ian despite limited resources and competing needs. Despite the best efforts of many dedicated clinicians there were however deficiencies in the care provided to Ian by BCMHS. This was not due to the failings of any individual clinician. Rather, the communication and teamwork underlying the effective functioning of a multidisciplinary team failed in Ian's case to meet his clinical needs. I do not find that the failings contributed to Ian's death.

272. In terms of Ian's care generally, it would have been beneficial for Ian to be psychiatrically reviewed, for example, every three months. Certainly, he should have been reviewed after he expressed concern about the efficacy of his medication in November 2016.

273. In terms of Ian's acute deterioration, it does not appear that this was readily detectable as at his appointment on 27 July 2017. Ian's mother believed that his condition began to decline shortly after that appointment. It would, however, have been desirable for RN Day to have had more frequent communications with Ms Slatcher after taking over as his case manager. As Ian's family point out in their submissions, this might have allowed RN Day to identify his deterioration earlier and also to assist to engage with him. In so finding, I do not wish to criticise RN Day, who was juggling a large caseload of patients within the constraints of already stretched resources. When RN Day eventually became aware of Ian's deterioration, she acted promptly and appropriately in the circumstances.

274. In relation to Ian's level of clinical need generally, Counsel Assisting submitted that, taking into account the context of the NSW public health care system, Ian was not a common or standard patient and should have been treated accordingly. Counsel Assisting highlighted Ian's history of threatened violence towards police and mental health workers and his history of rapid deterioration characterised by having little to no insight into his illness and being resistant to treatment. The LHD submitted that, considered prospectively, Ian was not a special case within the cohort of patients and noted that the issue of the competing acuity within the patient cohort was not examined at inquest. Although I note that there is some force to Counsel Assisting's submissions, I accept the submission put on behalf of the LHD that the relative acuity within the patient cohort was not an issue at inquest.

275. Counsel Assisting submitted that case management by nurses, no matter how skilled, is not a substitute for regular review by a psychiatrist and noted that Ian's case workers agreed that more regular psychiatric review was indicated. RN Mooney made multiple attempts to have Ian psychiatrically reviewed and RN Day agreed that three-monthly review was indicated. Despite these efforts, other patients were consistently prioritised over Ian. The multi-disciplinary model of care cannot function effectively if caseworkers cannot access a psychiatrist when they identify a clinical need.

276. In terms of the frequency of psychiatric review, the expert evidence differed on whether the frequency of review was appropriate for managing Ian's condition. Dr Eagle was of the view that Ian should have been psychiatrically reviewed after he expressed concerns about his medication on 22 November 2016, as a psychiatrist was "the only person who reviewed his medication". Professor Large was of the view that Ian received a high standard of care and that the support RN Mooney received at the multi-disciplinary team meetings was sufficient to address her concerns. Professor Large emphasised the importance of caseworkers and their longitudinal view of a patient's condition, although he agreed that the effective functioning of a multi-disciplinary team relies on case managers being able to escalate patients for psychiatric review when required. Prof Large also agreed that the benefits of longitudinal awareness were significantly diminished by a high turnover in case managers and that such turnover could justify more frequent psychiatric review.

277. In terms of RN Mooney's caseload and her capacity to provide care to Ian, Counsel Assisting noted that there was evidence at inquest that RN Mooney at certain points managed over 40 patients. The LHD conceded that this would be an excessive case load for a single manager but submitted that RN Mooney's *active* caseload was never that high and that it was likely this number included some inactive files which had not yet been closed. I find it unnecessary to determine what proportion of RN Mooney's cases were active or inactive, although she clearly managed a high number of patients. RN Mooney provided a high standard of care to Ian throughout her time as his case manager. To the extent that there were deficiencies in his care, these stemmed largely from the shortage of psychiatrists in the LHD and possibly from the limited handover provided to RN Day when she took over Ian's care.

278. As to whether these deficiencies contributed to or caused Ian's death, I note that the expert evidence was that Ian deteriorated not due to an absence of medication but rather due to the entrenched features of his condition. While it clearly would have been desirable for Ian to be psychiatrically reviewed when RN Mooney first identified a clinical need, I am unable to conclude that this contributed to or caused Ian's death. When RN Day was first notified of Ian's deterioration, she acted quickly to try and assist Ian to receive treatment. The deficiencies in the issuing of the CTO breach notice and order are discussed further, below.

Did any inadequacy in communication between BCMHS and NSWPF on 30 August 2017 cause or contribute to Mr Fackender's death?

279. There were several aspects of the communication between BCMHS and the NSWPF that were wholly inadequate and ultimately contributed to the events that followed. Much of this was conceded at the hearing and can be dealt with succinctly.

280. In relation to the initial information transfer, no clear arrangements were made for police to meet with Ian's caseworkers and discuss Ian's profile. When Ms de Braak took the breach order and breach notice to the police station on 30 August, she knew little of Ian's case and was unable to stop and discuss it with the officers. The "post-it" note attached to the papers was clearly an inadequate means of communicating risk when Ian had previously threatened violence and was known to possess a sword. A handover discussion should not occur at the front desk of the station but rather in a confidential environment without distractions.

281. After the paperwork was delivered to the police station, all subsequent interactions took place at the initiative of A/Sgt Towns, who happened to have attended the

hospital and attended BCMHS to seek further information. While RN Day had intended to organise a meeting with police she did not initiate any contact with them and there was clearly a risk that police would proceed to execute the CTO breach notice and order before such a meeting occurred. No file notes or other documentation was recorded during the conversations between A/Sgt Towns and BCMHS staff.

282. The failure to conduct a handover between police and mental health staff had a real impact on the events which unfolded. While RN Day was aware that Ian had possessed a sword since 2016, she could not recall whether this crucial information had been conveyed to police. This fact could have greatly affected the risk calculus of the officers at the scene. Additionally, while RNs Day and Sturgeon always understood that they were to attend with police to serve the breach notice (as this had always happened previously), this was not adequately communicated. Their shared view that after hours action was not warranted was not communicated because, on their evidence, it did not occur to them that police might attempt to engage with Ian after hours. Even when A/Sgt Towns asked RN Day what time BCMHS closed and was provided with the afterhours contact number, there was no discussion about what would happen if Ian was located overnight. I observe here that, like A/Sgt Towns, RNs Day and Sturgeon were helpful and honest witnesses who acknowledged the deficiencies in communication and had clearly reflected on the events that led to Ian's death.

283. It is understandable that A/Sgt Towns formed the view that she did regarding the urgency of the execution of the CTO breach order and notice; she was informed that Ian was overdue for his medication, that the staff were very concerned about his mental state, that he had a history of rapidly deteriorating and could be "very violent" when mentally unwell. The lack of communication about when and how the operation should be carried out was a contributing factor to Ian's tragic death. Had A/Sgt Towns concluded that the operation could occur the next day with BCMHS staff in attendance, things might have turned out differently.

Proposed recommendations directed to NSW Health

284. Counsel Assisting proposed that the following recommendations be made to NSW Health, the NSWPF and NSW Ambulance:

> *"(1) The current (2018) Memorandum of Understanding between NSW Health, Ambulance Service of NSW and NSWPF in respect of "Mental Health Emergency Response" be comprehensively reviewed and revised so that:*
>
> *(a) there is a section on CTOs and breach orders which provides clear guidance to all signatory parties as to:*
>
> *(i) the required contents of a handover between NSW Health staff and NSW Police Force officers where police are requested to assist in a CTO breach order (see further below);*
>
> *(ii) the agency which has responsibility for locating a person subject to a CTO breach order;*
>
> *(iii) when an ambulance should usually be contacted, i.e. prior to or after locating a person;*
>
> *(iv) the applicable legislative provisions and the NSW Police Force and NSW Health policies relevant to CTO breach orders including the relevant provisions of the Mental Health Act 2007, NSW Police Force policies on uninvited entry and other risk assessment policies and tools;*

(v) the use of firearms at CTO breach order executions involving NSW Police;

(vi) the availability of mental health resources out of business hours; and

(vii) the use of PACER, MHIT trained officers and other resources when executing a CTO breach order."

285. The LHD supported a review of the 2018 MOU but noted that in general the recommendations in relation to the MOU should avoid being overly prescriptive as the precise drafting would be a matter for the agencies involved.

286. Recommendations (1)(a)(i) and (ii) were accepted by NSWPF and supported in principle by the LHD. Both agencies noted that recommendation (1)(a)(iii) is a matter to be settled with NSW Ambulance in the course of reviewing the 2018 MOU. Recommendation (1)(a)(iv) was supported by NSWPF. In relation to the use of firearms, NSWPF rejected the proposed recommendation on the basis that its existing firearms training is sufficient. The LHD supported in principle a review of the guidance provided in relation to mental health resources outside of business hours. In relation to recommendation (1)(a)(vii), NSWPF supported the use of MHIT trained officers where possible, while the LHD did not support a recommendation in relation to PACER, which the LHD contends is not suitable for every LHD.

287. I would adopt recommendation (v), noting the objections of the NSWPF, as it would in my view be appropriate to review the adequacy of the existing firearms training as it applies to CTO breach order executions. I would also adopt recommendation (vii) despite the opposition of the LHD. It would be appropriate for the review of the MOU to consider providing guidance about the use of PACER where that resource is available, while accepting that the program is not appropriate for every LHD.

288. The further proposed recommendations were:

"(b) A section or appendix of the MOU be drafted on the handover or information exchange between police and mental health staff where police assistance is requested for a CTO breach. The section should outline appropriate practices including:

(i) the handover to be arranged in advance and take place in a setting where patient confidentiality can be maintained;

(ii) the exchange be performed (where practicable) by the case worker with carriage of the client or, if not practicable, by a person with some knowledge or awareness of the client and their history;

(iii) the police and case workers should have reference to a risk assessment tool or 'ready reckoner' of relevant considerations including:

a. risk considerations ie any history of self-harm, threats, impulsive or aggressive behaviour; any history of use of a weapon, the presence and nature of delusions, the level of compliance or cooperation at the time at which the operation will occur and known drugs and alcohol use;

b. the personnel intended to attend at the scene;

c. level of urgency and expected time frames for service of the notice/order, whether or not an afterhours approach should be attempted, and the number for the 1800 24/7 Mental Health Hotline;

d. the particular profile of the patient including their condition, medication, perception of emergency services workers and likely attitude towards them, and techniques that may be effective for de-escalation; and

e. resources for that patient including a photograph and contact details of helpful family or friends [the 'Contact MHS bubble' in Appendix B provides a helpful summary of relevant information];

(iv) How documentation of that information exchange should take place and the method for ongoing communication between police and health workers including the contact details of a nominated person from NSW Health and NSW Police Force."

289. This proposed recommendation in relation to handover was supported by both NSWPF and the LHD, with the NSWPF noting that in terms of risk assessment they rely on the history provided by the LHD.

290. Ian's family proposed that the following recommendations be directed to NSW Health:

"(3) That there be a review of the layout and content of a "Breach Order" issued pursuant to s. 58 of the Mental Health Act with a view to ensuring it:

(i) clearly describes the nature and limits of the power to execute the order; and

(ii) provides relevant guidance in that regard, including reference to any current MOU.

(4) That there be a review of pro forma terms of CTO Treatment Plans to ensure that such terms comply with s. 54(b) of the Mental Health Act.

(5) That there be a review of the adequacy of the "after-hours resources" it provides to police assisting with mentally ill patients, particularly in regional areas."

291. The LHD supported a recommendation to the effect that "consideration be given to reviewing the content and layout of a Breach Order issued pursuant to s. 58 of the MHA". It was submitted that this could occur as part of the review of the 2018 MOU pursuant to recommendation (1) of Counsel Assisting. In these circumstances I would recommend that there be a review of the nature and layout of a "Breach Order" issued pursuant to s. 58 of the *Mental Health Act* to ensure that it provides relevant guidance including as to the relevant MOU.

292. In relation to recommendation 4, the LHD supported a general recommendation to the effect that "consideration be given to the need for a review of the pro forma terms of a CTO Treatment Plan", noting however that the MHRT does not prescribe treatment and should avoid imposing inflexible burdens on a patient. Given the LHD's support for a general review of the pro forma terms of a CTO treatment plan, I am satisfied that such a recommendation is appropriate.

293. The LHD opposed the proposed recommendation 5 on the basis that there was no evidence at inquest of any deficiencies in the service provided through the "1800" after hours number. The LHD further noted that no issue was raised at inquest in relation to any discrepancies in service provision between urban and regional areas and submitted that it was beyond the scope of the inquest to make any recommendations in that regard. I respectfully agree with the submissions of the LHD and would decline to make recommendations in relation to matters that were not squarely raised or examined at inquest.

Proposed recommendations directed to the NSW Attorney General

294. Counsel Assisting submitted that the following additional recommendations be made to the NSW Attorney General:

> *"(1) Consideration be given to removing or modifying the terms of s. 58 of the Mental Health Act to clarify that any service requirement (i.e., to serve a breach notice in person or by post before issuing a breach order and seeking police assistance to take a person to a designated mental health facility) does not apply in circumstances where:*
>
> *(a) a non-complying patient is not contactable and reasonable attempts have been made to contact them and inform them of the need to comply with a CTO and the possible consequences of failure to comply; and*
>
> *(b) there is some clinical urgency/immediacy or issues of public safety that necessitate conveying the person for treatment quickly once they are located; and*
>
> *(c) police assistance is necessary to locate and transport the person.*
>
> *(2) For the avoidance of doubt, consideration of any reform should include how principles relating to the rights and dignity of mentally ill people and restraint as a last resort can be safeguarded if the service requirements are modified or removed."*

295. Counsel Assisting noted that this recommendation was proposed as s. 58 was arguably not complied with in Ian's case, because, while his case workers had attempted to contact him several times, Ian was not served with the breach notice prior to the execution of the breach order (contrary to subs. 58(4) and (5) of the MHA). Counsel Assisting observed, however, that it may not have been safe for staff to attend to serve the breach notice unaccompanied while Ian was experiencing a relapse and that the service requirements could have created a delay of several days when Ian required assistance more urgently. I note here for completeness that there was no evidence Ian was a danger to the public generally and he had only previously threatened violence when his condition had severely deteriorated and he perceived he might be forced to receive treatment. In any event, the appropriate balance is a matter for the legislature and invokes considerations greater than any one case. Ian's case is however illustrative of possible weaknesses in the current legislative regime.

296. The LHD supported a general recommendation regarding a review of s. 58 but submitted that care must be taken to avoid eroding consumer rights or reducing opportunities for compliance before coercion is used. The LHD submitted that the intention of the recommendation could be achieved by amending s. 58 to permit more flexible methods of service of a CTO breach notice.

297. I note the concerns of the LHD and would adopt the recommendation of Counsel Assisting with the following amendments:

> *"(1) Consideration be given to modifying the terms of s. 58 of the Mental Health Act to provide for more flexible means of service where:*
>
> *(a) a non-complying patient is not contactable and reasonable attempts have been made to contact them and inform them of the need to comply with a CTO and the possible consequences of failure to comply; and*
>
> *(b) there is some clinical urgency/immediacy or issues of public safety that necessitate conveying the person for treatment quickly once they are located; and*

(c) police assistance is necessary to locate and transport the person.

(2) For the avoidance of doubt, consideration of any reform should include how principles relating to the rights and dignity of mentally ill people and restraint as a last resort can be safeguarded if service requirements are modified or removed."

298. Counsel Assisting further proposed the following recommendations directed to the NSW Attorney General:

"(3) Consideration be given to giving legislative guidance to police about a time frame for the execution of a CTO breach order. It may be considered desirable to instead clarify this in an MOU or through handover but police should be expressly reassured that they are not legally required to execute a breach order (potentially including by forcible entry to a home) without consulting with Mental Health staff about the clinical urgency of executing the breach order.

(4) Consideration be given to removing the use of the word "apprehend" from the terms of s. 59 of the Mental Health Act."

299. Counsel Assisting proposed these recommendations in light of the evidence of the clear miscommunication between BCMHS and the NSWPF officers regarding the anticipated time frame for service of the breach order. Some officers gave evidence that they thought they had to immediately "arrest", "detain" or "apprehend" Ian because of the CTO breach notice. These terms were used virtually interchangeably and carry criminal connotations. The officers' misunderstanding likely contributed to the misplaced sense of urgency surrounding the police operation. Counsel Assisting submitted that a linguistic change could assist police to better understand their role in CTO breach operations. Counsel Assisting noted that the word "apprehend" appears unnecessary where the provision already contemplates the use of reasonable force to "take and assist a person to a designated mental health facility".

300. The LHD did not support recommendation (3) and submitted that legislative guidance would be unhelpful where the clinical circumstances of patients differ greatly. The LHD submitted that the issue is primarily one of information exchange and interagency communication and as such would be best dealt with via the review of the 2018 MOU so as to avoid legislation that is overly prescriptive.

301. I respectfully agree with this submission and consider that it would be more appropriate for the issue of time frames to be considered under the review of the MOU as set out in recommendation (1)(b)(iii)c, above.

302. In relation to recommendation (4), the LHD did not oppose consideration being given to amending s. 59 of the MHA but noted that the precise amendment would require careful consideration. I am satisfied that it is appropriate to adopt this recommendation.

303. Ian's family suggested further recommendations to the Attorney General, as follows:

"(2) That s. 59 of the Mental Health Act 2007 be reviewed with consideration given to removing the word "apprehend" and to amending the provisions to include the following terms:

a. Despite s.81, when a police officer takes action under this section, the use of force is to be avoided, or where the use of force cannot be avoided, only the minimum amount of force that is reasonably necessary is to be used.

b. As far as practicable, any restriction on the liberty of the person and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances.

c. When a police officer takes action under this section, the officer is to be accompanied by:

i. the psychiatric care manager of the affected person, and if not practicable, then a member of staff of the NSW Health Service, and

ii. an ambulance officer.

d. A forced or uninvited entry into any premises for the purposes of this section is to be used only as a last resort.

304. I am satisfied that, to the extent this proposed recommendation addresses the relevant procedures for the service of a CTO breach notice (sub paras (a), (c) and (d)), those matters are dealt with under recommendation 1 (review of the 2018 MOU). In relation to the use of force referred to in sub para (a), as noted by the NSWPF, those matters are dealt with pursuant to s. 230 of LEPRA as well as under the common law. The amendment to remove the word "apprehend" is dealt with in the proposed recommendations of Counsel Assisting.

Formal Findings

305. I find, pursuant to s. 81(1) of the *Coroners Act* that:

a) The deceased was Ian Fackender;

b) Ian died on 30 August 2017 at his home in View St, Kelso, NSW;

c) Ian died from the effects of gunshot wounds after he was shot four times by a NSW Police officer. Mr Fackender had longstanding schizophrenia that was at least partially resistant to treatment. At the time he was shot, Mr Fackender was acutely psychotic. Mr Fackender was moving towards officers with a large sword when he was shot by a police officer, who acted in defence of himself and another police officer.

Recommendations

To the NSW Police Force:

(1) Careful consideration is given to re-introducing the section from the *Memorandum of Understanding between NSW Health, Ambulance Service of NSW and NSWPF in respect of "Mental Health Emergency Response"* (July 2007) ("the 2007 MOU") on the "MARIA" guidelines into the current version of the MOU, or otherwise providing express guidance to officers within it, on assessing risk, specifically directed to police assisting in the execution of CTO breach orders. This guidance should take into account the limited availability of mental health services after hours and how information specific to a community treatment order ("CTO") patient may be obtained after hours.

(2) If a risk assessment section is introduced to the MOU as above, consider how practical guidance can be given to general duties NSWPF officers as to how that section is to interact with the ANZPAA guidelines and the overarching search warrant procedures.

(3) An experienced forensic psychiatrist be engaged as a matter of priority, i.e. within 6 months, to review the NSWPF Weapons and Tactics training curriculum and advise on how mental health considerations be effectively integrated into that training.

(4) The Chifley Police Area Command ("PAC") introduce a system to ensure that officers with four-day MHIT training are prioritized as responders to "mental health incidents".
(5) The Chifley PAC introduce operational SOPs for the use of radio (if not already in existence) or reinforce the need for radio as the primary communication device between officers.

To NSW Health, NSW Ambulance and the NSW Police Force:

(1) The current (2018) Memorandum of Understanding between NSW Health, Ambulance Service of NSW and NSWPF in respect of "Mental Health Emergency Response" be comprehensively reviewed and revised so that:
    (a) there is a section on CTOs and breach orders which provides clear guidance to all signatory parties as to:
    (i) the required contents of a handover between NSW Health staff and NSW Police Force officers where police are requested to assist in a CTO breach order (see further below);
    (ii) the agency which has responsibility for locating a person subject to a CTO breach order;
    (iii) when an ambulance should usually be contacted, i.e. prior to or after locating a person;
    (iv) the applicable legislative provisions and the NSW Police Force and NSW Health policies relevant to CTO breach orders including the relevant provisions of the *Mental Health Act 2007*, NSW Police Force policies on uninvited entry and other risk assessment policies and tools;
    (v) the use of firearms at CTO breach order executions involving NSW Police;
    (vi) the availability of mental health resources out of business hours; and
    (vii) the use of PACER, MHIT trained officers and other resources when executing a CTO breach order.
    (b) A section or appendix of the MOU be drafted on the handover or information exchange between police and mental health staff where police assistance is requested for a CTO breach. The section should outline appropriate practices including:
        i. the handover to be arranged in advance and take place in a setting where patient confidentiality can be maintained;
        ii. the exchange be performed (where practicable) by the case worker with carriage of the client or, if not practicable, by a person with some knowledge or awareness of the client and their history;
        iii. the police and case workers should have reference to a risk assessment tool or 'ready reckoner' of relevant considerations including:
            1. risk considerations, i.e. any history of self-harm, threats, impulsive or aggressive behaviour; any history of use of a weapon, the presence and nature of delusions, the level of compliance or cooperation at the time at which the operation will occur and known drugs and alcohol use;
            2. the personnel intended to attend at the scene;
            3. level of urgency and expected time frames for service of the notice/order, whether or not an afterhours approach should be attempted, and the number for the 1800 24/7 Mental Health Hotline;
            4. the particular profile of the patient including their condition, medication, perception of emergency services workers and

likely attitude towards them, and techniques that may be effective for de-escalation; and

5. resources for that patient including a photograph and contact details of helpful family or friends [the 'Contact MHS bubble' in Appendix B provides a helpful summary of relevant information];

iv. How documentation of that information exchange should take place and the method for ongoing communication between police and health workers including the contact details of a nominated person from NSW Health and NSW Police Force.

To NSW Health:

(1) That there be a review of the nature and layout of a "Breach Order" issued pursuant to s. 58 of the Mental Health Act to ensure that it provides relevant guidance including as to the relevant MOU.

(2) That consideration be given to the need for a review of the pro forma terms of a CTO Treatment Plan.

To the NSW Attorney General:

(1) Consideration be given to modifying the terms of s. 58 of the Mental Health Act to provide for more flexible means of service where:

(a) a non-complying patient is not contactable and reasonable attempts have been made to contact them and inform them of the need to comply with a CTO and the possible consequences of failure to comply; and

(b) there is some clinical urgency/immediacy or issues of public safety that necessitate conveying the person for treatment quickly once they are located; and

(c) police assistance is necessary to locate and transport the person.

(2) For the avoidance of doubt, consideration of any reform should include how principles relating to the rights and dignity of mentally ill people and restraint as a last resort can be safeguarded if service requirements are modified or removed.

(3) Consideration be given to removing the use of the word "apprehend" from the terms of s. 59 of the Mental Health Act.

Conclusion

306. I extend my sincere condolences to Ian's family for their loss. Ian's family participated in this inquest with enormous dignity and grace and generously shared their memories of Ian with the Court. I thank Ian's family for their attendance at and participation in this inquest.

307. I also extend my thanks to the Counsel Assisting team of Craig Smith SC, Kirsten Edwards, James Herrington, Caitlin Healey-Nash and Romola Davenport.

308. I close this inquest.

Teresa O'Sullivan
State Coroner
Date: 13 September 2022