CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Brett Furner
Hearing dates:	25 June 2024
Date of Findings:	25 June 2024
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in New South Wales Police Force custody, cause and manner of death, medical assessment of person in custody, charge room and custody management standard operating procedures
File number:	2023/74097
Representation:	Mr T Hammond, Counsel Assisting, instructed by Ms C Potocki (Crown Solicitor's Office)
Findings:	Brett Furner died on 5 March 2023 at Goulburn Base Hospital, Goulburn NSW 2580. The cause of Mr Furner's death was acute myocardial infarction due to coronary artery atherosclerotic disease. Mr Furner died of natural causes whilst in the lawful custody of the New South Wales Police Force.
Non-publication orders:	See Appendix A

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1. Introduction

1.1 On 5 March 2023, Brett Furner, a 54-year-old man, was arrested by NSW Police Force (**NSWPF**) officers in relation to an alleged property offence. After being taken into NSWPF custody, Mr Furner was conveyed to Goulburn police station. During the process of entering Mr Furner into custody, NSWPF officers present noticed that Mr Furner was rubbing his chest and displaying other symptoms consistent with suffering an acute myocardial infarction, commonly known as a heart attack.

1.2 Emergency medical services were contacted but Mr Furner suddenly collapsed and became unresponsive. Resuscitation efforts were commenced by the NSWPF officers present. After NSW Ambulance (**NSWA**) paramedics arrived at the scene a short time later, Mr Furner was taken to hospital where resuscitation efforts continued. However, Mr Furner could not be revived and was later tragically pronounced life extinct.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is arrested in relation to an alleged criminal offence they can be lawfully detained in the custody of the NSWPF. By depriving that person of their liberty, the NSWPF assumes responsibility for the care of that person as the person is unable to, for example, independently take steps to seek medical assistance. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that NSWPF officers have exercised the lawful powers available to them in a reasonable and appropriate way.

2.3 Two things should be noted at the outset. First, section 23 of the Act also makes an inquest mandatory in circumstances where a person has died as a result of police operations. Whilst the arrest of a person and their detainment in lawful custody is regarded as a NSWPF operation, there is no evidence that Mr Furner died as a result of such a NSWPF operation on 5 March 2023. Second, there is no suggestion that any NSWPF officer involved in this matter exercised the lawful powers available to them in anything other than a reasonable and appropriate away.

2.4 Separate from the above, it should also be recognised that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Mr Furner's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Mr Furner was born in 1968 and grew up in the Goulburn area. After becoming an apprentice plumber, Mr Furner later moved to Coolamon. In January 1989, Mr Furner met Julie Lawton-Gallard during a bus trip to a Christian youth convention in Perth. They formed a relationship and maintained a long distance relationship for a period of time, with Mr Furner in Coolamon and Julie in Crookwell, although they frequently travelled back and forth to see each other. Mr Furner and Julie later married in September 1993 with Julie moving to Coolamon.

3.3 After starting his own plumbing business, Mr Furner was involved in a serious car accident in June 1994. He sustained a significant back injury and a child died as a result of the accident. Criminal proceedings followed but were later discontinued. Overall, the incident was extremely traumatic for Mr Furner and according to Julie, he never recovered emotionally from it.

3.4 In 1995, Mr Furner began studying to become a minister with the Uniting Church after his back injury prevented him from returning to plumbing work. Mr Furner began an arts degree majoring in English literature, and he and Julie later moved to Wagga Wagga in around March 1995.

3.5 Mr Furner and Julie had their first child, Harrison, in April 1996. Their second child, Teagan, was born in February 1998. When Teagan was about nine moths old, the family moved to Galston so that Mr Furner could attend theological college. In May 1999, Mr Furner and Julie's third child, Callum, was born, followed by the birth of their fourth child, Chloe, in August 2000.

3.6 It was around this time that Mr Furner and Julie sought marriage counselling. This improved their relationship for a time but things became more challenging after the counselling stopped.

3.7 In 2001, Mr Furner completed his studies and became a minister of the Uniting Church. In January 2002, the family moved to Cobar where Mr Furner served as a minister for the local and wider community.

3.8 Sadly, Mr Furner later encountered a number of challenges in his later life which took their toll on his marriage, his relationship with his children, and his physical and mental health. By June 2006, Mr Furner's relationship with Julie had effectively come to an end. They later divorced and Julie and the children moved away to a different property.

3.9 From this point forward, Mr Furner only had limited communication with Julie and his children. He sent his children text messages on their birthdays and expressed his love for them but, sadly, otherwise had little to no contact with them.

4. Mr Furner's medical history

4.1 After moving to Cobar, Mr Furner's mental health deteriorated. He was diagnosed with depression and prescribed medication. After Mr Furner and his family later moved to southwest Sydney in 2005, his mental health declined further, resulting in him becoming easily angered and displaying delusional behaviour. After consulting a psychologist, Mr Furner was diagnosed with bipolar disorder and delusional disorder, and prescribed additional medication. Although the medication was of assistance, Mr Furner reportedly later became non-compliant with it and resorted to alcohol use to self-medicate. At the same time, the relationship between Mr Furner and Julie also deteriorated.

4.2 In 2006, the family moved to a farm outside of Goulburn. At this time, Mr Furner was drinking and smoking excessively, and had gained a significant amount of weight. By June 2006, Mr Furner and Julie's relationship had broken down. In January 2007, Julie and the children moved to a different residence in Goulburn. By 2010, Mr Furner had lost contact with his children, and he and Julie had only minimal contact via text messages.

4.3 Between 2015 and 2017, Mr Furner received treatment for issues relating to his mental health and alcohol misuse. He showed increased paranoid and delusional behaviour and was placed on a mental health plan following consultation with a psychiatrist.

4.4 In July 2016, Mr Furner was admitted to hospital on a background of alcohol withdrawal and mood fluctuation. On another occasion in January 2017, Mr Furner was taken to hospital after being struck by a vehicle whilst attempting to cross the road when intoxicated. The following month, Mr Furner completed a detoxification program.

4.5 In June 2019, Mr Furner was again admitted to hospital after presenting with chest pain. He was diagnosed with a triple vessel coronary artery disease and severe left ventricular dysfunction. Coronary artery stents were inserted and Mr Furner was prescribed medication to prevent blood clotting. Over the subsequent years, Mr Furner was admitted to hospital on several occasions for management of bipolar disorder, hypertension, acute alcohol detoxification, alcohol withdrawal, worsening paranoia, and non-compliance with his medication regime.

4.6 On 21 January 2023, Mr Furner was admitted to Goulburn Base Hospital, where he was found to have elevated blood pressure and abnormal liver function likely secondary to alcohol intake.

4.7 On 22 February 2023, Mr Furner presented to the emergency department at Goulburn Base Hospital with chest pain radiating into his neck and down his left arm. An electrocardiogram showed a myocardial infarction and investigations revealed critical stenosis of the left anterior descending coronary artery. Mr Furner was transferred to Canberra Hospital and underwent surgery to replace his coronary stenting, before later being discharged on 26 February 2023.

5. Events preceding 5 March 2023

5.1 Christine Packwood had previously met Mr Furner at an inpatient psychiatric facility in Goulburn and become friends with him. On 26 February 2023, following his discharge from hospital, Mr Furner

attended Ms Packwood's home in Goulburn. Earlier in the year, Mr Furner had been experiencing difficulties maintaining daily activities of living. The living conditions in his home were poor and unhygienic, the home itself was unkempt and without electricity and Mr Furner depended on his children to bring him groceries and to check in on him.

5.2 Ms Packwood allowed Mr Furner to have a shower and stay the night at her home. However, following an incident the next day, Ms Packwood told Mr Furner to leave and he did so. After this, according to Ms Packwood, Mr Furner began to harass her by repeatedly calling her and sending her text messages. Ms Packwood told Mr Furner not to come to her home.

5.3 At around 1:00am on 5 March 2023, Ms Packwood was at home in bed with her partner when she woke and reportedly saw Mr Furner standing in the bedroom. Mr Furner fled and ran out of the home. After inspecting the premises, Ms Packwood noticed that a fly screen had been removed from the lounge room window which was opened. Ms Packwood was also unable to locate her Samsung mobile phone, whilst Ms Packwood's partner found that some cash and identification cards were missing. At around 2:30am, Ms Packwood and her partner reported the incident to Goulburn police station.

5.4 Plain Clothes Senior Constable Peter Rajko and Detective Senior Constable Michael Egan were tasked to investigate Ms Packwood's complaint. After attending Ms Packwood's home later in the morning on 5 March 2023 to speak with her and her partner, Plain Clothes Senior Constable Rajko learned from Ms Packwood that Mr Furner had suffered a heart attack the previous week and had been taken to Canberra Hospital where he had a coronary stent inserted.

5.5 After leaving Ms Packwood's home, Detective Senior Constable Egan decided to attend Mr Furner's house to attempt to locate him. The police officers knocked on the door a number of times but were unable to raise Mr Furner.

6. The events of 5 March 2023

6.1 At around 11:49am, having just left Mr Furner's house, Plain Clothes Senior Constable Rajko and Detective Senior Constable Egan were patrolling Mundy Street in Goulburn, near the intersection of Auburn Street, when they saw Mr Furner walking on the footpath. The police officers approached Mr Furner and introduced themselves, indicating that they wanted to speak with him regarding the alleged incident at Ms Packwood's home earlier that morning.

Mr Furner's arrest

6.2 Mr Furner denied any knowledge of the incident and was cooperative with police at all times. During his interaction with police, Mr Furner showed no signs of physical distress or ill-health. Plain Clothes Senior Constable Rajko noticed that Mr Furner smelt of alcohol but did not consider that there was any "*obvious sign that he was an unhealthy person*". Overall, Plain Clothes Senior Constable Rajko did not observe anything about Mr Furner's appearance or demeanour which raised any concerns in his mind about Mr Furner's health. At the end of the interaction, police place Mr Furner under arrest and told him that he would be taken to Goulburn police station. The interaction was recorded on

NSWPF Body Worn Video (**BWV**) footage captured by a camera activated by Plain Clothes Senior Constable Rajko.

6.3 Plain Clothes Senior Constable Rajko contacted two other police officers, Constable Matthew Fahy and Probationary Constable Mitchell Smith, to request that they attend is location to assist in taking Mr Furner to Goulburn police station. Whilst waiting for these police officers to arrive, Mr Furner was observed to be in a positive mood, smoking and laughing and making jokes with Detective Senior Constable Egan. Overall, Mr Furner's interaction with Plain Clothes Senior Constable Rajko and Detective Senior Constable Egan lasted about 21 minutes and Mr Furner smoked about three cigarettes during this time. At no stage did Mr Furner indicate to the NSWPF officers present that he was unwell in any way.

Transfer to Goulburn police station

6.4 A NSWPF caged vehicle arrived on the scene a short time later. Mr Furner climbed into the back of the vehicle unassisted, and without any apparent difficulties. Constable Fahy observed that Mr Furner was "*moving freely of his own accord*", and his "*cognitive ability seemed fine*" and his "*fine motor skills seemed fine*". Probationary Constable Smith described the process of Mr Furner entering the police vehicle in this way:

> He was almost willing to get into the truck. Um, he just seemed relaxed about it. He didn't really seem like he was too fussed. He was actually one of the more compliant. So, normally, when we convey people, um, they'll be a bit snarky , or they'll , they say they want to get , won't want to get in the truck. He finish, finished his cigarette and walked over of his own accord . He got into the truck by himself, he didn't need any assistance. It was fine.

6.5 During the approximately five minute trip to Goulburn police station, Constable Fahy observed that Mr Furner was sitting quietly and upright, and that he showed no signs of any distress.

Events at Goulburn police station

6.6 Mr Furner arrived at Goulburn police station at around 12:13pm. He was removed from the back of the NSWPF vehicle and walked into the charge room by Probationary Constable Smith without any need for assistance. A CCTV camera in the police station captured Mr Furner to display no signs of any ill-health. After being seated in a dock, Mr Furner removed some property items and handed them to Probationary Constable Smith.

6.7 Plain Clothes Senior Constable Rajko and Detective Senior Constable Egan entered the charge room at around 12:18pm and began speaking with Mr Furner about the prospect of searching his home, either with his consent or with a search warrant. Mr Furner reportedly indicated that he was willing to give his consent if he was able to attend with the NSWPF officers and have a cigarette (after being told that he could not smoke inside the police station). During this interaction, Detective Senior Constable Egan observed that Mr Furner was rubbing his chest and asked if he wanted a blanket. Mr Furner declined and said that he was feeling hot before starting to take some slow, deep breaths. Detective Senior Constable Egan told Mr Furner to not stress and relax and that he would be given some water. Mr Furner appeared to calm down following this. Detective Senior Constable Egan and

Plain Clothes Senior Constable Rajko commenced the process of booking Mr Furner into custody but this took longer than usual due to a technical issue with the computer in the charge room.

6.8 At this time, Senior Constable Matthew Blackburn, the Acting Custody Manager, entered the charge room, approached Mr Furner and spoke briefly with him before going to use the computer. Approximately two minutes later, Senior Constable Blackburn noticed that Mr Furner was rubbing his chest with his left hand. Senior Constable Blackburn attempted to enquire about Mr Furner's welfare but Mr Furner was non-responsive. Senior Constable Blackburn asked Mr Furner if he wanted some water and after Mr Furner indicated that he did, Senior Constable Blackburn obtained a cup of water for him.

6.9 Mr Furner drank the water and Senior Constable Blackburn attempted again to ask Mr Furner what was going on but Mr Furner again did not answer and asked for another half a cup of water. Senior Constable Blackburn obliged and when he returned with a second cup of water he noticed that Mr Furner was rubbing his chest again and appeared to be hot and sweaty. This made Senior Constable Blackburn concerned and he asked Plain Clothes Senior Constable Rajko and Detective Senior Constable Egan whether Mr Furner had complained about any similar issues earlier. The two police officers said that Mr Furner had not.

6.10 As part of the booking process, Senior Constable Blackburn had at some stage earlier asked Mr Furner a number of questions about his medical history. From Mr Furner's answers, Senior Constable Blackburn learned that Mr Furner had a recent heart attack and had been treated at Canberra Hospital on 23 February 2023 (but not that he had coronary stents inserted), the name of Mr Furner's general practitioner, and that he had been prescribed heart (and other) medication. When this was mentioned, Detective Senior Constable Egan asked Mr Furner if he could go to his home to collect his medication but Mr Furner said that he did not have any at home because he had not filled is prescription. Senior Constable Blackburn considered Mr Furner's behaviour in rubbing his chest to be concerning and rang Triple Zero at 12:47pm. In a later recorded interview, Senior Constable Blackburn explained his reasoning in this way:

> It was just the rubbing of the chest. Obviously it never looks good. Someone's rubbing their chest, there's obviously an issue. Whether it's anxiety or heart problems or something like that.

6.11 Senior Constable Blackburn told the Triple Zero operator that Mr Furner had suffered a heart attack the previous Wednesday and had been prescribed medication which had not been filled. Senior Constable Blackburn described Mr Furner as being hot and clammy, but otherwise awake, responding normally and not changing colour.

6.12 Senior Constable Blackburn subsequently continued with the booking process but could hear that Mr Furner was making noises indicating that he was in pain. Senior Constable Blackburn asked Mr Furner if anything about his condition had changed and noticed that Mr Furner was struggling to breathe. Accordingly, Senior Constable Blackburn made a second call to Triple Zero at 12:55pm to provide updated information that Mr Furner was having difficulty breathing, his chest pains were worsening and he was not breathing normally. The Triple Zero operator indicated that an ambulance would attend in about five or 10 minutes.

6.13 Senior Constable Blackburn made the following entries in Mr Furner's Custody Management Record:

> Meant to be taking medication for heart disease after having heart attack on 22/2/2 [sic]
> […]
> Complaining of severe chest pain. Breathing heavy, sweating. Stated had heart attac[k] last week. NSW Ambulance called twice with updates. eta 5-10 mins.

Mr Furner's collapse and initiation of medical treatment

6.14 Senior Constable Blackburn noticed that Mr Furner was still in distress and went to check on him again. Mr Furner was clutching at his chest and repeatedly saying he was in pain and asking for an ambulance to be called. Senior Constable Blackburn told Mr Furner that an ambulance was five minutes away and stayed to keep watch over Mr Furner, who by this time was rubbing his legs and rocking forwards and backwards. Senior Constable Blackburn returned to his desk, whilst still keeping watch on Mr Furner, and saw Mr Furner collapse over onto his left side. Senior Constable Blackburn checked to see whether Mr Furner was still conscious and pressed a duress button. Senior Constable Blackburn moved Mr Furner so that he was lying supine on the floor and saw that Mr Furner was unconscious but still breathing. Senior Constable Blackburn called out to other NSWPF officers in the station to bring a defibrillator.

6.15 Leading Senior Constable Eric Woods, Constable Fahy and Probationary Constable Smith were the first officers to arrive. Constable Fahy assessed Mr Furner and was unable to find a pulse. He commenced chest compressions and instructed Probationary Constable Smith to obtain a defibrillator from the muster room in the police station. Constable Fahy and Leading Senior Constable Woods continued with cardiopulmonary resuscitation (**CPR**). After the defibrillator was brought to the scene, a shock was administered to Mr Furner and he briefly regained consciousness before deteriorating again. Senior Constable Blackburn used the NSWPF VKG radio to make an urgent call at 1:04pm for NSWA paramedics to attend. Senior Constable Blackburn made a second call using his portable radio at 1:05pm, requesting the urgent attendance of NSWA paramedics.

6.16 Eventually, Mr Furner regained consciousness but was heard to be breathing heavily and it appeared that he was in considerable pain. Senior Constable Blackburn and Leading Senior Constable Woods left briefly to open the access point at the rear of the police station to facilitate the entry of NSWA paramedics.

6.17 Intensive Care Paramedic (**ICP**) Paul Taylor was amongst the NSWA paramedic crews which arrived at the scene at around 12:57pm. Mr Furner was moved to a more open area, NSWA paramedics continued with chest compressions and a total of 9 defibrillations were administered. Mr Furner was noted to be in and out of ventricular fibrillation, in asystole and to be showing non-perfusing rhythms. A laryngeal mask airway was inserted initially and later changed to an endotracheal tube following successful use of a LUCAS[1] device. Ketamine was administered and the police officers and NSWA paramedics present took turns to deliver CPR to good effect until Mr Furner regained consciousness.

[1] Lund University Cardiopulmonary Assist System.

6.18 At around 1:57pm, Mr Furner was loaded into an ambulance and taken to the emergency department at Goulburn Base Hospital. On arrival, Mr Furner was noted to be in asystole and with fixed, dilated pupils. No pericardiac perfusion was identified. Possible reversible causes of Mr Furner's cardiac arrest were considered. CPR efforts continued and adrenalin was administered but Mr Furner remained in asystole with no return of spontaneous circulation. Following discussion with the intensive care team, a decision was made to cease CPR efforts at 2:08pm. Mr Furner was tragically pronounced life extinct at 2:11pm.

6.19 Shortly before 2:45pm, the circumstances of Mr Furner's death was declared by a NSWPF Assistant Commissioner to be a Critical Incident. Accordingly, a Senior Critical Incident Investigator was assigned to the matter and Mr Furner's death was investigated in accordance with the NSWPF Professional Standards Command *Critical Incident Guidelines*.

7. The post-mortem examination

7.1 Mr Furner was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Issabella Brouwer, forensic pathologist, on 8 March 2023. This examination identified the following relevant findings:

(a) increased heart weight;

(b) severe coronary artery disease in all three major coronary arteries;

(c) multifocal, segmental critical narrowing of the left anterior descending coronary artery;

(d) multifocal critical narrowing of the right coronary artery with a possible organising thrombus in the proximal segment of the right coronary artery;

(e) approximately 50% luminal narrowing of the left circumflex coronary artery;

(f) extensive myocardial scarring (old infarcts) as well as more recent haemorrhagic infarction; and

(g) toxicological analysis identified significant intoxication at the time of death (blood alcohol level of 0.171 g/100mL), with low levels of diazepam and its active metabolite.

7.2 In the autopsy report dated 5 June 2023, Dr Brouwer urger opined that the cause of Mr Furner's death was acute myocardial infarction with coronary artery atherosclerotic disease being an antecedent cause.

8. Conclusions

8.1 After considering all of the evidence gathered from the coronial investigation, no organisation or individual has been identified as having a sufficient interest in the subject matter of the coronial proceedings in accordance with section 57(1) of the Act. Accordingly, neither the Commissioner of the NSWPF or any individual NSWPF officer was considered to be a sufficiently interested party in the inquest. Similarly, unlike most other inquests, no issues apart from the statutory requirements

pursuant to section 81 of the Act were identified from the coronial investigation which required discrete examination during the inquest.

8.2 That said, as an inquest is mandatory, and because the circumstances of Mr Furner's death was declared to be a NSWPF Critical Incident, it is appropriate to give some consideration to the conduct of a number of NSWPF officers, and the application of certain NSWPF policies and standard operating procedures.

Relevant policy and legislative framework

8.3 The NSWPF *Charge Room and Custody Management Standard Operating Procedures* (**Custody SOP**) "*outlines the roles and responsibilities of all officers in control of, working within, or attending, charge room and custody facilities*". Section 12.2 of the Custody SOP relevantly provides:

> MEDICAL MATTERS
> All people in your custody have a right to medical attention if they need it.
> - Police are not expected to 'diagnose' people however, you have a duty of care to:
> - Seek medical attention immediately if you have concerns about a detained person's mental or physical condition
> - Continually assess the level of risk
> - Increase inspection frequency if the level of risk increases
> - Reasonably foresee what may happen if certain signs or symptoms exist.
>
> Any police officer regardless of their role or rank has the authority to call an ambulance.

8.4 The above provisions are repeated in the *NSWPF Handbook*.

8.5 The Custody SOP goes on to provide for the particular responsibilities of a Custody Manager, who is to:

(a) Continually assess a detained person's fitness for custody by conducting regular inspections; and

(b) immediately seek medical assistance by calling an ambulance if a person in custody, relevantly, appears to be ill, fails to respond normally to questions or conversation, cannot talk coherently, or cannot sit upright without assistance.

8.6 Similarly, the NSWPF Handbook provides that a Custody Manager is to:

> Ensure the person in custody (especially when they are in a dock) is kept under constant face to face observation by yourself or another officer until either:
> - the person is released; or
> - you have conducted your assessment of the detained person, identified the level of risk, and nominated an inspection frequency.

8.7 The NSWPF Handbook goes on to provide that a Custody Manager is to perform an initial assessment of detained persons to identify any risks including, relevantly, whether the person has any illness or condition that requires medical assistance. The Custody Manager is to consider whether the

detained person has any medical problem(s) that needs immediate attention and to make enquiries regarding any disclosures made by the person, for example, in relation to medication.

8.8 In addition, section 129 of the *Law Enforcement (Powers and Responsibilities) Act 2002*, provides:

> The custody manager for a detained person or protected suspect must arrange immediately for the person to receive medical attention if it appears to the custody manager that the person requires medical attention or the person requests it on grounds that appear reasonable to the custody manager.

Consideration

8.9 Having regard to the above, the available evidence establishes the following:

(a) Mr Furner's presentation when he was first spoken to by NSWPF officers gave no indication that he was at imminent risk of a sudden cardiac, or any other medical, event;

(b) Mr Furner's subsequent interactions with NSWPF officers whilst being transported to, and whilst in the charge room at, Goulburn police station also gave no indication that he was at imminent risk of a sudden cardiac, or any other medical, event;

(c) Mr Furner was kept under regular observation whilst being transported to Goulburn police station, and kept under continuous face-to-face observations whilst in the charge room;

(d) Frequent assessments were conducted by NSWPF officers to determine whether Mr Furner's presentation, and any underlying condition, required medical assistance;

(e) An appropriate medical history was taken from Mr Furner, and documented, whilst he was in NSWPF custody. Further, an appropriate enquiry was made by Detective Senior Constable Egan regarding the availability of Mr Furner's medication, including an offer to retrieve it from his home. Similarly, an appropriate assessment was made by Senior Constable Blackburn of Mr Furner's medical history in combination with Senior Constable Blackburn's own observations of Mr Furner's presentation in the charge room;

(f) Recognising that Mr Furner's presentation, coupled with his medical history, posed a risk to his health, Senior Constable Blackburn appropriately and pre-emptively made a call to Triple Zero to seek medical assistance for Mr Furner;

(g) Once it was apparent that Mr Furner's condition had suddenly deteriorated, Senior Constable Blackburn appropriately made two further calls to urgently seek the attendance of NSWA paramedics; and

(h) The NSWPF officers at Goulburn police station appropriately initiated resuscitation and other life preservation efforts once Mr Furner became unresponsive. Indeed, ICP Jason Pattison, one of the attending NSWA paramedics assessed the quality of the resuscitation efforts in this way:

> [W]e were very happy with what the police did initially as well , um, they did a really good job to, to have him shocked twice before our arrival and having people doing effective high performance CPR when we turned up was very good.

8.10 Two further matters should be noted:

(a) the independent Senior Critical Incident Investigator, Detective Sergeant Jason Irving, did not identify any breach of any relevant NSWPF policies or any relevant legislation by any of the directly involved NSWPF officers; and

(b) the majority of the conduct of the directly involved NSWPF officers described above is corroborated by objective BWV and CCTV footage from 5 March 2023.

8.11 Overall, the evidence establishes that each of the NSWPF officers directly involved in Mr Furner's management whilst he was in custody exercised the lawful powers available to them in an appropriate and reasonable manner. Further, each of the directly involved NSWPF officers complied with, and instituted, all relevant NSWPF policies and standard operating procedures in their management and assessment of Mr Furner whilst in custody.

9. Findings

9.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Tim Hammond, Counsel Assisting, and his instructing solicitor, Ms Clara Potocki from the Crown Solicitor's Office. I am most appreciative of the assistance that they have provided throughout all stages of the coronial process, their thoroughness and diligence, and the sensitivity and empathy that they have shown , particularly in their communication and interactions with Mr Furner's family.

9.2 I also thank Detective Sergeant Irving for his role in conducting a comprehensive Critical Incident investigation and for compiling the brief of evidence.

9.3 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Brett Furner.

Date of death

Mr Furner died on 5 March 2023.

Place of death

Mr Furner died at Goulburn Base Hospital, Goulburn NSW 2580.

Cause of death

The cause of Mr Furner's death was acute myocardial infarction due to coronary artery atherosclerotic disease.

Manner of death

Mr Furner died of natural causes whilst in the lawful custody of the New South Wales Police Force.

9.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Furner's family, and in particular, Julie and Mr Furner's children, for their most tragic loss.

9.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
25 June 2024
Coroners Court of New South Wales

Inquest into the death of Brett Furner
Coroner's Court File Number: 2023/74097

Appendix A: Non-publication orders

1. Pursuant to section 74 of the *Coroners Act 2009* there shall be no publication of the material contained in the "Sensitive Material Bundle" which forms part of the coronial brief of evidence, the contents of which are set out at Schedule A.

2. Pursuant to section 65(4) of the *Coroners Act 2009*, a notation be placed on the Court file that if an application is made under section 65(2) of that Act for access to the documents referred to in Schedule A, that the material shall not be provided.

Schedule A

Electronic Material		
1	Body Worn Video – Plain Clothes Senior Constable Peter Rajko – Arrest of Brett Furner	5 March 2023
2	Body Worn Video – Constable Michael Fahy – Charge Room	5 March 2023
3	Body Worn Video – Probationary Constable Mitchell Smith – Charge Room	5 March 2023
4	Body Worn Video – Plain Clothes Senior Constable Peter Rajko – Break and Enter	5 March 2023
15	Complete CCTV footage from the custody area of Goulburn Police station – Camera 15	5 March 2023

Magistrate Derek Lee
Deputy State Coroner
25 June 2024
Coroners Court of New South Wales