STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of BC.
Hearing Date:	13 March 2024
Date of Findings:	31 May 2024
Place of Findings:	State Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death as a result of fall from a height – manner of death – appropriateness of police response.
File Number:	2022/00222793
Representation:	Ms R McMahon, Counsel Assisting instructed by Ms L Kohler of the Crown Solicitor's Office Ms K Burke, for the NSW Commissioner of Police, instructed by Ms B Clarke of Hickson's Lawyers
Findings	**Identity:** The person who died is BC. **Date of death:** BC died on 26 July 2022. **Place of death:** BC died at Susan Gilmore Beach, Memorial Drive, Bar Beach Newcastle. **Cause of death:** The cause of BC's death is multiple blunt force injuries. **Manner of death:** BC died as a result of a fall from a height, carried out with the intention of taking his own life**.**
Non-publication order	Non-publication orders have been made pursuant to sections 75(1) and (2) of the Coroners Act 2009 (NSW) (the Act) in relation to non-publication of the deceased's identity and the identity of his relatives. A copy of these orders is on the Registry file.

Introduction

1 This inquest concerns the death of Mr BC.

2 Mr BC was born on 7 May 1944. He died on 26 July 2022 at Susan Gilmore Beach, Memorial Drive, Bar Beach in the state of New South Wales at the age of 78 years.

3 Mr BC died from injuries sustained as a result of falling or jumping from the cliff face at Susan Gilmore Beach.

4 There appears to be no dispute that Mr BC sustained the fatal injuries "as a result of 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 during the direct involvement of police officers (see sections 23 and 27 of the *Coroners Act).*

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

6 Mr BC's family recall him to be the "life of the party", charismatic and possessing the ability to engage with people in conversation. He had a love of fishing and the ocean, as well as playing darts, bowls and golf. He was a good listener and gave good advice. He is sorely missed.

7 I acknowledge the profound loss, and continuing anguish and heartbreak felt by Mr BC'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, particularly his partner, Ms GP and his brother, Mr DC, for their contribution and participation in this inquest. I hope that Mr BC'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 how 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, oral evidence was received from two police witnesses. Expert evidence was received from Dr Kerri Eagle, Forensic Psychiatrist, by way of an uncontested written opinion.

10 All 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, Ms Rebecca McMahon and Ms Kim Burke on behalf of the NSW Commissioner of Police. At times I have embraced their descriptions in these findings.

11 A non-publication order has been made relating to Mr BC, as well as his partner Ms GP and his brother, Mr DC, during these proceedings. In these findings further pseudonyms have been given to Mr BC, Ms GP and Mr DC for ease of identity. Mr BC is identified as “Brian”, Ms GP is identified as “Gail” and Mr DC is identified as “Don”.

A Brief Overview of Brian’s Life

12 Brian was born on 7 May 1944 at King George V Memorial Hospital in Camperdown to Mr CCC and Mrs JMC. Brian was the eldest of eight children and grew up in the Petersham area of Sydney.

13 Brian met and married his first wife, Ms BD around 1963. Together they had three daughters. Brian and Ms BD separated in 1971. Ms BD and their three children moved to New Zealand. Brian had little contact with his children until his daughters were teenagers.

14 Brian met Gail when they worked together at a business in Camperdown. Their friendship grew and they commenced an intimate relationship in the early 1970s. They resided together in Strathfield for around five years. They shared a passion for darts and represented NSW in various competitions. At this time, Gail recalled that, “I was concerned at different points about the betting because I was worried that he would become too dependent on the betting. I remember talking to (Brian) about my concerns and it seemed to slow a bit. I was aware that he did continue to bet but, not as much. Darts, lawn bowls and golf seemed to keep him busy.”

15 Brian was employed as an office manager for a steel manufacturing company in Sydney. The company he was working for was purchased by another company in Newcastle. Brian was offered employment with the new company in Newcastle as the factory manager and moved to Newcastle with Gail in the late 1980s or early 1990s. Brian continued to work with the company until December 2021.

16 In the late 1990s, Gail became aware that Brian had commenced an intimate relationship with another woman, Ms NG. Gail confronted Brian and he agreed to cease seeing Ms NG.

17 At around the same time, Gail became aware that Brian was playing Keno. Subsequently, Gail became aware that Brian had lost $10,000 playing Keno and provided him with $10,000 from her savings to satisfy his gambling debts. Again, after speaking with him, Gail believed that Brian had ceased playing Keno.

18 On 19 November 2021, Brian was admitted to the John Hunter Hospital for treatment of atrial fibrillation with rapid ventricular response. He remained in hospital for 10 days and was diagnosed with atrial fibrillation, new onset heart failure and three vessel coronary artery disease.

19 In May 2022, Brian underwent a quadruple coronary artery bypass graft at Lingard Hospital in Newcastle. The surgery was successful and he remained in hospital for one week before being discharged home. He subsequently attended at an "outpatient" cardiac rehabilitation centre at Lingard Hospital. He appeared to Gail to be more subdued after his surgery, however, actively embraced his physical rehabilitation, including committing to walking on a daily basis.

List of issues considered during the inquest

20 The following list of issues was prepared before the proceedings commenced and were considered and provided focus during the inquest, with the exception of ii (b).

i. What was the manner and circumstances of Brian's death?

ii. Relating to (i), whether the New South Wales Police Force's (NSWPF) response to the emergency call relating to Brian was:

a) An appropriate response in the circumstances; and
b) Consistent with NSWPF policies and procedures.

iii. Whether any recommendations are necessary or desirable?

The events on 26 July 2022

21 On the morning of 26 July 2022, Gail stated to police that "(Brian) was fine. We both woke up as normal." Gail did notice that he "was wearing a nice long-sleeved v necked jumper. On reflection I did think it was a little odd as he would only wear this jumper on special occasions. I didn't really think anything of it." Gail confirmed that Brian drove her to the Samaritans charity shop where she regularly volunteered. She told police that he had indicated that he intended to go to his cardiac rehab class at the Lingard Hospital.

22 Gail stated that she arrived home at 5pm which was a little later than her usual time of 4.30pm. She noticed that Brian was not at home and looked at her phone and saw that he had sent her a message at 4.38pm, stating "Hi, I am just going to have a few drinks with the boys. I'll see you at 7."

23 At 4pm, Brian's brother, Don received notice of a missed call. At 4.11pm, he received a second missed call from Brian, with Brian leaving a short voice mail message. At 4.13pm, Brian left a text message stating, "Hi (Don) can you phone me back please, thanks (Brian)." At 4.25pm, Don rang Brian and told him he would call him back in one hour. At this time, Don became concerned and he noted that Brian's demeanour reminded him of the time Brian had called him to inform him that their father had died.

24 During the afternoon, Brian contacted Ms NG and told her that he was going to drive his car up to the beach and take an overdose of pills. She indicated to police that he called her later from the beach to say goodbye.

25 At 6.20pm, Brian called Don and they spoke for 15 minutes. During the conversation, Brian stated “I am sorry to do this to you. But I know that you will be able to do what needs to be done.” He then said, “I am going to end my life today.” Brian then broke down and said, “I have really fucked things up. (Gail) is going to find out there is no more Super. I have gambled it all away. I can’t be with the woman I love. I have been with her for years. I have told so many lies. I just can’t go back.” Brian further stated, “I have made up my mind, I am going to drive my car off the cliff. All the lies I have told over the years. I can’t live with them.” Brian told Don that he had sent text messages to his three daughters and “that [this] was his goodbye.”

26 Don then asked Brian for Gail’s mobile number. Brian gave him her number and then said, “you can’t ring that number, you have to give me half an hour before you call. I wrote (Gail) a note and put it under the writing pad on [my] desk.” Brian further stated, “there is no Super, there is about a week’s rent left in the account.” Don said, “we can work this out, and to ask me to do nothing for half an hour is a real burden for me. I love you. We can work it out. Please don’t do this.” Brian responded, “I have made up my mind. I am going now, and I know you can do this I trust you.”

27 At 7.02pm, Don rang Brian’s daughter, Sandra and told her about the contents of his call with Brian. Sandra attempted to call her father, without success.

28 At 7.25pm, Don attempted to call Gail, without success. He left a voice message asking her to call him. At 7.26pm, Don called Gail again and they spoke about his concerns about Brian’s threats to harm himself. Don asked Gail if she could see a notepad near her as he had been told by Brian that Brian had left a suicide note for her. (Gail subsequently located the note after she had contacted triple zero at 7.39pm). The note read as follows:

Dear (Gail),
By the time you read this, I will have departed this life. I have used up all my superannuation mainly due to being on casual pay for some time and trying to win a better life for us. Please ask Sharon and Andre to look after you. I hope that my parting will get the family back together and that you will find someone in the future. Please forgive me for all the angst I have put you through over the years, Love (Brian) 26.7.22.

29 At 7.31pm, Don received a text message from Brian stating, “Hi (Don). Going now. Sorry to load you with this. My car is in the Bar Beach parking lot. Love you mate.” Don then attempted to contact Gail immediately, without success. He successfully contacted her at 7.37pm and informed her of the contents of Brian’s most recent message. Gail told Don she was going to call the police.

30 At 7.39pm, Gail contacted triple zero and reported her concerns that Brian was contemplating suicide and had parked his car at the Bar Beach carpark.

31 At 7.46pm, a NSW Police radio operator broadcast the following message:

"Husband has range infts brother in law 15 mins ago and said that he couldn't go anymore and has left his car at the bar beach carpark. (Brian)… is driving a little dark red Subaru reg …nil prev self harm attempts or threats…recent heart bypass but no mental health issues….This morning was wrg a red jumper check shirt and dark trousers but unsure if he has changed…contact inft asap also…no to all covid questions…chks otw"

32 At 7.48pm, Acting Sergeant Nicholas Marchant was the sole occupant driving a fully marked police vehicle. He acknowledged the radio broadcast and proceeded to the Bar Beach car park on Memorial Drive, Bar Beach.

33 At 7.48pm, Senior Constable Skinner and Probationary Constable Sweeney responded to the broadcast with lights and sirens and proceeded to the Bar Beach carpark.

34 At 7.50pm, Acting Sergeant Marchant acknowledged that he had arrived at the Bar Beach carpark. He located Brian and said to him, "you don't want to do it mate."

35 At 7.52pm, Acting Sergeant Marchant advised, "City 14 Urgent, he's just jumped."

Witness accounts at Bar Beach

Mr Darby Jones

36 Mr Darby Jones provided a statement to police dated 2 August 2022.

37 Mr Jones stated that he had arrived at the Bar Beach carpark at around 7.30pm on 26 July 2022, in the company of his girlfriend, Ms Eliza Ginns. Mr Jones and Ms Dunn were parked on the "waterside of the carpark about halfway along and we were facing Bar Beach. I parked behind a small red car. I can't remember the make and model".

38 Mr Jones described seeing a "man get out of the driver's seat of the red car. He glanced at us quickly and walked over to the white fence and stood looking out at the ocean. I am not sure how long he stood there for but he eventually walked back and got back into his car. He then got back out and walked back to the same spot he was standing before and looked out at the ocean".

39 Mr Jones then noticed a marked police car enter the carpark and park in front of the red car. He stated that "I watched the officer get out of the car. At the time, he would have been around 10 metres from the man in the red car."

40 Mr Jones then noted that he “looked back and saw the man from the red car was now on the cliff side of the fence. I saw the police officer was shining his torch on him and it looked to me like they spoke. I didn’t hear what was said”.

41 Mr Jones then indicated that another police car arrived and his attention was diverted to the second police vehicle. When he looked back he noted that “the man on the other side of the fence was gone and the first police officer I saw was on the other side of the fence shining his torch around and looked like he was searching for something.” Mr Jones indicated that he would have been about 8 metres from the man in the red car when he saw him and the illumination in the carpark was poor and very dark.

Ms Eliza Ginns

42 Ms Eliza Ginns confirmed to police in her statement dated 2 August 2022 that she was in the company of her boyfriend, Mr Darby Jones at the carpark at Bar Beach at around 7.30pm on 26 July 2022. They were seated in Mr Jones’ vehicle on the water side of the carpark.

43 Ms Ginns recalled parking behind a small car and noticed a man jump “out of the driver’s seat straight away when we pulled up. I remember thinking that we may have parked too close or something”. Ms Ginns recalls seeing the man “walk over and stand near the fence railing next to his car. He just stood there looking out toward the ocean. There was nothing strange or odd about what he was doing. He stood there for about five minutes. He walked back to his car and got into the driver’s seat and sat there. About five or ten minutes later, he got out of the car and lit a cigarette.” Ms Ginns recalls the man locking his car repeatedly as the lights on his car kept flashing.

44 Ms Ginns recalls seeing a police car enter the carpark. Ms Ginns stated that as the “Police car came into the car park, I saw the man climb underneath the railing onto the cliff side of the fence. The police car stopped in front of the man’s car. I saw the officer get out of the car and it appeared they said something to each other. I didn’t hear what was said and the man was facing away from me”. Ms Ginns recalled that “it was quite dark where we were. When I looked back where the man was, he wasn’t there anymore.” Ms Ginns recalls a number of additional police vehicles arriving at the carpark.

Acting Sergeant Nicholas Marchant

45 Acting Sergeant Marchant provided investigating police with the following account in the early hours of 27 July 2022.

“Stopped my vehicle in front of the Subaru, uh, that being Newcastle 14. Um, ua, At that point I saw a male standing, um, on the, uh, on the footpath, um, um, um, having a cigarette. Um, At that time he was on the correct side of the, um, of the fence, um, or what I would deem the correct side of the fence, not the cliffside but the, um, the car park side of the fence. Um, I believe he may have been wearing, um, a red kind of chequered shirt but I couldn't really tell, till what it was. It was pretty dark at that location. I hadn't turned, um, my side alley lights on or anything like that at all. Um, the um, as I as I was getting out

of the car, I quickly scanned, um, to see if I could see the name of this gentleman, um, that I was looking for. Um, I don't believe the name was even in the, the CAD job. I, I, I can't recall seeing the name at all. Um, as I, as I moved around to the front of the police vehicle, um, I looked up and saw that the, uh, gentlemen had, um, gone over the other side of the fence. Uh, I remember yelling out to him, um, "Stop mate. You don't want to do this." The same time I was trying to put my body worn video camera on. Um, and, um, I, I could see that he was still smoking at the time. Um, He was still, I could see the, the, the red of the cigarette but it was very dark. I couldn't actually, um, see him that well. I could see his, like, an outline of his, outline of his, um, body but that was about it. Um, um, remember I said a few times, "Mate, um, come back over the comma come back over", or, "Stop there, mate", I can't exactly remember what I, what I said to him. Um, I heard at one point my, my body worn turning on. Um, And I saw the mail throw the cigarette on the ground, and, um, he said, um, he said to me, um, "Tell JP I'm sorry", or I believe it was JP or Jan, I can't remember exactly what, what he said, whose name he said. I believe it was JP but I, uh, I'm not a hundred per cent sure. And, um, and then I saw sort of the outline of him running towards the cliff."

46 Acting Sergeant Marchant's body worn video commenced recording shortly after Brian ran towards the cliff.

Senior Constable Andrew Skinner

47 Senior Constable (SC) Andrew Skinner provided a statement to police dated 27 July 2022. He confirmed that he had responded to a job broadcasted on police radio for a "Concern for Welfare" at Bar Beach carpark. At the time, he was in the company of Probationary Constable Luke Sweeney.

48 SC Skinner was the observer, with Probationary Constable Sweeney driving the fully marked police vehicle. SC Skinner heard a further broadcast indicating, "he's just jumped". Probationary Constable Sweeney activated the vehicles' lights and sirens and they arrived shortly afterwards at the Bar Beach carpark. He noted that there were around 30 to 40 vehicles parked in the carpark.

49 SC Skinner recalled seeing Acting Sergeant Marchant standing on the eastern side (ocean side) of the fence, "shining his torch". SC Skinner activated his torch and combed the cliff face for signs of the male, without success. He then commenced searching for the cigarette butt that the male had been smoking. He located a partially smoked cigarette butt and secured it with a "witches' hat". He then commenced canvassing the persons present in the carpark.

50 At 8.28pm, SC Hansen located Brian at the bottom of the cliff, unresponsive and deceased. A Critical Incident was subsequently declared at 8.46pm by Inspector Jordan and Detective Inspector Mitchell Dubojski was allocated the role of officer in charge of the critical incident investigation.

Cause of Death

51 On 28 July 2022, Dr Donovan Loots, Staff Specialist in Forensic Pathology conducted a post mortem external and toxicological examination.

52 Dr Loots concluded that the direct cause of Brian's death to be from multiple injuries. The summary of those injuries was reported as:

i) Catastrophic head injury.
ii) Catastrophic chest wall injury with right tension pneumothorax and bilateral haemothoraces.
iii) Multiple pelvic fractures with disruption of the pelvic ring.
iv) Multiple other appendicular skeleton fractures.

53 The toxicological examination and analysis disclosed the following:

i) No alcohol detected in the blood and citrous humour samples
ii) Frusemide <1 mg/L
iii) Salicylic Acid <5 mg/L

Dr Loots concluded that the "post mortem toxicology was non-contributory to the cause of death".

Detective Inspector Mitchell Dubojski – Officer in Charge of the investigation

54 Detective Dubojski prepared a statement dated 24 January 2023. He also gave evidence during these proceedings on 13 March 2024.

55 Detective Dubojski interviewed a number of witnesses, including family members and obtained written statements and oral interviews, which have been included in the brief of evidence.

56 Detective Dubojski obtained documentary and primary evidence relating to Brian's mental health, physical health, financial circumstances, employment history and gambling history.

57 On 13 March 2024, Detective Dubojski confirmed during his oral evidence at the inquest that there was no evidence that Brian had any known mental health issues. Detective Dubojski was asked:

Q. It is the case, isn't it, that throughout your investigation and speaking to family members and looking at the medical records that you were unable to identify any formal mental health diagnosis with respect to (Brian)?

A. That's right.

58 Detective Dubojski confirmed that Brian and Gail had separate financial accounts. Gail confirmed that she had retired from work in 2017 and had a superannuation balance of $55,000. Gail informed Detective Dubojski that, "I never made any inquiry about (Brian's) superannuation balance. I just assumed it would have been quite a bit of money and there would be sufficient to maintain us both once he had stopped working." In addition, Gail

indicated, “he always kept his finances to himself, and I never asked I really had no reason to have any suspicion or otherwise. We did everything together and I trusted him.”

59 Gail advised Detective Dubojski that she spoke with Brian just prior to his cardiac operation in May 2022 to the effect that she had no knowledge of his financial circumstances if anything went wrong with the operation. Brian then transferred $8000 into her bank account and they discussed payment of credit cards and household bills.

60 Gail told Detective Dubojski that Brian appeared to take a greater interest in their finances in mid July 2022. She recalled that he was talking about superannuation payments being available.

61 Detective Dubojski confirmed that Brian’s OnePath Super account was closed on 23 March 2022, with the financial benefit of $23,466 being paid into his CBA account. Similarly, his ANZ Smart Choice Super account was closed on 3 May 2022, with the financial benefit of $5,340 being paid into the same CBA account.

62 Brian’s Commonwealth Bank credit card was in debit to the sum of $5,133 and his Latitude Mastercard was at the credit limit at the time of his death.

63 Detective Dubojski confirmed that Brian’s CBA account showed extensive ATM withdrawals. The CBA banking records indicate that between 1 January 2021 and 7 July 2022, the account was credited with an amount of $177,000. During that same period the records confirm that a total of $133,000 was withdrawn by ATM. At the time of his death, Brian’s CBA account had a balance of $5.65.

64 Detective Dubojski spoke with a number of family members about their knowledge of Brian’s recent gambling history. Gail confirmed that he had previously been addicted to playing Keno and the pokies, however, she believed that it was no longer an issue. His daughter, Sandra, also believed that his gambling addiction had resolved. Ms NG did not believe that he was currently gambling in any form.

Expert Evidence – Dr Kerri Eagle, Forensic Psychiatrist

65 Dr Kerri Eagle provided her expert opinion in a report dated 24 October 2023. Dr Eagle’s opinion was sought in relation to Brian’s mental health history and the likelihood of any suicidal ideation, as well as her assessment of the NSWPF’s response to the emergency call relating to Brian on 26 July 2022 and the appropriateness of the police response.

66 Dr Eagle noted that, “the opinions in this report based on a structured retrospective evaluation of information provided about (Brian), often referred to as a psychiatric or psychological autopsy. There are inherent limitations in any retrospective psychiatric assessment of a person’s presentation, mental state, personality structure and diagnosis. Limitations can arise due to the reliance on third party perspectives, inadequate documentation, gaps in the

information provided and the inability to conduct a clinical assessment of the individual".

67 Dr Eagle noted that, "there was no available information to indicate that (Brian) had ever been diagnosed or treated with a mental illness or had a history of suicidal behaviour".

68 Dr Eagle confirmed, "correspondence dated 23 December 2021, from John Hunter New England LHD, Cardiovascular Department, noted that (Brian) had a medical history that included gastroesophageal reflux disease, atrial fibrillation (failed cardioversion), heart failure (presumed tachycardia mediated/ischaemic +/- alcohol) and triple vessel coronary artery disease (angiogram 26 November 2022 (sic)). It was noted he worked for an oil company, enjoyed playing bowls and consumed excessive alcohol (4 beers and 4 Bicardi). Smoking and alcohol cessation was discussed with (Brian)."

69 After reviewing all available material, Dr Eagle provided the following Diagnostic Formulation.

"(Brian) did not appear to display signs and/or symptoms of a major mental illness, such as a psychotic disorder or severe mood disturbance. He appeared to have experienced an emotional crisis at the time of death in response to a situation where he felt he had limited options left to him due to a gambling problem that had resulted in major financial stressors, and shame in the face of potential disappointment from others.

(Brian) was noted to have potentially consumed harmful amount of alcohol in clinical notes. It is not apparent whether he was intoxicated on the evening of his death, but the toxicology report did not indicate any alcohol in his postmortem sample. He may have had an alcohol use disorder, although there is insufficient information available to confirm that diagnosis.

(Brian) had a Gambling Disorder. The available information suggested he had engaged in persistent and recurrent problematic gambling behaviour leading to distress and impairment in functioning, including gambling increasing amounts of money, concealing the extent of his gambling, incurring debt, jeopardising his relationships, and relying on others to relieve financial situations."

70 Dr Eagle noted that Brian, "appears to have developed a suicide plan with intent."

71 Dr Eagle was asked to comment on the impacts associated with gambling, mental health issues, including the risk of suicidality. Dr Eagle opined that:

"A comprehensive review of all the literature associated with gambling, mental health issues and the risk of suicide is beyond the scope of this report. Suicide is a multifactorial phenomenon. However, a number of studies have indicated an association between gambling and suicide. A recent systemic review of 20 studies conducted in Finland indicated that suicidal behaviour was positively associated with stressors associated with gambling, and that

two processes that connected gambling and suicidal behaviour were indebtedness and shame, which also functioned as barriers to seeking help. The findings are consistent with other studies that have suggested that financial problems in those with Gambling Disorder were associated with suicide risk".

72 Dr Eagle was also asked to comment on the incidence of depression or other mental health issues associated with post-cardiothoracic surgery. Dr Eagle opined:

"A positive association between cardiac disease and depressive disorders has long been identified. The association is felt to be mediated by psychosocial and physiopathological mechanisms (biological changes associated with the cardiac disease). It has been suggested that routine screening of depressive symptoms in cardiac settings would be of benefit and has been recommended by the American Heart Association and the National Heart Foundation of Australia."

Dr Eagle further noted that:

"The prevalence of major depressive depression in survivors of acute myocardial infarction or coronary artery bypass grafts have been reported at around 15%."

73 Dr Eagle was provided with a number of NSWPF policies and procedures relating to police responsibilities when dealing with persons with perceived mental illness issues.

74 Dr Eagle noted the NSWPF Operations Manual: Incidents Involving People with Mental Illness. In that document, Dr Eagle noted that police are empowered to detain people pursuant to section 22 of the *Mental Health Act 2007.* It is noted that:

"The person must appear to be either mentally ill or mentally disturbed, and:

1. *The person is committing or has recently committed an offence*

2. *The person has recently attempted to kill themselves or someone else OR it is probable that they will do so.*
3. *The person has attempted to cause serious physical harm to themselves or someone else."*

75 Dr Eagle further noted the "NSW Police Handbook: Mentally Ill People", which encourages the "least restrictive actions" by police, including taking the person to hospital for assessment.

76 Dr Eagle also noted the "Self Harm/Suicide – Threat/Attempts in Progress Documents" which in her opinion "appear to form part of a NSW Police administrative process for responding to an attempted suicide/self harm incident. The documents do not provide practical or clinical guidelines on how

to respond or exercise any mental health assessment, risk assessment or discretion to detain under section 22 of the *Mental Health Act 2007".*

77 Dr Eagle was asked to provide her expert opinion as to whether "the NSWPF's response to the emergency call relating to (Brian), including Senior Constable Marchant's attendance and interactions with (Brian) in the moments prior to his death, was an appropriate response." Dr Eagle noted that (Brian) appears to have developed a suicide plan with intent. Dr Eagle commented that, "the short interaction between (Brian) and SC Marchant did not provide any reasonable opportunity to engage (Brian), who did not waiver in his apparent intent to end his life."

78 Dr Eagle noted that, "it was potentially open, in my view, to the officer to detain (Brian) under section 22 of the *Mental Health Act 2007* and transport him to hospital for a psychiatric assessment on the basis that he was mentally disordered and probably going to end his life." Dr Eagle however, conceded that "It is not clear that the officer did have the time or opportunity to detain (Brian) before he jumped from the cliff."

Abandonment of issue 2. (ii) at the commencement of these proceedings

79 On 15 May 2023, those assisting me wrote to Ms Natalie Marsic, General Counsel with the Office of the General Counsel, NSWPF, to advise that I had formed a preliminary view that the Commissioner of the NSW Police Force ("Commissioner") had a sufficient interest in the subject matter of the current inquest ("15 May 2023 Letter").

80 The letter also contained a request on my behalf for a statement from an appropriate senior NSWPF officer which (amongst other things) outlines NSWPF policy and procedure relating to dealings with persons who are at imminent risk of self-harm and further documentation, including, "any NSWPF policies, protocols and trainings relating to dealing with persons who are at imminent risk of self-harm, in force on 26 July 2022 and current versions if they differ."

81 Further correspondence was sent by email by those assisting me on 8 November 2023 ("8 November 2023 Email") to the Office of the General Counsel, NSWPF requesting a response to the 15 May 2023 Letter. A request was also made on my behalf for:

a. confirmation that all of NSWPF's mental health policies (in full) had been provided; and

b. details about the internal review of NSWPF's mental health policies (including an outline of the terms of the review, when a report is proposed to be finalised and whether that report is proposed to be made public).

82 On 19 February 2024, a Directions Hearing was convened given the paucity of the response from the Office of General Counsel in relation to the statement request. On 19 February 2024, Ms Clarke appeared on behalf of

the Commissioner. Ms Clarke sought that the scope of the 15 May 2023 statement request be limited.

83 The matter was relisted for a further Directions Hearing on 27 February 2024. The ambit and scope of Ms Clarke's request was agreed to and the matter was adjourned to 27 February 2024. On 27 February 2024, further orders were made directing that additional statements from the Commissioner were to be served by 8 March and the inquest was confirmed to commence on 13 March 2024.

84 In written submissions, Counsel Assisting, Ms McMahon, commented that,

"Counsel assisting informed the Court on the morning of the hearing and at previous directions hearings, that (Brian's) family had expressed that it was very important to them that the hearing was finalised as soon as possible. In light of the importance of finality to (Brian's) family, the court determined to proceed with the hearing on 13 March 2024. As a consequence, the Court was required to abandon issue 2 (ii) because of New South Wales Police Force's (NSWPF) incomplete and late provision of relevant policies and procedures."

85 Ms Burke, counsel for the Commissioner, noted in her written submissions that, "it was not anticipated at the commencement of the one day inquest hearing that submissions would be in written form. Significantly, it was not anticipated that the abandonment of draft Issue 2(ii), addressed albeit slightly, in opening submissions, would be grounded upon quite strident criticisms, in written submissions about the asserted lateness of material from NSWPF". Ms Burke sought leave to re-open evidence in this matter and tender a letter dated 16 February 2024. I intend to grant that leave, together with the admission into evidence of the 15 May 2023 Letter and the 8 November 2023 Email forwarded by those who assist me.

86 Whilst Ms Burke accepts that, "the Commissioner's response to the requested material was late", she stated "explanations for that delay were provided." On the material currently available to the Court, no explanation has been received as to why there was such an initial delay in forwarding a response to the 8 May 2023 Letter. Furthermore, Superintendent Langley's statement was served on 12 March 2024 which was clearly non-compliant with directions made that outstanding statements were to be provided by 8 March 2024. Sergeant Nerida Taylor's statement, dated 8 November 2023, was served on 16 February 2024.

87 On 26 February 2024, the representatives for the Commissioner wrote to those assisting me, noting that the NSWPF "operates as a decentralised organisation, with decision-making authority for the policies, procedures and training material across various commands within the organisation and that completion of the original request for policies relating to responding to emergency calls relating to person who were at imminent risk of self-harm."

88 Inspector Craig Clark of the Newcastle City Police District, where Acting Sergeant Marchant was stationed confirmed that:

"the District does no operate any local policies in relation to the response of General Duties officers, nor any other officers attached to the District, in regard to mental health. This includes those persons who may be mentally disordered and/or ill, as well as any person who intend to end their own life by way of jumping from a dangerous location and/or height."

89 Ms Burke submitted in her written submissions that "an inference is available on [Inspector Clarke's] evidence, that is within the Brief of Evidence, that the Newcastle Police District Command may follow the policies and procedures in terms of mandatory training and education referred to by Sergeant Taylor and Superintendent Langley. He was not called to give evidence."

90 Unfortunately, the complete policies and procedures alluded to above, may or may not have been provided in relation to numerous requests. In addition, the lateness of the response did not afford an opportunity to seek an expert review of the material in light of the family's request that the evidence in the matter was finalised on 13 March 2024.

91 On 12 March 2024, the representatives for the Commissioner wrote further to those assisting me confirming that the NSWPF mental health review ("the review") which was commissioned by the Commissioner in September 2023 was being actioned by Acting Superintendent Kristy Hales but noting that they did "not hold instructions as to when the review will be finalised" nor did they "hold a copy of the terms of reference within that review."

92 Ms Burke also raised her concerns with Counsel Assisting's assertion in her written submissions that "it is hoped that the mental health review provides a more streamlined approach to policies and procedures relating to mental health, which may assist those responsible for accessing relevant NSWPF policies and complying with Court orders."

93 The issues surrounding the relevant current policies and the difficulty accessing them is concerning. This is particularly so, when the findings of the review have not been made public more than two months after this inquest. It is confounding and unclear why there is not a streamlined approach to policies and procedures within the NSWPF relating to mental health which are readily available to be assessed, analysed and reviewed by experts.

94 Front line officers are continually exposed to traumatic scenarios, resulting in significant and often long term sequelae. A collaborative response to protect both serving police officers and often vulnerable members of the community should be encouraged and adopted. It is hoped that the "review" will embrace such a response.

95 In addition, it is noted that many serving police officers are moved between Local Area Commands, including various regional areas of NSW and a streamlined approach would be an important and supportive instruction for all serving police.

Family statements

96 Gail spoke with emotion to the Court and provided a photograph of Brian fishing. Gail confirmed his love of fishing, darts, bowls and golf. She recalled them travelling to Port Macquarie every year. It was their special place. She recalled Brian to be kind and patient with a love of practical jokes. Gail noted that Brian "loved his daughters even though he didn't see them as much as he should have."

97 Don also spoke to the Court. In addition, he provided three photos depicting their parents and siblings.

98 Don spoke eloquently of his love of his brother and the support that he had given over the years. He indicated that Brian was both fun-loving as well as being very logical. He indicated that Brian could make a serious situation light-hearted.

99 The Court appreciates the heartfelt effort both Gail and Don have made in such emotional circumstances to provide this insight into the character of their partner and brother.

Manner and Cause of Brian's Death

100 The cause of Brian's death is not in issue. Dr Loots confirmed that Brian died from multiple injuries.

101 The manner of Brian's death requires further scrutiny. The available evidence, both from Acting Sergeant Marchant, as well as Mr Jones and Ms Ginns appears to confirm that Brian ran over the cliff face rather than falling off it. In addition, there are a number of phone calls, text messages and the letter left for Gail, indicating his determination to self-harm.

102 A finding of suicide must never be presumed, but is required to be proven on the basis of the available evidence. In *R v London Coroner; Ex parte Barber* [1975] 1 WLR 1310 at 1313, Lord Widgery CJ stated:

> *"[Perhaps one of the most important rules that coroners should bear in mind….[is] that suicide must never be presumed. If a person dies a violent death, the possibility of suicide may be there for all to see, but it must not be presumed merely because it seems on the face of it to be a likely explanation. Suicide must be proved by the evidence, and if it is not proved by evidence it is the duty of the coroner not to find suicide, but to find an open verdict…"*

103 On the balance of probabilities, the Court is satisfied that Brian jumped from the cliff at Susan Gilmore Beach, Memorial Drive, Bar Beach, with the intention to end his own life.

Conclusions

104 Brian was a gregarious, fun loving person with significant family and community supports.

105 He had recently undergone significant cardiac surgery in May 2022. He appeared to have responded well to the surgery and was actively engaged in his physical rehabilitation.

106 Brian had no known history of mental illness.

107 Brian did have a history of significant and entrenched gambling which had resulted in financial ruin.

108 On 26 July 2022, Brian had clearly developed a suicide plan with intent. At 7.39pm, Gail contacted triple zero and at 7.46 pm a call for assistance was broadcast over police radio.

109 Acting Sergeant Marchant responded to the broadcast and arrived at the Bar Beach carpark at 7.48pm. He attempted to engage with Brian, however, Brian jumped from the cliff face to his death. In the circumstances, it is the Court's view that A/Sergeant Marchant responded appropriately and professionally. His actions should be commended.

110 I would like to record my gratitude to counsel assisting, Ms Rebecca McMahon, and her instructing solicitors, Ms Leanne Kohler and Ms Rosanna Muniz for their assistance, their commitment, and their untiring efforts to prepare and present this case.

111 I would also like to acknowledge and thank the Officer in Charge of the investigation, Detective Inspector Mitchell Dubojski.

112 Finally, I would like to again record my most sincere condolences to Brian's family. His family have willingly assisted the Officer in charge, as well as the team assisting in circumstances of great emotional shock and grief.

Findings

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 BC.

Date of Death

BC died on 26 July 2022.

Place of Death

BC died at Susan Gilmore Beach, Memorial Drive, Bar Beach, New South Wales.

Cause of Death

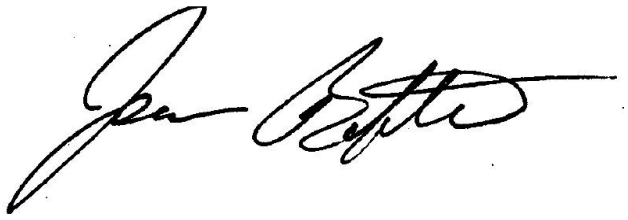
The cause of BC's death was multiple blunt force injuries.

Manner of Death

BC's death was as a result of jumping from a cliff, with the intention of taking his own life.

I decline to make any recommendations.

I close this inquest.



Magistrate Joan Baptie

Deputy State Coroner

31 May 2024