CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jet Gallagher
Hearing dates:	22-24 October 2024
Date of findings:	9 December 2024
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Rebecca Hosking, Deputy State Coroner
Catchwords:	CORONIAL LAW – intentional self-harm – NSW Police and NSW Ambulance powers pursuant to ss 20 and 22 of the *Mental Health Act 2007* – extent to which information from friends and family should be taken into account when assessing risk of self-harm
File number:	2021/66808
Representation	**Counsel Assisting the Inquest**: Kate Holcombe of Counsel, instructed by James Prindiville of the Crown Solicitor's Office **Commissioner of Police, NSW Police Force**: Christine Melis of Counsel, instructed by Aurhett Barrie of the Office of General Counsel, NSW Police Force **NSW Ambulance**: Ben Bradley of Counsel, instructed by Matthew Renwick of McCabes Lawyers **Peter Clemenson and Alannah Keating**: Patrick Rooney of Counsel, instructed by Caroline Blair of Makinson d'Apice Lawyers **Senior Constable Carmel Kaczmar**: Misha Hammond of Counsel, instructed by Harrison Foulcher of Cardillo Gray Partners

Findings	**Identity** The person who has died is Jet Gallagher **Place of death** 4/161 Broadmeadow Road, Broadmeadow NSW 2292 **Date of death** 5 March 2021 **Cause of death** In keeping with hanging **Manner of death** Jet Gallagher died of intentional self-harm

Contents

Introduction

Publication

1. In accordance with s 75(5) of the *Coroners Act* 2009 (NSW) (**the Act**), I make an order permitting the publication of a report of the proceedings as I consider that it is desirable in the public interest to permit a report of the proceedings of the inquest to be published.

Findings made in accordance with s 81(1) of the Act

2. Section 81(1) of the Act requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

3. These are the findings of an inquest into the death of Jet Gallagher.

4. Jet Gallagher was aged 19 years when he died at his home at 4/161 Broadmeadow Road, Broadmeadow NSW 2292, between 7.00am and 9.30am on 5 March 2021. The death was caused by hanging and the manner of death was intentional self-harm.

The role of the coroner

5. Pursuant to s 81 of the Act, a coroner holding an inquest concerning the suspected death of a person must make findings as to whether the person has died and, if so, the date and place of the person's death, and the cause and manner of their death.

6. In addition, the coroner may make recommendations in relation to matters arising out of the death in question which have the capacity to improve public health and safety in the future.

The issues examined at inquest

7. The inquest considered the adequacy and appropriateness of the conduct of NSW Police and NSW Ambulance (**NSWA**) officers attending upon Jet on 4 March 2021 including:

    a) the adequacy of any communication between attending Police and NSWA officers, and Jet's brother, Jorden Gallagher;

    b) whether Jet's risk of suicide was appropriately identified and managed;

    c) whether Jet ought to have been taken to hospital pursuant to sections 20 or 22 of the *Mental Health Act 2007* (NSW) (**MH Act**); and

    d) the general care and attitude of attending officers towards Jet.

8. Tendered to the Court was a 3 volume brief of evidence.

9. At the inquest, the Court received evidence from numerous witnesses. In addition, Professor Matthew Large (who, amongst other things, is the Medical Superintendent of the Eastern Suburbs Mental Health Service as well as a Conjoint Professor in the Discipline of Psychiatry and Mental Health at UNSW) prepared a report and provided oral evidence at the inquest.

10. As will be seen, I reached the conclusions that follow.

    a) It was not inappropriate for police to defer to NSWA officers in circumstances where the scene presented as a mental health incident and not a criminal incident.

    b) The communications between NSWA officers and Jorden on the evening of 4 March 2021 as to Jet's care were inadequate.

    c) While information should have been obtained from Jorden by NSWA officers relevant to their assessment of Jet's risk of self-harm, ultimately their decision not to involuntarily transfer Jet to a mental health facility pursuant to s 20 of the MH Act was not inappropriate.

    d) The general care and attitude of attending NSWA officers towards Jet on 4 March 2021 did not accord with best practice.

    e) Following Jet's death, NSWA have implemented and are continuing to plan improvements to policies, education, and training of officers to improve the NSWA response to mental health presentations.

Background

11. Jet was born on 11 June 2001. He was the much-loved younger brother to four siblings, Jorden, Scarlett, Levi and Siobhan. At 6 months old, Jet was placed in foster care. He was also loved by his foster father who, with Jet's siblings, attended the inquest either in person or via AVL. Each family member gave a statement at the conclusion of the inquest providing the Court with insight into the difficulties Jet had in his life, the special young man who he had become, and the loss in their lives and the broader community by his death.

12. In his family statement, Levi painted a picture of a difficult childhood. Jet had diagnoses of depression, anxiety, and oppositional defiance disorder (**ODD**). Despite that, Jet worked hard, completed his HSC, and from 2019 Jet lived in his own unit in

Broadmeadow and obtained work as a tiler. In 2020, Jet had two friends die by suicide which had a significant impact on him.

13. Between 2 June 2020 and 24 February 2021, Jet was a patient of psychologist, Liam Feeney. In his notes, Feeney reported:

    a) Jet commenced smoking marijuana at age 11 or 12 and described the onset of mental health issues at the same age including ADHD, ODD, stress, anxiety, and difficulty sleeping;

    b) Jet talked about making a claim for compensation for victims of crime in relation to his foster mother's treatment of him; and

    c) on 24 February 2021, Jet spoke about trying to cut down on smoking and gambling.

Post-mortem examination

14. An external autopsy was performed by Dr Du Toit-Prinsloo who found that the direct cause of death was in keeping with hanging.

15. Dr Du Toit-Prinsloo's external examination showed features in keeping with hanging as a cause of death, with a cotton sheet ligature in situ and a corresponding circumferential ligature abrasion around the upper neck. Dr Du Toit-Prinsloo also observed a protruding tongue with a desiccated tip and fine petechial haemorrhages.

16. The toxicology report showed that cannabinoids and benzodiazepines (and its active metabolites) were present in Jet's blood. Superficial abrasions were also observed on Jet's nose and right knee. No traumatic injuries or fractures of the spine, hyoid bone, or thyroid cartilage were seen on CT imaging.

17. Dr Du Toit-Prinsloo's opinion is consistent with the report of Jet's friend who found him and attending police.

Manner of death

18. A finding that death is intentionally self-inflicted should not be made lightly and should only be made where the evidence of intention meets the standard set out in *Briginshaw v Briginshaw* 60 GLR 336. The material available in Jet's case including his medical history, his disclosure of suicidal thoughts to his brother Jorden, and the circumstances in which he died, support the conclusion that Jet intentionally hung himself.

Jurisdiction

19. Jet's death was a reportable death – being an unnatural death – as defined in s 6 of the Act. Section 21(1)(a) of the Act confers jurisdiction on a coroner to hold an inquest into a reportable death.

20. For the sake of completeness, I have considered whether an inquest was mandatory pursuant to ss 23(1)(c) and 27(1)(b) of the Act as a death occurring "as a result of police operations" and determined that it is not. It is clear from the evidence given by Jorden that Jet was having suicidal thoughts on the evening prior to his death. To the extent that there was a "police operation", it involved the police attendance on Jet and Jorden on the night before his death. At the time, Jet was walking, talking, and responding to police and was able to indicate that he had no plans of self-harm that evening.

21. The evidence is clear that Jet went home with his brother Jorden, went to sleep and then, the following morning, returned home and hung himself. While the events of the prior evening are a relevant consideration during this inquest, I find that they do not meet the threshold required for this inquest to be considered to be mandatory under ss 23(1)(c) and 27(1)(b) of the Act.

The events leading up to the death

Prior to the arrival of paramedics

22. Much of the facts of this matter are not in dispute and I am grateful for the submissions by Counsel Assisting from which I have drawn extensively and in relation to non-contentious issues, directly at times, in these findings.

23. At about 8.30pm on 4 March 2021, Jet met with his brother Jorden at the Australia Hotel in Cessnock. Jet played on the poker machines and then, as reported by Jorden, became angry at himself for wasting his money.

24. The pair left the Hotel at around 10.10pm. Jorden reported that Jet was "chronically sad." Jet took a number of Valium tablets and smashed his phone. Jet was telling Jorden how much he loved him and their sister and was expressing suicidal thoughts. Out of concern, Jorden commenced recording their conversation. During the conversation, Jet can be heard to say:

> *I just want to die man… I'm fucking over it… I keep doing the same shit and I just don't want anything to do with me anymore…*

As soon as I go home, I'm fucking done, man…. I'm fucking done…

I fucking love youse, but please respect my decision… I've been too fucked up in life…from a young age and I'm fucking over it… I'm fucking going to kill myself tonight or tomorrow and I don't give a shit…what you say…. I'm telling you right now…I'm doing it and actually I'm just fucking over it… Fucking drive my car into a tree.

25. Jorden stopped recording Jet and at about 10.43pm phoned 000. The 000 recording appears in two audio files and appears to cut out very briefly. During these audio recordings:

    a) Jorden tells the dispatcher that Jet has intentionally overdosed on Valium, after taking eight Valium. He says that Jet had also had some alcohol (beer) and that this was 30-40 minutes prior.

    b) Jorden described Jet falling down, but then getting back up and walking, running, or jogging away from him. At one stage, Jorden described Jet wading into a nearby creek, before climbing out again.

    c) Jorden told the dispatcher that Jet had been "having a hard time" lately.

    d) Jet can be heard in the background speaking to Jorden, although it is difficult to make out precisely what Jet was saying. From the tone of his voice, he appeared upset and argumentative at times. Jorden can be heard trying to reassure Jet, saying, for example:

        It's ok. It's not fatal… I know you're stressed out…What's most important to me is getting you feeling better.

26. Jorden told Jet that he would stay at Jorden's house that night, that the ambulance officers have to check him out, and if he has to go to hospital, then Jorden will go with him.

27. At about 11.00pm, Senior Constable (**SC**) Carmel Kaczmar and (now former) SC Glenn Morrissey responded to a call via police radio regarding Jet. The call indicated that Jet was overdosing. This call came from NSWA in circumstances where when Jorden called 000, he requested an ambulance.

28. Before arriving at the scene, the responding NSWA paramedics, Alannah Keating and Peter Clemenson (together, **the paramedics**) were told that the 000 caller was the patient's brother and the patient knew 000 had been called, but that he "keeps running away from caller". According to the paramedics, the "job came through as an overdose, not alert and violent."

29. At about 11.10pm, SC Kaczmar and Morrissey located Jet and Jorden at the Metro Station in Bellbird and approached them.

30. In her statement, SC Kaczmar observed Jet to be "highly intoxicated". Prior to the paramedics arriving, SC Kaczmar recalls the following conversation taking place:

> Jorden: *He's lost about $800 bucks in the pokies tonight. All his pay and now he wants to kill himself. He's taken a heap of Valium.*
>
> SC Kaczmar: *Ok, we have an ambulance coming to speak with him soon.*
>
> Jet: *Fuck off. I don't need the ambulance. I'm fine.*

31. SC Kaczmar prevented Jet from leaving, and then had a further conversation:

> SC Kaczmar: *Jet, I can't let you leave. You need to speak with the ambulance. Your brother is worried about you.*
>
> Jet: *For fuck sake I'm fine. I just want to go. I've got work tomorrow. I was just upset because I fucken lost $800 bucks. I'm fine. I'm not going to do anything. I just want to go. I've got work tomorrow.*

32. At 11.16pm, police radioed that they were:

> *With the patient, he is coherent, keep the ambos coming.*

33. At about 11.17pm, the paramedics located Jet and his brother and the police officers. Keating observed Jet to be alert, orientated, and calm. Clemenson also observed Jet to be "of sound mind" and not violent.

34. Given the inquest is focused on what occurred after the arrival of the paramedics and these matters are contentious, I will detail that evidence separately. That relates to the period between 11.17pm and 11.32pm when Jet was being attended to by police and paramedics.

The departure of police and paramedics

35. At 11.32pm, police radioed:

> *Patient has been assessed and he is fine to go into the care of his brother.*

36. At 11.47pm, the NSWA incident detail report notes that the incident had been closed. The NSWA electronic medical record indicates that the paramedics had left the scene and closed the incident by 11.53pm.

37. Jorden says that as soon as the police and paramedics left, Jet “was in psychosis”, he did not know who Jorden was, and he ended up falling asleep and rolling over on the side of the road while waiting for a taxi. Jet went home with Jorden that night.

38. On 5 March 2021, Jet woke up at about 7.00am and left Jorden’s house with nothing but his car keys. Jorden tried to get Jet to stay, but he left.

39. Jorden then sent messages to his family because he was worried about Jet. At 9.23am, Jet’s brother, Levi, messaged a friend of Jet’s, Declan, asking Declan to look for Jet because he was worried Jet was suicidal. Declan attended Jet’s apartment and, finding the door open, went inside. Jet was found by Declan to be deceased and hanging in the shower.

40. It is not in contention that the manner of death was intentional self-harm.

The period 11.17pm to 11.32pm

Jorden Gallagher

41. Jorden provided a statement dated 13 March 2021 and gave oral evidence at the hearing.

42. Jorden had not seen Jet in about 18 months as they did not live close to each other. He noticed Jet was skinny, but he was happy, he had been paid, and he was worried about his upcoming car ‘rego’ payment. Jet had been working with their brother Levi doing concreting and labouring. They both had about 4 beers and were not affected by the alcohol. Jet played the pokies and lost most of his $800 pay. Jorden sent him to the bar so he could extract Jet’s last $80 to give to him.

43. They went outside the Australia Hotel. Jet was looking around and could not find his phone. Jorden returned to the hotel and they let him in to retrieve the phone. Jet then looked at his phone and Jorden thought that either looking at his phone or the honking of a horn from a passing car triggered Jet. Jet smashed his phone and then “lost it”. Jet was frantic and exploding. He had taken Valium from Jorden’s wallet but Jorden did not know that at this stage. Jet was walking away and yelling. At some point, the money Jorden had retrieved was also thrown away.

44. After Jorden discovered that Jet had taken the Valium, he called the ambulance. Jet told him he took the whole packet – 8-10 tablets. Jorden did not know whether that amount was fatal. He recorded his conversation with Jet to show the family so they would know how stressed Jet was.

45. Jorden described Jet as being “in psychosis”. He was reckless and agitated, he was walking away from him down the street, upset the whole time, and resisting help. Jet thought he was going to die from the Valium and Jorden told him “that is not happening”. Jet jumped fences and got muddy and bloody.

46. The police arrived first, spoke to Jet and Jorden and said to wait for the ambulance. They asked Jet if he was OK and he said he was fine. He told them he was working the next day. He had brought his work lunch to Jorden’s place before they went out. Jet then walked away from police, talking to himself. They grabbed him (without cuffs) and they kept him talking.

47. The 000 operator said the ambulance would be there with lights and sirens and they did not come with light and sirens. After the paramedics arrived, Jorden tried to tell the female paramedic (Keating) that Jet was making threats to kill himself and that he had taken a number of Valium, but she “put her hand up near my face and said ‘we are talking to Jet’”.

48. Jorden then spoke with the attending police officers and told them about his recording of Jet but “they weren’t interested” and, instead, told him that they were speaking with Jet. He was not given a chance to speak with the paramedics or to show them his recording. He told them Jet had taken 8-10 Valium tablets.

49. Jorden felt that no one looked like they wanted to be there.

50. Jorden said he tried to tell the police that Jet was not fine, that he had taken a whole packet of Valium, and he wanted to kill himself. The decision was made that Jet could go home with Jorden. Jorden said he told them he wanted Jet taken to hospital.

51. There was no guidance given to Jorden about Jet’s care when he took him home. While the paramedics and police were there, Jet was calm. He changed after they left.

52. They called a taxi which never came and then they walked back to Jorden’s house. Jorden said that at one point Jet seemed to not know who Jorden was or what had happened including to his phone and where he left his car.

53. When they got home, Jet crashed. Jorden went to try and find the money that had been thrown away without success. When he got back, he went to sleep and then heard the door close when Jet got up to leave.

54. Jorden saw Jet at the gate and told him to stop but he took off. Jorden called their brother Levi and Jorden’s then girlfriend Emily. He later spoke to their sister Siobhan.

Levi sent Jet's friend Declan a Facebook message and Declan went to Jet's house and found him hanging in the shower.

Ambulance case notes

55. The NSWA incident detail report notes:

> *He has taken some medications. VALIUM 8. He took it now (less than 30 minutes ago)… Overdose VALIUM… This was intentional.*
>
> *Dispatch code: 23CO1V You are responding to a patient who has apparently overdosed/been poisoned.*

56. The NSWA electronic medical record completed by Keating describes the conversation between Jet and the attending paramedics as follows:

> *C/T 19yo M ?MH emergency. O/A Police on scene with pt and pt's brother at petrol station, pt alert and orientated. Pt states his brother has called the ambulance tonight. Pt states that he has just had his 4x valium today and 4x beers tonight. Pt states he took his brother's valium as he hasn't filled in his prescription yet. Pt denies wanting to harm himself or others. Pt denies having a plan to kill himself. Pt states he has just had a few beers with his brother tonight and took some Valium was he was starting to feel anxious. Pt states he hadn't seen his brother in 2 years. Pt states he just wants to go home to sleep as he has work tomorrow. O/E pt GCS15, PEARL, afebrile and well perfused. Pt had capacity and competency and was able to receive, believe, retain and explain. Pt declined transport to hospital. Pt states he regularly sees his psychologist for his depression and anxiety and did not want to go to hosp to speak to anyone tonight. Pt hemodynamically stable and left in the care of his brother.*

57. There is no note of a conversation between Jorden and either paramedic.

Alannah Keating

58. Keating provided a statement dated 10 November 2021 and gave oral evidence.

59. As at 4 March 2021, she had been a paramedic for about 10 months.

60. At the time of giving evidence, she did not have a strong recollection of the night such that her statement would be a more accurate reflection of what occurred that night.

61. When she arrived at the scene, she noticed that Jet was not wearing a shirt but he was oriented and talking to police. He did not appear to be affected by alcohol or anything else.

62. She did not recall any specific conversations with police other than a quick briefing on arrival.

63. Keating said she did not speak with Jorden because she was assessing Jet, him being the patient. She said Clemenson spoke to Jorden.

64. She took Jet to the ambulance and was checking his vital signs while talking to him. He was “within the flags” meaning his signs were within normal ranges.

65. She did not recall what she said to Jet but believes she would have said something like “Do you have any thoughts of harming yourself or anyone else?”. She believes Jet said that he did not. She also believes she would have asked Jet if he had future plans to kill himself, which she believes he denied.

66. She recalled Jet stating he had consumed 4 beers and 4 Valium. She was not aware that he may have taken 8 Valium. She did not recall asking him why he was anxious. She did not ask him if the Valium was an intentional overdose. She thought they had been taken through the day.

67. When asked what she thought the impact of the Valium would be she said she thinks it calms you down. She was unsure if 4 tablets would be considered an overdose. Her evidence was that she could have called the “poisons line” if she wanted to ascertain this information. She indicated had she known he had taken 8 tablets she would have called the poisons line.

68. She indicated that she considered that Jet was able to retain information and explain it back to her. She offered to take Jet to hospital so he could speak with a mental health professional, which he declined. As the junior paramedic, she was not empowered to involuntarily take Jet to a mental health facility pursuant to s 20 of the MH Act. That said, she considered the power pursuant to s 20 was not triggered in circumstances where Jet was coherent and appeared to have capacity to make his own medical decisions.

69. Following her assessment of Jet, she had a conversation with Clemenson, and they agreed that given Jet denied having suicidal thoughts, declined transport to hospital, and wanted to go home to bed as he had work the next day, it was not appropriate to take him to a mental health facility pursuant to s 20 of the MH Act.

70. She did not recall Jorden trying to speak to her and does not believe she would have put her hand up in his face. She said that if Jorden had tried to play her a recording, she would have listened to it.

71. With the benefit of hindsight and 5 more years' experience, Keating acknowledged that friends and family are important in these situations. Keating said that if she knew of earlier threats of suicide, she would have taken them into account but, reflecting on this now, she is not sure if it would have changed her assessment given Jet's presentation before her.

72. Keating says that because Jet had "capacity and competency and was alert" she did not have the power to take his rights away.

73. Keating acknowledged that despite the decision to let Jet go home with Jorden that night, no advice was given to Jorden in respect of aftercare. She said that reflected her inexperience at the time. If she were in the same situation now, she would make sure the person was able to care for the patient and she would advise them they can always call the ambulance service if the patient's condition deteriorated. She conceded that not doing so was an oversight.

74. While acknowledging they were with Jet for only a short period, she felt it was enough time to complete her assessment.

75. Keating said her practices have changed following Jet's death in that she has gained field experience, and she now puts more information in her paperwork.

Peter Clemenson

76. Clemenson provided a statement dated 26 November 2021 and gave oral evidence at the hearing. Clemenson was the senior paramedic of the two paramedics.

77. As to his assessment of Jet, Clemenson says that Jet:

    a) was walking around, he was steady on his feet, he appeared slightly intoxicated (based on the manner in which he was speaking but he was not slurring or rushed in speech); and he was answering questions and coherent;

    b) knew where he was and what day it was, he was conscious, he was able to receive information, believe that information, retain that information, and explain it back to him;

    c) told him that he had taken four Valium through the day and had four beers that night; and

    d) denied wanting to harm himself or others and denied wanting to kill himself.

78. Clemenson recalls Jet saying that “he regularly sees his psychologist about his depression and anxiety” and that he did not want to go to the hospital that night.

79. He did not recall a lot of his conversation with Jorden as it was not recorded. However, he stated:

> *I do remember Jet’s brother coming over to me with his phone while I was assessing Jet. Because of my requirement to assess the patient, I remember directing Jet’s brother over to talk to someone else at the scene.*

80. He could see that Jorden was concerned and was looking for answers to questions. Jorden was asking him questions, but his attention was elsewhere (he had a trainee partner with him, Keating, and he was trying to listen to the conversation between her and Jet).

81. Clemenson did not confirm when the Valium was taken and acknowledged that timing can be important. He knows it can be the cause of an overdose and indicated he would have rung the poisons line if he thought that was required. He acknowledged that Jet’s presentation could have reflected the calming effect of Valium. He said that if he knew it was 8 Valium then he may have called the poisons line.

82. Clemenson was asked whether he considered whether Jet was concealing a suicidal intention. Clemenson said it did not appear that he was. Jet was concerned with getting to work the next day and having future plans is inconsistent with suicidal ideations. He said one needs to be careful when questioning a patient as suggesting they aren’t being truthful can break trust.

83. With respect to Jorden, Clemenson said that, at the time, his concentration was on what was happening in the ambulance with Keating and Jet. He acknowledged he may have appeared to be dismissive. He said he was “pretty sure [he] asked [Jorden] to tell police” the information Jorden was trying to convey. However, he acknowledges that he did not circle back to police to ascertain whether Jorden gave them any relevant information.

84. Having now read a transcript of the recording, Clemenson agreed that it painted a different picture of Jet and that it was relevant information. However, he said that the recording reflected Jet in crisis and his presentation when assessed by Keating was different. For the purposes of s 20 of the MH Act, more weight would have been given to his presentation.

85. Clemenson indicated his preference was for Jet to go to hospital but given his refusal, he did not consider himself empowered by s 20 to take him involuntarily. He considered Jet needed to be in the care of someone that night. He did not recall having a conversation with Jorden regarding aftercare.

86. He acknowledged the assessment was short, indicating that Jet did not really want to talk to the paramedics, and he considered it was adequate time to form a view and assess Jet's mental state.

87. If he were in the same situation today, he would have a conversation with a friend or family member of a patient about their care concerns.

Senior Constable Kaczmar

88. SC Kaczmar gave statements dated 24 March 2021 and 6 October 2023 as well as oral evidence at the hearing.

89. SC Kaczmar and Morrissey were first on the scene having been radioed after the call from an ambulance. SC Kaczmar's notes recorded:

> *took Valium 5mg tablets. 6 beers stubbies. Talking about going to work tomorrow. Aussie Hotel. Put $800 through pokies.*

90. SC Kaczmar says she conveyed this information to the paramedics. There is no mention in her notes of suicide attempt or threats. While she indicated in evidence that she recalled Jorden telling her Jet wanted to kill himself, she reflected that given the passage of time, her notes are likely more accurate.

91. She considered Jet to present as substantially intoxicated, slurring, yelling, and unsteady on his feet. She did not ask him questions, rather, she aimed to keep him calm until the ambulance arrived.

92. She does not recall Jorden trying to play her the recording and says if she had been asked to listen to a recording she would have. She also said if she knew of specific threats of harm, she would have conveyed these to the paramedics.

93. When the paramedics arrived, she introduced Jet and Jorden to the paramedics and stood to the side. In relation to the assessment as to whether Jet should be taken to hospital involuntarily, she acknowledged she had an independent power to do that but as a police officer she would ordinarily defer to NSWA. She did not consider police were as well equipped to deal with mental health crises as NSWA officers were. She undertook elective training in this area when offered as she thought it would be useful.

Glenn Morrissey

94. Morrissey gave a statement dated 4 January 2022 and oral evidence at the hearing.

95. He could not recall what they were told about the callout. He does recall Jet acting as if he were affected by alcohol (not slurring, but more so that it was obvious he had been drinking). Jet's shoes were wet, he was steady on his feet, and he was able to walk without stumbling or tripping over.

96. He recalls talking to Jorden but not what they talked about. He could not recall Jorden trying to play the recording. He did say that if he tried to play it, he would have listened.

97. Morrissey said that when attending mental health callouts, you talk to the patient but also anyone else who is present. On this occasion, he tried to build a rapport with Jet by talking about concreting. While they were there, Jet was not talking about self-harm and, to Morrissey's mind, he did not fit the criteria in s 22 of the MH Act for involuntary transport to a mental health institution. He could not recall knowing that Jet had taken Valium.

98. In relation to training, Morrissey indicated he thought the training methods offered by NSW police were inadequate.

Acting Superintendent Kirsty Hales

99. A/Superintendent Hales is the current Acting Commander for the Mental Health Command; a new unit established in July 2024 in response to NSW Police commitment to mental health. The Mental Health Command provides strategic guidance and oversight for mental health responses of NSW Police.

100. A/Superintendent Hales confirmed there is a memorandum of understanding in place as between NSW Health (including NSWA) and NSW Police to assist in the sharing of information so that they can work together as partner agencies to respond to mental health issues (**MOU**). The MOU was introduced in 2007 and updated in 2018.

101. As in this case, the call initially came in for an ambulance to be dispatched. NSWA initiated the police callout. The role of police, where there is no criminal activity, was to identify who they are dealing with and pass any information they gather to arriving paramedics. That was the action taken in this case.

102. Clause 3.1.1 of the MOU states:

> *Carers play an important role in the lives of people living with a mental illness. Partner agencies should make every effort to work with carers who can assist, provide information and critical knowledge regarding how best to work with the person with mental health issues. Information gained from family and carers may be highly relevant in determining the best care plan for the individual.*

103. A/Superintendent Hales indicated that it can be difficult where information differs between family members and the patient. Family relationships may be dynamic and it is important that the views of the patient are taken into account. There is the risk that family members can provide misleading information, for example in domestic violence matters.

104. A/Superintendent Hales gave evidence as to the current mandatory police training regime in relation to mental health, which includes:

    a) academy students: mandatory 3-hour session incorporating operational and clinical components concerning mental health;

    b) constables of 1-5 years' experience: online exam pertaining to 'de-escalation' at mental health incidents; and

    c) ongoing education: biannual online training: 2023/2024 'Communicate to Connect'.

105. Training is also developed in response to coronial findings and recommendations and in response to issues faced by frontline workers or information gained from expert opinions. Training is disseminated by a variety of means including in person, using scenario-based presentations, simulations, and online training to reach and appeal to a wider audience.

106. The next major topic of police training will focus the application of s 22 of the MH Act.

107. In the current matter, A/Superintendent Hales considered the police deferral to paramedics to be appropriate; however, she also acknowledged that police did give consideration independently to whether the threshold for transportation involuntarily under s 22 had been made and determined it had not.

108. A/Superintendent Hales acknowledged that, in this instance, Jorden had useful information which was not obtained (which was contrary to principles of best practice) but also considered that Jet's presentation at the time of assessment would be given more weight.

Professor Large

109. Professor Large is the Medical Superintendent of the Eastern Suburbs Mental Health Service and the former Clinical Director. He has experience with patients within hospital settings and in the field.

110. He gave evidence that suicide risk is very difficult to predict. In his experience, factors such as gender and recent discharge from a mental health facility are significant risk factors, whereas recent suicidal behaviours and suicidal ideation represent only a modest increased risk of suicide.

111. He considered that the assessment required to be undertaken by ambulance officers under s 20 and police under s 22 of the MH Act presents a very high bar before involuntary admission is appropriate. As a society we value personal liberty and this, Professor Large says, is reflected in the MH Act. Professor Large outlined that restrictive practices are not generally used to support those with suicidal ideation as people like to feel as if they have choices.

112. He considered that in Jet's case it was appropriate for the police to defer to the paramedics to make the decision as to whether he should be transported involuntarily.

113. He indicated that Valium can be problematic in suicidal situations as, in addition to a calming effect, it can also reduce the natural defences to suicide. He noted that Valium remains in the system for 72 hours. He confirmed that a dose of even 10 tablets would not in and of itself cause an overdose, however, it may have played a role in Jet's decision the next day.

114. Based on his review of the material, Professor Large considered the decision by the paramedics (and accepted by police) not to involuntarily transport Jet to a mental health facility was appropriate given Jet was coherent, co-operative, had future plans, appeared capable of making decisions about his own health care, and did not appear mentally disturbed.

115. He endorsed the reliance on the presentation of the patient over views of family and friends but acknowledged that if the attending officers had heard the recording, they may have made a different decision. He indicated that even if Jet had been taken to hospital he would likely have been discharged/not admitted.

Dr Thomas Evens

116. Dr Evens is the Acting Executive Director of Medical Services and Research for NSWA. He gave a statement dated 28 August 2024, in which he adopted the contents of the statement of A/Professor Jason Bendell dated 31 October 2023. Dr Evens also gave oral evidence at the inquest.

117. Of the response by paramedics to their assessment of Jet, Dr Evens confirmed that the primary obligation of the paramedics was to talk to Jet provided he had capacity. He indicated that the decision of a patient presenting with a mental health issue should be complied with. A person suffering from a heart attack can refuse treatment and so should a person with mental health symptoms.

118. Noting he was returning to Jorden's house in his care, he acknowledged that with Jet's consent, it would have been appropriate to talk to Jorden about when he should call another ambulance if Jet's condition deteriorated.

119. Dr Evens spoke to a number of changes made by NSWA since Jet's death to improve services provided to those impacted by mental health. These include:

    a) Introducing a targeted Mental Health Educational Work Plan for NSWA.

    b) A suite of new clinical practice guidelines relevant to the management of mental health related presentations – including highlighting in the clinical practice guideline the importance of obtaining a corroborative history by obtaining information from friends and family.

    c) Updating the existing NSWA protocol to include the STATE and THREAT acronyms as a checklist to assist in field assessments as to mental health risks. This was released on 28 June 2021. These provide structure to guide thinking and assessment, noting that paramedics are generalists and they won't have the same knowledge as a specialist mental health practitioner.

    d) The introduction of a virtual care clinic providing 24/7 clinical assistance for field officers.

120. In addition, the new guidelines incorporate the MOU to ensure NSWA officers would be confident that sharing information between agencies would not breach confidentiality.

121. Dr Evens confirmed that the MOU is currently under review with a view to updating and improving it.

122. While he acknowledged Professor Large's evidence that risk of suicide is largely unpredictable, he indicated that the tools currently being applied by NSWA officers such as the STATE and THREAT assessment acronyms have been prepared in conjunction with mental health experts. His view was that better educated NSWA officers will engage better with patients and be able to provide a better therapeutic response.

The statutory findings

123. The evidence establishes on the balance of probabilities that Jet Gallagher died at his home at 4/161 Broadmeadow Road, Broadmeadow NSW 2292, between 7am and 9.30am on 5 March 2021. The cause of death was in keeping with hanging and the manner of death was intentional self-harm.

Issues

A. The adequacy of any communication between attending NSW Police officers and/or attending NSWA officers, and Jorden Gallagher

124. Jorden had information which was relevant to the assessment of whether Jet should have been transported to a mental health institution involuntarily pursuant to either s 20 (by NSWA) or s 22 (by police) of the MH Act. That information included a recording of Jet indicating an intention to suicide as well as the fact that he had consumed 8-10 Valium tablets (and not 4) with the intention of suicide by overdose.

125. The MOU was in place at the time Jet was assessed. As extracted above, that document makes it plain that information from friends and family can be valuable to first responders when assessing a patient.

126. Jorden was adamant that he tried to speak to, and play the recording for, both police and the paramedics. I accept his evidence. It is particularly supported by Clemenson's evidence that Jorden came over with his phone and Clemenson told him to talk to police as he was listening to the conversation between Jet and Keating.

127. Dealing with police first, they were called by NSWA to assist. On arrival, it was apparent that there was no criminal activity and they were presented with a patient having a mental health issue. As such, they attempted to de-escalate the situation, keep Jet safe, and wait for the ambulance to arrive. Neither officer recalled being asked to listen to a recording and they said that if they were asked, they would have listened to it. While I found both officers to be honest witnesses, given the passage of time, I consider Jorden's evidence to be more credible in this regard.

128. Further, in context, the police were deferring to NSWA in circumstances where Jet's presentation was medical rather than criminal. It was appropriate in this case for the police to defer to NSWA. This position was supported by the evidence of Professor Large.

129. In saying that, given the MOU, it would have been open to the police to listen to the recording and obtain further information from Jorden with a view to providing that information to the paramedics before they determined whether Jet was to be taken to a mental health facility on an involuntary basis.

130. Turning to the paramedics, based on the dispatch records, they ought to have known that Jet was reported to have had an intentional overdose of 8 Valium tablets. Despite this, without reference to this, they responded on the basis of information provided by Jet to the effect that he had 4 Valium throughout the day and was not suicidal.

131. Both Keating and Clemenson were dismissive of Jorden when he attempted to convey to them not only his views but also the objective evidence in the form of the recording as to Jet's recent suicidal intentions.

132. While Clemenson says he told Jorden to speak to the police, he did not circle back to the police once Jet had been assessed to ascertain what Jorden had been trying to tell him.

133. In the circumstances, the paramedics failed to obtain information from Jet which was important to their assessment.

134. There is no doubt that the patient is paramount, however, that should not be to the exclusion of friends and family.

135. There is also the possibility of friends and family providing inaccurate or biased information, however, that does not preclude obtaining the information – it simply means information gathered must be balanced by the NSWA officer when making their assessment pursuant to s 20 of the MH Act.

136. In addition, the paramedics determined that Jet was able to go home with Jorden. No attempt was made by either Keating or Clemenson to provide Jorden with any advice as to aftercare or when it would be appropriate to call an ambulance if he deteriorated. Keating gave evidence that now, as a more experienced paramedic, she would check if the friend or family member was capable of caring for the patient and advise when an ambulance should be called. Clemenson also indicated that if placed in the same

position today he would have a conversation with a friend or family member about aftercare.

137. The communication as between the paramedics and Jorden was inadequate both in respect of obtaining relevant information from Jorden as to Jet's mental state and as to aftercare.

B and C. Whether Jet Gallagher's risk of suicide was appropriately identified and managed; and, whether Jet Gallagher ought to have been taken to hospital pursuant to sections 20 and/or 22 of the *Mental Health Act* 2007 (NSW)

138. While both the police and the paramedics had the power independently to have Jet taken to a mental health facility involuntarily, Morrissey and SC Kaczmar indicated that in the situation that presented, they would defer to the paramedics as they were presented with a medical issue. This was endorsed by the evidence of Professor Large.

139. Section 20 of the MH Act provides:

> *(1) An ambulance officer who provides ambulance services in relation to a person may take the person to a declared mental health facility if the officer believes on reasonable grounds that the person appears to be mentally ill or mentally disturbed and that it would be beneficial to the person's welfare to be dealt with in accordance with this Act.*

140. While Keating, as the junior paramedic, did not have the power to make the decision under s 20 of the Act, she considered the power was not triggered in circumstances where:

a) Jet was coherent;

b) he told her he was not suicidal and he talked about going to work the next day; and

c) he was alert and he appeared to have capacity and the competency to make his own medical decisions such that she would not have the right to take his liberty away.

141. Clemenson said that while he wanted Jet to go to hospital, given his refusal, he did not consider he had the power to take him involuntarily in circumstances where:

a) Jet was answering questions and was coherent, able to absorb and relay information, and denied wanting to harm himself or others; and

b) Jet confirmed he saw a psychologist and would prefer to speak to his psychologist than be taken to hospital.

142. While Clemenson acknowledged that having read the transcript of the recording taken by Jorden, it painted a different picture of Jet. He said that Jet's presentation at the time of assessment would have been more important to his assessment.

143. Professor Large reported that it is a high threshold to be met for involuntary transportation to a mental health institution pursuant to ss 20 and 22 of the MH Act. As noted above, as a society we value our liberty and this, Professor Large says, is reflected in the legislative test.

144. Professor Large considered the decision by Clemenson not to transport Jet on an involuntary basis was appropriate as Jet was capable at the time of making his own decisions about his medical care. He also indicated that had he been transported to Maitland Hospital, it is unlikely he would have been admitted.

145. Notwithstanding the finding that the communication as between the paramedics and Jorden was inadequate, the evidence does not indicate that the decision not to involuntarily transport Jet to a mental health facility was inappropriate.

D. The general care and attitude of attending officers towards Jet Gallagher

146. For the reasons outlined above, the primary first responders in this case were the paramedics.

147. While ultimately the decision made not to transport Jet to a mental health facility involuntarily was appropriate, the care provided to Jet on the evening before his death was very basic and did not accord with best practice. The paramedics:

a) did not have regard to the NSWA dispatch notes which indicated an intended suicide attempt and the suspected consumption of 8 Valium (when told by Jet it was 4 Valium, there was no attempt to ascertain why there was a discrepancy);

b) did not take the opportunity to engage with Jorden who had objective information relevant to their assessment; and

c) did not provide any recommendations as to aftercare in circumstances where Clemenson believed that Jet would be better off in hospital that evening.

Recommendations

148. I have above outlined the changes that have been implemented and plan to be implemented by NSWA which address the need for more training and education for NSWA officers responding to mental health incidents. Given the steps taken by NSWA since Jet's death, I do not consider it necessary to make specific recommendations in this inquest.

Conclusion

149. I will close by conveying to the Gallagher family my sympathy for the loss of Jet.

150. I thank the assisting team, Kate Holcombe and James Prindiville, for their outstanding support in the conduct of this inquest.

151. I thank the officer in charge, Senior Constable Nicole Davison for her work in conducting the investigation and compiling the brief of evidence.

Findings required by s 81(1) of the *Coroners Act* 2009 (NSW)

152. As a result of considering all of the documentary and oral evidence from the inquest, I make the following findings:

> *Identity: The person who has died is Jet Gallagher.*
>
> *Place of death: 4/161 Broadmeadow Road, Broadmeadow NSW 2292*
>
> *Date of death: 5 March 2021*
>
> *Cause of death: In keeping with hanging*
>
> *Manner of death: Intentional self-harm*

153. I close this inquest.

Magistrate R Hosking
Deputy State Coroner
NSW Coroners Court Lidcombe
Date 9 December 2024