STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jacob Daniel CARR
Hearing Dates:	9-12 May 2022, 28-29 June 2022, 1 August 2022, 6-7 July 2023
Date of Findings:	30 November 2023
Place of Findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in police operation – gunshot wound inflicted by police officer – appropriateness of actions of NSW Police Force officers – adequacy of care and treatment provided by NSW Ambulance
File Number:	2019/00256729
Representation:	Mr R Ranken, Counsel Assisting instructed by Ms A Boatman and Ms L Burgoyne of the Crown Solicitor's Office Mr P Rooney, instructed by Mr M Renwick of McCabes for the Ambulance Service of NSW Ms C Palmer, instructed by Mr A Barrie of the Office of General Counsel for the Commissioner of Police Mr B Haverfield, instructed by Mr M Treharne of Walter Madden Jenkins Solicitors for Senior Constable Glen Wymark, Constable Matthew Phillips and Chief Inspector Craig Thorpe Mr R Reitano, instructed by Ms E Lucas of McNally Jones Staff Lawyers for Richard Brown
Findings	**The identity of the deceased** The person who died was Jacob Daniel Carr

Date of death
He died on 17 August 2019

Place of death
Royal North Shore Hospital, St Leonards

Cause of death
Gunshot Wound to the leg

Manner of death
Misadventure

Recommendations

To the NSW Commissioner of Police

1. Consideration be given to amending the Critical Incident Guidelines to provide instruction that where a Duty Officer is presented with immediate resourcing constraints that would prevent the separation of involved officers in strict compliance with the terms of the Critical Incident Guidelines, the Duty Officer should consider what alternative means may be available to meet the intent of the guidelines to ensure the integrity of the involved officers subsequent evidence, for example by ensuring any body worn cameras worn by the officers or relevant in-car-video are kept operational and recording until they are able to be properly separated in accordance with the Guidelines.

To NSW Ambulance

2. Consideration be given to improving Incident Reporting concerning any equipment failures to ensure they are communicated to a specified person within each directorate using the particular equipment who has responsibility for the monitoring of the continued efficacy of the directorate's equipment.

Non-publication order

Non-publication orders prohibiting publication of certain evidence pursuant to the *Coroners Act 2009* have been made in this Inquest. A copy of these orders, and corresponding orders pursuant to section 65 of the Act, can be found on the Registry file.

Introduction

1. This inquest concerns the death of Mr Jacob Daniel Carr.

2. Mr Carr was born on 1 January 1966. He died on 17 August 2019 at the Royal North Shore Hospital at the age of 53 years.

3. Mr Carr was transported by ambulance to the Emergency Department at the Royal North Shore Hospital on the evening of 17 August 2019, with a gunshot wound to his left mid thigh.

4. There appears to be no dispute that Mr Carr sustained the shotgun injury to his leg during a "police operation". As such, his death was reportable to the Coroner because it was both an unnatural and sudden death; as well as, occurring as a result of the direct involvement of police officers, (see section 23 and 27 of the Coroners Act).

5. The identity, date and place of Mr Carr's death are not in dispute. This inquest has focused on the manner and cause of Mr Carr's death and the relevant contributing circumstances.

6. Mr Carr's sister, Ms Nicole Sosa spoke on behalf of her family. She expressed that "We want you to know that Jake was a thoughtful, sensitive, hilarious, loving father, brother, son, uncle, brother-in-law and friend, who was loved by many. He was a great listener and always had a word of wisdom in a crisis. He was taken from us too young, at age 53. He's loved and missed".

7. I acknowledge the profound loss, and continuing anguish and heartbreak felt by Mr Carr's family. I would like to express my sincere condolences and respect for their loss. I would also like to acknowledge and thank his family members for their contribution and participation in this inquest. I hope that Mr Carr's memory has been honoured by the careful examination of the circumstances surrounding his death and the lessons that have been learned from the circumstances of his passing.

The role of the coroner and the scope of the inquest

8. A coroner is required to investigate all reportable deaths and to make findings as to the person's identity; as well as when and where the person died. A coroner is also required to identify the manner and cause of the person's death. In addition, a coroner may make recommendations, based on the evidence deduced during the inquest, which may improve public health and safety.

9. During these proceedings, evidence has been received in the form of statements and other documentation, which was tendered in court and admitted into evidence. In addition, evidence was received from a number of witnesses involved on the night of the shooting; as well as the subsequent review of policies and departmental procedures. Expert evidence was received from two experts being Dr Kerri Eagle and Professor Anthony Brown.

10. All of the material placed before the Court has been thoroughly reviewed and considered. I have been greatly assisted by the written submissions prepared by counsel assisting, Mr Robert Ranken and the other legal representatives appearing on behalf of various interested parties. At times I have embraced their descriptions in these findings.

11. During these proceedings, significant issues and concerns arose relating to the manner of Mr Carr's death, which required the introduction of additional evidence relating to the tourniquet that was applied to Mr Carr's leg to staunch the bleeding.

A Brief Overview of Mr Carr's Life

12. Mr Carr was born on 1 January 1967 at King George V Memorial Hospital in Camperdown to Fleurette and Thomas Carr. Mr Thomas Carr died in 1993 or 1994. Mr Carr has a younger sister, Ms Nicole Sosa.

13. Mr Carr has an adult daughter. He had periodic contact with her as she was growing up, however, the relationship appeared somewhat estranged.

14. Mr Carr finished high school in year 10. He obtained the relevant licences for operating bobcats and driving heavy vehicles and was employed in those industries for a number of years. Mr Carr had been receiving the disability support pension since 2003.

15. Mr Carr's medical history was significant for a chronic, painful and debilitating condition known as keratitis. Keratitis is an inflammation of the cornea that produces an ocular discharge and can cause serious eyesight problems. His chronic pain impacted on his mental health and he sought assistance from a number of treatment providers over a number of years.

16. Mr Carr had been residing in a granny flat at the rear of a substantial 2-acre property at 167 Mona Vale Road, Ingleside, owned by his mother for approximately 12 years. His mother resided in the main house with Ms Nicole Sosa and her husband Mr Alex Sosa, and Ms Sosa's two adult sons from an earlier relationship.

The list of issues considered during the inquest

17. The following list of issues was prepared before the proceedings commenced and were considered and provided focus during the inquest:

Issues relating to NSW Police Force officers:

i. The manner and cause of Mr Carr's death on 17 August 2019

ii. Whether the actions of NSW Police Force ("NSWPF") officers on 17 August 2019 were appropriate. In particular:

   a. The adequacy and appropriateness of planning (including risk assessment) and communication on 17 August 2019 prior to the

attendance of NSWPF officers at 167 Mona Vale Road, Ingleside at or around 9.47 pm;

b. The adequacy and appropriateness of planning (including risk assessment), decision-making and communication prior to entering Mr Carr's granny flat at 167 Mona Vale Road, Ingleside at or around 9.53 pm;

c. The adequacy of the investigation regarding Mr Carr's potential access to firearms;

d. Whether it was appropriate for the attending NSWPF officers to enter Mr Carr's granny flat on 17 August 2019 having regard to the information and circumstances known to those officers at the time;

e. Whether it was appropriate for the attending NSWPF officers to enter Mr Carr's granny flat in the manner in which they did;

f. Whether the STOPAR model was considered and properly applied by the attending NSWPF officers;

g. Whether there was a realistic chance of avoiding the fatal outcome if a tactical option of "contain and negotiate" had been implemented by the attending NSWPF officers;

h. Whether, with the benefit of hindsight and reflection, any steps could have been taken by NSWPF officers on 17 August 2019 that may have led to a different and better outcome for Mr Carr.

Issues relating to potential recommendations regarding NSWPF

iii. Whether the applicable NSWPF policies and procedures, including the NSWPF Domestic and Family Violence Standard Operating Procedures 2018 were followed by the officers who were present at 167 Mona Vale Road, Ingleside.

iv. Whether the events of 17 August 2019 reveal inadequacies of deficiencies in the above-mentioned policies such that recommendations pursuant to section 82 of the *Coroners Act* 2009 are necessary or desirable, with a particular focus on risk assessment, planning and communication when police are called to a domestic violence incident in circumstances where possession of firearms has not been ruled out.

v. Whether the events of 17 August 2019 reveal inadequacies or deficiencies in training at the NSWPF relating to the issues and policies outlined above such that recommendations pursuant to section 82 of the *Coroners Act* 2009 are necessary or desirable.

vi. Whether the policies and procedures relevant to a Level 1 Critical Incident were followed and if not, whether there was sufficient justification to depart from those procedures.

Issues relating to NSW Ambulance Service Officers

vii. Was there inadequacy in the care and treatment provided by NSW Ambulance to Mr Carr on 17 August 2019 and, if so, did this cause or contribute to his death, with particular attention to:

a. The appropriate provision of pain relief or sedation to Mr Carr;

b. The decision to cover Mr Carr with a space blanket impeding ambulance officers from monitoring the efficacy of the tourniquet;

c. Whether it is possible that Mr Carr removed the torniquet from its original position;

d. The appropriateness of having only one paramedic in the rear of the ambulance with Mr Carr;

e. Whether the second haemorrhage inside the ambulance was of critical importance;

f. Whether immediate notification of the incident to Inspector Parish could have led to a different and better outcome for Mr Carr.

viii. Whether the events of 17 August 2019 reveal inadequacies or deficiencies in NSW Ambulance Service policies such that recommendations pursuant to section 82 of the *Coroners Act* 2009 are necessary or desirable.

Background to issues relating to firearms and Mr Carr's mental health

18. Mr Carr had a history of criminal offending between 1983 and 2005. The recorded offences included being carried in a conveyance, middle range PCA, offensive behaviour, possession of drugs, fraud related offences, receiving goods, goods in custody, malicious damage, assault occasioning actual bodily harm and unlicenced driving.

19. The Computerised operational police system (COPS) also recorded two Apprehended Violence Orders (AVOs) where Mr Carr was listed as the Defendant.

20. The first Order, dated 11 July 1996, was granted to his former partner, Ms "L". Ms "L" told police that there had been physical and verbal abuse during the relationship and that Mr Carr had issues with drug use, particularly amphetamines. After they had separated, Ms "L" stated that if "he doesn't get his way he gets verbally abusive towards me." At the time Ms "L" called the police on 27 June 1996, she said that he "was standing over me, and had his fist clenched."

21. The second order related to his mother and the final Order is dated 1 July 2002. The Police Facts sheet provides the following details:

- Mr Carr had an argument with his mother
- He struck Mrs Carr to the left side of her face which also forced her back onto the kitchen cupboards

- He then held a knife to her throat and then took hold of a BBQ fork and held that to her stomach
- he threw a chair at a wall mirror
- he approached Mrs Carr's motor vehicle and threw an object at the car which caused the rear window to shatter.

22. Mr Carr had a documented medical history which was significant for depression, Attention Deficit Disorder, substance misuse and suicidal ideation. Dr Eagle provides further detail referred to later in these Findings.

23. In 2019, his mother and sister commented on his more recent presentations in their police statements. These observations included his sister commenting that "I do know he was clinically depressed and had suicidal ideation" and that he "would talk about suicide" and say things like "I'm not going to be here much longer." Ms Sosa commented that since "moving back to the property earlier this year I noticed Jacob's mental health had deteriorated. I noticed Jacob would have more verbal outbursts where he was not able to control his temper. He would normally verbally abuse mum or myself in relation to something around the property…We did not take the outbursts too seriously as the things he was getting upset about seemed trivial to us." Ms Sosa described her brother as exhibiting a changeable mood and that he would have an outburst every couple of months.

24. His mother commented that his eye condition had been getting worse and caused him "great difficulty and distress". She noted that he was socially isolated and was taking Lyrica. She believed that the Lyrica was making Mr Carr suicidal. In her statement to Police, Mrs Carr noted that he would "easily lose his temper around me. I put it down to the fact he was socially isolated and was depressed and I was just the one who was around for him to take it out on. It didn't normally cause me much concern. He felt so stuck here, no life, no job, no girlfriend and his eyes were getting worse. Whenever he lost his temper with me, he would come back the next day and apologise for losing his temper." Mrs Carr also commented that "in recent years, he has been coming up to me and putting his hands around my throat. He would say things like "I could kill you anytime you know." I never really took what he said seriously or took much notice of his behaviour. I thought he would be joking and just mucking around."

25. On 13 February 2018, Senior Constable Wymark and two other police attended Mr Carr's home and he was taken by ambulance to hospital after having expressed suicidal thoughts.

26. Mr Carr's GP, Dr Norrie noted in his statement to police that Mr Carr had had a "meltdown" on 22 December 2018, due to the pain he was experiencing with his eye condition and that he wanted to kill himself due to the pain, chronic insomnia and that he was going blind. Dr Norrie noted that Mr Carr had become more depressed and suicidal over time in the context of his chronic eye condition.

27. Ms Sosa told Police in her statement that “I never saw Jacob with any weapons apart from an antique gun which had belonged to my father. I knew this gun had the operational hammer cut off, so it could no longer be fired. Even though I did not see Jacob with other firearms, I had heard him say things like, "I'll shoot myself". I don't ever recall him threatening us with a firearm in recent years”.

28. Ms Sosa recounted an incident approximately 22 years earlier when the family owned, and were residing at, the caravan park at Wiseman’s Ferry. The incident which she recounted appears to be the same incident involving her mother being threatened with the BBQ fork. Ms Sosa stated that after assaulting their mother, Jacob left the house saying something like, "I'm gonna go and get the gun." Ms Sosa stated that “I am unaware if he had a firearm”.

29. Mrs Carr confirmed that she had been given a revolver by her father that he had used in the First World War. She referred to it as an “artefact” and that her husband had previously made arrangements for the revolver to be ‘disabled’. Mrs Carr indicated in her oral evidence that “I think it was shoved in my wardrobe and I don’t, I don’t remember seeing it.” Mrs Carr also confirmed that she had purchased a 12-gauge pump-action shotgun for her husband a number of years ago when they were living at Wiseman’s Ferry. She couldn’t recall seeing the shotgun after her husband’s death.

30. Mrs Carr told police in her statement “I have heard Jacob mention firearms in the past but I never took any notice of what he was saying.” In her oral evidence Mrs Carr stated “Well this is going back many years. He’s – he probably did- I don’t know, I don’t remember him ever saying, “I’ve got a firearm and I’m going to shoot you.”

31. Police spoke with Mr Carr’s friends about their knowledge of Mr Carr possessing guns. Mr Ling had known Mr Carr for about 2-3 years and would see him about once a month. Mr Ling stated that he recalled “Mr Carr mentioned a shotgun on one occasion but said he did not have shells for it.”

32. Another friend, Ms Leach last saw Mr Carr in 2018. She recalled that Mr Carr had told her that he possessed firearms for protection.

33. Another friend, Mr Watkins, had known Mr Carr since he was eight years old. Mr Watkins informed police that he was aware that Mr Carr was in possession of firearms and that he kept a shotgun beside his chair in the lounge room of his flat. Mr Watkins told police that Mr Carr had spoken to his mother, Mrs Carr about the firearms and that Mrs Carr had wanted them stored safely away from the children.

The events on the evening of 17 August 2019

34. At 1.53 pm on 17 August 2019, Mr Carr received an SMS text message from his GP, Dr Jeremy Smith, stating “*Medicare records show me that you’re Dr Shopping, getting extra scripts from Dr Norrie* (Mr Carr’s other GP). *Abusing Seroquel and Lyrica, about 8 day. I can no longer see you. Letter in post. Dr Jeremy Smith.”*

35. The Carr family had planned to celebrate the engagement of Ms Sosa's son, Brodie and his partner Kila on Saturday, 17 August 2019 with a party at the premises at 167 Mona Vale Road, Ingleside, commencing around 4 pm. Approximately 60-120 guests attended and were celebrating in the garden area near the tennis courts, about 200 metres from Mr Carr's granny flat.

36. Ms Sosa recalled seeing Mr Carr at around 5 pm. He appeared to be mingling with the guests and watching the entertainment. At one point Ms Sosa recalls seeing Mr Carr with his mother and introducing her to the guests. Ms Sosa stated that her brother "seemed merry and had been drinking alcohol, but I could not say what".

37. Ms Sosa recalled seeing Mr Carr speaking with Church Pastor Paul Ravestyn for a number of hours during the party. Pastor Ravestyn had been known to the family for a number of years. Ms Sosa recounted that her brother had commented to Pastor Ravestyn that "I would like you to do my funeral" and had been discussing "his struggles and childhood issues".

38. Pastor Ravestyn provided a statement. He confirmed that he had spoken to Mr Carr during the party for about one hour and a half. He stated that Mr Carr appeared sober during their discussion. He commented that Mr Carr told him that he "cries out to God 5 times a day for healing on his eyes" and that he had been "clean" for 13 years. Pastor Ravestyn said Mr Carr told him that he had great respect for the Pastor and "he asked me to do his funeral." Pastor Ravestyn said "I don't think he plan on dying that night." Pastor Ravestyn indicated that Mr Carr had confided that he had been the subject of family violence as a child and that he had thought about taking his own life. He described an attempt to shoot himself with a gun and popping pills and alcohol after the death of his father. He said Mr Carr indicated that he threw the gun away of this incident. At the conclusion of their talk, Pastor Ravestyn believed that Mr Carr was in "good spirits".

39. Mrs Carr left the party after about 5 minutes and returned to her home. At about 9.15 pm, Mrs Carr stated that Mr Carr came into her lounge room and sat down next to her on the lounge. Mrs Carr indicated that he appeared to her "to be very drunk" and "he was going on with his usual rot that he goes on with when he is drunk. He was going on and on about the sewerage associated with the granny flat and complaining how it was a problem". Mrs Carr said, "he was talking over the top of her [and] he then said to me, "I want to be buried at Wisemans Ferrry". He has said this to me before on other occasions. He has stated he wanted to be buried at Wisemans Ferry as that is where a number of his good friends are buried. I didn't reply to him as I didn't want to agitate him further.

    He said, "You know I hate you?"

    He then said, "You know I could kill you right now". I just ignored him as he has said these types of things before. He also said, "You think you're so fucking strong." At some stage he put his right arm around my shoulders. He was saying, "I love you Fleury, you know I love you Fleury". He then all of a sudden jumped

up from next to me and stood over me whilst I was still sitting on the lounge. He put both of his hands around my neck and began to squeeze my neck. I couldn't breathe. I was being pushed back onto the lounge as he was holding and squeezing my neck. I felt as if I was losing consciousness. I tried to push Jacob away from me, and I also used both my fists to punch out at him. I know that my fists connected with his face because his glasses cut the back of my right hand. Jacob's face was unlike I have ever seen before. He was angry. I'll never forgot what I saw on his face - the anger. I kept fighting Jacob off and eventually he let go of my neck. I was struggling to breathe and was trying to get myself together.

Jacob started pacing up and down the lounge room floor. I said to him, "Go, just go" and so he opened the rear lounge room door that adjoins a bedroom and walked through it to outside the main house.

40. Mrs Carr then rang Mr Sosa and asked him to come inside. She then told Mr Sosa "Jacob tried to kill me, he tried to choke me". Mrs Carr confirmed that Mr Sosa then took some photographs of her neck and hands on his mobile phone. Mrs Carr then told Mr Sosa, "Enough is enough, we have to call the police". Mr Sosa then called Ms Sosa who came straight inside and Mrs Carr stated that she told them that "We have to call the police now, we have to call the police". Mrs Carr stated that “I felt like I had to stop Jacob and get some help for him now. I felt that police could get Jacob the help he needed”.

Triple-0 call to Police

41. Ms Sosa then contacted triple-0. A transcript of the call has been tendered in evidence and confirms that Ms Sosa stated that “my brother tried to kill my mother” and that “my brother tried to strangle my mother”.

Ms Sosa was asked by the operator is “anyone injured and need an ambulance”?

Ms Sosa responded saying, “No she’s in shock. She’s been strangled, attempt to strangle”.

The operator enquired, “Does she need and ambulance?” and Ms Sosa indicated “No”.

The operator then asked, “Where, what is he doing at the moment?”

The following exchange is then recorded:

> Ms Sosa: “He’s gone, he’s very dangerous, he’s got um”
>
> Operator: “What is he doing at the moment though?”
>
> Ms Sosa: “He’s gone back to his house. It’s a big property and it he lives out the back in a house and he’s gone back there, and um”
>
> Operator: “What any weapons or access to guns at all?”
>
> Ms Sosa: “He could possibly have”
>
> Mrs Carr: “He’s on drugs”

Ms Sosa: "….and he's on, he does take drugs"

Operator: "Are you saying he possibly has access to guns?"

Ms Sosa: "Yes"

Mrs Carr: "It's on the file, he's already been charged once, he tried to kill me"

After some further discussion, the following is recorded:

Operator: "So you said he's affected by drugs or alcohol?"

Ms Sosa: "Yes"

Operator: "Any mental health issues we should be aware of?"

Ms Sosa: "Yes. He's got you know ah depression, bi-polar"

Operator: "Any AVO's or court orders in place?"

Ms Sosa: "No"

The basis of Ms Sosa's belief that Mr Carr may have a firearm

42. In her oral evidence, Ms Sosa stated that she was aware that her brother, Mr Carr had possession of the antique pistol which he had told her was inoperable. She stated that he showed her that the "hammer part was shaved off" and that Mr Carr had told her it was originally their father's gun. Ms Sosa denied that she had any knowledge of any other firearm on the property prior to 17 August 2019, saying, "I didn't see ever, ever see any other firearm ever." Ms Sosa further stated, "I only suspected he did in, in the fact that he had threatened with one. So that's as far as I had an understanding around it. A suspicion that he may have".

43. Ms Sosa confirmed in her evidence that at the time she made the triple-0 call she "had no idea what guns. But I expected he, he possibly could have a firearm". Ms Sosa then stated, "Because of the history of him, his past, mentioning that he had a gun in the past and that's what I based it on and I wanted whoever went in there to be prepared for anything, but I had no idea what he had." She further stated, "I just wanted anybody who went in there to be warned that he possibly could have but I didn't know accurately anything so I had no knowledge that he did. He may not have but I just – there's not, it's nothing I knew. But because I know him and I know that he had something, he mentioned in the past that's what I based it on."

Police response to Triple-0 call

44. A police job was broadcast via VKG at 9.37 pm, requesting police attend a domestic incident.

45. Three police responded to the broadcast and attended at 167 Mona Vale Road, Ingleside. The three police officers were Leading Senior Constable (LSC) Richard Brown, Senior Constable (SC) Glen Wymark and Probationary Constable Matthew Phillips.

46. Senior Constable (SC) Glen Wymark and Probationary Constable Matthew Phillips were partnered for their shift, with SC Wymark driving a fully marked police vehicle, call sign Northern Beaches 36. SC Wymark was not carrying a Taser nor was he wearing a body-worn video that evening. Probationary Constable Phillips was wearing his body-worn video and was armed with both a Taser and OC spray.

47. In his oral evidence, SC Wymark confirmed that as he was driving to the scene, Probationary Constable Phillips was monitoring the CAD log to confirm and receive additional information enroute. SC Wymark confirmed that the CAD log stated that “Mother is in a bit of shock. Ambo declined”. In addition, they were aware that the person of interest was affected by alcohol and was still at the address and at the rear of the property. SC Wymark confirmed that the broadcast had noted that the “POS has access to firearms”. SC Wymark stated that Probationary Constable Phillips had conducted checks on the mobile data terminal which advised that there were no firearms registered to the address and no person residing at the premises had been issued with a firearms licence.

48. Probationary Constable Phillips confirmed that he had been assessing the CAD information as SC Wymark was driving to the location of the job. He indicated that the “radio was hectic that night”.

49. P/Constable Phillips stated that he checked the mobile data terminal in the car to assess if there were any firearms registered to the person of interest. He confirmed that he had not made an enquiry as to the registration of any firearms to the address they were attending.

50. Both officers were ‘first on scene’ and were met by Mr and Mrs Sosa at a garden gate well within the property and close to the party guests.

51. A minute and a half after the arrival of SC Wymark and P/Constable Phillips, LSC Brown arrived at the scene. LSC Brown was rostered as the mobile supervisor and was required to attend domestic violence complaints to ensure that operational orders are complied with by attending police. He was the sole occupant of the fully marked police vehicle with call sign Northern Beaches 14. As the sole occupant of the vehicle, LSC Brown was unable to source information from the CAD system and was wholly reliant on the VKG broadcast. As such, LSC Brown was aware of the following:

- the complainant was 85 years of age
- the complainant had been allegedly assaulted by her son
- the assault allegation included an element of strangulation
- the person of interest was an intoxicated person
- the person of interest possibly had access to firearms

52. LSC Brown joined SC Wymark, P/Constable Phillips and Mr and Mrs Sosa at the gate on the property. All agreed that a discussion ensued about firearms, however the details vary between accounts provided in oral evidence.

53. Mrs Sosa indicated in her oral evidence that the police were speaking mainly with her husband. She recalled the police asking her, “where is he, where is the granny flat?” Mrs Sosa vaguely remembered asking the police, “Do you want to see my mother? And recalled her husband responding and saying “she’s safe”. Mrs Sosa was asked whether the police asked her about Mr Carr possessing firearms and she responded, “No. They didn’t ask me anything about that”, however she stated, “I think I heard them ask Alex, yes.” She also indicated that she thought her husband “said something like I don’t know.” Mrs Sosa recalled saying to police, “Let me go in, I think I should go in and see if I can calm him down” and they said, “No, stay back, stay back. Please stay back.”

54. Mr Sosa confirmed that he had never seen Mr Carr in possession of any firearms and had only been inside the granny flat on one occasion. He confirmed that the police had asked him about the possibility of Mr Carr possessing firearms and he responded, “I don’t know, because I didn’t know.” Mr Sosa was questioned about whether he had said “I don’t know or No, I don’t know” and he responded “Well, for my thinkings kind of the same. No. I don’t know. Same, here, you got any questions, “No I don’t know.” Or, yeah, I know – but for me is well I didn’t know, I don’t know. I didn’t know if he has any gun.”

55. Mr Sosa stated that he had asked the police if they wanted to see Mrs Carr “Because she was upset and she was shaking and she wasn’t in a good, having a good time but they say “No, let’s go and see the man.” You know and so they never asked me anything Fleur so I didn’t say anything.” He denied that he had told the police that Mrs Carr “was safe” or “that she didn’t need an ambulance or medical attention.”

56. SC Wymark accepted that the triple-0 call was suggestive of recent firearm possession and SC Wymark stated in his oral evidence that he was “Wanting to be, I guess, more alert and aware that there is a possibility of weapons or a firearm at that address.” SC Wymark recalled speaking with Mr Sosa prior to LSC Brown arriving. He stated that Mr Sosa “was still providing me with a very brief account of what had happened or at least he had been told had happened in the house.”

57. SC Wymark recalled LSC Brown asking Mr Sosa about the presence of firearms, and he stated that Mr Sosa responded, “No, not that I know of.” SC Wymark confirmed that he was aware that Mrs Sosa had made the triple-0 call and was present with her husband, however, it would appear from the evidence that she was not asked about her knowledge of any firearm at this time. SC Wymark commented that, “Given that there was nothing further that we could find in our investigation prior to even attending and entering the property, we had no further information in relation to firearms, other than this one warning.” (the VKG broadcast/CAD message).

58. SC Wymark was asked whether he considered speaking with Mrs Carr about her knowledge of the presence of firearms, and he stated, “Our intention was to go and speak with Jacob. We knew that Fleurette was inside the home and appeared safe. There was no risk posed to her at that point. Our decision was to go and speak with Jacob.”

59. P/Constable Phillips could not recall which officer asked about the firearms when they first arrived at the property and were in the company of Mr and Mrs Sosa. He did recall the male's response was "either a "no" or "I'm not sure" or "I don't know". But it wasn't a definitive yes or a definitive no, so it was along the lines of, "No, I don't know."

60. LSC Brown indicated that after he arrived and was in the company of the other two police and Mr and Mrs Sosa, "I spoke to them. I asked if the mum needed an ambulance. They said, "No". Then I asked-enquired as to whether or not there were any firearms and they said – I think I – "I don't know". I took that as a "No". LSC Brown also stated, "I made the decision that at the time, with the information given to us, that there was no firearms there."

61. LSC Brown was asked "Did you think at that point to make any further enquiry of either Ms Sosa or her husband as to why it may have been reported that he possibly did have access to firearms?" LSC Brown responded "I didn't ask that. I just asked as to, "Does he have access to firearms?"

62. Unfortunately, none of these verbal exchanges were captured by any of the three police officers on their body worn video recording devices (BWV). It would appear that the police did not ask Ms Sosa any questions relating to the possibility of Mr Carr's possession of firearms despite her earlier report to triple-0. On Ms Sosa's evidence, she had knowledge of her brother's recent possession of an inoperable antique revolver in his granny flat, however it would appear police were not informed of this as they did not question Ms Sosa and only questioned her husband.

63. The three attending police were of the view that they should attend on Mr Carr at the granny flat rather than speak with Mrs Carr and obtain a confirmation of her complaint relayed through her daughter. LSC Brown stated, "I didn't because I believe that when I asked about the mum, she was fine and with the operational orders, like we prefer to arrest the offender first. Make sure he's under control before taking out and speaking to the other witnesses and victim to get their DVECs (Domestic Violence Evidence in Chief)."

64. SC Wymark was asked whether a decision had been made at that time to arrest Mr Carr, and he responded, "I didn't form the opinion that we were to arrest him right at that point, no". Later he stated, "We needed to speak with him in order to ascertain his version of events. It could well be the case that he had not committed an offence and therefore had not – an arrest was not warranted. We needed – we were there to investigate before we make any decision to arrest." He further stated, "Essentially ask him what his involvement was with his mother and based on the information he may have given us, would determine whether or not an arrest was warranted at that point or detention in relation to an AVO. Really that's- that was the position that we'd taken." SC Wymark was asked if this had been discussed with LSC Brown and P/Constable Phillips and he responded, "I don't remember the exact discussion. There was discussion that we were to go down there, speak with him. There was the likelihood of an arrest to be made but we're there to investigate before we take such action."

65. LSC Brown and SC Wymark were asked if they would have approached the scene differently had they been able to confirm the presence of firearms and both confirmed that they would have "informed the radio and obviously spoke to our duty officer at the time, Mr Thorp, and probably would have ascertained to get out negotiators and other people like the TOU (Tactical Operations Unit) to deal with it because obviously I don't know whether or not that firearm, that pistol, was able to be used or not."

Events leading up to police entering the granny flat

66. SC Wymark's comment in his evidence about approaching the granny flat was somewhat prescient when he stated, "I didn't like the fact that it was a very dark area, very little lighting down towards the granny flat, a party going on with a bonfire, lots of music, very difficult to hear and there was an instinctive feel that I didn't – I didn't feel comfortable at that point."

67. LSC Brown and SC Wymark's unspoken plan was to engage with Mr Carr and encourage him to leave his home so they could arrest him for a domestic violence related assault.

68. SC Wymark indicated that he "assumed it to be my job so I took (the) lead in engaging with Mr Carr."

69. After they had arrived at the granny flat, P/Constable Phillips activated his body worn video (BWV) as he understood that it was a requirement under the standard operating procedures for officers wearing BWV attending domestic violence incidents. LSC Brown also activated his BWV.

70. The BWV records the following exchanges between SC Wymark and Mr Carr:

- SC Wymark asked Mr Carr to come to the door and Mr Carr replied, "No, I fucking don't, go on enter. Fuck you, fuck me dead".
- Mr Carr asked who called the police, guessing it was his mother. He then stated, "I got nothing against you coppers but I've forgiven her for years, she can get fucked".
- SC Wymark then asked him to open the door again and he responded, "I ain't opening no fucking door. It's open brother."
- He was again asked to come to the door and Mr Carr responded, "You come in".
- SC Wymark asked him, "Why?" and he stated, "Fuck it, I'll fight you motherfuckers. Let's go cunt."
- SC Wymark responded with, "We don't want to fight" and Mr Carr replied, "I'll fucking fight. Fucking, you cunt's against me. You're going to fucking, ahh fuck it"
- SC Wymark again stated, "We don't want to fight you."

71. SC Wymark stated in his oral evidence that by this time “We were verbal looping by continually asking “Come to the door””. He further stated that “By asking the same thing over and over again and getting the same response, which in this case was, basically telling us to get fucked.”

72. The BWV shows LSC Brown and P/Constable Phillips retrieve their OC spray from their appointment webbing and shake the cans in preparation for use. LSC Brown indicated that at that time “I believed it was to be a physical fight with fists but you just don’t know with a domestic. He could possibly have a knife in his back or – you know, in his back pocket or something like that.” LSC Brown recalled holding his taser and preparing his sidearm for easy access. LSC Brown confirmed that at that time he had discounted the possibility that Mr Carr was armed with a firearm.

73. SC Wymark entered the granny flat first, followed by the other two officers. As he entered the front door he could see the lounge room in front of him, a galley kitchen to his left and then a hallway further in on his left. SC Wymark could see Mr Carr further down the hallway but he was obscured by a “door or a doorway” and he was unable to see his hands and called to him to show his hands.

74. SC Wymark stated that after a number of similar commands to show his hands, LSC Brown has “lit the area up with his torch and I’ve seen what appeared to be a shotgun.” He then stated that “I took a step to my right calling upon him to drop the gun” and “I’ve drawn my firearm”. SC Wymark stated that “I saw him take a few steps forward, maybe one or two steps forward, attempting to pump the action of the shotgun.” The BWV records a “clicking sound” and then the sound of SC Wymark’s revolver being discharged.

75. In his directed interview with police, SC Wymark recalled seeing the arm holding the firearm “coming straight up” so that it was aimed at a height above the chest, neck area and he thought maybe it was pointed at LSC Brown and him and Mr Carr was going to shoot. The other two police gave similar accounts. The BWV shows Mr Carr advance to a position where the end of the shotgun barrel was in line with the point where the hallway meets the lounge room, with his left hand gripping the sliding forestock, immediately before SC Wymark discharged his pistol. The maximum distance between Mr Carr and SC Wymark appeared to be less than five metres.

76. Mr Carr fell to the ground whilst still in possession of the firearm. The police were able to secure the firearm. They were aware that Mr Carr was injured and proceeded to move him from the narrow hallway into the lounge room area and applied his belt as a torniquet around his left thigh above the wound.

77. Mr Carr indicated that there were three guns at the flat and stated, “Please, I’m about to die”. He further stated, “no more” and “just let me go mate” and “it fucken hurts you cunts”. He continued in a similar vein for some time.

78. Further police arrived and secured the crime scene; as well as assisting the original police in administering first aid to Mr Carr and applying a police issued tourniquet, in addition to the belt already in situ.

79. Constable McNeill and SC Hennessey were first to respond to the shooting broadcast. Constable McNeill recounted in his statement that Mr Carr was stating, “Just kill me man, you’re fucking pieces of shit, my fucking mother called the police, I knew she would that’s why I got the guns out, I thought fuck you cunts” and “why don’t you shoot me in the head, please man.”

80. Chief Inspector (CI) Craig Thorp arrived at the scene and assumed the role of duty officer for the now declared critical incident. CI Thorp confirmed that it was a particularly busy Saturday night for the local police, with a number of incidents occurring at around the time of the shooting. He confirmed that although his police resources were stretched, they “still met our minimum requirement though.”

81. CI Thorp was briefed at the scene by other police and proceeded to remove the three police that were involved in the shooting from the granny flat where they were still administering first aid to Mr Carr. CI Thorp confirmed that critical incident guidelines and procedures require that police involved in a shooting should be separated from other police officers. CI Thorp indicated that this procedure was a requirement to ensure that there is no collusion or contamination of evidence by, or between, police identified as being involved in a shooting.

82. CI Thorp confirmed that he had permitted the three police involved in this incident to remain together as he had inadequate staffing resources to allow each of those three officers to have a support officer allocated individually. The three police were effectively acting as each other’s support person.

83. CI Thorp indicated that he was aware that one of the involved officers had activated his body worn video during the incident and had extensive experience of working with LSC Brown and had “full faith in his integrity and his capability of ensuring that that wouldn’t occur” (that is, collude with each other).

84. CI Thorp accepted that there was a possibility that the BWV capturing the shooting may have malfunctioned or otherwise not captured the events.

85. CI Thorpe gave them a “direction for them not to talk about the incident. I said it was okay to talk about your feelings. I asked them to take some contemporaneous notes, but I had told them not to talk about the actual incident itself to each other.”

86. The three police were then directed to travel together in CI Thorpe’s police vehicle to Dee Why police station without any accompanying independent police officer. Once at Dee Why police station each of the three officers involved were separated and allocated to an independent officer.

Details of firearms used and recovered at the scene

87. Senior Constable Richard Giblin provided a statement confirming that he had attended the scene and searched the scene and secured four firearms. One of those firearms had been identified in the BWV footage as being the shotgun removed from Mr Carr’s possession. SC Giblin rendered the shotgun safe after

ejecting six live rounds from the magazine. This firearm was later identified as a 12-gauge Mossberg model 500 ATP8 pump action repeating shotgun, with a magazine which had the capacity to hold seven 12-gauge cartridges. The gun was not registered. SC Giblin also located a red coloured 12-gauge shotgun cartridge on the floor of the main bedroom between the door and the bed.

88. Detective Sergeant Matthew Schibeci attached to the Sydney Crime Scene Section provided a statement confirming that he located “on the floor in the south western corner of the living room, alongside a covered timber chair I saw a Fired Cartridge Case (FCC). I placed marker (3) alongside this FCC to indicate its location. I made an examination the Fired Cartridge Case and saw that it was a "Winchester" brand .40 S&W. I saw damage to the primer indicating that it had been struck by the firing pin of a firearm. I collected a swab from the inside of the Fired Cartridge case for Gun Shot Residue.”

89. The firearms secured by SC Giblin, together with SC Wymark’s police issued pistol were transported for examination by Senior Constable Stephen Hay attached to the Forensic Ballistics Investigation Section, Forensic Evidence and Technical Services Command. The firearms, ammunition and other weapons were identified as follows:

- One .40 Smith & Wesson calibre GLOCK Model 22 self-loading pistol, serial number P15342, (XF000794923)
- Two GLOCK detachable box magazines, (X0003B14069) and Twenty nine .40 Smith & Wesson calibre cartridges, (X0003814069)
- One .40 Smith & Wesson calibre fired cartridge case, (XF000177765)
- One impact damaged .40 calibre fired copper jacketed bullet, (XF000177769)
- One 12-gauge MOSSBERG Model 500 ATP8 pump action repeating shotgun, serial number H339663, (X0003343261)
- One .22 Long Rifle calibre ANSCHUTZ Model 1450 bolt action repeating rifle, serial number 1085029, (without bolt or magazine)
- One .22 Long Rifle calibre FABRIQUE NATIONALE self-loading rifle, serial number 110937, (X0003343264)
- One .455 Revolver Mk II calibre WEBLEY Mk VI six chamber revolver, serial number 302889, (X0003805324)
- One set of UNKNOWN manufacture nunchaku (commonly known as Kung fu fighting sticks), (X0003805323)
- One .22 rimfire rifle bolt, (X0003343262)
- One .22 Long Rifle calibre cartridge, (X0003343265)
- Seven 12-gauge cartridges, (X0003343266)
- Two .22 Long Rifle calibre cartridges, (X0003813279)
- Two 12-gauge cartridges, (X0003813281)
- Two .450 Revolver calibre cartridges, (X0003813282}

- Two .22 Short calibre cartridges, {X0003813280)
- Four .310 Cadet calibre cartridges, (X0003814070)

90. SC Hay was of the opinion that the .455 Revolver Mk II calibre Webley Mk VI six chamber revolver was not in working order due to the firing pin having been filed down.

91. SC Hay was of the opinion that the 12-gauge Mossberg model 500 ATP8 pump action repeating shotgun was in working order and was capable of propelling a projectile by means of an explosion.

92. SC Hay was also of the opinion that the .22 Long Rifle Anschutz Model 1450 bolt action repeating rifle was not in working order when received in his office due to a missing bolt. The bolt was transported separately and when fitted rendered the firearm capable of propelling a projectile by means of an explosion.

93. SC Hay was of the opinion that the .22 Long Rifle Fabrique Nationale self-loading rifle was capable of propelling a projectile by means of an explosion.

94. SC Hay was of the opinion that "The police firearm with serial number P15342 was discharged once at the scene in a southerly direction, hitting the deceased in the left leg, causing the entry and exit wound. The bullet then impacted the side of the refrigerator, ricocheting into the upright metal handle of the broom before coming to rest on the bristles of the broom head on the floor".

95. SC Hay's opinion appears to be consistent with the other physical evidence relating to SC Wymark's appointments, specifically that he was issued two 15-round magazines for his pistol. An entire magazine was recovered, together with a magazine containing 13 rounds, with an additional round being recovered from the chamber of the pistol. In addition, the BWV confirms that only one shot was successfully fired.

96. DNA analysis was undertaken in relation to the firearms in Mr Carr's possession. A mixture of DNA was detected on the trigger and other areas and Mr Carr's DNA could not be excluded from that mixture.

97. Detective Chief Inspector David Silversides was the manager of the licencing and compliance unit at the Firearms Registry at the time of the incident. The Firearms Registry has an integrated Licencing System known as ILS which records the registration of firearms and other prohibited weapons.

98. Detective Silversides confirmed that prior to 1996, the only firearm recovered from Mr Carr's flat which required registration was the Webley brand revolver. He explained that after 1996, all firearms manufactured after 1900 needed to be registered, however, prior to 1996, handguns manufactured after 1900 and prohibited long arms were the only guns requiring registration. Since 1996, all the firearms recovered from Mr Carr's flat required registration.

99. Detective Silversides confirmed that Mr Carr's father, Mr Thomas Carr had held a firearms licence between 1987 and 1994, being a shooter's licence under the earlier scheme. He was able to confirm that there has "never been any firearms registered and linked to his licence", including the Webley revolver of the shotgun that Mrs Carr stated she had purchased for her husband.

100. Detective Silversides confirmed that the Firearms Registry currently is capable of identifying and actioning information relating to deceased firearms licence holders. He stated that the registry receives a fortnightly report from Births, Deaths and Marriages NSW which is then matched with the ILS to determine if a deceased person held a firearms licence or a permit to acquire a firearm. He was able to confirm that no firearms were registered to Mr Thomas Carr at the time of his death.

Evidence of Sergeant David Lamb

101. Sergeant David Lamb is a senior operational safety instructor with Weapons and Tactics Review and Policy within the NSW Police. The branch recently changed name to become Operational Safety Training and Governance (OSTG).

102. Sergeant Lamb prepared a statement to provide an overview of the force used by the officers in this inquest. He gave evidence relating to the current tactical options available to NSW Police, starting from simple police presence through the various weapons or "force options" available such as "OC spray, batons, weaponless control, communication, taser and firearm and active armed defender tactics."

103. Sergeant Lamb confirmed that the police at Mr Carr's residence had limited "force options" available to them, due to the close proximity of Mr Carr and the Police inside Mr Carr's home. Specifically, he confirmed that both OC spray and tasers would have been seen as an unsafe and limited option.

104. Sergeant Lamb referred to a training concept known as STOPAR. The anagram stands for "Stop, Think, Observe, Plan, Act and Review". He described it as "a critical thinking model designed to assist police in relation to identifying an issue or problem and then making a plan in doing that. The tactical options model can also be seen as something similar in relation to a critical thinking model to use." He further noted that STOPAR is "designed to be like non-linear, so you don't have to follow STOPAR from, you know, like following A,B,C,D. You can go back to different aspects, depending again what's happening in front of you."

105. Sergeant Lamb confirmed that the police should make all relevant enquiries, particularly relating to firearms, before approaching a person of interest. He perceived that the police in these circumstances had exhausted the obvious options and their behaviour was consistent with the STOPAR model. He agreed with their decision that it was appropriate to attempt to arrest Mr Carr as the complaint received by Police indicated that a significant assault had been committed. He was also of the view that the officers did not need to speak with the complainant prior to the arrest, given the nature of the assault, the presence

of a large number of guests at the party and the need to locate and control Mr Carr.

106. Sergeant Lamb was of the view that the attempts at communicating with Mr Carr were resulting in "looping" and that it had become apparent that Mr Carr did not intend to present himself at the front door of his home.

107. Sergeant Lamb was asked to comment on the appropriateness of the use of force by SC Wymark and he responded by saying, "Yeah, I mean – I mean that's in accordance with our training, having a shotgun point at you and the trigger being pressed, like well within our training and practices in relation to drawing and discharging a firearm."

108. Sergeant Lamb confirmed that non-verbal communication between police officers in this type of situation was consistent with the current police training, stating "You don't want to indicate that or telegraph any sort of movements that you're going (to) do if you're going to try and effect an arrest, then that takes the advantage away from us."

Arrival of Paramedics and transportation to Royal North Shore Hospital

109. Prior to the arrival of NSW paramedics, Constable McNeill had applied a SOFTT-W tourniquet to Mr Carr's leg in addition to his belt which had been applied initially. The SOFTT-W tourniquet was standard issue to NSW Police at that time.

110. Ambulance Officers (AO) Brian Joyce and Christopher Bray responded to the call to attend an incident involving a gunshot wound to a person. Enroute, they were provided with some information including that the patient was a 67 [sic] year old male that had been shot in the leg, was bleeding heavily although a belt had been applied as a torniquet and the weapon had been secured.

111. On their arrival at the granny flat they observed Mr Carr on the floor with an amount of blood around his leg and with two belts applied to his "leg above the wound which had stemmed the flow of blood dramatically."

112. AO Joyce indicated that at that time there was no ambulance policy or procedure requiring that all improvised tourniquets were to be replaced with a NSW Ambulance (NSWA) device. He indicated that he wasn't aware if the policy had changed. AO Joyce confirmed that the torniquets issued by NSWA had been replaced since 2019. AO Joyce was shown a document titled "Haemorrhage Control Arterial Tourniquet" and was specifically directed to a reference which stated, "All improvised, eg, belt, cord, torniquets should be replaced with a NSW Ambulance issued device proximal to the initial application site and then improvised device should be removed." He confirmed that he hadn't received any training consistent with that direction.

113. AO Joyce confirmed that he placed a NSWA issued MAT tourniquet "above the wound but below the improvised tourniquets and tightened it and then ensured that there was no blood seepage. He then removed the first "improvised" tourniquet and again checked the MAT tourniquet for integrity. After reassuring

himself that there was no seepage, he removed the second "improvised" tourniquet. AO Joyce confirmed that he tightened the tourniquet to its maximum capacity and conceded that it would have caused the patient pain and discomfort. He confirmed that Mr Carr was complaining about the pressure on his leg, which was solely related to the tourniquet rather than any other pressure.

114. AO Joyce confirmed that each ambulance had two tourniquets as standard issue. He agreed that Mr Carr was agitated and "a little bit aggressive" and that handcuffs had been applied to his ankles as he was being loaded onto the spine board to be transferred over the property to the ambulance. AO Joyce confirmed that Mr Carr's arms were not restrained. He further confirmed that Mr Carr was wrapped in a space blanket to reduce hypothermia given his loss of blood. AO Joyce was asked if it was possible to apply the space blanket in such a way that the tourniquet would have been in plain view. He responded that it was possible, however, it would "reduce the effectiveness of the procedure of putting the space blanket on."

115. AO Bray confirmed that Mr Carr was verbally distressed and unco-operative. He recalled that Mr Carr was complaining about the pain in his leg and his belief that "we were holding his leg", however "it was the tourniquet he was complaining about. The pain from the pressure from the tourniquet."

116. AOs Bray and Joyce were joined by two intensive care paramedics, AO Antony Clarke and AO Dominic Sudano. On this shift, AO Sudano was the driver and AO Clarke took the lead role. Both officers confirmed that they had only been required to use a tourniquet two or three times in their lengthy paramedic experience.

117. AO Clarke assessed Mr Clarke's condition as critical with an estimated blood loss in the vicinity of two litres. He further stated that "even though he's got a tourniquet applied, I still don't know how effective that tourniquet is. Has – if he, if he's severed a femoral artery, has it retracted up in towards the pelvis and he's still bleeding above the tourniquet? Has the bullet fractured his femur, so he's still bleeding out of his femur into his thigh? So, he's a critically unwell patient." His focus was on prioritising lifesaving treatment which necessitated his urgent transfer to a tertiary hospital for blood transfusion and emergency surgery. AO Clarke confirmed that a space blanket was applied to "mitigate hypothermia coagulation as it is a pathway to dying" and he confirmed at that time there was no training or policy to ensure constant visual assessment of the tourniquet. He confirmed that the policy has now changed requiring constant observation.

118. Mr Carr was placed in the intensive care ambulance. AO Sudano was the driver of the ambulance, SC Blomfield was in the front passenger seat with LSC Gould stationed in the rear of the ambulance with AO Clarke. AOs Bray and Clarke were following closely in their ambulance.

119. AO Clark confirmed that he did not consider administering any pain killing medications such as morphine or other analgesia as "a lot of our medications are contraindicated and the patient that's hypotensive has basically no blood

volume" and the introduction of such medication could precipitate a cardiac arrest.

120. AO Clark recalls the police removing the restraints from Mr Carr's legs as they were traveling to hospital, and he noted at that time that there was "no perfusion to his legs suggesting that the tourniquet and that was intact".

121. AO Clarke recalled that just before they reached Terry Hills, "I noticed the patient's condition changed and I've immediately looked and noticed the tourniquet was loose." He noted that Mr Carr's pulse rate was dropping and his Glasgow Coma Scale reading had dropped from the maximum of 15 to 11. He called to AO Sudano to pull the ambulance over and stop.

122. AO Clarke provided the following account:

> "I lifted the blanket which was covering the patient's left leg and observed that the tourniquet appeared to be loose and more proximal as to where it was when we left the scene. I observed what appeared to be fresh blood underneath the patients left leg. Upon observing this, I believed that something had …..I applied manual pressure to the exit wound site to obstruct further haemorrhage. Officer SUDANO got into the rear of the Ambulance and commenced assisting me. Officers JOYCE and BRAY also got into to the rear of the Ambulance as well. I placed a large trauma dressing over the existing dressings and commenced wrapping it as tight as possible to try and stem the bleeding. Officer SUDANO raised the patients left leg and tied it to an IV bracket to elevate it. I believe Officer JOYCE commenced manually pumping the IV fluid to get it flowing faster to try and replace the patient's circulatory volume. One of the Police officers who was in the front of the Ambulance commenced driving and Officer BRAY followed in his Ambulance. At some point the patient stopped talking but he was still responding to verbal commands and squeezed my hand when asked. Officer SUDANO attempted to gain IV access through the left external jugular vein which was unsuccessful while I attempted to gain IV access through the right antecubital fossa which was also unsuccessful. One of the Police officers stayed in the rear of the Ambulance and was pumping the IV fluid while we worked on the patient. When we were around Chatswood, the patient's heart rate continued to drop to the point where we could no longer detect a carotid pulse. The patient was totally unresponsive to any stimulus, was extremely pale and had pulseless electrical activity".

123. AO Sudano recalled that the tourniquet was not in the same position as it was when they left the premises at Ingleside. He observed "about 500ml of blood under the patient's left leg on the exposure blanket. The blood was a liquid pool indicating a fresh haemorrhage…..I immediately noticed that the tourniquet was not in the same position as at the time of departure from the residence. It was positioned medially within his left inguinal fold/groin and externally pulled up to the level of the hip joint. The strap of the tourniquet had much less tension at the last inspection and was not embedded in the soft tissue of the thigh. There was enough slack for me to get my hand under the strap of the tourniquet. I moved the tourniquet distally down the thigh with both hands without having to

loosen the strap. I pulled tension into the strap of the tourniquet and attempted to re tension it however it was at the max position and could not be wound any further. At the time, both Officer CLARKE and I believed that it was an equipment failure and therefore the tourniquet was not reapplied as per procedure instead relying on a second pressure bandage and elevation of the limb to near vertical."

124. AOs Clarke and Sudano were of the view that Mr Carr may have manipulated the tourniquet, either accidentally or deliberately, resulting in it loosening with catastrophic consequences. AO Clarke commented that "over the following days I did test a tourniquet to see if the tourniquet could be easily manipulated and I found that it could be."

125. Inspector Carolyn Parish was the Duty Operations Manager at the Artarmon Superstation on the night of the shooting. Inspector Parish raised a number of concerns in her statement to police and in her oral evidence.

126. Ordinarily, in her capacity as the Duty Operations Manager, Inspector Parish would be contacted to attend such a significant call for assistance associated with a police shooting. Inspector Parish noted that there was a delay of around 15-20 minutes prior to her being contacted. She indicated that if there had not been a delay she would have potentially been better placed to assist paramedics on the scene and engage the Medical Retrieval Team MRT) to assist with transporting Mr Carr either by specialist ambulance or by helicopter to hospital.

127. Inspector Parish spoke to AO Clarke and Sudano after Mr Carr had been transported to hospital. Inspector Parish was requesting a briefing from the two paramedics in relation to the placement and failure of the tourniquet; as well as other details of the transportation and treatment.

128. Inspector Parish noted in her statement to police:

> "I asked if the packaging of the tourniquet was around and identified that it had been left at the scene of the shooting. I wanted the packaging because it had a batch number and expiry date on it. I intended to research the batch number and expiry date to determine whether that particular tourniquet had ever been recalled. At that time I was aware that a particular batch of tourniquets had been recalled around August, 2018, and I wanted to know whether this particular tourniquet was part of that batch or not. Inspector Parish spoke with LSC Parker and arranged for photographs to be obtained of the tourniquet's packaging.
>
> LSC Parker forwarded three photographs of the packaging to Inspector Parish who identified the tourniquet used at the scene of the shooting had batch LOT SL 107967 with an expiry of June 2022."

129. Inspector Parish also noted the following circumstances in her statement to police. "I walked into the paediatrics Resus Bay and saw the ED Specialist sitting at a computer. The ED Specialist seemed frustrated and asked me questions about the tourniquet and blood volume. It was clear to me the ED Specialist was asking questions because of the apparent lack of blood on the

stretcher on which the patient had been. I told the ED Specialist that I wasn't on scene and could not answer his questions, however, I would get the Paramedics to answer his questions.

130. Further, Inspector Parish recalled “The NUM, (Nurse Unit Manager), Ms Claire LONGO, was in Resus Bay 2 on the computer. We started talking and she said to me, “I just had a call from Toby FOGG regarding the shooting as MRU (Medical Retrieval Unit) were watching the incident unfold. He questioned me as to why they were not dispatched. He told me to put an IIMS (Incident Information Management System) in." Toby FOGG is an Emergency Physician and Retrieval Specialist at Royal North Shore Hospital.

Claire further stated something similar to, "What was Dominic doing to the patient's leg when they brought the patient into the Resus Bay? The nurse that was standing there could put her hand through the tourniquet and Dominic seemed to be fiddling around the area of where the gunshot wound and tourniquet were."

131. Inspector Parish sourced the Clinical Safety Alert 46/18 which was released in August 2018, regarding the withdrawal of First Generation MAT (Mechanical Advantage Tourniquet) tourniquets due to notification of the product breaking on two occasions when placed under tension. Inspector Parish was unable to establish if this tourniquet was captured by the alert and returned to RNS hospital.

132. Inspector Parish arranged to inspect the tourniquet and confirmed that it was a MAT Tourniquet manufactured by PYNG Medical. Inspector Parish noted that “I took three photos of the tourniquet. I conducted a physical inspection of the tourniquet and could not see anything wrong with it. I then conducted a mechanical examination of the tourniquet and found that it was mechanically sound and operated effectively. I put the buckle which is attached to the strap onto the clip and pulled it tight. It was firm and effective. The turning mechanism when tightening was firm, didn't feel loose, and appeared not to be broken inside. It made a normal audible clicking sound as I turned it. I pulled strongly at two sides of the tourniquet and the strap did not move and did not slide through the buckle. I pressed the release button and it made a normal audible click and released as per normal. There was no fraying on the strap and the material surrounding the tourniquet was blood soaked. I formed the opinion that the tourniquet was in good working order, was operating normally, was not broken or defective in any way, and should not come loose if used in accordance with normal practice”.

133. Inspector Parish subsequently received confirmation that this tourniquet was “not a tourniquet of the type related to the alert of withdrawn tourniquets.”

134. In her oral evidence, Inspector Parish confirmed that there were two ways in which the MAT tourniquet could be loosened, being a quick release buckle and another buckle for a more gradual release of pressure. Inspector Parish was asked to compare the MAT to the tourniquet which has replaced the MAT, known as the SOFT TW. Inspector Parish agreed that both types of tourniquets have similar release mechanisms, that is, “That the tension in that strap can

also be released by simply lifting up one side of that buckle". Inspector Parish indicated that the SOFT TW buckle is made of metal rather than plastic, although agreed that that related to the buckle rather than the release mechanism. Inspector Parish agreed that the difference was less about the material that both tourniquets were constructed from, as compared with the ease and ability to get a hand underneath the tab to lift the tab upwards and effect the release of the pressure of the tourniquet.

135. Inspector Parish raised her concern that both intensive care paramedics, AOs Clarke and Sudano should have travelled in the rear of the ambulance, rather than AO Clarke and the police officer. Inspector Parish accepted that NSW ambulance are fitted with two safety restraints in the rear of the ambulance and in the circumstances of Mr Carr's transportation, both officers should have been in the rear with the two police officers seated in the front of the ambulance, effectively in the driver's and front passenger seats. Inspector Parish stated "It's a gunshot wound. There's a large amount of blood loss. There – it has a high index suspicion that the patient may deteriorate, ie going into cardiac arrest. If you have one paramedic in the back of the ambulance, you can't do everything yourself. And in a normal cardiac arrest that we treat, there's always two paramedics in the back."

136. Inspector Parish noted that Mr Carr's legs were restrained with handcuffs, however, his arms were not. She perceived that restraining a patient's arms may have been more effective in providing ambulance officer safety. Inspector Parish noted that "you can't just put someone in an MRD (mechanical restraint device). You've got to schedule them as well…But certainly my thoughts would've been if this gentleman was under arrest, we've restrained his ankles, would the police- should the police be restraining the hands? That to me would be more of a risk to my paramedic's safety than the legs." Inspection Parish agreed that the restraint of his arms would be solely for paramedic safety rather than any issue with maintaining the integrity of the tourniquet.

137. Inspector Parish further noted, "It is my understanding that the patient was covered with a blanket during the extrication and transport to hospital. This would have prevented continual observation of the tourniquet and any bleeding and haemorrhage control. In my opinion, and I believe it would be accepted as common practice, a tourniquet should not be covered at any time so that the Paramedics can maintain constant visual assessment of it, so as to react to any failings of the tourniquet or interference by the patient."

Expert evidence – Professor Anthony Brown

138. Professor Anthony Brown is a professor of emergency medicine in the discipline of anaesthesiology and critical care with the school of medicine at the University of Queensland. He is an adjunct professor with the school of public health and social work at the faculty of health at Queensland University of Technology. He is a fellow of the Australasian College for emergency medicine. He is the senior staff specialist at the emergency and trauma centre with Royal Brisbane and Women's Hospital.

139. In his report, Professor Brown describes the MATR tourniquet as follows:

> "The MATR is exceedingly easy to use, designed for application in under 30 s, if necessary by using just one hand. It consists of extendable black webbing with an adjustment buckle on one end, with a spring-loaded pressure gate in the buckle that grips the webbing when closed. This buckle then engages onto the buckle hook on the end of a firm, rigid plastic 'C' shaped cuff or chassis. This chassis is covered in orange neoprene. Next to the buckle and hook device, and on top of the 'C' cuff is a folding turnkey that only rotates clockwise to tighten. Application of the MATR is simply by placing the webbing around the limb to be occluded, manually tightening the webbing after hooking onto the 'C' chassis, and final tightening the whole cuff by a series of micro adjustments of the turnkey.
>
> There are only two ways to release the MATR. One is a slow release process whereby the spring-loaded pressure gate within the buckle is held depressed, that allows the webbing to slowly slide through the gate and thus gradually release tension. It is specifically designed to *not* allow rapid release. The other way is a rapid release process whereby the labelled 'Release' button on the side of the 'C' cuff below the turnkey, and next to the buckle is pushed in or depressed. This instantly releases the locking mechanism with the turnkey quickly rotating anti-clockwise, and losing all tension on the tourniquet, which immediately becomes loose and non-occlusive. It is most unlikely that the slow release process whereby the centre of the buckle has to be held depressed could be deployed by someone who is not trained or instructed, either at all, or long enough to cause total tourniquet failure. It is more commonly used as the technique for gradual loosening of the device, and needs to be taught and practised by a first aid provider.
>
> Conversely the rapid release process whereby the Release button is pushed in can be done easily without any instruction or training, and even without intention. Once the button is pushed in, the locking mechanism instantly releases, and the tourniquet is rendered totally inoperable (ie it does not occlude the blood flow at all). The MATR then becomes loose, and would have to be taken off and reset before the device could be redeployed.
>
> The MATR has a locking mechanism that is integral to the buckle on the end of the webbing. Once the webbing has been manually tightened enough to only allow no more than 1 – 2 fingers underneath the webbing, the turnkey is then deployed clockwise that fully tightens the device by a series of fine micro adjustments. Once tight, the turnkey can be folded onto the tourniquet itself, and the turnkey cannot then be loosened even if mishandled.
>
> The buckle itself has a built in pressure gate that engages by gripping onto the webbing, to prevent any slipping or loosening of the tourniquet after it is deployed. Once tightened, the MATR will indent the skin, and will not be able to be moved at all relative to the occluded limb.

> The MATR has undergone extensive testing, and mechanical failure has been shown to be exceedingly rare, being only 4% in the first generation MAT. Those reported failures occurred prior to certain rectifications made in the second generation MATR. The new MATR device is robustly designed for use in any weather and at any temperature, underwater or in sand."

140. Professor Brown confirmed in his oral evidence that he had not used the MATR on a "critically ill exsanguinating patient." He had undertaken training in the device and commented that, "When confronted with a wound that is bleeding with ambient noise, with other people in the way, it does become a more (of a) challenge, but it is designed to be very, very easy to use. The one question that we kept asking and that is asked by everyone using it is how tight do you make it? And the simple answer is, you make it tight enough to occlude the pulse or the bleedings that you are aiming to stop."

141. Professor Brown confirmed that "there are basically three ways you can undo it. Although one we didn't do because we thought it was illogical. You can unclip the whole device but once it's on tension it's actually quite hard to do. So, the two ways that we were taught and shown is that on the strap or the webbing there is a buckle, and the buckle has a toothed latch. And if you press the latch, it is designed to allow the strap to slowly move through the buckle and slowly release tension. The other way to release the tourniquet is very rapid. And that is there is a release button which is clearly labelled as, release, and what it does is it unhooks the pulley system which is the turnkey and so the tensor in the what is called the C-cuff, basically disappears. So, there is no tension, and it is now undone, and that it very rapid. That is one – a touch of the button and the turnkey undoes anti-clockwise it in under a second, whereas the other one might take several seconds."

142. Professor Brown agreed that he was speaking about the MATR system with a quick release button, rather than the earlier model MAT where the quick release was achieved by lifting the tab on the buckle, similar to a backpack buckle.

143. Professor Brown confirmed that Mr Carr was in a "state of haemorrhagic shock. And in fact, all those findings are consistent with a shock state from blood loss. Professor Brown confirmed that "Really, the only necessity at that point was to proceed as fast as possible to the hospital having stopping [sic] the bleeding. So, the key is, stop the bleeding and then the only modality of care that will make an impact will be surgical repair of the injury to the femoral vein and artery plus replacement of blood loss…" In those circumstances, Professor Brown agreed that once the tourniquet had been applied and the bleeding staunched, the only imperative was to transport Mr Carr as quickly as possible for emergency surgery.

144. Professor Brown was asked to consider Mr Carr's request for pain relief, specifically morphine. Professor Brown confirmed that "when you are in a state of advanced shock from major blood loss, giving any form of either pain relief such as morphine or sedation, such as diazepam is extremely dangerous because it has the side effect of catastrophically dropping the blood pressure further and you can convert somebody who is – if you like – holding on in shock

to someone who goes into cardiac arrest. So, in a situation like this, it would not be safe to administer sedative or pain relief drugs."

145. At 10.50 pm, Mr Carr's pulse, respiratory rate and GCS (Glasgow Coma Scale) had all fallen. Professor Brown stated, "These are interesting vital signs because ostensibly they are in the normal range. However, they have come down from a state of haemorrhagic shock from being raised pulse and raised respiratory rate. This indicates the terminal phase of shock whereby Mr Carr was holding on in a state of advanced shock but if blood loss were to restart, which we suspect is what happened, then in fact in the terminal stage as the heart and the lungs literally stop, your pulse goes from being high to slowing down. And although a pulse of 84 is actually normal, it is seriously low for somebody in a state of shock. And likewise, although, a respiratory rate of 12 is normal, it is seriously low in someone who has a haemorrhagic shock, and the altered conscious level has gone from normal, 15, to becoming unconscious. This is literally minutes from cardiac arrest when you see this."

146. Professor Brown opined, "My impression is that the second bleed which is when the MATR came loose was a fatal bleed. It would have been possible to reapply the MATR, but I understand completely that it was absolutely reasonable to suspect it might have failed, although I believe it was undone. Having said that, the second bleed would have taken Mr Carr from possibly survivable if he'd gone to the Royal North Shore Hospital, had an operation, have a massive transfusion, to now unsurvivable shock where the second bleed you cannot estimate with any degree of accuracy that it was 500mls but that, plus the first bleed now essentially, Mr Carr had no circulation. His pulse, his respiration, his conscious level fell, and he was going to die. I don't believe – even had the MATR been reapplied, it would've changed the outcome."

147. Professor Brown was asked to comment on AO Clarke's decision not to apply a second tourniquet, but rather apply a pressure pad to stem further bleeding. Professor Brown stated, "I think absolutely that the first thing you are instinctively is to place pressure on the bleed. I think it is – as we've said – completely reasonable to mistrust or not be sure whether the MAT responder tourniquet had broken as opposed to come off. The other point is that now Mr Carr's blood pressure would have been very, very, very low and therefore, the arterial pressure leaking would've been low and in fact, direct pressure may have been all that was necessary."

148. Professor Brown commented that Mr Carr's state at that time was unsurvivable. He stated, "Mr Carr's circulation which is normally 5 litres of blood would be almost empty and therefore, he would not be circulating fresh blood to the brain and to the heart with oxygen, therefore, the brain and the heart would be starved of oxygen, and he would effectively be in a state of virtual cardiac arrest. And once you get to – what is known as irreversible or late shock then he was not going to survive."

149. In his report, Professor Brown stated:

"The importance of preventing hypothermia in patients suffering from significant blood loss and the relevance of the decision to use a space blanket on Mr Carr in such circumstances are paramount.

The reason for this is that there are three feared complications of traumatic haemorrhage known as the 'fatal triad'. These include coagulopathy, hypothermia and acidosis.

This lethal triad is intricately related to the pathophysiology of haemorrhagic shock. Not only is each factor an independent risk factor for mortality, but they inter-relate with one leading to another in a destructive positive feedback loop, that rapidly increases mortality unless treated aggressively.

Thus it is essential to reduce the chances of hypothermia, by reducing radiant heat loss using a space blanket, reducing convective heat loss by using a cotton or wool blanket, heating all fluid and blood administered, and minimising the amount of unheated intravenous fluid or blood given, and by increasing the ambient temperature if possible (most trauma resuscitation bays are heated to 28 – 30^{o}C).

Any decision to use a space blanket or woollen / cotton blanket would assist in reducing the onset of hypothermia within the lethal triad above. However, this contribution of reducing temperature loss remains minor compared to stopping the bleeding, and urgent transfer to hospital for definitive surgical repair of the femoral artery and vein in Mr Carr's case."

150. Professor Brown provided the following observations in relation to the use of a space blanket. He stated:

"The use of a space blanket in a situation such as with Mr Carr, who was suffering from acute blood loss with shock would have been considered standard and appropriate practice.

However, it should not have precluded the paramedics from observing the MATR.

According to Duty Operations Manager (Inspector) Parish, a tourniquet should not be covered at any time (by a blanket or similar), so that the Paramedics can maintain constant visual assessment (Ins C Parish).

I absolutely concur with this statement, although this level of detail of Paramedic care is outside my scope of practice."

151. Professor Brown was asked to comment on the two types of heat loss in a patient, being radiant heat loss and convective heat loss. He stated,

"Radiant heat loss is reflective heat loss, and that is effectively maintained by a shiny surface such as the space blanket which is actually not a blanket. It's like silver foil type plastic. It's got no intrinsic warmth of its own. Convective heat loss is heat loss that then goes beyond reflection, and it's the sort of traditional warm, snug blanket like a woollen or a thick blanket. So, the space blanket acts to radiate back heat loss and the woollen or thicker cotton blanket acts to provide

warmth from convective loss. And they work slightly differently. And they are ideally used together."

152. Professor Brown confirmed that no form of space blanket can achieve the minimising of radiant heat in a see-through or transparent material. He indicated that, "Clearly, the ideal is not to cover the tourniquet. You could put blankets above and below but, yes, there is no visibility through either of those types of blankets if you were to put it over the wound."

153. In his statement, Professor Brown commented that, "Any decision to use a space blanket or woollen cotton blanket would assist in reducing the onset of hypothermia within the lethal triad above. This contribution of reducing temperature loss remains minor compared to stopping the bleeding and urgent transfer to hospital for definitive surgical repair of the femoral artery and vein in Mr Carr's case." Professor Brown indicated that the hierarchy of priorities in Mr Carr's case was to stop the bleeding by applying a tourniquet and then secondly, his urgent transportation to hospital and thirdly, to reduce the onset of hypothermia.

154. Professor Brown agreed that the need to maintain a visual assessment of the tourniquet was a higher priority than the potential benefits of reducing hypothermia.

155. Professor Brown was asked to comment on the appropriateness of using physical restraints, such as medical restraint devices. He commented that using physical restraints "in someone who is in advanced shock – it's again, a difficult situation because intuitively you would not want to make them more agitated or more distressed and yet the very fact that there is a tourniquet there had made them like that. Look, I think – again, this would have been in a very difficult situation. I think the use of a restraint device would have been perfectly acceptable. Opting to have a police person at the back of the vehicle is another alternative. I again reiterate, I don't think in this situation you necessarily have front of mind that the patient is going to undo their own tourniquet." He further commented that "at no point prior to then had Mr Carr been observed attempting to interfere with the tourniquet."

156. Professor Brown was asked to comment on some of the areas of concern raised by Inspector Parish. Firstly, he was asked to comment on the delay in contacting her and the associated lost opportunity to engage with the medical retrieval team in Mr Carr's transfer to hospital. Professor Brown stated, "But again, in the heat of the moment there was absolutely nothing in the back of the ambulance that mattered other than going to hospital. Putting in a drip, waste of time. Giving fluid, waste of time. Giving drugs, waste of time. The only thing that would've made a difference is if the tourniquet hadn't been loosened but they were doing everything right which is hastening without stopping to the hospital." He further commented, "The amount of blood that a retrieval team carries, I believe is small. There is potentially a delay while you wait for them to arrive, which is a disaster."

157. Secondly, Professor Brown commented on whether or not there should have been two paramedics in the rear of the ambulance. In his report, Professor

Brown stated, “I agree with Duty Operations Manager (Inspector) Parish that two ambulance officers should have been in the back of the ambulance, *providing* this was with a guarantee of safety”. Professor Brown stated in his oral evidence, “I absolutely retract what I put. I apologise if I have misled. On reading through my report last night and today, it’s very apparent exactly what you said. There is in fact, there was no role or anybody in the back of the ambulance other than basically making sure that Mr Carr got to hospital as quick as possible. There were no drugs to give. There were no fluids that would’ve made a difference. We’ve discussed whether anybody expected him to fiddle with his tourniquet, and the answer is no, we didn’t expect that, so, I agree there was no role at all for two paramedics…”

Cause of Death

158. Dr Melissa Thompson conducted an autopsy on 20 August 2019.

159. Dr Thompson noted:

> “At autopsy, a round 9 mm entry gunshot wound was present on the anteromedial left thigh, 72 cm superior to the left heel. A 20 x 25 mm exit wound was present on the posterolateral left thigh, 67 cm superior to the left heel and was surrounded by cutaneous bruising up to 170 mm in maximal extent. The trajectory of the bullet was front to back. Superior to inferior and medial to lateral. Dissection of the wound track confirmed transaction of the femoral artery and vein.
>
> These are large vessels that carry a significant volume of blood. Injury to such vessels will lead to substantial blood loss. If the blood loss cannot be stopped, exsanguination and death will result. No other significant injuries not attributable to CPR were noted”.

160. Dr Thompson noted:

> “Toxicological analysis of postmortem femoral blood detected alcohol at a concentration of 0.150 g/100 ml. A corresponding level of 0.167 g/100 ml was detected in vitreous fluid. Mirtazapine (an antidepressant medication) was detected at a non-toxic concentration. Quetiapine (an antipsychotic medication) was detected at a low concentration. Lignocaine, an anaesthetic and antiarrhythmic agent, was detected at a low level. The provided ambulance and medical records do not indicate whether this was administered during the process of resuscitation. The benzodiazepines nordiazepam and temazepam were detected at low levels. Each of these drugs is also a metabolite of diazepam and may indicate earlier use of this substance. The codeine metabolite codeine-6-glucuronide and morphine were detected at low concentrations. Oxycodone, also an opioid, was also detected at a low concentration. Cannabinoids (delta-9-tetrahydrocannablnol and delta-9-THC acid) were detected.
>
> Based upon the reported circumstances of death, postmortem examination and ancillary investigations, I am of the opinion that the

cause of death is gunshot wound of the left thigh. This has led to blood loss significant enough to cause death (exsanguination)."

The use of the Material Advantage Tourniquet (MAT) at NSW Ambulance

161. Prior to Mr Carr's death in September 2019, NSWA were the only ambulance service in Australia still using the MAT and were in the process of reviewing the availability of alternative arterial tourniquet devices. Part of this review was due to new equipment becoming available on the market and the fact that NSWA had been using the MAT tourniquet for over ten years.

162. Additionally, NSWA had received formal IIMS (Incident Information Management System) reports of MAT device failures prior to Mr Carr's death. The failure or malfunction of medical devices within NSWA is a reportable incident.

163. In August 2018, following consultation with the supplier Teleflex Medical, all first generation MAT devices in service (green-coloured MAT) were withdrawn across NSWA and replaced with second generation MAT devices (orange-coloured MAT). Teleflex Medical agreed to replace the first generation MATS and cover the costs of replacement.

164. Reports of second generation MAT failures were reported after August 2018. For logistical reasons, NSWA experienced some difficulty in providing the failed tourniquet to the manufacturer and relied on photographs of each tourniquet for the purposes of an examination. One partial second generation MAT was retrieved from the treating team of paramedics and sent to the manufacturer for testing.

165. In May 2019, the manufacturer advised that the company would be discontinuing the supply of MATs in five months time to allow customers the opportunity to review their inventory levels. The manufacturer advised NSWA in June 2019, that their examination of the functionality of the tourniquet failed to identify a fault with the second generation MAT.

The delayed transition from the MAT to the SOFTT-W at NSW Ambulance

166. In January 2018, a brief was prepared for tabling at the Clinical Advisory Committee at NSWA. The brief considered the need to review the management of uncontrolled haemorrhage, including the use of alternative tourniquet devices, wound packing and practices.

167. In April 2018, "the Clinical Advisory Committee endorsed the request and asked that the NSWA Trauma Team review the current haemorrhage control equipment and practices and to make recommendations if it was determined that more suitable devices were available. The review was to include an analysis of the benefits, limitations and the feasibility of introducing new equipment". A document entitled "Managing Uncontrolled Haemorrhage – SOFTT-W Clinical Case for Change" was also developed to document the

recommendation to transition to the SOFTT-W tourniquet as stocks of the MAT devices were depleted.

168. The document Managing Uncontrolled Haemorrhage – SOFTT-W Clinical Case for Change stated, “The SOFFT-W works by a completely different mechanism compared to the MAT. The MAT works via a mechanical ratchet mechanism. The SOFFT-W is tightened by using a metal windlass which is directly attached to the circumferential strap. The metal windlass is secured by a composite tri ring attached to the main strap. The tri-ring secures the windlass in place to stop loosening. The tri-ring and windlass are made of robust materials that have been tested in various harsh environments within the military and proven to be reliable and effective.” The briefing document noted that, “The one limitation of the SOFTT-W that was identified was that the windlass is limited to about three or four rotations due to windlass location being close to the sewn end of the circumferential strap and width of internal band. It was identified that initial tightening of circumferential strap through friction buckle is therefore critical to performance.’

169. In September 2018, the recommendation contained in the document “Managing Uncontrolled Haemorrhage – SOFTT-W Clinical Case for Change” was endorsed by the Clinical Advisory Committee and logged with the NSWA Business Case Registry.

170. From the time of the endorsement of the clinical case for change in September 2018, until Mr Carr’s death in August 2019, little progress appears to have occurred in advancing the NSWA service’s transition to the SOFTT-W tourniquet. This was despite the fact the NSWA had received at least three reports of failures of the second generation MAT-R devices.

171. The three incidents were reported as follows:

    a. On 21 October 2018, a second generation MAT-R device failed to maintain tension when applied to a patient. Despite attempts to retighten the device, the defect persisted and another tourniquet was applied. The failed device was not retained by the treating paramedics.

    b. On 19 November 2018, a second generation MAT device snapped when being applied and was discarded in favour of a SOFFT-W device.

    c. On 17 February 2019, a MAT-R device snapped while the tensioning turnkey was being tightened. The Helicopter retrieval crew placed a second unspecified tourniquet to the patient.

172. After the report of the last incident on 17 February 2019, the Trauma Clinical Manager for NSW Ambulance, Mr Colin Deans, forwarded an email dated 22 February 2019 to Ms Michelle Shiel, Acting Director of Models of Care. In his email he referred to the fact that the Clinical Advisory Committee had previously endorsed the transition to SOFTT-W arterial tourniquets and that since the withdrawal of the first generation MAT devices, there had been three failures in six months of the second generation MAT devices.

173. In his email to Ms Shiel, Mr Deans stated:

> "We have approval to transition – there is no identified funding that would allow us to facilitate a complete withdrawal of MATs and rollout the SOFTT-W. The attempt to identify funding may delay the change even further than if we continue to even if we to progress with the transition. Could this be brought to Allan's attention as a risk/issue to see if there is anyway we may be able to have the SOFFT-W work prioritized to enable a timely transition?"

174. On the same day, Ms Shiel forwarded Mr Deans' email to Mr Allan Loudfoot, Executive Director of Clinical Systems Integration and Chair of the Clinical Advisory Committee. Ms Shiel noted in her email, "The CAC have already endorsed a new type of replacement tourniquet however the issue of funding the transition from current to new may need the profile raised."

175. Mr Loudfoot was unable to recall exactly when he first became aware of the reported failures of the second generation MAT devices, however he assumed that it would have been close in time to the lodgement of the IIMS reports. Mr Loudfoot recalled having discussions with Mr Deans about the failures of the second generation devices, including a discussion on 4 April 2019. As a result of that discussion, he asked Mr Deans to complete a risk assessment regarding the progressive transition from the MAT to the SOFTT-W devices.

176. After the 4 April 2019 meeting, Mr Deans prepared a briefing note regarding the failure of the MAT devices, including the ongoing risk of further device failures until the transition to the SOFTT-W was completed. The draft briefing note contained a Risk Assessment Form, which concluded that the failure to transition from the MAT to the SOFTT-W devices, presented as an extreme risk of death or life threatening injury occurring either monthly, or at least several times per year.

177. The risk assessment identified additional control measures, which included issuing an alert to all paramedics about the potential for MAT failures; as well as ensuring that ambulance vehicles were stocked with sphygmomanometer cuffs which can be used as a backup arterial tourniquet. However, even with the additional control measures, the risk was still identified as being a "high" risk.

178. According to NSWA policy, a risk rating identified as being "high" required the issue to be escalated to senior management with a detailed action plan identifying strategies to reduce the risk rating.

179. On 8 May 2019, there was a further reported failure of a second generation MAT device. The failure occurred when the internal mechanism broke and all pressure was lost and it could not be further tightened.

180. Mr Deans confirmed that representatives from NSWA attempted to discuss the available recourses relating to the failures, including replacements or compensation, with Teleflex. Mr Deans confirmed that no contract for supply existed and therefore compensation was an unavailable option. He further confirmed that the supplier of the SOFTT-W device was TacMed, which had no

business association with Teleflex, so a simple substitution was not an available option.

181. Shortly after Mr Carr's death a file note prepared by the Contracts and Procurement Advisory Unit, dated 27 August 2019 stated the following:

> "NSW Ambulance have been using the Material Advantage Tourniquet (MAT) through supplier Teleflex for many years without any formal contract, however there have been incidents of the product failing while in use and a discontinuation of supply has been advised by the supplier. No financial compensation from the supplier was offered or complied. Due to lack of a contract the system has failed to provide NSW Ambulance a safeguard of possible financial loss for product obsolescence/write-off due to the manufacturer decision to discontinue/fault. Clinical System Integration now proposing a transition plan to SOFTT-W arterial tourniquet through a supplier Tamed (sic) Australia. There is no noticeable procurement strategy in place for this transition."

182. Mr Loudfoot recalled asking Mr Deans to prepare an up-to-date costing on an initial rollout of SOFTT-Ws to all operational vehicles and stations. Mr Loudfoot stated that "the estimated cost for an immediate withdrawal of all MATS and replacement with the SOFTT-W was subsequently estimated at around $150,000 at the time. I did not have the budget or authority to approve that course."

183. In addition, Mr Loudfoot noted that they were also assessing the amount of time that a supplier would require to manufacture the number of devices needed across NSWA. He stated that, "From a practical point of view, we couldn't just remove all of the MATs unless there was something to replace them with."

184. Mr Loudfoot further noted that, "In or about September 2019, the process of gradually transitioning from the MAT to SOFFT-W was approved. In October 2019, the transition from the MAT to SOFTT-W was commenced."

185. Mr Deans stated that, "In October 2019, the NSWA Executive Director Clinical Systems Integration agreed to transition phase arrangements for replacement of the MAT with the SOFTT-W (ie on a one for one basis as MAT devices were used or expired, they would be replaced by a SOFTT-W). Funding had not been identified to enable a full withdrawal of MATs across NSWA. The transition from MAT to SOFTT-W on a one for one basis commenced in December 2019. The risk of further failures whilst transitioning was recorded on the NSW Ambulance Clinical Governance Risk Register."

186. Mr Dean clarified that each ambulance had two devices in the first aid kit as well as one in the car, making a total of three tourniquets per ambulance. He estimated that there were 4000 vehicles statewide, making a total of 12,000 units which required replacement. He concluded that it would take at least two years to effect the transition on a one for one basis.

187. Sometime between 14 – 18 October 2019 a Briefing Note was submitted to the Acting Chief Executive for her consideration. This was at a time that the supply

of MAT devices from Teleflex was due to cease; as well as being some weeks after Mr Carr's death. Mr Loudfoot retired from NSWA in November 2019.

188. Almost one year later, in September 2020, the NSWA Director of Clinical Governance requested a re-calculation of the costs associated with the withdrawal and replacement of the MAT devices still in service. A brief on the costing was prepared, however, funding still needed to be identified. Ultimately, no funding was identified.

189. In October 2021, a statewide Clinical Safety Notice was issued directing the removal and destruction of MATs from ambulance station stores and vehicles by 1 November 2021. Individual ambulance stations were required to bear the cost of removing, destroying and replacing the MAT with the SOFTT-W. The timing of this direction may have been purely coincidental, however, it should be noted that this matter was listed before the Coroners Court on 18-19 November 2021.

190. The evidence suggests that the reason for the failure to expedite the transition from the MAT to the SOFTT-W was a perceived lack of financial funding and an apparent unwillingness of at least one senior executive to prosecute the case for the transition.

191. Mr Loudfoot estimated that the cost for an immediate withdrawal of all MAT devices and replacing them with SOFTT-W devices was estimated to be $150,000. He stated that he did not have the financial budget available at that time, nor did he have an authority to approve such an amount.

192. The Executive Director of Finance and Corporate Services for NSWA, Mr Brian Jackson confirmed that an Executive Director such as Mr Loudfoot had a delegation to approve funding up to a limit of $200,000 provided it could be absorbed into their budget. In contrast, Mr Loudfoot contended that any amount exceeding $50,000 was still required to be submitted to the finance department even though it did not exceed his financial delegation of $200,000. He indicated that he would refer such an expenditure to the Clinical Cases for Change section, however, he noted that none of the Clinical Cases for Change cases that he had lodged previously with the business registry at NSWA were approved while he was employed at the service.

193. The experience of the Aeromedical Operations Directorate, a unit within the NSWA was somewhat different. The Aeromedical Directorate replaced the MAT devices with SOFTT-W tourniquets in 2013. At that time, the second generation MATs were not in production. Dr Coombes, the Executive Director of Aeronautical Operations, confirmed that the reason for the replacement in 2013 was twofold. The first reason related to concerns already identified with the efficacy of the first generation MATs, and secondly, that the MATs were much larger and bulkier than the SOFTT-W devices. Dr Coombes was unaware that NSWA still stocked the MAT device.

194. Dr Coombes gave evidence that her Directorate had not experienced any specific failure of a MAT device prior to their replacement in 2013. Dr Coombes indicated that the transition was as a result of the Directorate's "horizon

scanning" and hearing anecdotally of failures of the first generation MATs, as well as reports in medical media and journals.

195. Dr Coombes indicated that the level of communication between NSWA Directorates between 2012 and 2018 regarding equipment was less than satisfactory. Dr Coombes stated:

> "So we wouldn't necessarily have been aware if there was going to be a change in the wider ambulance service. We wouldn't, in aeromedical, necessarily be consulted about change that the wider ambulance service was doing, and if we change within aeromedical because our scope of practice is completely different to the scope of practice of the wider ambulance service, we wouldn't necessarily have told them every time we were changing a piece of equipment."

196. The Clinical Practice Committee was established in 2018. Dr Coombes explained that even though the Aeromedical Service adopts their own process when considering a Clinical Case for Change, that now feeds into the Clinical Practice Committee for consideration across the whole of NSWA.

197. Dr Coombes did indicate, however, that while there is a centralised incident reporting system, the Aeromedical Operations unit would not be advised of the incident unless her team had been invited to participate as part of the internal investigation team.

The Evidence of Dr Kerri Eagle, Consultant Forensic Psychiatrist

198. Dr Eagle reviewed Mr Carr's medical treatment records, including records relating to his mental health; as well as physical presentations. Dr Eagle was asked to review the available medical evidence relating to Mr Carr in order to provide a "psychiatric autopsy." Dr Eagle noted that there are limitations associated with such an assessment, including the sole reliance on third party medical records and the inability of Mr Carr to participate in the review.

    Dr Eagle also had access to the Brief of Evidence which was tendered in these proceedings; as well as the body worn video filmed at the time of the police intervention at Mr Carr's home.

199. Dr Eagle noted that Mr Carr had a "complex psychiatric presentation. His predominant difficulty appeared to be an intractable poly substance use disorder on a background of psychological vulnerabilities arising from his reported adverse childhood experience. His substance abuse and psychological vulnerabilities appeared to have resulted in emotional regulation difficulties, depressive symptoms and maladaptive personality traits. These difficulties also interfered with his interpersonal capacity and relationships, and as such were barriers to his recovery. He had multiple comorbid physical health problems that precipitated and exacerbated his depressive symptoms and emotional difficulties. His experience of chronic pain from his back and eyes further contributed to his abuse of prescribed medications, which in turn likely worsened his mood and psychological difficulties".

200. Dr Eagle provided the following professional opinion of Mr Carr's mental health in the period leading up to 17 August 2019:

> "I am of the opinion that Mr Carr displayed signs of a deteriorating mood and mental state that was adversely impacting on his social function and lifestyle in the 12 months leading up to his death. The deterioration in his mood and mental state had occurred in the context of the worsening of his eye condition, his increasing abuse of prescribed medications to cope and his associated functional decline. There is insufficient information regarding his psychiatric presentation and mental state prior to his death to determine if he was experiencing a depressive episode, as part of a major depressive disorder. The information suggests he was experiencing a general worsening of his fluctuating emotional state and function in the context of a number of ongoing stressors. His emotional state and function would likely have been exacerbated by the abuse of prescribed medications, in particular benzodiazepine class medications and pregabalin. The deterioration in Mr Carr 's emotional state occurred on a background of psychological vulnerabilities and maladaptive personality traits that made him susceptible to deteriorations in his mood".

201. Dr Eagle noted that Mr Carr had ingested both alcohol and Pregabalin on the evening of 17 August 2019. Dr Eagle was of the view that "Mr Carr's emotional state, behaviour and judgement would have been impaired by his documented level of alcohol intoxication. Alcohol would have heightened his emotional arousal, reduced his level of self control and impaired his capacity to reason. The effect pregabalin may have had on Mr Carrs' mental state is less clear. Dr Eagle noted that, "Pregabalin in toxic doses has been reported to cause somnolence (poor sleep), confusion, restlessness, agitation, depression and seizures. is difficult to know whether the medication had any specific impact on his mental state that evening over and above the alcohol intoxication."

202. Dr Eagle also considered whether Mr Carr was exhibiting signs of suicidal ideation on the evening of 17 August 2019. Dr Eagle noted that Mr Carr's lengthy discussion with Pastor Ravestyn may have "triggered traumatic childhood memories. His subsequent interaction with his mother about a minor grievance possibly provoked a heightened emotional response in the context of alcohol intoxication and reduced emotional control".

203. Dr Eagle also noted that Lyrica, also known as pregabalin, "have been associated with increased risk of suicide or suicidal behaviours. Mr Carr had a known history of suicidal ideations and suicide attempts. He had psychological vulnerabilities and maladaptive personality traits that increased his susceptibility to emotional distress and hopelessness. He also had distressing physical problems that he was finding increasingly difficult to cope with. It is more likely, in my view, that Mr Carr's suicidal thoughts fluctuated in response to his emotional state and circumstances, rather than as a direct result of a medication."

204. Dr Eagle considered whether the evidence disclosed an intention on Mr Carr's behalf to achieve "suicide by cop" or "death by police". Dr Eagle stated that,

"There does not appear to be sufficient information to reliably conclude, from a psychiatric perspective, whether or not Mr Carr intentionally pointed a gun at police in order to provoke police to shoot him to cause his death". Dr Eagle further noted that "his intention in confronting police with a gun was less clear. He did not ask them to shoot him. He did not express suicidal thoughts to police prior to entry to the unit. He said he wanted to fight police. It seems more likely he was angry and aggrieved at police presence, and confronted them with a gun to prevent them from entering the property or to provoke a confrontation."

205. Dr Eagle considered the actions of the three police that attended at Mr Carr's home. Dr Eagle commented that, "Once the officers had entered the premises and Mr Carr had confronted them with a gun, there did not appear to be a safe opportunity at that stage from a psychiatric perspective to engage in de-escalation strategies. Any opportunity to safely de-escalate the situation would need to have occurred prior to entry of the premises. Mr Carr could reasonably have been considered at risk of engaging in self harm or suicide (as suggested by SC Wymark), given his level of apparent agitation and distress in the context of alcohol intoxication. The appropriateness or otherwise of the police officers' decision to enter the premises is beyond my role or expertise."

206. Dr Eagle did note that, "The officer that spoke to Mr Carr appeared to use non-threatening language. He encouraged Mr Carr to speak to the police officers at the door. The language used appeared appropriate in the circumstances. Given his mental health background, Mr Carr was likely feeling disempowered, aggrieved and threatened in response to the police presence". Dr Eagle opined that if the police "had being aware of Mr Carr's previous emotional volatility and behaviours, his recent apparent deterioration in function and mental state, and his abuse of prescribed medications, they might have attempted to continue to communicate with Mr Carr outside the premises. The additional information would also have reasonably heightened a concern that Mr Carr was at risk of deliberate self harm."

207. Dr Eagle noted that, "Interactions with mentally disordered persons who are hostile, agitated, or displaying heightened emotional or aggressive behaviours have been found to be more effective if de-escalation strategies are able to be utilised. De-escalation strategies are more successful when communication with the person is conducted in a respectful, empathic, calm and controlled manner (rather than yelling, commanding or shouting). Other factors such as embracing reciprocity, authenticity, simple and direct instructions, and fostering choice by providing options has been shown to improve outcomes. Non-therapeutic communication styles in response to aggression, for instance characterised by inflexible adherence, or authority, disengagement and use of physical means to gain control, have been associated with negative outcomes."

208. Dr Eagle commented that, "I think that the officers all remained very composed and they didn't raise their voices, they didn't appear hostile or aggressive. They attempted to encourage Mr Carr to communicate with them. They gave him some options to come to the door, for instance. I thought Mr Carr was very angry and sounded very emotionally aroused, which was, you know, his level anger and I think that in that short period of time he - his level of anger just hadn't reduced." Dr Eagle further stated that, "As long as you can remain

composed and things are safe then emotional arousal will naturally decline. So if a person is very angry and aroused it takes a lot of physical exertion to maintain that level of emotional arousal, and it will naturally decline. That's a physiological fact. So the body will naturally not be able to maintain it and it will start to come down and then you may find that the person hears you and, and rival to make some more headway. It's very difficult to do that in a scenario where you're feeling urgency or under threat, obviously."

209. Dr Eagle acknowledged that there is no defined period of time within which that process may occur and was largely dependent on the circumstances, the perception of risk in terms of what may be happening with the person or other people who may be in danger or any other priorities.

210. Dr Eagle noted that in terms of de-escalation strategies, there are a number of potential benefits in being able to physically see the person of interest. This may include developing a rapport through eye contact; as well as physically being present in the room so that the person can respond to body language cues and the tone of voice. It can also assist in gauging what risks there may be.

CONSIDERATION

211. Mr Carr's cause of death was as a direct result of a gunshot wound to his left thigh.

212. It is clear from the evidence that the gunshot wound to Mr Carr was sustained during a confrontation with police inside his home.

213. Police had attended his home in response to a complaint received from his family that he had seriously assaulted his mother. Police made enquiries as to the possible presence of firearms in Mr Carr's possession through the Police CAD system, which indicated that there were no firearms registered to Mr Carr.

214. The gunshot wound was occasioned by SC Wymark discharging his police issued Glock .40 calibre firearm at Mr Carr at 9.54 pm on 17 August 2019.

215. At the time that SC Wymark shot Mr Carr, Mr Carr was not only in possession of a loaded shotgun but he had also attempted to shoot at SC Wymark at very close range. The distance between the two men has been estimated to be no greater than five metres.

216. The incident was captured on body worn video (BWV) and depicts the three police calmly entering Mr Carr's home after a period of attempted negotiation with Mr Carr, albeit with OC spray and tasers readied. Mr Carr was clearly belligerent and combative in his exchanges with the police at this time. Mr Carr was obscured from view down a darkened hallway and police were unable to see his hands clearly. The BWV highlights the very short period of time between SC Wymark seeing the barrel of the shotgun being pointed at him, hearing the click of the rifle as Mr Carr attempted to discharge his firearm and SC Wymark's decision to shoot Mr Carr.

217. SC Wymark's action in response to Mr Carr's deliberate decision to discharge his firearm was both lawful and necessary in the circumstances. At that time, Mr Carr's intention was either to kill the police or alternatively, he was recklessly indifferent as to the consequences of his decision to discharge his firearm at the police. Indeed, given how confined the space was within Mr Carr's home, it was a real possibility that not only SC Wymark could have been shot, but that the other two police that had entered with him could also have been shot.

218. The evidence establishes that SC Wymark discharged his firearm in the course of his duties as a police officer. He discharged his firearm as a direct response to the immediate and real threat posed by Mr Carr's actions and in the defence of himself and the two other police officers.

219. The BWV captured the split-second decision-making forced on SC Wymark by Mr Carr's actions. SC Wymark's response was an appropriate, necessary and lawful response in the circumstances.

220. The evidence confirms that the police then immediately rendered appropriate first aid until the paramedics arrived on scene.

221. CI Thorp arrived at the scene at 10.04 pm. He directed the three police involved in the shooting to remove themselves from any further involvement in the incident and directed them to remain together, unsupervised. He directed the three officers to refrain from discussing the events, however, indicated that there was nothing wrong with them discussing their feelings with each other.

222. Due to staffing constraints, CI Thorp then directed the three officers to drive to Dee Why Police station unsupervised by another independent police officer. This was a clear breach of his responsibilities under the Critical Incident Guidelines and Checklist as the responsible Duty Officer.

223. CI Thorp based his decision on the fact that he had a lack of human resources at his disposal that night, that the incident was caught on BWV and he noted his experience of the integrity of one of the officers. He was clearly concerned about the welfare of each of his officers. Whilst it is true that this incident was successfully captured on BWV, it is not always the case that the video is successfully downloaded and available for scrutiny.

224. The circumstances of the evening placed CI Thorp in an invidious position, however it is crucial that the Critical Incident Guidelines and Checklist are adhered to in practice. There is no compelling reason why one or more of the officers could not have been directed to activate their BWV during the trip back to Dee Why Police station.

225. In these circumstances, the use of BWV has been crucial to determining a number of issues that have arisen in this inquest. Not only does BWV provide an evidentiary basis for determining culpability, it also provides a real time appraisal of the circumstances surrounding split second actions and decision making. It would have assisted this inquest greatly if the BWV had been activated at the time the police had been speaking with Mr and Ms Sosa.

226. The inquest has also focused on the adequacy of the immediate care that NSWA paramedics provided to Mr Carr.

227. It was tragically ironic that one of the two tourniquets applied to Mr Carr's leg prior to the attendance of paramedics was a SOFTT-W device issued to NSW Police. This device was then removed and replaced with a MAT tourniquet.

228. It became clear during this hearing that in order to enhance Mr Carr's chances of survival a hierarchy of priorities needed to be adopted. The first priority was to stop the bleeding from his wound with an effective tourniquet, secondly, to urgently transfer him to a hospital for blood transfusions and surgery and thirdly, to reduce the onset of hypothermia.

229. The evidence is clear that owing to his initial blood loss at the scene of the shooting, Mr Carr could not afford any further blood loss. As such, the integrity of the tourniquet was crucial. Professor Brown was of the view that while it is important to reduce the onset of hypothermia, it is crucial to ensure that the patient has no further loss of blood. As such, it is clear that the paramedics should have left the tourniquet exposed for visual verification.

230. The care provided by the paramedics appears to have been appropriate.

231. The failure of the tourniquet was catastrophic. It remains unclear how the tourniquet lost pressure. Mr Carr was described as being in pain from his wound, and this pain which was exacerbated by the application of the tourniquet. His right hand was being held continually by SC Gould in the rear of the ambulance, while his left hand was covered by the space blanket. AO Clarke stated that when Mr Carr's GCS reading dropped to 11, he asked Mr Carr to squeeze his hand to indicate that his level of consciousness, and Mr Carr complied. It is assumed that AO Clarke was referring to Mr Carr's left hand, although it is unclear.

232. There appear to be at least five possible scenarios which may explain the failure of the tourniquet.

    i. The first scenario is that Mr Carr has attempted to reduce the pain he was experiencing and rather than loosening the device has accidentally activated the quick release buckle.
    ii. The second possibility is that he has deliberately activated the buckle to relieve the pressure and associated pain.
    iii. The third, is similar to two above, but was done as an attempt to self-harm. Dr Eagle perceived that this was a less likely explanation given the known circumstances.
    iv. The fourth possibility is that the device simply failed. This appears to be less likely given the evidence of Inspector Parish, but cannot be completely discounted.
    v. The fifth explanation is that some other unidentified factor was at play.

    Ultimately, the evidence is equivocal as to how the tourniquet failed.

233. It is of significant concern that NSWA were aware of reports of the failures of the second generation MATs prior to Mr Carr's death, however there did not appear to be an urgency to prosecute a transition from the MAT devices to the SOFTT-W devices by some in senior management.

234. Mr Loudfoot had the authority to approve the transition. His evidence was unhelpful and at times evasive as to his ability to fund the transition. It is clear that the total purchase price could have been actioned from within his budget allocation, although it was unclear from his evidence why he departed from the recommendation prepared by Mr Deans for a complete replacement of stock to a gradual transition on a one for one basis. More confounding, however, was the delay associated with the process, particularly when it was very clear that the risk assessment had been estimated as "high" and remained high for over two years.

235. In addition, the evidence suggested that at the time of Mr Carr's death, various Directorates within NSWA were failing to adequately communicate with each other, particularly in relation to the monitoring of the efficacy of equipment and equipment failures. Indeed, the impression given was that each Directorate operated in a silo from the others. This may have impacted on the urgency or lack of urgency to prosecute the case for the wholesale replacement of the MAT devices to reduce the h`igh-risk assessment and associated danger to the public.

Recommendations

236. Counsel assisting has submitted that two recommendations should be considered pursuant to section 82 of the Act. Section 82 permits a Coroner to make recommendations which are necessary or desirable in relation to the death of a person the subject of an inquest.

237. The first recommendation is directed to the NSW Commissioner of Police, as follows, that:

> "Consideration be given to amending the Critical Incident Guidelines to provide instruction that where a Duty Officer is presented with immediate resourcing constraints that would prevent the separation of involved officers in strict compliance with the terms of the Critical Incident Guidelines, the Duty Officer should consider what alternative means may be available to meet the intent of the guidelines to ensure the integrity of the involved officers subsequent evidence, for example by ensuring any body worn cameras worn by the officers or relevant in-car-video are kept operational and recording until they are able to be properly separated in accordance with the Guidelines".

238. Counsel representing the Commissioner of Police, submits that the proposed recommendation is unnecessary. It is submitted that CI Thorp's "attention to the welfare of the directly involved officers was admirable." The Commissioner accepts that he did not comply with the Duty Officer Checklist, however it is submitted that officer welfare requires that an officer in these circumstances is

not left isolated. It is further submitted that the BWV Standard Operating Procedures indirectly contemplate the use of BWV in these circumstances.

239. Counsel representing the Commissioner of Police submits that "It follows that the recommendation is not needed. However, the NSWPF would be open to considering providing training in relation to pragmatic options that may be used in situations where a critical incident occurs at a remote location and there are limited resources available for the purpose of separating officers and assigning a supervisor.

It is contemplated that such training would:

a. Specifically address how to manage officer welfare and simultaneously ensure that the cross contamination of evidence does not occur; and

b. Recommend that Inspectors on Duty (being Duty Officers or their equivalent in regional areas: District Inspectors or Officers-in-Charge) explain the lack of resourcing to directly involved officers and request that the officers turn on their BWV so they:

   i) are protected from any allegations of cross contamination of evidence; and

   ii) Have a record/evidence of their accountability in relation to the direction not to discuss the critical incident."

240. Counsel representing CI Thorp supported the recommendation, although submitted that Counsel Assisting's assertion that CI Thorp's "decision to not separate the officers and to allow them to return to Dee Why Police station together unsupervised was based on considerations of the officer's welfare, it was not, in the circumstances, justifiable." Counsel representing CI Thorp submitted that he was an "honest and reliable witness. Further, he was open to and made appropriate concessions (e.g. acknowledging body worn video as a useful tool in the circumstances). He gave evidence of the extenuating circumstances he faced. The Chief Inspector's evidence and position was that the extenuating circumstances of resource availability, competing operational priorities and tyranny of distance were, it is submitted, sufficient to justify his decision."

241. It is accepted that CI Thorp presented as a reliable and co-operative witness. It is accepted that he was motivated by the interests of his officers who had just been exposed to a frightening and tragic event, which would not doubt have the potential to have long lasting traumatic and emotional consequences. The reasoning behind CI Thorp's decision to depart from complying with the Critical Incident Guidelines was clear, however, he is still required to attempt to achieve the intention of the Guidelines. It is accepted, however, that CI Thorp was placed in an invidious position.

242. The Court welcomes the NSW Police Commissioner's suggestion for further training as outlined above. It is such a vital consideration that NSW Police are supported and encouraged to comply with Standard Operating Procedures and Critical Incident Guidelines to protect both Police Officers and the public. The proposed Recommendation is not intended to be perceived as a criticism, but

rather a constructive guideline or tool, to ensure that alternative options are defined for future compliance and guidance.

243. The second recommendation is directed to NSW Ambulance, as follows:

> "Consideration be given to improving Incident Reporting concerning any equipment failures to ensure they are communicated to a specified person within each directorate using the particular equipment who has responsibility for the monitoring of the continued efficacy of the directorate's equipment."

244. Counsel representing the NSWA submitted that the lack of financial resources confronting NSW Ambulance was not simply "perceived" but was an actual lack of financial resources. In that regard, he referred to the evidence of Mr Brian Jackson, Executive Director, Finance and Corporate Services, where he stated that the service was forecasting a budget blow out of $28,000,000 by 30 June 2020.

245. Counsel appearing for NSWA submits that there should be no criticism of either the attending paramedics or the executive arm of NSWA. In addition, he indicates that NSWA do not oppose the making of the proposed recommendation.

CONCLUSIONS

246 Mr Jacob Carr had a long history of significant and debilitating pain associated with his chronic eye condition and physical ailments. He had an entrenched dependence on prescribed and illicit drugs, although he had previously exhibited a commitment to addressing his dependence. Mr Carr had a complex psychological presentation, which was exacerbated by his consumption of drugs and alcohol.

247 The post-mortem report indicated that Mr Carr had a significant blood alcohol content in his system (even allowing for post-mortem changes); as well as prescribed and illicit substances. These must have had an impact on his ability to make rational decisions immediately prior to the arrival of police.

248 There is an available inference that these conditions and intoxication contributed to Mr Carr's decision to arm himself with a shotgun after he believed that his family would contact the police.

249 It is clear that his family are not to blame for the unfolding events on the night that they called police. The photographs taken by Mr Sosa of Mrs Carr's injuries provide a graphic depiction of the physical consequences of domestic violence.

250 Mr Sosa was rightly concerned by the violence meted out by Mr Carr on his elderly mother-in-law, and it is important that men in our society recognise and "call out" other men for such abuse. Ms Sosa was also placed in an invidious

position when she made the decision to report the assault on her mother by her brother. These were both brave and appropriate decisions.

251 SC Wymark should be commended for his conduct. He acted professionally and appropriately prior to entering Mr Carr's home. There is little doubt, that being confronted at close range with a shotgun is an experience which would have the real potential to traumatise a person. To have to respond to that threat with lethal force must have long-term and significant consequences. SC Wymark's response was an appropriate, necessary and lawful response.

252 Mr Carr died from a single gunshot wound inflicted by a police officer acting in the course of his duties during an altercation at this home at 167 Mona Vale Road, Ingleside on 17 August 2019.

253 The COVID-19 pandemic has focused our attention on the importance of appropriately resourced and funded public health. It is a matter of public safety that the most reliable and efficient medical equipment is available to paramedics "at the coal-face".

254 I would like to record my gratitude to counsel assisting, Mr Robert Ranken, and his instructing solicitors, Ms Amber Boatman and Ms Leah Burgoyne for their assistance, their commitment, and their untiring efforts to prepare and present this complex case.

255 I would also like to acknowledge and thank the Officer in Charge of the investigation, Detective Chief Inspector Joseph Doueihi.

256 Finally, I would like to again record my most sincere condolences to Mr Carr's family. His family have been constant in their commitment to these proceedings, despite the length of time and the attendant uncertainty.

FINDINGS

246. I make the following findings pursuant to Section 81 of the *Coroners Act 2009* (NSW):

The identity of the deceased

The person who died was Jacob Daniel Carr

Date of death

He died on 17 August 2019

Place of death

Royal North Shore Hospital, St Leonards

Cause of death

Gunshot Wound to the leg

Manner of death

Misadventure

RECOMMENDATIONS

I make the following recommendations:

258 To the NSW Commissioner of Police that:

> "Consideration be given to amending the Critical Incident Guidelines to provide instruction that where a Duty Officer is presented with immediate resourcing constraints that would prevent the separation of involved officers in strict compliance with the terms of the Critical Incident Guidelines, the Duty Officer should consider what alternative means may be available to meet the intent of the guidelines to ensure the integrity of the involved officers subsequent evidence, for example by ensuring any body worn cameras worn by the officers or relevant in-car-video are kept operational and recording until they are able to be properly separated in accordance with the Guidelines".

259 To NSW Ambulance that:

> "Consideration be given to improving Incident Reporting concerning any equipment failures to ensure they are communicated to a specified person within each directorate using the particular equipment who has responsibility for the monitoring of the continued efficacy of the directorate's equipment."

260 I close this inquest.

Magistrate Joan Baptie

Deputy State Coroner

30 November 2023