CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Kevin Edwards
Hearing dates:	11 March 2024 – 12 March 2024; 5 August 2024 – 13 August 2024
Date of findings:	17 October 2024
Place of findings:	Coroners Court of NSW at Lidcombe
Findings of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – death as a result of a police operation – 23(1)(c) and 27(1)(b) of the *Coroners Act 2009* – diagnosis of drug-induced psychosis – diagnosis of substance abuse disorder – methylamphetamine – adequacy of mental health care and treatment – appropriateness of discharge plan – community treatment order – nature and adequacy of community mental health follow up – whether actions of NSW Police were reasonable and appropriate – motorway – use of OC spray – police restraint – first aid by police – adequacy of NSW Police first aid training – non-provision of CPR
File number:	2022/163555

Representation:	**Counsel Assisting the Coroner**: Mr A Casselden SC and Ms E Sullivan (March 2024), Ms C Newman (August 2024), instructed by E Trovato and A Johnson (Crown Solicitor's Office) **Family of Kevin Edwards:** Mr B Fogarty instructed by R Pietrini (Legal Aid) **NSW Commissioner of Police, NSW Police Force ('NSWPF'):** Ms K Burke instructed by S Robinson (NSWPF Office of General Counsel) **Sergeants Tesoriero, Jackson and Roberts:** Mr D Nagle instructed by D Longhurst (Police Association NSW) **Illawarra Shoalhaven Local Health District:** Mr J Harris instructed by D Hew (Norton Rose Fulbright) **Dr Luciano Diana**: Mr C Jackson instructed by J Alderson (Avant Law)
Findings:	**The identity of the deceased** The person who died was Kevin Neil Edwards. **Date of death** Kevin died on 5 June 2022. **Place of death** Kevin died at Liverpool Hospital. **Cause of death** Kevin's cause of death is unable to be ascertained. **Manner of death** Kevin died while experiencing a mental health episode, in the course of being restrained by the police who were attempting to prevent harm to Kevin and other road users on the M5 motorway.

Recommendations:	To the Commissioner of the NSW Police Force:
	1) The CPR/First Aid TECC PowerPoint presentation dated 2018-2019 be reviewed and updated to include the matters raised in Recommendation 3 from the inquest into the death of Omar Mohammad, with an emphasis being given to starting CPR in cases of a person who is unresponsive/unconscious and is not breathing normally. 2) That the annual mandatory CPR training be conducted in a venue with access to equipment allowing the playing of the PowerPoint presentation and any training videos (including videos which demonstrate what agonal breathing is); 3) That the CPR training materials and competency assessment (including the model and delivery) be reviewed by an independent external first aid expert to ensure compliance with the ARC Guidelines relating to the delivery of CPR with a particular focus on the recognition of when CPR should be initiated. 4) That the CPR training materials be reviewed and updated annually to ensure the information provided to police officers is up to date. 5) That scenario based training be rolled out in relation to the identification of abnormal/agonal breathing. 6) Consideration be given by NSWPF to consider updates required to the content of NSWPF training PowerPoints (such as Professor Holdgate's opinion that there should be a low threshold for commencing CPR; ensuring content is in line with the Australian Resuscitation Council's guidelines including not putting a casualty in the recovery position if they are not breathing)

Contents

INTRODUCTION 6
Purpose of an inquest and the role of the Coroner 6
The proceedings 7
Factual overview 7
Issues 8
BACKGROUND 9
CONSIDERATION OF ISSUES 35
Issue 1: Statutory Findings – Manner and Cause of Death 35
Manner and cause - evidence 35
Manner and cause – submissions 40
Manner and cause – consideration 41
Issue 2: The adequacy of the clinical care and treatment that Mr Edwards received at Shellharbour Hospital during the period 10 May to 30 May 2022 41
Issue 2(a) Was it appropriate to discharge Mr Edwards on 30 May 2022? 41
Evidence 41
Issue 2(b) Was the discharge plan appropriate in the circumstances? 43
Evidence 43
Issue 2(c) Relatedly, should a Community Treatment Order (including as to depot injections) have been sought prior to discharge? 48
Evidence 48
Issue 2(d) The nature and adequacy of follow-up in the community by the Illawarra Community Mental Health Service 52
Evidence 52
Issue 2(a), (b), (c) and (d) - Submissions 55
Issue 2(a), (b), (c) and (d) – Consideration 59
Issue 3: Whether the actions of the NSW Police Force (including in particular, Sergeant Mark Jackson, Sergeant Anthony Roberts and Sergeant Ethan Tesoriero) on 5 June 2022 were reasonable and appropriate in the circumstances (having regard to the applicable NSW Police Force policies and procedures) 61
Issue 3(a) – The interactions with Mr Edwards on the M5 61
Issue 3(b) – The use of OC spray against Mr Edwards 61
Issue 3(c) – The apprehension and restraint of Mr Edwards 61
Evidence 61
Submissions 63
Consideration – issues 3(a), (b) and (c) 65

Issue 3(d) - The nature and timing of the first-aid provided (including the non-provision of CPR and the repeated use of sternum rubs) 65
Evidence 65
Submissions 75
Consideration – issue 3(d) 76
Issue 4: Whether any recommendations are necessary or desirable in connection with Mr Edwards' death.. 77
Submissions 77
RECOMMENDATIONS.. 81
FINDINGS REQUIRED BY SECTION 81(1) 82
The identity of the deceased.. 82
Date of death.. 82
Place of death 82
Cause of death 82
Manner of death 83
ACKNOWLEDGEMENTS AND CONCLUDING REMARKS 83

INTRODUCTION

1. Mr Kevin Edwards (**Kevin**) was pronounced deceased on Sunday, 5 June 2022 at Liverpool Hospital, having been brought to the Emergency Department following an interaction with police on the M5 highway at Moorebank Avenue. Kevin was 41 years old at the time of his death.
2. I held an inquest into Kevin's death at Lidcombe Coroners Court on 11-12 March 2024 and 5-13 August 2024.
3. Kevin was dearly loved and supported by his family friends. Kevin's mother, father and sister, Joanne, attended the inquest each day. At the conclusion of the evidence, Joanne read out a touching family statement which gave the Court some insight into the man Kevin was and demonstrated just how much Kevin is missed.
4. Kevin's family gave him the nickname "Boomerang", as from time to time he would move out of the family home but he would always return. Kevin knew that his parents supported him, never gave up on him and he always knew that they would be there for him.
5. Kevin's parents described Kevin in the following way:

   "He was a laugh, he had a great sense of humour. He loved the outdoors, fishing and surfing. He had a large appetite, loved home cooking and KFC".
6. In the preparation of these findings, I have been assisted by the oral submissions of Counsel Assisting, and I have also been assisted by the submissions of counsel for the interested parties.

Purpose of an inquest and the role of the Coroner

7. Kevin's death occurred, relevantly "as a result of police operations" in that the police conduct was a contributing factor in a broad sense. Consequently, 23(1)(c) and 27(1)(b) of the *Coroners Act 2009* (***Coroners Act***) are enlivened and form the jurisdictional basis under which this inquest is required to be held.
8. Coronial proceedings are an inquisitorial exercise in fact finding – that is, an investigation aimed at discovering the truth, to the extent possible.
9. The inquest hearing is a public examination of the circumstances of Kevin's passing. My primary function – as the Coroner presiding – is to explore the circumstances in which Kevin's death occurred, with a view to making specific findings of fact as specified in s 81 of the Coroners Act, as to:

a. The person's identity;
b. The date and place of the person's death; and
c. The manner and cause of the person's death.

10. In this inquest, Kevin's identity and the date, and place of his death were not in issue.
11. Rather, the central issue concerned the manner and cause of his death, including the circumstances surrounding how Kevin came to be on the M5 motorway.
12. Further, a Coroner has the power to make recommendations under s 82 of the *Coroners Act* where it is considered necessary or desirable to do so in relation to any matter connected with the person's death which is the subject of the inquest. Coroners can make recommendations directed at opportunities for systemic improvement including as to matters of public health or safety or with respect to the investigation of his deaths.

The proceedings

13. The inquest hearing into Kevin's death was held over nine hearing days.
14. During the hearing, a comprehensive brief of evidence comprising ten volumes of documentary material, was tendered. Some oral evidence was then adduced from various witnesses.
15. As noted above, at the conclusion of the evidence on 12 August 2024 a touching family statement was read out by Joanne, and Kevin's family shared a moving photographic slide show depicting Kevin's life.

Factual overview

16. In the months prior to his death, Kevin had various encounters with police, admissions to hospitals for mental health reasons and suspected drug use. Most recently, Kevin had been admitted to Shellharbour Hospital (and specifically, the Eloura Mental Health Unit) on 10 May 2022; he was discharged from that facility on 30 May 2022 with a diagnosis of drug-induced psychosis and paranoid personality disorder. On 4 June 2022, the day prior to Kevin's death, a home visit was conducted by two mental health clinicians from the Illawarra Community Mental Health Service.
17. Kevin's interactions with police in the early hours of 5 June 2022 arose following calls from the public regarding an unknown male running in and out of traffic across lanes of the M5 near the Moorebank overpass. Kevin was first located

in the westbound lanes of the M5, directly beneath the Moorebank overpass. Sergeant Mark Jackson was first on scene, arriving around 3.41.14am. Shortly after, Sergeant Jackson made verbal attempts to convince Kevin to remove himself from the road and to safety but was unsuccessful. Following this, Sergeant Jackson made a broadcast over police radio requesting assistance on the basis that there was a highly intoxicated male in a dangerous situation on the M5. Sergeant Jackson continued to try and engage with Kevin, asking him to get off the road, but Kevin continued to evade him, running through traffic on the M5. Sergeant Jackson then administered oleoresin capsicum (**OC**) spray in an attempt to subdue Kevin. A physical altercation then ensued between Sergeant Jackson and Kevin with Sergeant Ethan Tesoriero and off-duty officer Sergeant Anthony Roberts arriving to assist (as well as a member of the public). Kevin was handcuffed at about 3:49am. As soon as he was handcuffed, Kevin went quiet. Approximately 30 seconds later, Kevin was positioned with his chest pressed up against the concrete bollard separating the lanes of the M5 and his arms pulled back, with handcuffs applied. He was then rolled or dropped over the concrete bollard onto the westbound lanes by police (where traffic had been stopped).

18. Whilst in police custody and apparently soon after handcuffs were applied Kevin’s physical condition declined. During the period from 3.50.37 to 4.00.53am, the extent of the police first aid administered was placing Kevin into the recovery position, monitoring his breathing and pulse infrequently, and applying ‘sternum rubs’. When paramedics from NSW Ambulance attended at around 4.00am, no CPR had been given to Kevin. At around 4.25am, Kevin was conveyed to Liverpool Hospital Emergency Department. He was declared deceased at 4.52am.
19. An autopsy report dated 21 September 2022 was prepared by Dr Kendall Bailey who opined that while there were many potential contributing factors to Kevin’s death, she could not identify a definitive cause of death.
20. The events leading up to Kevin’s death are discussed in further detail below.

Issues

21. As is the usual practice, an issues list was disseminated to the interested parties in advance of the hearing.
22. The issues which were the focus of the inquest hearing were:

1) Determination of the statutory findings required by s 81 of the *Coroners Act* including as to the manner and cause of Kevin's death on 5 June 2022.
2) The adequacy of the clinical care and treatment that Kevin's received at Shellharbour Hospital during the period 10 May to 30 May 2022, including:
   a. Whether it was appropriate to discharge Kevin on 30 May 2022;
   b. Whether the discharge plan was appropriate in the circumstances;
   c. Relatedly, whether a Community Treatment Order (including as to depot injections) should have been sought prior to discharge; and
   d. The nature and adequacy of follow-up in the community by the Illawarra Community Mental Health Service.
3) Whether the actions of the NSW Police Force (**NSWPF**) (including in particular, Sergeant Jackson, Sergeant Roberts and Sergeant Tesoriero) on 5 June 2022 were reasonable and appropriate in the circumstances (having regard to the applicable NSWPF policies and procedures), including in terms of:
   a. The interactions with Kevin on the M5;
   b. The use of OC spray against Kevin;
   c. The apprehension and restraint of Kevin; and
   d. The nature and timing of the first-aid provided (including the non-provision of CPR and the repeated use of sternum rubs).
4) Whether any recommendations are necessary or desirable in connection with Kevin's death

BACKGROUND

23. Kevin was born on 29 May 1981 in England. He immigrated to Australia as an infant with his mother, Diane Edwards and father, Glen Edwards,[1] as well as his older brother Gary. Kevin attended Parramatta Marist High School.[2]

---

[1] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 2 at [5]-[8].
[2] Ibid, p 2 at [10].

24. Kevin left school after obtaining his high school certificate in Year 10; he then began work as a motor mechanic at 'JB Auto'.[3] He resigned from this job after six months and commenced working for Linfox delivering goods.[4] Kevin held this job between 1997 and 2001.[5]

25. During the period 1997 to 1999, Kevin's family began to notice a shift in his behaviour.[6] He had begun staying out late, and around this time was thought to be using illicit drugs (aged 17). Kevin had also come to the attention of police for relatively minor offences.[7]

26. Around this time, Kevin informed his parents that he was smoking heroin.[8] He sought help and in 1998, completed the Rapid Drug Detox Program at Cumberland Hospital.[9] Kevin then went on to attend a live-in rehabilitation program at Odyssey House in Campbelltown.[10]

27. Following his rehabilitation, for a six-year period between 1998 and 2004, Kevin was able to maintain stable employment. During this period, his family believed that he was using heroin infrequently.[11] When he did use heroin, Diane Edwards noted that it "always led to him committing crimes and interacting with police."[12]

28. During 2004, Kevin ceased his employment, and his heroin use became more regular.[13] During 2006, Kevin was attending the Parramatta Drug Court once a fortnight for about 12 months.[14] He participated in a court-ordered methadone program. During this time, he spent three months in prison on remand. He completed his custodial sentence at Silverwater Prison, remaining on the methadone program.[15]

---

[3] Ibid, p 3 at [10]; Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 4 at [21].
[4] Statement of Diane Edwards dated 26 July 2022, vol 2, Tab 112, p 2-4 at [12].
[5] Ibid, p 32.
[6] Ibid, p 4 at [13].
[7] Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 7 at [37].
[8] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 5 at [17].
[9] Ibid, p 5 at [18].
[10] Ibid at [18]-[19].
[11] Ibid, p 6 at [21].
[12] Ibid.
[13] Ibid, at [22].
[14] Ibid, p 7 at [23].
[15] Ibid.

29. In 2007, Kevin elected to cease his engagement in the methadone program.[16] During this period, he was sentenced to imprisonment for seven months at Parklea Correctional Centre.[17]

30. Between 2009 and 2010, Kevin alternated between abstaining from heroin use and relapsing; he continued to attempt rehabilitation at various times.[18]

31. In March 2011, Kevin was involved in an incident with police where he sustained a traumatic brain injury. It appears he had been running from police and then hit his head on the ground after jumping over a 1.8-metre metal gate fence.[19] Kevin was taken to Westmead Hospital where he was in ICU for a number of weeks. Despite requiring part of his skull to be removed (a craniotomy), Kevin made a quick and full recovery.[20] It appears there were no long-term cognitive injuries.[21]

32. From 2013, both Kevin's parents noted a shift in his behaviour, describing it as "delusional".[22] He began talking to himself, falsely believed people were using guns to shoot at the house and kept a knife under his bed.[23] This was the first time Diane and Glen Edwards were aware of any mental health issues affecting Kevin.[24] Years later, Kevin acknowledged that he was using "ice" heavily around this time, which he said had made him delusional.[25]

33. From 19 April 2014 to 24 April 2014, Kevin spent five days admitted to the Mental Health Unit of Cumberland Hospital, Westmead.[26] The principal diagnosis was "drug induced psychosis" with "substance abuse disorder".[27] Kevin admitted to having used ice for the past twelve months.[28] Kevin was discharged to WHOS Rehabilitation centre in Lilyfield where he undertook a

---

[16] Ibid, at [24].
[17] Ibid.
[18] Ibid, p 8 at [46]-[47].
[19] Ibid, at [48].
[20] Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, pp 8-9 at [48]-[49].
[21] MDT Meeting dated 15 April 2021 – Shellharbour Hospital Records (Part 2), Vol 5, Tab 155, p 238.
[22] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 12 at [39].
[23] Cumberland Hospital Mental Health Unit – 'Medical Report as to Mental State of a Detained Person' dated 19 April 2014, Vol 3, Tab 152, p 173.
[24] Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 10 at [58].
[25] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 13 at [39].
[26] Cumberland Hospital Mental Health Unit – 'Transfer/Discharge Summary' dated 24 April 2014, Vol 3, Tab 152, p 120.
[27] Cumberland Hospital Mental Health Unit – 'Admission Registration Form' dated 23 April 2014, Vol 3, Tab 152, p 119; see also 'Transfer Discharge Summary' dated 24 April 2014, p 72.
[28] Cumberland Hospital Mental Health Unit – 'Admission Registration Form' dated 23 April 2014, Vol 3, Tab 152, p 120; We Help Ourselves (WHOS) Rehabilitation Medical Records 'Client Details' Vol 6, Tab 159, p 8.

residential rehabilitation program for a four-month period from 17 April until 24 July 2014.[29]

34. In 2017, Kevin served an 18-month custodial sentence for a number of offences, namely larceny, aggravated break and enter in company and destroy or damage property. While in custody, Glen Edwards described his son as "the healthiest he had ever been, since he was 18".[30]

Mental health decline 18 months prior to death

35. From March 2021, Kevin's mental health deteriorated significantly; he became increasingly erratic. Glen Edwards referred to his son's mental health as "spiralling out of control".[31] Diane Edwards noted a significant shift in Kevin's personality over the last 18 months of his life (despite his 20 years of addiction): he became paranoid and psychotic.[32]

24 to 31 March 2021 – Cumberland Hospital, Westmead

36. On 24 March 2021, Kevin was found by police, shirtless, running in and out of traffic on the M4 highway.[33] He was taken to Blacktown Hospital for a mental health assessment; he was then transferred to Cumberland Hospital for containment, diagnostic clarification and treatment.[34] Kevin had expressed the belief that someone was following him and also that "someone had inserted a microchip behind his ear"; his urine screen indicated the presence of several substances, including methamphetamines.[35] A diagnosis of drug induced psychosis and anti-social personality disorder was recorded.[36]

37. On 31 March 2021, Kevin was discharged into the care of his parents, with a one-week supply of Clopixol tablets; they were advised to contact the Illawarra Community Health Team.[37]

---

[29] Cumberland Hospital Mental Health Unit – 'Transfer/Discharge Summary' dated 24 April 2014, Vol 3, Tab
152, p 120; We Help Ourselves (WHOS) Rehabilitation Medical Records 'Client Details' Vol 6, Tab 159, p 8.

[30] Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 11 at [64].

[31] Ibid, at [67].

[32] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 28 at [97].

[33] Cumberland Hospital Mental Health Unit - 'Request by a member of NSW Police Force for assessment of a detained person' dated 23 March 2021, Vol 3, Tab 152, p 112; Blacktown Hospital Medical Records – 'Discharge Transfer Documents' dated 23 March 2021, Vol 3, Tab 152, p 5.

[34] Blacktown Hospital Medical Records – 'Discharge Transfer Documents' dated 23 March 2021, Vol 3, Tab 152, p 6.

[35] Cumberland Hospital Mental Health Unit Records - 'Discharge Transfer Documents' dated 31 March 2021, Vol 3, Tab 152, p 12.

[36] Ibid, p 13.

[37] Ibid; NB: Clopixol is an oral anti-psychotic drug.

14 April to 20 May 2021 – Shellharbour Hospital (Eloura Mental Health Unit)

38. On 14 April 2021, Kevin voluntarily attended Shellharbour Hospital with police. He had earlier presented to the police station with concerns about a microchip being placed in his right ear.[38] The discharge includes the following notes:

> On review, Mr Edwards was noted to express paranoid delusions of being drugged 9-12 months ago with the claim that he had the microchip inserted on his right ear. He reported having the onset of auditory hallucinations 3 months ago which were commanding and derogatory in nature. He also reported feeling at times that he was being followed. Mr Edwards explained that he had presented to the police in the hopes that he would have his concerns made official by being documented by the police. He was noted to agree to staying as a voluntary patient as he expressed that he wanted to figure out the source of the Bluetooth microchip. Mr Edwards had an MRI scan of the brain with mastoid views which was noted to be unremarkable. This was presented to Mr Edwards to the MRI evidence. However, he was noted to be guarded about his beliefs that he had voiced earlier and became agitated and aggressive on the ward. Mr Edwards was placed under the *Mental Health Act* as mentally ill and was transferred to the High Care Area for ongoing care due to the level of aggression he had been exhibiting with severe thought disorder. He was commenced on risperidone 2mg once daily and was later increased to 3mg once daily with mild effect. On review of his past history, Mr Edwards was noted to have had previous admissions to Cumberland Hospital for drug-induced psychosis with discharge on a regular anti-psychotic medication. However, he was noted to be non-adherent with the medication once he had returned to the community which likely precipitated in the relapse of the current psychotic symptoms.
>
> Since the commencement of the oral risperidone, Mr Edwards has been noted to have improved in his mental state. He was commenced on paliperidone 150 mg IM loading dose on 10 May 2021 with the next initial

[38] Shellharbour Hospital Records (Part 2) – 'Triage Form Shellharbour Hospital' dated 14 March 2021, Vol 5, Tab 155, p 362.

dose on 17 May 2021 with good effect. Mr Edwards has been noted to be at his baseline mental state with no current evidence of psychosis or thought disorder. Mr Edwards had a CTO hearing on 21 May 2021 and was granted 6 months of the CTO with community mental health team follow up. Mr Edwards was discharged home with plan for 48 hour follow up by the CMHT, follow up with his GP and advised to present to the emergency department if in crisis.[39]

39. On 10 May 2021, Kevin was permitted to leave to reside with his parents; he remained an involuntary patient (meaning police could bring him back should he be "AWOL").[40] Kevin was to return on 14 May 2021 for a review.[41]

25 May to 20 November – Community Treatment Order

40. On 15 May 2021, Kevin's family called police to report a change in his behaviour.[42] Kevin was noted to be "agitated and anxious".[43] Following a dispute between Kevin and a neighbour, the police arrived and placed Kevin under arrest on suspicion of assault.[44] He was taken to Shellharbour Hospital where he was re-admitted as an involuntary patient.

41. On 25 May 2021, Kevin was released to a Community Treatment Order (**CTO**).[45] Kevin was discharged home, with a 48-hour follow up by the Community Mental Health Team scheduled.[46] He was instructed to follow up with his GP and to present to the Emergency Department if in a state of crisis.[47]

---

[39] Ibid, pp 201-202.
[40] Shellharbour Hospital Records (Part 2) – 'Family Meeting and Dr Tietze Review' dated 10 May 2021, Vol 5,
Tab 155, p 224.
[41] Ibid, p 225.
[42] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 16 at [53].
[43] Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 14 at [84].
[44] Ibid, p 15 at [87].
[45] Shellharbour Hospital Records (part 2) – 'Discharge Referral' dated 25 May 2021, Vol 5, Tab 155, p 203.
[46] Ibid, p 202.
[47] Ibid.

CTO Treatment Plan

42. From 25 May until 20 November 2021, Kevin was subject to the CTO. The treatment plan mandated the following:
    a) Taking 100mg Paliperidone intramuscular every four weeks;
    b) Attending reviews with a doctor or delegate at least bi-monthly for reviews of his mental state, medication and continued care planning; and
    c) Meeting with the primary clinicians or delegate at least fortnightly.[48]

Reduction in depot injections

43. From 26 July 2021, Kevin began raising concerns with symptoms associated with the Paliperidone injections; he reported feeling slow and lethargic. RN Adam Knight suggested reducing the dose of depot.[49] On 28 July 2021, Kevin ceased Paliperidone injections and was instead treated with Aripiprazole injections.[50]
44. On 11 August 2021, RN Knight contacted Diane Edwards to discuss Kevin's transition in medication. Mrs Edwards was informed that her son would have to take oral medications (Ablilify tablets) to facilitate the transition; she expressed concern that he would not take the oral tablets.[51]
45. On 6 September 2021, Kevin complained of the side effects of this medication, stating that his mood was flat and that he felt "like a shell".[52] Accordingly, that same day, Dr Marcus Ng (psychiatrist), reduced Kevin's medication regime to Aripiprazole 300mg IM 4-weekly.[53]

---

[48] Illawarra Community Mental Health – 'CTO Treatment Plan' dated 20 May 2021 Vol 5, Tab 153, p 148.
[49] Illawarra Community Mental Health Unit – 'Mental Health Progress Note' dated 26 July 2021, Vol 5, Tab 153, p 92.
[50] Illawarra Community Mental Health Unit – 'Mental Health Review' dated 7 September 2021, Vol 5, Tab 153,
p 36.
[51] Illawarra Community Mental Health Unit –'Mental Health Progress Note' dated 11/08/2021, Vol 5, Tab 153, p 93, 94.
[52] Illawarra Community Mental Health Unit – 'Psychiatrist Review South FACT OPD' dated 6 September 2021,
Vol 5, Tab 153, pp 102-105.
[53] Illawarra Community Mental Health Unit – 'Mental Health Care Plan' dated 7 September 2021, Vol 5, Tab
153, p 29.

46. On 25 September 2021, Kevin again raised concerns about his depot medication regime – the injections "were not agreeing with him". He reported feeling "dulled" and having a loss of libido.[54]

47. On 7 October 2021, Dr Ng again changed Kevin's medication regime:
    - Aripiprazole 400mg IM 4-weekly – ceased today.
    - Lurasidone 40mg nocte commenced today.
    - Nil other medications.[55]

48. On 25 October 2021, RN Alison Stickland spoke with Mrs Edwards. She reported no concerns regarding her son's mental state and believed that he was compliant with his oral medication.[56]

CTO Lapses

49. Throughout the CTO, Kevin repeatedly vocalised his desire to come off it.[57] On 6 September 2021, Dr Ng noted that:

    > If allowing CTO to lapse, could trial increasing time between depot doses and monitoring closely for EWS of relapse rather than ceasing abruptly.[58]

50. On 7 October 2021, Dr Ng formulated a plan to "Observe on oral medication next few weeks and let CTO lapse".[59]

51. On 22 November 2021, a final review was conducted by Dr Ng and RN Strickland. Notes record that Kevin's "schizophrenic like illness" was in remission; his insight and judgement were "reasonable" and his compliance with medication was recorded as good.[60] The plan was noted as follows:

---

[54] Illawarra Community Mental Health Unit – 'Psychiatrist Review South FACT OPD' dated 25 October 2021,
Vol 5, Tab 153, pp 129-130.
[55] Illawarra Community Mental Health Unit – 'Psychiatrist Review South FACT OPD' dated 7 October 2021, Vol 5, Tab 153, p 111.
[56] Illawarra Community Mental Health Unit – 'Mental Health Progress Note' dated 25 October 2021, Vol 5, Tab
153, p 132.
[57] See generally: clinical notes contained in Illawarra Community Mental Health Unit, Vol 5, Tab 153.
[58] Illawarra Community Mental Health Unit – 'Psychiatrist Review South FACT OPD' dated 6 September 2021,
Vol 5, Tab 153, p 105.
[59] Illawarra Community Mental Health Unit – 'Psychiatrist Review South FACT OPD' dated 7 October 2021, Vol 5, Tab 153, p 114.
[60] Illawarra Community Mental Health Unit – 'Psychiatrist Review South FACT OPD' dated 22 November 2021, Vol 5, Tab 153, pp 140, 141.

> **Plan**
>
> Continue lurasidone 40mg nocte for at least one year before consideration of reducing or ceasing under guidance of doctor.
>
> Collateral information form mother and inform of discharge plan.
>
> Work with mother around monitoring of mental state and EWS of relapse.
>
> Monitor closely for EWS of relapse.
>
> Motivational interviewing regarding substances.
>
> IDAS in the future if desired.
>
> Complete support with current housing issues then can discharge from FACT to GP care.
>
> Welcome re-referral in the future.
>
> Safety plan discussed.[61]

52. In the Discharge Referral dated 26 November 2021, it was noted that:

> Kevin maintained his obligations for the order and was changed to oral medication prior to its completion. Kevins symptoms had resolved and he was willing to continue treatment under the management of the GPs at Shellharbour Family Healthcare
>
> Kevin's carers Mother and Father aware of discharge and happy with Kevins progress. Kevin also was assisted with documentation for Housing and referred to St Vincent de Pauls service to get help with finding accommodation.[62]

Further Mental Health Decline – February 2022

53. Kevin's mental health further declined in February 2022. Around this time, Mrs Edwards observed him to be increasingly paranoid and anxious.[63] He was fixated on electronic devices (including setting up cameras in a room, which were not plugged in; pulling apart his mobile phone); he also pulled apart the inside of the boot of his car, pulled drawers out in order to search for potential

---

[61] Illawarra Community Mental Health Unit – 'Psychiatrist Review South FACT OPD' dated 22 November 2021, Vol 5, Tab 153, p 141.

[62] Illawarra Community Mental Health Unit – 'Discharge Referral dated 26 November 2021', Vol 5, Tab 153, p 17.

[63] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 18 at [60].

hidden objects and made a small hole in his wardrobe into the wall as if to look into the wall to ensure nothing was hidden within it.[64]

54. On 23 February 2022, Kevin was admitted to Wollongong Hospital after he had been observed on a neighbour's roof yelling. Police conveyed Kevin to hospital.[65]

10 to 30 May 2022 – Shellharbour Hospital, Eloura Mental Health Unit (AAA)

55. On 10 May 2022, Kevin was staying at his parents' home in Shell Cove; police attended the residence following a report from a woman that she had been followed by a man acting weirdly during the school drop off. The woman managed to take photographs of the man who had followed her (which are readily identifiable as Kevin).[66] On arrival, police observed Kevin repeating conversations "on a loop" and saying nonsensical things.[67] Kevin became "agitated and anxious" which led the police to call the mental health team.[68] NSW Ambulance attended, and ultimately, Kevin did not cooperate and was aggressive; it was necessary to sedate him, and convey him to hospital.[69] Further details of how Kevin presented are noted in the NSW Health form completed by Senior Constable Weston on 10 May 2022 describing the circumstances of Kevin's apprehension.[70]

56. Kevin was then admitted to the Eloura Mental Health unit as an involuntary patient under s 22 of the *Mental Health Act 2007* (***Mental Health Act***) on the basis of "antisocial behaviours and persecutory thoughts."[71] Subsequent assessments by medical practitioners on 10,[72] 11,[73] and 16 May 2022[74]

---

[64] Ibid, pp 19-20 at [64] - [65].
[65] Wollongong Hospital Records – 'Triage Form' dated 23 February 2022, Vol 6, Tab 156, pp 7-8.
[66] Statement of Alana Oppert dated 22 June 2022, Vol 6, Tab 170, p 6.
[67] Statement of Detective Senior Constable Darryl Smith dated 18 July 2022, Vol 6, Tab 175 p 2 at [7].
[68] Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 17 at [101].
[69] Statement of Detective Senior Constable Darryl Smith dated 18 July 2022, Vol 6, Tab 175 pp 2-3, at [9] – [12];Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 18 at [103].
[70] Request by a Member of NSW Police Force for Assessment of a Detained Person dated 10 May 2022, Vol 5,
Tab 155, p 133.
[71] Discharge Referral dated 27 May 2022, Vol 5, Tab 155, p 9.
[72] This Form 1 report concluded that Mr Edwards was "Mentally disordered – possible drug induced psychosis vs intoxication however diagnostic clarification required): Vol 5, Tab 155, pp 30 – 31.
[73] This Form 1 Report (prepared by Dr Luciano Diana referred to "Erratic and disorganised behaviour"; disordered thinking and concluded: "He is mentally disordered, likely affected by amphetamines, a danger to self and others": Vol 5, Tab 155, pp 32-33.
[74] This Form 1 Report by Dr Luciano Diana noted: "Previous diagnosis of schizophrenia, wife mother reporting

(pursuant to s 27 of the *Mental Health Act*) confirmed that Kevin was a mentally ill person.

57. On 10 May 2022, a chest x-ray was conducted; it relevantly noted that the cardiac and mediastinal contour was normal and the lungs were clear.[75]

58. On 12 May 2022, notes from a ward round (including consultant psychiatrist Dr Luciano Diana and psychiatry registrar Dr Stephen Khoo), refer to Kevin stating he wanted to go home, he "believes there is nothing wrong mentally…"; he denied having a microchip implant (amongst other denials), but believed that his friends' wife had 'spiked his coffee with amphetamines which is why his urine screen was positive'.[76] His thought content was noted to be "fixated on someone throwing fruit at neighbours house, wants to leave hospital, doesn't have a mental illness".[77]

59. On 12 May 2022, Kevin signed a 'Nomination of designated carer' form which excluded his mother (Diane Edwards) and sister (Joanne Edwards) from information or consultation about his treatment.[78]

60. On 13 May 2022, notes from a ward round referred to Kevin being irritable, and "at times intimidating and demanding".[79] A physical examination conducted by Dr Monique Costello, junior medical officer, was undertaken on this date ("delayed due to patient behaviour and refusing examination"); notes from that examination noted "Patient reported no concerns"; and "Patient denies any medical conditions".[80] Some bruises and abrasions were noted.[81]

61. On 14 May 2022, during a review by the Registrar (James Crawford), Kevin expressed his "displeasure about his ongoing involuntary admission"; he refused to engage with questions regarding the circumstances of his admission. As to 'Impression', it was noted: "Not currently meaningfully engaging in

---

worsening paranoia and persecutory delusions, especially involving neighbours. Followed a woman his car …".
As to a conclusion: "On balance of probability this is a paranoid psychosis with a risk of harm to others": Vol 5,
Tab 155, pp 34-35. A similar report was prepared by Dr Khoo on the same day: see Vol 5, Tab 155, pp 36-37.

[75] Ibid, p 127.
[76] Ibid, Vol 5, Tab 155, pp 53-54.
[77] Ibid, p 54.
[78] Ibid, p 21.
[79] Ibid, pp 58-59.
[80] Ibid, pp 125-126.
[81] Ibid, p 127.

review".[82] A subsequent note entered by nursing staff (Molly Hurst RN) noted that Kevin was "behaviourally unsettled on the unit today", and that he was "rude, irritable and elevated during interactions", and that he used stand over tactics when engaging with staff.[83]

62. On 15 May 2022, a review by the Registrar (Finlay McDonald) referred to Kevin being superficial and guarded; there was a "concerning presentation with paranoid ideation. At this time not engaging in substantial review of mental state".[84]

63. On 16 May 2022, notes from a ward round recorded that Kevin denied using amphetamines and stated that he was at a friend's house and "she may have put something in his drink"; he denied hearing voices or others being able to hear his thoughts; he stated that he was going to move to Doonside with a friend, Debbie. His behaviour was described as "evasive, dismissive, guarded", and his insight as "poor". The 'Impression' was recorded as "likely psychotic illness".[85]

64. On 17 May 2022, nursing notes record "nil evidence of psychosis observed this morning"; and also that Kevin was "happy to [accept] treatment".[86]

65. On 19 May 2022, notes (of Dr Costello) record a visit from Diane Edwards the day prior; it is noted: "Believes he is getting back to normal self … Believes lack of sleep is possible the reason for his set off, plus also the spiked drink."[87]

66. On 21 May 2022, nursing notes record that Kevin was settled and accepting of treatment; and also that he expressed "moderate insight".[88] Similar notes are recorded on 22 May 2022.[89]

67. On 23 May 2022, notes from a ward round recorded that Kevin was sleeping well; that his mother visited the day prior and "thinks he is doing well"; he was not hearing voices or thoughts that someone was following him; he denied various allegations (such as throwing fruit at neighbours or following a woman

---

[82] Ibid, p 62.
[83] Ibid, p 63.
[84] Ibid, p 64.
[85] Ibid, pp 69-71.
[86] Ibid, pp 74-75.
[87] Ibid, pp 81-82.
[88] Ibid, pp 86-88.
[89] Ibid, p 91.

in his car). A Mental State Examination recorded linear thought form and a good mood; his insight remained poor.[90]

68. On 23 May 2022, Kevin had lodged a further appeal to the Mental Health Review Tribunal (**MHRT**) against the refusal to allow him to discharge himself.[91]

On 24 May 2022, Dr Khoo (Psychiatry Registrar) prepared a report for the MHRT on behalf of Dr Diana. It relevantly stated (underlining emphasis added):

> **Current admission:**
>
> 40 yr old male from Shellcove living with his parents and working part time as an arborist in Sydney, brought into hospital by police with behavioural disturbance, paranoid delusions and thought disorder in the context of suspected ICE use. Police allege that the patient had been following a woman home from a school after picking up her child, as well as reports regarding the patient allegedly throwing fruit at his neighbour's house. Kevin Edwards has been guarded and suspicious when attempting to discuss the events leading to his admission, he reports a delusional belief of being drugged without his knowledge days or weeks earlier than his presentation by a friend's wife as his explanation for returning a positive urine Amphetamine test, despite these tests being unlikely to detect these substances this long after substance use.
>
> Kevin had been very evasive and dismissive of the events leading to the police bringing him to hospital, alleging that they had made a mistake, denying having followed the woman, despite later describing the woman he allegedly had followed and accusing her of using substances due to her appearance. Kevin reports that he had not thrown fruit at his neighbour, denies that anything had happened, and denies any involvement. He reports that his neighbours must have misinterpreted the actions of someone else who may have been feeding birds, but denies being involved in throwing fruit, denies feeding the birds, denies any wrongdoing, and unable to engage

[90] Ibid, pp 94-95.
[91] Ibid, p 131.

meaningfully with treatment due to high levels of avoidance and evasiveness.
Considering the previous diagnosis of Schizophrenia and previous treatment with CTO and antipsychotic depot medication, as well as the apparent highly concerning behaviours leading to this admission with considerable risk to the public, the treating team believe that management with antipsychotic medications is necessary, including consideration of further uptitration of oral medications and consideration of Injectable depot antipsychotic medications and ongoing treatment on a CTO prior to discharge. This will require some additional time in hospital considering the patient's ongoing evasiveness and minimal engagement with treatment, suggesting an element of underlying paranoia and ongoing psychotic mental illness.
There is documentation and collateral which reports that Kevin's mental state was more stable while he was managed on depot antipsychotics with CTO in place.

Background:

Previous admission in April 2021 with the diagnosis of schizophrenia, polysubstance abuse and antisocial personality
traits
- Treated with Depot antipsychotics [Paliperidone] and CTO

There remains ongoing mental illness, as per the Mental Health Act (2007), as evidenced by:
A) Paranoid beliefs regarding being drugged, and of wrongful admission, evidenced by ongoing guardedness, evasiveness and minimal engagement with the psychiatric reviews.
This mental illness remains associated with a risk of the following significant harms:
A) Risk of significant : Harm to others especially when intoxicated by illicit substances and the patient’s alleged stalking behaviour, and alleged inappropriate behaviours towards the neighbours.
B) Risk of deterioration in mental state, with a contingent recurrence of the above risks, if discharged prior to the establishment of a observably efficacious treatment regimen

> The treating team requests an inpatient order of SIX (6) weeks with the therapeutic goals of this period being continuing observation of her mental state, continuing psychological therapy, continuing rallying of community supports, safety planning. It is the opinion of the treating team that a SIX (6) week inpatient order is the least restrictive, safest and most effective form of care at this stage.
>
> **Plan**
>
> Ongoing monitoring of mental state
>
> Ongoing up-titration of antipsychotic medications
>
> Consideration of switching to an Injectable Depot form of the antipsychotic medication
>
> Consideration of CTO application[92]

69. Also on 24 May 2022, Dr Monique Costello (JMO) telephoned "Debbie" (Debbie Curtis) to obtain a collateral history; Debbie said she had known Kevin for five years and that they had been back together since December 2021.[93] The following is also recorded:

> Kevin said that one of the neighbours and someone else knows (Debbie not sure who) were involved in the hacking.
>
> Debbie has been in contact with Kevin daily for most of his admission.
>
> She believes he has improved and is much more his usual self, happier and more joyful.
>
> Debbie is looking forward to Kevin being discharged and moving back to Doonside to live with her.
>
> Debbie is able to assist with helping Kevin to be compliant with medication. She believes Kevin doesn't want a depot.
>
> Debbie has no concerns for discharge.[94]

70. On 25 May 2022, Kevin came before the MHRT for a mental health inquiry. The Tribunal determined (pursuant to s 35 of the *Mental Health Act*) that Kevin was a mentally ill person and that he "must be detained in or admitted and detained in Shellharbour (Psych Unit) for further observation or treatment or both, as an

[92] Ibid, pp 196-198.
[93] Ibid, p 99.
[94] Ibid, pp 99-100.

involuntary patient until a date no later than 15 June 2022". The reasons were noted as follows (underlining emphasis added):

> Mr Edwards continues to experience paranoid delusions. He plans to move out of area when discharged. There is a need to ensure a safety discharge plan until hand-over to the Community Mental Health team. If Mr Edwards were to be discharged at this time without appropriate support in the community his mental state would be likely to deteriorate. If this occurs he would present a risk of damage to his reputation and harm to others.[95]

71. On 25 May 2022, a nursing note recorded that following his MHRT hearing, Kevin was "making sarcastic remarks … about team and nursing staff, laughing inappropriately". PRN medication administered as per Kevin's request to "settle down and relax".[96]

72. On 26 May 2022, a note from the ward round (entered per Dr Monique Costello, JMO) recorded that Kevin was "feeling good" and did not think he needed community health follow up, "though did state that it is up to the treating team"; it notes: "is not hearing voices, doesn't feel others can know what he is thinking. TV is not sending him messages. Neighbours do not have it in for him. Mother visited yesterday, which was good … Stating his drink was spiked by a friend in dapto … Denies ever taking amphetamines". The plan was noted as: "Discuss with Doonside community mental health team regarding discharge. Risperidone 3mg nocte".[97] This appears to have been the first contemplation of Kevin's potential discharge.

73. A subsequent progress note later that day at 11.48am (entered by Dr Khoo, psychiatry registrar), recorded the following:

> Contacted the Western Sydney LHD Mental Health Line
> Informed them that our patient will likely discharge next week and checked if they can provide Community Mental Health Follow Up on discharge for patients on oral medications only.
> - Happy to provide this, and if patient is not requiring CTO then can contact the Mental Health Hotline on the day of discharge to provide

[95] Ibid, 'Determination of Tribunal' dated 25 May 2022, pp 18-19.
[96] Ibid, p 103.
[97] Ibid, pp 105-106.

details for referral to their service for case management or brief follow up.

- If requiring CTO then will need to contact them to make a referral to arrange CTO Plan if CTO is being sought.

PLAN:

Will discuss with Dr Diana re: discharge timing.

Refer to CMHT (Doo-side – Western Sydney) on day of discharge.[98]

74. At 2.25pm, a further note was entered by Dr Costello, who noted: "Discussed plan for follow up with community team on discharge. Will remain on oral medication. Hoping for discharge within next 1-2 weeks".[99]

75. On 27 and 28 May 2022, nursing notes record that Kevin was settled, engaging well with others and accepting of medication.[100]

76. On 29 May 2022, nursing notes recorded that Kevin was calm, polite and pleasant with staff and engaging appropriately with other consumers; "nil paranoia or delusional content expressed to staff" and he accepted his medication. Kevin was visited by his parents "which appeared to go well".[101]

Discharge from Eloura Mental Health Unit – 30 May 2022

77. On 30 May 2022, notes of a ward round at 9.50am conducted by Dr Diana and Dr Costello record that despite there being, "no outward signs of psychosis", Kevin "continues to be evasive about his legal issues" and is recorded to have "poor" insights.[102] The records further note that the plan is for Kevin to be "discharged today to his own care" with "Debbie Curtis as primary carer" and to "continue risperidone 3mg nocte".[103]

78. A discharge nursing note (entered around 10.41am by Sarah Quinnell, EEN) stated that Kevin was discharged at 10.30am, "picked up by mum, Consumer called primary carer and aware of d/c … 48hr follow up booked, handover given to CMHT and Informed consumer of appointment, organ card given to consumer, D/C medications from pharmacy collected and given on d/c".[104]

---

[98] Ibid, p 108.
[99] Ibid, p 109.
[100] Ibid, pp 111-116.
[101] Ibid, pp 117-118.
[102] Progress Note dated 30 May 2022, Vol 5, Tab 155, pp 121-122.
[103] Ibid.
[104] Ibid, p 123.

Records confirm that Kevin was provided with five days' supply of Risperidone.[105]

79. A note entered by Dr Costello at around 3.10pm recorded "Phone discussion with mother Diane: Outlined discharge plan; Diane was agreeable".[106]

80. The 'Discharge Referral' for this admission (dated 30 May 2022) notes, among other things, the following (emphasis added):[107]

> Associated diagnoses: paranoid personality disorder; Observation for suspected mental and behavioural disorders; Mental and behavioural disorders due to use of other stimulants, including caffeine, acute intoxication
>
> …
>
> Date of admission: 10/05/2022 17:14
>
> Date of discharge: 30/05/2022 10:17
>
> <u>Reason for admission: Antisocial behaviours, persecutory thoughts</u>
>
> …
>
> Plan as per treating team
>
> 1) Discharge to care of partner in Doonside
> 2) Community Mental Health Follow up for 2 weeks on discharge by Western Sydney CMHT
> 3) Recommend Kevin to contact the local drug and alcohol service for ongoing assistance maintaining abstinence from methamphetamine and other illicit substances on discharge.
> 4) Continue to take Risperidone 3mg oral tablets at night.
> 5) Follow up with GP for MHCP
> 6) Present to a local hospital emergency department or call the Mental Health Hotline if there is decompensation of mental state.
>
> …
>
> **Health Status**
>
> **Formulation / Clinical Impression**
>
> ***As authored by treating registrar***

[105] Ibid, p 10.
[106] Ibid, p 124.
[107] Discharge Referral dated 27 May 2022, Vol 5, Tab 155, p 9.

Behavioural disturbance and psychotic symptoms in the context of methamphetamine use with a history of schizophrenia like illness, Polysubstance Use Disorder and Antisocial traits. On admission the police allege that Kevin had been following a woman in his car after she had picked up a child from school, which he denies yet then described the woman's appearance. Police also allege that Kevin has been throwing rocks and fruit at his neighbour. Collateral history included a decline in functioning and increasing paranoia and disordered thinking over the past 12 months. Admission for observation and diagnostic clarification was considered reasonable given the heightened risk of harm to others. Kevin has also had a court case adjourned to a later date due to being in hospital.

Kevin was admitted to hospital as an involuntary patient under the mental health act (as a Mentally Ill Person). 'Kevin's presentation most closely fits a diagnosis of paranoid personality disorder with acute exacerbation when intoxicated by methamphetamine and underlying narcissistic and antisocial trains. While there are some features of a schizophrenic illness [Paranoia, guardedness, and fixed persecutory beliefs], there was no sign of affective blunting nor any psychomotor retardation during this admission.

Paranoid personality disorder (MH Inpatient)

Observation for suspected mental and behavioural disorders (MH inpatient)

Mental and behavioural disorders due to use of other stimulants, including caffeine, acute intoxication (MH Inpatient)

<u>Medication being taken on discharge</u>

Risperidone (risperidone 3 mg oral tablet) 1 tab(s), Oral, Tablet, at night[108]

81. This document was prepared by Dr Kevin Bragg (Psychiatry Registrar), Eloura Mental Health Unit, on behalf of Dr Stephen Koo (Registrar) and Dr Diana Luciano (Psychiatrist).[109]

---

[108] Shellharbour Hospital Records (Part 2), Vol 5, Tab 155, pp 8-11.

[109] Ibid, p 10.

Events during period 31 May to 4 June 2022

82. In the week preceding his death, Kevin was residing at his parents' home.[110] Glen and Diane Edwards recall their son's behaviour in the days following discharge from Shellharbour hospital. Although Kevin was going out for periods (including an excursion to the Blow Hole at Kiama on 1 June 2022 with Debbie Curtis) and doing some physical exercise, he was quiet and having great difficulty sleeping.[111] Mr Edwards described his son as being "confused and spaced out."[112]

Events of 4 June 2022

83. On 3 June 2022, a progress note from the Illawarra Community Mental Health Service (**ICMHS**) (per Kathryn Williams RN) entered at 4.16pm records the following:

> **Progress Note**
> Discussed with James CNC (who completed triage)
> Kevin cannot see his GP for an appointment for further prescriptions
> Discussed with Dr Argyle who is agreeable to write a further prescription for Risperidone 3 mgs
> Same completed and located in ACT room
> Please give script at home visit[113]

84. On 4 June 2022, a progress note from ICMHS at 8.53am records Kevin being discussed at an ACT Morning Meeting that day as follows:

> Present: SW ODonoghue, RN Bertakis, RN Rosser, RN Van Der Merwe
> 41 year old male recently discharged from inpatient unit
> Kevin cannot see his GP for an appointment for further prescriptions
> Script has been completed by Dr Argyle
> Please complete 7 day follow up and provide script for meds
> HV rescheduled from am to pm slot due to staffing capacity

---

[110] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, pp 23-24 at [80].
[111] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 23-24 at [81]-[84]; Statement of Glen
Edwards dated 26 July 2022, Vol 2, Tab 114, pp 20-21 at [116]-[124].
[112] Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 22 at [132].
[113] Illawarra Community Mental Health Unit records, Vol 5, Tab 153, p 9.

Plan:

HV rescheduled to afternoon

Call Mother Diane to confirm time [mobile number listed][114]

85. Consistent with this, it appears that Kevin had a 10am appointment booked with the Acute Mental Health Team (as arranged by Diane Edwards). Mrs Edwards then received a call advising that the appointment would be pushed back to 2pm.[115]

86. Mrs Edwards stated that she had arranged this home visit to assist Kevin to obtain a prescription for Risperidone (an oral anti-psychotic medication), noting he had been discharged with 5 days' supply of medication only, and advised to obtain a script from the GP (for Risperidone, 3mg oral tablets to be taken once daily).[116] Kevin had been unable to secure an appointment with a local GP.[117] It may be however, that this ACT visit was to occur by way of follow-up in any event.

87. At 2pm that day, clinicians Sharon Ible (CNE) and Troy Crowther (MHC) from the Acute Care Team attended the Edward's residence in Shell Cove to conduct the 'home visit' with Kevin.[118] Kevin and Glen Edwards were home at the time, however Glen was not permitted to remain in the room for the meeting.[119] Glen overheard some of the visit and Kevin's discussions with the Acute Care Team. He described Kevin's responses as being "false" and said he was talking a lot of [crap]" to the staff.[120] He said the meeting went for about 20 minutes.[121]

---

[114] Ibid, p 10.

[115] Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 22 at [130].

[116] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 23 at [78]; Shellharbour Hospital Records (Part 2) – 'Discharge Referral' dated 27 May 2022, Vol 5, Tab 155, pp 9-10.

[117] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 25 at [84].

[118] Illawarra Community Mental Health Unit records – 'Mental Health Review' dated 4 June 2022, Vol 5, Tab
153, p 7.

[119] Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 23 at [135].

[120] Ibid, at [136] (including as to doing a lot of physical training; that he was in a relationship with an Asian girl;
that he wanted to do a course so he could get a job as a personal trainer; that he was a friend of a local UFC fighter.

[121] Ibid, at [135].

88. Following the visit, notes were recorded by one of the clinicians (it is unclear who or at what time). The notes are significant and are excerpted in full (underlining emphasis added):[122]

> **Consumer view of progress:**
> Kevin
> Home visit conducted by CNE Ible and MHC Crowther
> …
> Kevin advised that he is feeling 'Really good ay' mate'
> Kevin advised that he has been doing some training at the local UFC gym
> ACT staff asked Kevin about reports he was moving to Doonside (Sydney), Kevin advised that he had not done same due to his sister just having a baby
> Kevin advised that the wind and rain also was part of the reason h' didn't relocate also Kevin advised that he needed to be with his parents incase something happened and he needed to fix it
> Kevin advised that he is being compliant with his medications
> Kevin advised that he believes that the medication is working effectively for him
> Kevin advised that he had attended 3x local GP's to receive a further prescription, however was unsuccessful due to nil appointments available
> ACT staff advised kevin that ICMH psychiatrist had completed a prescription for Risperidone 3mg x 30 and then provided same to Kevin
> Kevin thanked ACT staff for same and then stated 'So have you go some money for me to go and fulfil prescription?'. ACT staff advised that unfortunately they are unable to provide same
> Kevin advised that since he has been out of hospital, things have settled down and returned to normal
> Kevin advised that relationship with mother and father is fine
> Kevin advised that he has also been looking at possibly attending

[122] Illawarra Community Mental Health Unit records – 'Mental Health Review' dated 4 June 2022, Vol 5, Tab 153, pp 7-8.

TAFE to complete a personal trainer course
Kevin advised that he enjoys working out and doing fitness
ACT staff asked Kevin about his current thoughts, Kevin replied ‘they are very good currently’ ACT staff asked Kevin to elaborate a little on this response. Kevin declined to do the same
ACT staff asked Kevin if he was able to advise what was happening, in which lead to his admission, Kevin stated ‘I would rather not mate, It was all dealt with in the hospital and I want to leave it there’
ACT staff asked Kevin if he had used any illicit substances or alcohol since being discharged Kevin replied with a sarcastic laugh and then stated ‘No mate, don’t be silly, I don’t do that stuff’
ACT staff advised Kevin that notes indicate that admission to hospital was for a Drug induced psychosis, Kevin replied ‘It was all a big mistake and fake, nothing like that happened’
Kevin then became deflective in relation to answering any further questions around hospital
Kevin advised that he is currently being supported by his mother and father
Kevin advised that he is living with them for the near future, however will look around for somewhere else soon
Kevin advised that he has a couple of people that he knows around the area
Kevin then asked ACT staff if they were aware of Alex Volkanovski and stated that he was one of his best mates that just lives around the corner
Author advised Kevin that he was unaware of same and asked who he was, Kevin replied ‘The president of the rebels’
Kevin then advised that Alex was going to give him a job at the UFC gym as a cleaner, until he becomes a personal trainer
ACT staff discussed with Kevin around attending an appointment with GP, Kevin replied ‘Which one, I have 3 different’ ones’
Author asked Kevin which GP is his main one, Kevin replied ‘The Dr at Dapto Medical Centre’
ACT staff encouraged Kevin to schedule an appointment with same

and request for a MHCP and referral to psychologist
Kevin advised that he is currently engaging with one via the UFC gym and that he is not in need of same from GP
ACT staff discussed with Kevin around his current thoughts surrounding suicide, self-harm or harm to others, Kevin replied ‘No mate, none of that, no mate, that silly talk’
Kevin advised that he is aware of the contact details for the MH Line, Lifeline and that he will call if needed
Kevin then stated ‘My mental health is all good mate, not needing anything’
Kevin then advised that he was going to get ready to go and do a work out
ACT thanked Kevin for having a conversation
ACT were then leaving house, however Chris (father) asked ‘Is there anything that you can give Kevin to help with sleep?
ACT staff advised that they had just provided Kevin with a prescription of Risperidone Chriss stated ‘If that is what he is already taking, its not really working for him’
ACT staff advised that they are unable to prescribe any other medications and advised that if further medication required to please attend an appointment with GP
Chris advised that he will assist Kevin with same
ACT staff asked Chriss if he had any current acute concerns for Kevin, Chris denied same
ACT staff asked Chris if he was in need of any assistance for himself to help with caring for Kevin
Chris advised that himself and wife are OK at the moment
ACT staff provided Chris with cards for the MH Line, ICMH and STRIDE and advised that if needing assistance to please call, Chris agreeable to same
ACT staff then left premises
Reasons for Review:
Scheduled for discussion in clinical review on Monday 6/6/22 - ?discharge

Copy of MH review faxed to GP Dr Chandran and Dapto Medical Centre

Clinicians involved in the Review: MHC Crowther, CNE Ible[123]

89. Glen Edwards' statement confirms that at the conclusion of the home visit, the female clinician provided him with her number and stated that if he had any concerns about Kevin, to contact her. Glen Edwards intended to ring "this lady" on Monday. His concerns were "that Kevin was becoming erratic, he was talking fast, his conversation was all over the place and didn't make sense. He also wasn't sleeping properly."[124]

Last sighting of Kevin Edwards by his parents

90. That same day, Saturday, 4 June 2022 at around 4pm, was the last time Diane and Glen Edwards saw their son alive. Kevin left the Shell Cove residence telling his parents he was going to fill his Risperidone prescription at the local pharmacy. He was carrying a small black backpack. Kevin returned after some 10-15 minutes, stating that he had forgotten something. He walked into his bedroom for a moment and then left the house again in his car.[125]

Events

91. On Sunday, 5 June 2022 at approximately 1.40am, the evidence suggests that Kevin approached a taxi rank at Liverpool train station. He spoke with Jashif Javed, a cab driver with 13Cabs, who had observed Kevin beforehand "acting in a strange manner";[126] Kevin first asked: "Can I go to Granville?", then straight away said "Parramatta"; he sat in the front passenger side door and "looked very nervous, he was talking a little bit like he was drunk".[127] Moments later another man opened the passenger door of the taxi. This apparently startled Kevin, who said: "He's after me," jumped out of the taxi and then vanished.[128]

92. Around 1.54am on Sunday, 5 June 2022, Kevin was sighted via CCTV at Moorebank Avenue walking east in the westbound carriageway. Police were called and patrolled the area from around 2.06am until 2.14am but could not

---

[123] Ibid, pp 7-9.
[124] Statement of Glen Edwards dated 26 July 2022, Vol 2, Tab 114, p 23 at [138].
[125] Statement of Diane Edwards dated 26 July 2022, Vol 2, Tab 112, p 26 at [85]; Statement of Glen Edwards
dated 26 July 2022, Vol 2, Tab 114, p 23 at [139].
[126] Statement of Jashif Javed dated 21 June 2022, Vol 1, Tab 70, p 2 at [7].
[127] Ibid.
[128] Ibid at [8].

locate Kevin. At around 3.34am a further call was made to Triple Zero raising an issue about persons in the westbound carriageway near the Moorebank Avenue overpass. At the same time, an off-duty officer had also called the police about a pedestrian standing in the middle of the freeway. At around 3.35am a priority 2 CAD job was broadcast by police regarding a concern for welfare in relation to an intoxicated male walking in the middle of the road just before the Moorebank Avenue exit. At 3.37am Sergeant Jackson from Liverpool Police Station and Alpha unit in marked car LP14 acknowledged the job.

93. At 3.41am Sergeant Jackson arrived on scene finding Kevin in the westbound lanes of the M5 Western Motorway directly beneath the Moorebank Overpass. CCTV records show some immediate interactions between Kevin and Sergeant Jackson.

94. At approximately 3.42am, Sergeant Jackson broadcast over police radio, “Yeah, I’ve got this male. He’s highly intoxicated. If I can get another car down here”. CCTV footage then shows Sergeant Jackson conducting a U-turn in his police vehicle, face the opposite direction and Kevin jumping or rolling over the centre median.

95. At 3.42am Kevin returned to the westbound carriageway standing close to Sergeant Jackson. Sergeant Jackson then moved his vehicle to the left-hand shoulder, or breakdown lane, with Kevin remaining on the roadway.

96. At 3.43am three incident vehicles from the M5 Control Centre arrive in the westbound lane to provide a blockade of all westbound traffic. At about this time Kevin moved into the eastbound carriageway and it appears that Sergeant Jackson uses a torch to warn vehicles travelling eastbound of his presence. Around this time, the physical interaction between Kevin and Sergeant Jackson is partially obscured by foliage, but at one point, Sergeant Jackson uses his OC spray whilst both men were in the eastbound carriageway and a wrestle ensued with witnesses stating that Kevin then pushed Sergeant Jackson towards the centre median.

97. At about 3.48am off-duty Officer Sergeant Anthony Roberts can be seen on body-worn video footage assisting to restrain Kevin in the westbound carriageway. Two other bystanders, Mr Ibrich and Mr Aziz also exited their vehicles and moved to assist police. Seconds later, Sergeant Tesoriero, travelling in a marked car, LP 37, and wearing a distinctive high-visibility vest

then approaches on foot in the westbound carriageway and assists with the restraint of Kevin. The struggle continues on the concrete median strip.

98. At around 3.49:41am the sound of the handcuffs ratcheting closed is heard with Sergeant Tesoriero stating on radio, “Liverpool 37, one in custody”.

99. The remainder of events are captured on body-worn video of Sergeant Jackson, but in short form, at around 3:50am Kevin was manoeuvred, and perhaps dropped, over the centre median from the eastbound lane into the westbound lane. At this time Sergeant Jackson told police radio that Kevin had stopped breathing and was not conscious. During the period from 3.50am to the arrival of paramedics from the NSW Ambulance Service at around 4:00am, no CPR was administered despite reference being later made to Kevin having shallow breathing. Measures were also taken by Sergeants Tesoriero and Roberts to check Kevin’s pulse and to assess his breathing.

100. At around 4:25am, Kevin was conveyed to Liverpool Hospital Emergency Department. Tragically, notwithstanding various interventions, he was declared deceased at 4:52am.

CONSIDERATION OF ISSUES

Issue 1: Statutory Findings – Manner and Cause of Death

<u>Manner and cause - evidence</u>

101. As outlined above, there is no dispute as to Kevin’s identity or the date and location of Kevin’s death.

102. Two expert witnesses gave evidence about the cause of death, namely Dr Kendall Bailey, Forensic Pathologist and Professor Alison Jones, Toxicologist.

<u>Dr Kendall Bailey</u>

103. Dr Kendall Bailey, the pathologist who performed a postmortem examination of Kevin, concluded that the direct cause of death could not be ascertained.[129]

104. However, Dr Bailey noted that whilst no definitive cause of death could be identified, there were many potential contributing factors including cardiac enlargement and a large liver, both of which are linked to sudden cardiac death; methamphetamine and its metabolite detected in blood at a level that was potentially fatal; the potential diagnosis of schizophrenia, which is correlated with an increased risk of sudden cardiac death; and also, the

[129] Autopsy report dated 7 June 2022, Vol 1, Tab 2A, p 2.

circumstances proximate to death – namely the physiological stress of the altercation with police, the impact of the OC spray (which would have increased blood pressure), and the mechanical pressure of being restrained, which could have precipitated a cardiac arrest. Dr Bailey stated that the degree to which each of these factors influenced Kevin's death cannot be determined.[130]

105. In her oral evidence, Dr Bailey stated that "once you have a competing potential cause of death, I can no longer say in the absence of any other pathology, my opinion is this is the most likely thing that happened. In this case I have multiple potential pathologies and I cannot tell you which one is the most important or contributory at all."[131]

106. Dr Bailey also commented that statistics indicate that there is an increased risk of sudden cardiac death in patients with schizophrenia.[132]

107. In relation to the role that the physical restraint of Kevin may have played in Kevin's death, Dr Bailey opined that in the totality of circumstances where Kevin had a larger heart, a stimulant was in effect, and he was in anerobic exertion from running, the small decrease in lung capacity caused by the restraint could have been one of many factors in a scenario which could have led to a fatal dysrhythmia.[133]

108. In her oral evidence, Dr Bailey opined that it was likely the combination of all of Kevin's risk factors which added up to the "perfect storm".[134] Based on the levels of methamphetamine in Kevin's blood and the overlap between the non-toxic and fatal level of methamphetamine in the literature, Dr Bailey could not say with 100 percent certainty that the methylamphetamine in Kevin's system was the cause of his death.

109. In relation to the potential impact of a headlock upon Kevin's death, Dr Bailey considered that if he was not in a headlock or experiencing neck compression at the time he lost consciousness, it was difficult to say how that contributed to his death, if at all.[135]

---

[130] Ibid p 4.
[131] Transcript of proceedings, 8 August 2024, p 249.
[132] Ibid, p 250.
[133] Ibid, p 250-251.
[134] Ibid, p 251.
[135] Ibid, p 252.

110. Ultimately, Dr Bailey was unable to determine the cause of death and was unable to say whether one of the identified potential causes of death was more likely than another.

Professor Alison Jones

111. Professor Alison Jones prepared two toxicology reports addressing the significance of the amount of amphetamine and methylamphetamine present in Kevin's blood following his death, including whether the amounts were likely to have caused or contributed to Kevin's death.[136]

112. Professor Jones opined that the methylamphetamine detected in Kevin's blood at or around the time of his death was in the toxic to fatal range.[137] In her opinion, this conclusion is supported by the police reports of Kevin's acute agitation and family reports of paranoia which is in keeping with the commonly observed effects of methylamphetamine, especially in toxic doses. However, she noted that individual tolerance and other factors mean that the relationship between blood concentrations of methylamphetamine and clinical effects is not absolute.

113. Professor Jones noted that Kevin's heart was found to be enlarged at autopsy with a focal area of 75% stenosis in the right coronary artery. The cardiac enlargement and coronary artery stenosis would make sudden cardiac death more likely, especially in the presence of an arrythmia, causing drugs such as methylamphetamine in toxic/fatal levels. The additional factor of fear, on the motorway and being chased by police, would, in her opinion, increase his heart rate and risk of arrythmias. In her opinion, the methamphetamine detected in Kevin's post-mortem blood sample would likely have been contributory to his risk of developing arrythmias and could potentially have directly caused cardiac death.[138]

114. In relation to the administration of OC spray, Professor Jones noted that Kevin was running and hiding from police just before he was found and sprayed with OC. She further noted that the pain of OC exposure can increase the heart rate in individuals, but in addition that vigorous exercise or fear also acts on the heart

[136] Toxicology Report of Professor Alison Jones, 3 September 2022, Vol 7A, Tab 175C; Supplementary Report of Alison Jones, 13 March 2024, Vol 7A, Tab 175D.
[137] Toxicology Report of Professor Alison James, 3 September 2022, Vol 7A, Tab 175C, p 4.
[138] Ibid, p 6.

to increase heart rate and blood pressure. She stated that whilst occasionally death has been reported due to OC, in the case of Kevin, a sudden unconscious state followed by death was most likely due to a cardiac event and that methylamphetamine and increases in catecholamines (due to fear/running) were likely contributory to the fatal cardiac event.[139] Such effects, in her opinion, are exacerbated by the taking of methylamphetamine.

115. Ultimately, Professor Jones opined that the while the dose of methylamphetamine that triggers the onset of psychosis is variable, acute agitation and paranoia are consistent with methylamphetamine toxicity, that is, methylamphetamine psychosis. She opined that acute methylamphetamine toxicity was likely to be a major contributor to death in this case.[140]

116. In her oral evidence, Professor Jones explained that even in a structurally normal heart, methamphetamine use can cause a sudden cardiac death. An underlying cardiac pathology can significantly increase the risk of such an event. In the case of Kevin, Professor Jones noted that structural abnormalities such as a thickness of the ventricular wall or narrowing/stenosis of a coronary arteries were factors present which would have increased the risk of sudden cardiac death. Professor Jones explained that methamphetamine:

> *"sensitises the myocardium to the action of catecholamines. What do I mean by that? It means that the pacemaker, that part of the heart, and the heart muscle become very sensitive to the adrenaline that is circulating, the epinephrine, otherwise known as adrenaline, that is circulating in the body."*[141]

117. Professor Jones explained that an arrythmia in the ventricular part of the heart (known as a ventricular tachycardia) can result in a sudden cardiac death.

118. Professor Jones affirmed the view expressed in her report that the factor of fear on the motorway and being chased by police (exercise) would have increased Kevin's heart rate and in turn, the risk of an arrhythmia. She also affirmed that it was likely that Kevin ingested methamphetamine within a few hours prior to his death as when a person ingests that drug, its toxic effects including agitation

[139] Ibid, p 11.
[140] Ibid, p 12.
[141] Transcript of proceedings, 8 August 2024, p 238.

and paranoid delusions are evident within between minutes and a few hours after exposure.[142]

119. As to the concentration of methamphetamine detected in Kevin's bloodstream during the post mortem two days after his death, Professor Jones confirmed her view that despite the potential for post mortem redistribution of methamphetamine, the process whereby "drugs move from areas of high concentration in the body like the liver to areas downstream with low concentration", this would not change her view that the level of methylamphetamine in Kevin's blood was in the toxic to fatal range at the time of his death. Professor Jones emphasised that even small amounts of methylamphetamines can cause a fatal cardiac arrythmia.[143] Professor Jones also opined that behaviours such as acute agitation and paranoia are behaviours that are more indicative of the toxic end of exposure to methamphetamine.

120. In relation to Kevin's tolerance of methamphetamines, Professor Jones explained in her oral evidence that even in cases where an individual had been taking methamphetamine for a lengthy period of time, there would remain a risk of toxicity or death from a toxic concentration of the drug.[144]

121. Professor Jones maintained that it was unlikely that the application of OC spray was itself the direct cause of Kevin's death. She stated that the only avenue through which it may have contributed to Kevin's death was through the pain response which would have occurred when the OC spray was applied to Kevin's eyes.[145]

122. As to the presence of risperidone in Kevin's system at the time of his death, Professor Jones opined that the failure to detect risperidone in Kevin's blood indicates that the levels of risperidone in his blood were not above the detection level of the assay by the NSW toxicology laboratory. She stated that it is unlikely that Kevin took risperidone on 3 June 2022.[146]

123. However, the evidence of Dr Fong was put to Professor Jones in that the elimination half-life of risperidone reportedly is 2 to 5 hours for rapid

[142] Ibid, p 242.
[143] Ibid, p 240.
[144] Ibid, p 241.
[145] Ibid, p 243.
[146] Ibid, p 244.

metabolisers, and 15 to 20 hours for slow metabolisers. The detection limit of risperidone is 0.005 mg/L from FASS lab NSW. She agreed with this evidence and ultimately agreed that if Kevin's last dose of 3 mg risperidone was on 3 June 2022, it would be approximately 2 days at the time of his passing. Assuming Kevin was the slowest metaboliser (with a half-life of 20 hours), risperidone unlikely was able to be detected from his post-mortem blood.[147] Therefore, she was unable to confirm whether or not Kevin had taken risperidone on the day preceding his death.

124. Professor Jones noted it was possible that Kevin was more sensitive to methamphetamine having not been exposed to it more recently in the time before his death.[148]

Manner and cause – submissions

125. Counsel Assisting submitted that the manner of Kevin's death involved an altercation with police as well as a combination of inadequate first aid treatment at the scene by NSWPF officers, toxic levels of methylamphetamine and potentially other medical conditions experienced by Kevin.

126. Counsel Assisting submitted that the cause of Kevin's death is, consistent with the expert evidence, unable to be unascertained.

127. The Edwards family submitted that Kevin's death was caused by a sudden cardiac death from a fatal arrhythmia. It was submitted that there were several factors which contributed to this arrhythmia. Firstly, acute methylamphetamine toxicity. Secondly, structural abnormalities in Kevin's heart including a 75% stenosis in his right coronary artery and a thickening of the ventricular wall. Thirdly, Kevin's mental illness of schizophrenia including likely psychosis and his history of drug-induced psychosis. Fourthly, the manner in which Kevin was apprehended, restrained and moved on the motorway, including the application of OC spray to Kevin's eyes from a close range which increased his heart rate. Fifthly, the mechanical chest compression which occurred when Kevin was restrained for a period against a concrete barrier. Lastly, the failure by NSWPF officers to commence cardiopulmonary resuscitation until NSW Ambulance officers arrived on the scene at 3.58am.

---

[147] Ibid.

[148] Ibid, p 246.

128. Counsel for the family ultimately submitted that Kevin died of natural causes.

Manner and cause – consideration

129. As to the manner of Kevin's death, I find pursuant to the evidence that he died while experiencing a mental health episode, in the course of being restrained by the police who were attempting to prevent harm to Kevin and other road users on the M5 motorway.

130. Having regard to the expert evidence of Dr Bailey and Dr Jones as set out above, which I accept, I find that the cause of Kevin's death is unable to be ascertained.

Issue 2: The adequacy of the clinical care and treatment that Mr Edwards received at Shellharbour Hospital during the period 10 May to 30 May 2022

131. I summarise the evidence below under each issue, but then outline the various submissions made and my findings with respect to these issues together at 186-192 below.

Issue 2(a) Was it appropriate to discharge Mr Edwards on 30 May 2022?

Evidence

132. In relation to the question as to whether it was appropriate to discharge Kevin on 30 May 2022, I rely significantly on the expert evidence of Associate Professor Danny Sullivan.

133. Associate Professor Sullivan prepared a comprehensive report and gave evidence detailing a thorough analysis of Kevin's mental health issues, his admissions into hospitals and mental health units and the behaviours with which he presented during peak mental health episodes.[149]

134. He noted that in May 2022, Kevin was admitted to Shellharbour Hospital. He presented with "behavioural disturbance, paranoid delusions and thought disorder in the context of suspected ice use and on a background of a previous admission with schizophrenia-like illness and diagnoses of polysubstance abuse and antisocial personality traits".[150] The provisional diagnosis was one of stimulant-induced psychosis.

135. In Associate Professor Sullivan's opinion, Kevin would have met a diagnosis of severe substance use disorder involving, most recently methamphetamine.

[149] Expert Report of Dr Danny Sullivan, 3 May 2024, Vol 7A, Tab 176B.
[150] Ibid, p 11 at [50](e).

Furthermore, a diagnosis of schizophrenia appears to Associate Professor Sullivan to be most likely, due to the persistence of symptoms during inpatient admissions while not taking stimulants.[151]

136. Dr Diana in his evidence stated that Kevin's presentation suggested a drug-induced psychosis rather than schizophrenia because of the relatively rapid improvement over days, and the fact that amphetamine was found in his urine screening on admission.[152] However, notwithstanding his difference in opinion regarding the diagnosis, Associate Professor Sullivan said in oral evidence that there is no essential difference between the treatment for drug-induced psychosis and treatment for schizophrenia.[153]

137. Associate Professor Sullivan in his report considered that the admission to hospital as a '"mentally ill" person was appropriate, as Kevin would not have complied with voluntary admission.[154] He stated that it was appropriate that Kevin be detained in a locked area, due to his irritable and agitated behaviour. It was apparent to him that Kevin was keen to leave hospital, and it was not clear that his statements could be relied on as truthful, given his eagerness to be discharged. He was poorly engaged in treatment and the notes document that he was recurrently uncooperative, guarded or evasive.

138. In Associate Professor Sullivan's opinion, while Kevin was an inpatient, he received appropriate psychological and psychiatric therapy, including antipsychotic medication in an appropriate dosage. However, given Kevin's poor insight, guardedness and demonstrated reluctance to take oral medication, in his opinion the only management which could have been effective for Kevin was long-acting injectable antipsychotic medication. This would have required him to be on a CTO, in Professor Sullivan's opinion.[155] I will return to this issue below at [159] and following.

139. Associate Professor Sullivan noted in his evidence that the discharge plan was multidisciplinary, involving an assessment of Kevin's capacity to manage his own needs, as well as observations that his symptoms had begun to subside.[156]

---

[151] Ibid, p 13 at[58]-[59].
[152] Statement of Dr Luciano Diana, 25 July 2024, Vol 7A,Tab 159K, p 5 at[32].
[153] Transcript of proceedings, 9 August 2024, p 8.
[154] Expert Report of Dr Danny Sullivan, 3 May 2024, Vol 7A, Tab 176B, p 14 at [66].
[155] Ibid at [71]-[72].
[156] Transcript of proceedings, 9 August 2024, p 11.

He noted that Kevin's clinical presentation by the time of his discharge did not clearly warrant continuing involuntary detention. As his behaviour had settled, the only ongoing benefit of detention was to enforce continued abstinence from substance use, and for new medications to take effect.[157]

140. Further, the MHRT in its decisions about Kevin in May 2022 at least left open the possibility that he would be discharged prior to the recommended date of 15 June by stating that Kevin should be detained until that date, "unless discharged prior".

141. Ultimately, it was the evidence of Associate Professor Sullivan, who had the benefit of all of the notes, all of Kevin's history, and the brief of evidence, albeit that he did not have the benefit of Kevin's clinical presentation, that Kevin's admission, treatment and the timing of his discharge were appropriate. His view was that there was no lawful basis to continue Kevin's detention in the circumstances of his improvement and presentation at the time of his discharge.

Issue 2(b) Was the discharge plan appropriate in the circumstances?

Evidence

142. Associate Professor Sullivan opined that Kevin's discharge from the Eloura Mental Health Unit on 30 May 2022 was appropriate and preceded by appropriate planning (other than he should have been discharged on a CTO). He stated that the issue was not that the discharge plan was poor, but rather that Kevin sought to evade it.[158]

143. On 24 May 2022, Dr Khoo, psychiatry registrar, prepared a report for the MHRT on behalf of Dr Diana. The full report was adduced in evidence in the inquest but it is apt to note the following references:

> 40 yr old male from Shell cove living with parents and working part time as an arborist in Sydney, brought into hospital by police with behavioural disturbance, paranoid delusions and thought disorder in the context of suspected ICE use.
>
> Considering the previous diagnosis of Schizophrenia and previous treatment with CTO and antipsychotic depot medication, as well as the

[157] Expert Report of Dr Danny Sullivan, 3 May 2024, Vol 7A, Tab 176B, p 16 at [78].
[158] Ibid, p 16 at [78].

> apparent highly concerning behaviours leading to this admission with considerable risk to the public, the treating team believe that management with antipsychotic medications is necessary, including consideration of further uptitration of oral medications and consideration of Injectable depot antipsychotic medications and ongoing treatment on a CTO prior to discharge. This will require some additional time in hospital considering the patient's ongoing evasiveness and minimal engagement with treatment, suggesting an element of underlying paranoia and ongoing psychotic mental illness.
>
> There is documentation and collateral which reports that Kevin's mental state was more stable while he was managed on depot antipsychotics with CTO in place.[159]

144. Dr Khoo also reported that as at that date there remained ongoing mental illness as evidenced by paranoid beliefs regarding being drugged, and of wrongful admission, evidenced by ongoing guardedness, evasiveness and minimal engagement with the psychiatric reviews. He reported that this mental illness remained associated with a risk of a number of significant harms, including harm to others, risk of deterioration in mental state if discharged prior to the establishment of an observably efficacious treatment regimen, and that it was the opinion of the treating team that a 6-week inpatient order was the least restrictive, safest and most effective form of care at that stage.

145. On 25 May 2022, Kevin came before the MHRT for a mental health enquiry. The MHRT determined that Kevin was a mentally ill person and that he "must be detained in or admitted and detained in Shellharbour (Psych Unit) for further observation or treatment or both, as an involuntary patient until a date no later than 15 June 2022". The reasons were noted as follows:

> Kevin continues to experience paranoid delusions. He plans to move out of area when discharged. There is a need to ensure a safety discharge plan until handover to the Community Mental Health team. If Mr Edwards were to be discharged at this time without appropriate support in the

[159] Mental Health Report to the Mental Health Tribunal, 24 May 2022, Vol 7A, Tab 159H, Annexure B, pp 196-7.

community his mental state would be likely to deteriorate. If this occurs he would present a risk of damage to his reputation and harm to others.[160]

146. It was explored in some detail in the inquest that there was a notable change in the hospital records in respect of Kevin's progress between 24 and 26 May 2022. On 26 May 2022, the notes record positive progress demonstrated by Kevin and a plan to "discuss with Doonside community mental health team regarding discharge". [161] The notes also record a recommended medication of Risperidone 3mg. This appears to be the first contemplation of Kevin's discharge.

147. Later that day, Dr Khoo made a progress note that indicated Kevin was likely to be discharged the following week and to check if the Western Sydney LHD can provide Community Health Follow Up on discharge for patients on oral medications only.[162] At 2:25pm that day, a further note was entered by Dr Monique Costello, who noted: "Discussed plan for follow up with community team on discharge. Will remain on oral medication. Hoping for discharge within next 1-2 weeks".[163]

148. Dr Khoo agreed in oral evidence that it would appear that by 26 May 2022, the decision had been made that Kevin would be discharged on oral medication.[164] He was questioned at some length about this decision, in light of the contents of his report to the MHRT only two days earlier and there being no material change in Kevin's mental state at the time of the decision. Ultimately, Dr Khoo was unable to confidently state why his opinion had changed in such a short time but noted that ultimately those decisions were made by Dr Diana.[165]

149. As stated by Dr Diana in his oral evidence, it was the opinion of the team that Kevin's symptoms had begun to rapidly settle and that his presentation was such that it was no longer appropriate to detain him.[166] That was certainly the position come discharge on 30 May 2022.

---

[160] 'Determination of Tribunal' dated 25 May 2022, pp 18-19.
[161] Shellharbour Hospital Records (part 1) – Progress notes, Vol 5, Tab 155, pp 105-106.
[162] Ibid, p 108.
[163] Ibid, p 109.
[164] Transcript of proceedings, 7 August 2024, pp 130-131.
[165] Transcript of proceedings, 6 August 2024, p 131-132.
[166] Transcript of proceedings, 7 August 2024, p 170.

150. Dr Kevin Bragg, who was the final signatory of Kevin's discharge referral on 30 May 2022 from the Eloura ward of Shellharbour Hospital, also gave evidence. He explained that although he was not the registrar working under Dr Diana (which was Dr Khoo at the time), it was standard practice that when one registrar was unavailable, the other registrar would sign discharge summaries in the other's absence.[167] Dr Bragg did not have any recollection of having discussions with Dr Khoo or Diana prior to signing Kevin's discharge referral.[168] Although it would be part of his usual practice to review notes pertaining to the current admission in the leadup to the discharge, Dr Bragg could not recall whether he did this prior to signing Kevin's discharge referral.[169]

151. In terms of the carer, the discharge plan listed Debbie Curtis as Kevin's designated carer upon discharge. Numerous questions were asked of witnesses throughout the evidence about the decision to make Debbie Curtis the designated or primary carer for Kevin upon his discharge from Eloura. It is apparent from the evidence of the staff at Eloura, namely Dr Costello, Dr Khoo and Dr Diana that it was not known to the hospital that Kevin had previously been subjected to an AVO for the protection of Debbie or that he had apparently inflicted violence upon her in the past.

152. The hospital notes do record an awareness that Debbie Curtis had cancer but not what her treatment might be or whether she was physically able to undertake the obligations of a designated or primary carer for Kevin. Some notes record that it was thought that Kevin might become Debbie's carer upon his discharge and that they could, in effect, care for each other. Associate Professor Sullivan gave evidence to the effect that there may be therapeutic benefits for both Kevin and Debbie in such an arrangement.[170]

153. Dr Diana said in his statement that the option for Kevin to stay with Debbie seemed reasonable to him, noting that they had been in contact every day and Kevin appeared enthusiastic about going and staying with her. He also noted that Debbie reportedly understood the reasons for his admission to hospital,

[167] Ibid, p 156.
[168] Ibid.
[169] Ibid, p 156-157.
[170] Transcript of proceedings, 9 August 2024, p 23.

understood his issues with substance abuse, and was willing to offer him accommodation.[171]

154. In oral evidence, Dr Diana accepted that if the issue of the AVO or Debbie's cancer diagnosis had been known to him, they possibly would have raised red flags for him.[172] Dr Diana further accepted that there was a supportive, caring family, and in hindsight that more could have been done as to inquire as to the suitability of Debbie as a carer, but ultimately said that "[Kevin's] choice was to go live with his friend and we had to go with that."[173]

155. It was submitted on behalf of the Edwards' family that the appropriate designated carer(s) ought to have been his parents, and ultimately that was where Kevin lived upon discharge, albeit that such an arrangement was contrary to the discharge plan.

156. However, Associate Professor Sullivan's view was that ultimately Kevin was an adult who excluded his mother and sister from his care plan, as was his right, and nominated Debbie as his primary carer. Debbie was somebody who had a fixed residence, told the nurses on multiple occasions that she agreed and was willing to undertake the care for Kevin, to assist him to comply with the discharge plan and take his medication, and the fact that Kevin could have been discharged, for example, to a motel.

157. Associate Professor Sullivan in his oral evidence stated, in this regard, that:

> "*…the team is making a decision based upon the best available evidence that they can regard. In this case they're keen to look at how it is that they can discharge Mr Edwards from hospital in the knowledge that he'll comply with treatment and take medication, so if they're receiving assurances from someone who appears responsible and not mentally ill and who Mr Edwards appears to trust and wished to collaborate with, I think it's very difficult for a team not to accept that information and regard it as an appropriate discharge plan.*[174]

158. Intrinsically related to the issue as to whether the discharge plan was appropriate, is the issue as to whether Kevin should have been discharged on

---

[171] Statement of Dr Luciano Diana, 25 July 2024, Vol 7A, Tab 159K, p 5 at [34].
[172] Transcript of proceedings, 7 August 2024, p 172
[173] Ibid, p 183.
[174] Transcript of proceedings, 9 August 2024, p 10.

oral medication or on a CTO with a depot injection. I will now turn to this in detail.

Issue 2(c) Relatedly, should a Community Treatment Order (including as to depot injections) have been sought prior to discharge?

Evidence

159. As alluded to above, Associate Professor Sullivan considered that a CTO was, in Kevin's case, the most appropriate manner of discharge. He explained his reasoning as follows:

> "This is based upon his poor insight, demonstrated history of poor compliance with oral medication, relapsing illness, and the potential for ongoing methamphetamine use. While Mr Edwards advocated strongly to be on oral medication, I consider this was because he did not wish to take medication at all. It can be difficult to justify a Community Treatment Order when a person appears to have regained decision-making capacity, and claims that they will comply with treatment and follow up."[175]

160. Associate Professor Sullivan went on to observe that:

> "Patients with the dual diagnosis of both a mental illness or substance-induced mental illness, and a persisting substance use disorder, pose great difficulties for contemporary mental health services. Long-term detention to preclude access to substance use is expensive, ties up beds and the number of patients who would require sustained treatment far exceeds the availability of beds. Consequently, mental health admission is indicated when there is behavioural disturbance or at times when a person requires containment and compulsory treatment. Mental health services are overwhelmed by numerous patients with dual diagnosis whose substance use leads to recurrent relapses and admission to hospital." [176]

161. In his oral evidence, Associate Professor Sullivan reiterated his criticism of the discharge plan in relation to the prescription of risperidone as opposed to an application for a community treatment order. He stated that Kevin's history,

---

[175] Expert Report of Dr Danny Sullivan, 3 May 2024, Vol 7A, Tab 176B, p 16 at [81].
[176] Ibid at [83].

lifestyle and attitude towards his condition indicated that he was unlikely to comply with oral medication. He said, noting that it was with the benefit of hindsight, that:

> "*I think one can see that Mr Edwards was really unmanageable except through compulsion and for that reason he would have required a community treatment order*."[177]

162. He also noted that it was "observable that the only period of time that he had demonstrated a significant improvement was when he was treated with compulsory medication through 2021 while on a community treatment order".[178]

163. From the material, Associate Professor Sullivan found it difficult to determine whether the MHRT had indicated it would not consider a CTO, or whether the diagnosis of paranoid personality disorder meant the treating team did not think a CTO could be obtained.

164. However, Associate Professor Sullivan also conceded that even if a CTO had been applied for, it could not be guaranteed that it would be obtained. In this regard he stated:

> "*When a person states verbally their willingness to take treatment and is able to acknowledge having some form of mental disorder, they're taken as having sufficient insight to be able to…have a decision-making capacity related to their compliance with treatment, so for a tribunal seeing that person at a slice in time, if that person says: 'Yes, I recognise that my behaviour was disordered', whether they mean it or not: 'Yes, I have improved with treatment; yes I'm happy to keep taking the treatment because I can see it makes me get better', even if they are lying through their teeth, the tribunal really has to accept what they say and make their decisions based on their presentation".*[179]

165. Dr Diana said in his evidence that he did consider whether or not a CTO was necessary.[180] He considered there to be some drawbacks, including a further hearing before the Tribunal which may have delayed his release. This was in circumstances where Kevin was actively seeking discharge and Dr Diana

---

[177] Transcript of proceedings, 9 August 2024, p. 5.
[178] Ibid, p 5.
[179] Ibid, p 13.
[180] Statement of Dr Luciano Diana, 25 July 2024, Vol 7A,Tab 159K, p 6at [38].

considered it to be a more restrictive alternative but that he would have applied for the CTO if he had deemed it necessary.

166. Ultimately, Dr Diana's evidence was that he was impressed at how rapidly Kevin's illness had subsided and that it seemed to him that whether or not Kevin had a CTO, he would do well if he kept away from amphetamines. However, if he resumed the ingestion of such drugs, Dr Diana considered his prognosis to be much less certain.[181] It is noted that Professor Sullivan in his oral evidence said that there was no evidence that compulsory treatment for substance abuse disorder works long term.[182]

167. In oral evidence, Dr Diana expanded on his reasoning at the time as follows:

> *"At the time I thought that we could've managed with monitoring by the community mental health team oral medications and we were also influenced by the fact that he had a friend that he was going to live with who understood the background of Kevin and would've been a positive influence in maintaining adherence to oral medications.*
>
> *…*
>
> *the other issue with, with the case is that there wasn't the indication that this admission had been caused by schizophrenia at the end. We were persuaded that this was more a drug induced psychosis and consequently whether he had been on a depot medication previously or not, he still would've been admitted with this disturbance. So the depot was not an antidote for the effects of amphetamines."*[183]

168. In relation to the rapidity at which Kevin's symptoms apparently subsided, he stated:

> *"…at the point of discharge there was no indication of the previously noted possible delusion of control. In schizophrenia that'd be unusual. You would expect that the symptoms would've persisted beyond the brief amount of time that he had the symptoms for and also what was apparent as I said were the personality features that he displayed which I – you're always looking at what's the focus of the treatment? The*

[181] Ibid, p 5 at [40].
[182] Transcript of proceedings, 9 August 2024, p 14.
[183] Transcript of proceedings, 7 August 2024, p 168.

psychosis, the continuing substance use and the personality features."[184]

169. Dr Khoo gave evidence that he had available to him, at the time of discharge, Kevin's previous diagnosis of schizophrenia and that Kevin had previously been treated with a CTO and antipsychotic depot medication.[185]

170. An entry in the Eloura Hospital Records made by Dr Khoo on 23 May noted that Kevin's behaviour was denial and dismissive and that his insight was poor. Dr Khoo gave evidence that those factors would be reasons to consider a CTO.[186]

171. However, Dr Khoo also stated that against a background of substance abuse, the success of a CTO depends heavily on the amount of substance use that occurs after a patient is discharged and that substance abuse can lead to a relapse in psychosis[187]

172. On the subject of why on 24 May 2022 Dr Khoo considered the possibility of a CTO, only for a decision to be made to discharge Kevin on oral medication two days later, Dr Khoo said that discussions with the Edwards family may have been a factor.[188] He recalled that Kevin's level of paranoia and delusions may have decreased over time. As stated earlier however, ultimately the evidence indicated that the decision was made by Dr Diana.

173. On that topic, when asked what changed between 24 May and 26 May in terms of Kevin's presentation to make a definitive decision that a CTO wasn't warranted, Dr Diana answered that it was the rapid resolution of his symptoms, namely the

> "*previous persecutory delusions that he had at the point of admission, he was – looking at the mental state examination he was coherent, he was linear, there wasn't a loss of reality testing in a presentation and there were no – didn't appear to be any residual psychotic symptoms at that time*."[189]

---

[184] Ibid, p 167.
[185] Transcript of proceedings 6 August 2024, p 125
[186] Ibid, p 127
[187] Ibid, p 127
[188] Ibid, p 132.
[189] Transcript of proceedings, 7 August 2024, p 170.

174. Ultimately he stated that given Kevin had a previous diagnosis of schizophrenia, it was worthwhile to persist with antipsychotic treatment and to have had him followed up by a community mental health team for continuing monitoring.[190]

Issue 2(d) The nature and adequacy of follow-up in the community by the Illawarra Community Mental Health Service.

Evidence

175. In relation to the follow-up care, Associate Professor Sullivan noted that the discharge planning was complicated by Kevin's poor engagement and by apparently moving out of the catchment area. At discharge, his care was transferred to the Blacktown CMHT, although he did not in fact move to the area. As a result, there was a delay for some days while the care was transferred back to the appropriate area team.[191]

176. The evidence of the two clinicians, Troy Crowther and Sharon Ible, who visited Kevin on 4 June 2022 was that only the discharge referral and discharge plan were provided to them ahead of their visit to Kevin, and that they were not aware of his prior admissions and mental health difficulties. They gave evidence that this was standard practice and that the CMHT would generally read some of the notes from the inpatient unit as well as the discharge summary, but they would not ordinarily go further "back" than the patient's most recent discharge.[192]

177. Mr Crowther and Ms Ible both gave evidence that they used their experience to assess Kevin's presentation, asked him numerous questions and believed that he presented in a manner consistent with not being under the influence of drugs or alcohol, noted that he confirmed he was compliant with his oral medication, that he was cogent and coherent and made sense, and that his mental health was good.[193] They did not probe further when Kevin became agitated, but noted in their evidence that many patients are evasive about the reasons for their admission(s), particularly when it is drug related, and that such evasion does not, of itself, equate to an indication that somebody is relapsing.

178. In his report, Associate Professor Sullivan opined:

[190] Ibid, p 167.
[191] Expert Report of Dr Danny Sullivan, 3 May 2024, Vol 7A, Tab 176B, p 16, [84].
[192] Transcript of proceedings, 7 August 2024, pp 207-208.
[193] Transcript of proceedings, 7 August 2024, p 206, 226.

“The assessment of the Illawarra CMHT on 4 June 2022 was undermined by Mr Edwards' guardedness and denial of substance use. The clinicians had apparently spoken beforehand to Mr Edwards’ mother. His father noted that he could not sit in on the assessment but overheard Mr Edwards. The team provided an opportunity for the parents to contact them, but Mr Edwards’ death occurred before they had an opportunity. I consider there was appropriate and adequate effort to seek collateral information, noting the complexity of this when a person being assessed refuses permission to speak to others who may hold differing perspectives.

The assessment sought evidence of psychotic symptoms and these were not apparent, although it was likely that he was not disclosing these symptoms. On 4 June when assessed by the ACT Team, Mr Edwards would not have met the threshold for involuntary readmission. Although it is clear that the assessing clinicians held concerns that Mr Edwards was denying symptoms or refusing to discuss salient topics, they did not, in my opinion, have grounds to detain him on the basis of that his presentation on the day.

In the absence of evidence of mental state deterioration or of symptoms warranting readmission to hospital, it is difficult to consider other more effective treatment interventions for a voluntary patient. Compliance with oral medication might be monitored through the use of a compliance aid such as a Webster-pack, witnessed medication taking or, in exceptional circumstances, blood tests to assay for serum levels. In practice, this is rarely done except for clozapine and not simply to demonstrate compliance.

The deterioration in mental state between 4 and 5 June 2022 was stark and likely reflects significant acute intoxication with methamphetamine. It is noted that there was no evidence of risperidone on toxicology and in fact, it is unlikely that Mr Edwards had taken or would have taken any oral medication after discharge from hospital. In any event, even had he been taking oral or injected medication, persistent methamphetamine use would still likely induce psychosis and in that sense, it is not clear that the prescription of antipsychotic medication would have necessarily averted

the tragic events which led to the death of Mr Edwards."[194]

179. The Illawarra CMHT took notes of their meeting with Kevin, asked Kevin's father if he had any concerns, confirmed with Kevin that he had a follow-up appointment with a GP to manage his care in the community thereafter, provided Kevin's father with some contact numbers should any concerns subsequently arise and decided in all of the circumstances that Kevin's presentation was such that he was no longer required to be managed by their team and ought to be further managed under the care of his GP. This was discussed by the wider team on 6 June 2022 and confirmed, albeit the team was unaware of Kevin's passing the day before.

180. Associate Professor Sullivan agreed in oral evidence that it can be difficult for community team members assessing a patient in their own home to broach topics such as drug use, and said further that if they expect that the patient would deny drug use if asked, then there may be no particular benefit to asking the questions and in fact rapport might be lost or the patient may become defensive or hostile. He went on to say that given the purpose of the assessment on 4 June 2022 was to monitor Kevin's progress after discharge, he was of the opinion that the community mental health team members executed their duties sufficiently.[195]

181. Associate Professor Sullivan ultimately opined that Kevin's behaviour preceding his death was consistent with him experiencing marked persecutory ideation and possible hallucinations which he did not voice to anybody apart from the taxi driver. While there was evidence adduced in the inquest about Debbie Curtis taking Kevin to Oaks Flat Police Station on 1 June 2022 following some behaviours that would appear consistent with the onset of paranoid delusions and some psychotic symptoms, it appears that this was not reported to anybody else and was not known by Kevin's parents, Shoalhaven Hospital or the Illawarra CMHT. Unfortunately, nobody raised any concerns to the Illawarra CMHT about Kevin exhibiting any worrying behaviours or acting in a manner that could have raised concerns about his relapsing into psychosis.

[194] Expert Report of Associate Professor Danny Sullivan, Vol 7A, Tab 176B, p 16 at [85]-[88].
[195] Transcript of proceedings, 9 August 2024, pp 14-15.

Issue 2(a), (b), (c) and (d) - Submissions

182. In light of the expert evidence provided by Associate Professor Sullivan, Counsel Assisting submitted that:

- The discharge of Kevin from Shellharbour Hospital on 30 May 2022 was appropriate.
- There was some competing evidence as to Kevin's diagnosis. However, the evidence of both Dr Diana and Associate Professor Sullivan was consistent in that regardless of the diagnosis, whether schizophrenia or drug-induced psychosis, the treatment would be similar and the diagnosis would have resulted in the prescription of risperidone. Therefore, the diagnosis itself is not really of significance for the purposes of the issues in this inquest. Rather, the issue was the treatment of Kevin and whether that should be via a depot injection and CTO or self-administered orally.
- Dr Diana in his statement conceded that he did not have any recollection of Kevin's 2021 admission whilst Kevin was under his care in 2022. If Dr Diana had been aware, then it is possible that the discharge plan may have been different, namely involving the application for a CTO. However, Counsel Assisting submitted the ultimate outcome may not have been any different if Kevin continued to use amphetamines.
- As such, in light of Kevin's previous non-compliance with oral medication, and the fact that a year prior he had been discharged on a CTO with depot injections, on balance, it was probably more appropriate to discharge him on a similar plan. At the same time, there is inferential evidence that Kevin was taking his risperidone, so it may be that he was in fact compliant, and that a CTO may have made no difference.
- In all of the circumstances, it is open to find that the discharge plan was, on balance, appropriate.
- In all of the circumstances, it is open to find that the follow-up in the community was adequate.
- On the issue of the decision to appoint Debbie Curtis as carer, this was ultimately peripheral, as Kevin did not comply with the discharge plan and went to live with his parents instead in any event.

183. The Edwards family submitted that:

- The treatment received by Kevin at Shellharbour Hospital from 10-30 May 2022 was adequate, with the exception of the attempts to communicate with the family to obtain collateral history, to determine Kevin's baseline and to plan his discharge.
- It was not appropriate to discharge Kevin into the care of Debbie Curtis as this was not an environment which was consistent with safe and effective care. It was also inappropriate to discharge Kevin without him being on a CTO with injectable depot.
- The follow up support and engagement Kevin received from the Illawarra Community Mental Health Service (**ICMHS**) was a "one-off" which only occurred due to follow ups made by Kevin's parents. No attempts were made by ICMHS to confirm who Kevin's treating GP was or whether Kevin had any upcoming appointments for a psychiatric review. In the family's view, this was inadequate.
- Regarding the decision to discharge Kevin on 30 May 2022 and the one-off community follow up on 4 June 2022, the Edwards family asks the Court to consider ICLHD (including the Community Health Service) did in light of its statutory obligations under the *Mental Health Act*. In particular, the family notes:
  - s 3 (Care and Treatment, Rights of Patients or Detained Persons, Designated Carers and Principal Care Providers);
  - s 68 (Principals for Care and Treatment);
  - The objectives of the NSW public health system set out in s 105;
  - Provisions regarding the role or recognition of and notification to "designated carers", "principal care providers" and "close friends or relatives", information sharing and discharge planning in ss 71-72B, 73, 75 – 79; and
  - s 12 (general restrictions on detention of persons).
- That the authorised medical officer (Dr Diana) did not properly turn his mind to whether discharging Kevin on 30 May 2022 into the care of Debbie Curtis without a CTO and depot medication was consistent with "safe and effective care" and/or Dr Diana did not have sufficient information on hand about the

service he was discharging Kevin into to be satisfied it was consistent with safe and effective care. The service ought to have taken more steps to gather collateral information from Kevin's parents, noting that Glen Edwards had never been excluded under the nominated carer form.

- It was ultimately not appropriate to discharge Kevin in the circumstances. Kevin should have been discharged on a CTO with depot injection medication, regular caseworker reviews and consultant psychiatric reviews, all supervised by the Community Health Service and discharged into the care of his parents.
- The discharge plan was not appropriate in the circumstances as, among other things, it did not adequately ensure Kevin would be compliant with his medication, that he would be mentally well and would not be at risk of relapse, harm and/or misadventure. A CTO had more of a chance at ensuring this. The discharge plan was not based on adequate engagement with Kevin's family (again noting that Kevin's father, Glen Edwards was not excluded). The plan had also been almost entirely left entirely to Dr Monique Costello. Such an important task should not have been left to someone who was junior and was at the time inexperienced with involuntary patients with complex mental illnesses.
- It was inappropriate to leave the discharge referral to Dr Bragg, who at the time only three to four months into his stage 1 psychiatry registrar placement and had not been involved in Kevin's care during his involuntary admission in May 2022. It is also submitted that Dr Bragg should not have completed and signed off the discharge referral without discussing it with Dr Diana or at least Dr Khoo.
- On the CTO issue, the family submitted that the Local Health District ought to have applied for a CTO as was contemplated by Dr Khoo on 24 May 2022.
- In relation to the community follow up issue, the family submitted everything was left to Kevin and his family to follow up. It is submitted that the follow up was superficial and deficient due to the failure to obtain collateral, the fact that there was only a one-off visit and that there was no psychiatric review scheduled.

184. Dr Diana submitted that he did turn his mind to a CTO based on his conversations with Diane Edwards. It was submitted that a CTO might not have been granted as at the time of discharge, Kevin demonstrated a linear and coherent thought process, did not want depot, had accepted medication while in care and had expressed a willingness to continue his medication on discharge. It was submitted that in these circumstances, it would be difficult to apply coercive measures to a person who is capable of making their own decisions.

185. Dr Khoo and the Local Health District submitted that:

- The criticisms expressed in the submissions of the other parties regarding the adequacy of the discharge plan, CTO, depot medication and community follow up are not consistent with the expert evidence.
- The specific diagnosis received by Kevin, in relation to which there is some dispute between the evidence of Professor Sullivan and Dr Diana, was not significant as it would not have resulted in a major difference in the treatment plan which was devised for Kevin.
- Dr Diana, rather than Dr Khoo, was responsible for the discharge plan and criticism should not be raised against Dr Khoo.
- The discharge plan was comprehensive and appropriate in the context of a discharge from a public hospital in the community.
- The selection of Debbie Curtis as a potential carer did not change the outcome as Kevin went to his parents' home. The family's submission that the selection of Ms Curtis was inappropriate is something which can only be said in retrospect. "Carer" in this context did not mean a designated carer under the *Mental Health Act* but rather, as identified by Dr Diana, a point of stability, support and encouragement for Kevin.
- Efforts made to obtain collateral history by hospital staff were demonstrably good efforts. The hospital has to rely on the frankness of the people with whom they are engaging.
- On behalf of the LHD, it was submitted that Dr Diana had to consider the least restrictive form of care in circumstances where Kevin said he was willing to comply with oral medication. Dr Diana also appears to have had in

his mind that the Western Sydney Community Team were willing to give Kevin support without a CTO.

- There is a real question as to whether had Dr Diana and his team applied for a CTO, whether it would have been granted by the Tribunal. This is based on the oral evidence of Dr Sullivan which suggested it may have been difficult to obtain a CTO. It seems unlikely that a CTO, even with depot medication, would have changed the outcome, noting that Kevin took methamphetamine at some stage on 4 June 2022.
- The hospital completed a handover to the community team with the expectation that Kevin would be followed up. The evidence of Dr Bragg demonstrated that a GP was informed automatically.
- It was not the fault of the LHD that Kevin was not discharged to Western Sydney, as Kevin voluntarily elected to live elsewhere. Had he gone to Western Sydney, there may have been a follow up.
- The community follow up was a standard one and was intended to assess Kevin's presentation.
- Glen Edwards had an opportunity to express his concerns to Ms Ible at the conclusion of the follow up visit. Although Glen Edwards did not believe he had the ability to raise any issues, Ms Ible did offer this opportunity. The ultimate decision to discharge Kevin was made a few days later by a multidisciplinary team.
- While with the benefit of hindsight different steps might have been taken to obtain collateral information from the family, there was no failure of care.

Issue 2(a), (b), (c) and (d) – Consideration

186. Ultimately, the totality of the evidence suggested that there were no appropriate medical grounds to lawfully detain Kevin as at the time of his discharge on 30 May 2022. In light of this, and the expert opinion of Associate Professor Sullivan, in relation to issue 2(a), I find that Kevin's discharge on 30 May 2022 was appropriate.

187. Having regard to all of the evidence in respect of issue 2(b), particularly the expert evidence of Associate Professor Sullivan, I find that the discharge plan was, overall appropriate in the circumstances.

188. I note Kevin's family's concerns about the appropriateness of Debbie Curtis being the designated carer for Kevin, in light of the nature of their relationship, her potential physical limitations in light of her cancer and treatment, the fact that Kevin had previously lived with her and then left with no notice, and Kevin's previous drug usage whilst in Ms Curtis' presence. I have also considered the evidence of Dr Diana and Associate Professor Sullivan that Kevin was an adult with autonomy over his decision making. However, I consider that, ultimately, the issue is peripheral in light of the fact that Kevin did not comply with the discharge plan and in fact went to live with his parents instead of Debbie Curtis.

189. I now turn to issue 2(c), namely, whether a Community Treatment Order should have been sought prior to discharge. It is very difficult in these circumstances to say with certainty whether this should have been the course adopted.

190. Ultimately, with respect to whether a Community Treatment Order (including as to depot injections) should have been sought prior to discharge, I find that, in light of Kevin's previous non-compliance with oral medication and the fact that a year prior he had been discharged on a CTO with depot injections, and relying on the evidence of Associate Professor Sullivan, in all of the circumstances it was probably more appropriate to discharge him on a similar plan.

191. Having considered those specific issues pertaining to Kevin's discharge, and the evidence of Associate Professor Sullivan, I find that overall, the clinical care and treatment received by Kevin at Shellharbour Hospital from 10-30 May 2022 was adequate.

192. Turning now to issue 2(d), I accept the evidence of Associate Professor Sullivan that when Kevin was assessed by the ACT Team on 4 June 2022, he would not have met the threshold for voluntary readmission and that the assessing clinicians did not have grounds to detain him on the basis of his presentation that day. I find that, consistently with the expert evidence, the follow-up in the community was adequate in the circumstances.

Issue 3: Whether the actions of the NSW Police Force (including in particular, Sergeant Mark Jackson, Sergeant Anthony Roberts and Sergeant Ethan Tesoriero) on 5 June 2022 were reasonable and appropriate in the circumstances (having regard to the applicable NSW Police Force policies and procedures)

Issue 3(a) – The interactions with Mr Edwards on the M5

Issue 3(b) – The use of OC spray against Mr Edwards

Issue 3(c) – The apprehension and restraint of Mr Edwards

Evidence

193. For convenience, and due to their interrelated nature, I will summarise the evidence in respect of these three issues together.

194. The three involved officers each first gave their version of the evidence of 5 June 2022 during the preliminary hearing held on 11 and 12 March 2024. The transcripts of their evidence were tendered in these proceedings. The officers were not recalled to give evidence during the August hearing.

195. It is acknowledged that the events of 5 June 2022 took place on a busy motorway in the early hours of the morning. There was an inherent risk of serious injury or death present for both Kevin and the responding officers. It is in this context that the actions of the officers must be considered.

196. At the outset, it is important for me to acknowledge the candour of the involved officers when giving their evidence. They made appropriate concessions and acknowledged potential shortcomings in their actions on the day that Kevin died. The involved officers were all clearly affected by Kevin's tragic death and the the circumstances leading to it, and I am grateful for their assistance in this matter and the frankness of their evidence.

197. I also acknowledge the graciousness of Kevin's family in their attitude towards the involved officers, and their commendable empathy towards them, in circumstances where they are grieving the loss of their beloved son. It is obvious to me that Kevin was raised in a very loving and compassionate family.

198. Senior Sergeant William Watt is the NSWPF co-ordinator of Operational Safety Training & Governance. He provided an expert opinion and gave evidence on the actions of police involved in the arrest and subsequent death of Kevin on 5 June 2022 and gave oral evidence on this topic.

199. In relation to the OC spray, Senior Sergeant Watt in his statement stated that OC Defensive Spray may be used only for the protection of human life or as a less than lethal option for controlling people where violent resistance or confrontation occurs, or is likely to occur.[196]

200. Senior Sergeant Watt acknowledged that a subject who is affected by drugs, alcohol or suffers a mental disorder may require a different choice of tactical option to gain and maintain control in an effort to resolve the incident confronting the officer. The use of any or all of the options is a matter of judgment for the officer at the time, dependent on the circumstances. When making these judgments, the overriding consideration is the level of threat posed by the subject. Regardless of any altered mental state or other reason for their behaviour, the threat posed by a subject must be given greater weight than the cause for their behaviour.[197]

201. In Senior Sergeant Watt's opinion, the use of OC spray appears to have been in accordance with training and policy given the risk posed by Kevin while Sergeant Jackson climbed the divider and the dangers unique to the location – the need to rapidly gain control of Kevin was significant, given these risks.[198] A prolonged struggle or an escape attempt would have increased the risk of serious injury or death by being struck by high speed vehicles. In his opinion, there was a real and immediate risk of death or serious injury should Kevin or Sergeant Jackson have moved into the lanes of traffic.

202. Ultimately, in his oral evidence, Senior Sergeant Watt stated that having regard to the NSWPF policies and procedures, Sergeant Jackson's deployment of OC spray was justified because of the imminent risk of confrontation, high risk location on a road with a 100km/h speed limit, the size differential and the poor visibility. The OC spray was needed to gain an advantage and control of the situation.[199]

203. The decision to move Kevin across the divider/bollard was, in Senior Sergeant Watt's opinion, within the ambit of both first aid training provided to police and, on the face of it, was designed to limit the danger posed by high-speed traffic to

---

[196] Police expert statement of Sergeant William Watt, Vol 8, Tab 176E, p 13.
[197] Ibid, p 15.
[198] Ibid, p 17.
[199] Transcript of proceedings, 9 August 2024, p 32.

both police and Kevin. As Kevin had gone limp, it was noticeable from the body worn video (**BWV**) footage that manoeuvring him was difficult and ultimately Kevin sustained an injury to his forehead as a result. Senior Sergeant Watt stated that the physical movement of Kevin could have been done better, and that it was not optimal to drop someone while trying to get them over the fence but that officers were not trained in that specific movement in such circumstances.[200]

204. However, Senior Sergeant Watt said that the decision to handcuff and restrain Kevin was appropriate in the circumstances. In his opinion, it was reasonable to have Kevin handcuffed and restrained to move him from one side of the bollard to the other. Senior Sergeant Watt said that he would have made the same decision, because the risk of being struck by a vehicle at a high speed was very high and the outcome was almost inevitably fatal.[201]

Submissions

205. Counsel Assisting made the following submissions in respect of these issues:
    - Sergeant Jackson's actions in administering OC spray to Kevin were appropriate and in accordance with NSWPF training, policies and procedures.
    - In all of the circumstances, the actions of the NSWPF officers in their interactions with Kevin on the M5, and their apprehension and restraint of him, were appropriate.
    - The decision to ultimately remove the handcuffs from Kevin should have been made much sooner than they were. Similarly, the BWV should have been turned on much earlier but the delay can be readily explained by the immediacy of the unfolding high stress events and human error.

206. The Edwards family submitted that:
    - The officers were confronted with an unpredictable emergency that potentially risked their lives, Kevin's lives and the lives of other road users. They accept that there was little opportunity for calm, considered and timely decision-making.

[200] Ibid, p 32.
[201] Ibid.

- The danger in moving Kevin carefully, thoughtfully and safely over the bollard was not considered.
- In relation to the administration of OC spray, the use of the spray was, consistent with the opinion of Ms Wilson, one of the circumstances surrounding Kevin's death and may have contributed to it. However, the family accept that in the heat of the moment and in terms of tactical responses, the use of OC spray was reasonable in the circumstances.

207. Submissions made on behalf of the three involved officers included that the officers acknowledged that the level of care they provided to Kevin was not sufficient, in light of the inadequacy of the training they had received. Furthermore:

- I was invited by counsel for the three involved officers not to make direct criticism of them, in light of the difficult and stressful circumstances they faced on 5 June 2022.
- It was acknowledged on behalf of the involved officers that their actions in moving Kevin over the bollard could have been undertaken with more care and precision, however the difficulties involved in the manoeuvre, including Kevin being bigger in stature than the officer trying to move him and the fact that he was not responsive at that time were identified.
- The involved officers submitted that there were some problems with the evidence of the bystander Ms Bene, including inconsistencies between her evidence and the BWV footage and the degree of her intoxication at the time.
- The involved officers also submitted that when updates are implemented in respect of NSWPF training policies and procedures, there is a difficulty in respect of the dissemination of that material to all officers.
- Finally, the involved officers submitted that the insufficient response by Parliament to the impact of methamphetamine on the community has resulted in first responder police officers effectively performing mental health triage services because the systemic issue is not being adequately addressed.

Consideration – issues 3(a), (b) and (c)

208. In respect of issue 3(a), the interactions with Kevin on the M5, I find that, in all of the circumstances, the actions of the NSWPF were reasonable and appropriate in the circumstances.

209. In respect of issue 3(b), the use of OC spray against Kevin, I find that the actions of the NSWPF were reasonable and appropriate in the circumstances.

210. In respect of the apprehension and restraint of Kevin, I note the concessions, in my view appropriately made by the involved officers that their actions in moving Kevin over the bollard could have been undertaken with more care and precision, and the expert evidence of Senior Sergeant Watt, which I accept, that this manoeuvre could have been done better. Further, I accept Associate Professor Anna Holdgate's opinion that it appears from the footage that the danger of moving Kevin carefully, thoughtfully and safety was not considered. However, I also accept that the officers were in difficult and stressful circumstances, and I note the submission of NSWPF that widespread issues of methamphetamine use in the community has resulted in police officer first responders having to perform mental health triage services. On balance, therefore, I find that the apprehension and restraint of Kevin was reasonable and appropriate in the circumstances, despite the shortcomings.

211. I turn now to the nature and timing of the first-aid provided.

Issue 3(d) - The nature and timing of the first-aid provided (including the non-provision of CPR and the repeated use of sternum rubs)

Evidence

Sergeant Jackson

212. Sergeant Jackson, a serving police officer within the NSWPF for 20 years, indicated he commenced service in 2003, and prior to entering the Academy undertook a first aid training course and again in 2013 and 2019. Since then, 10 or 15 minutes was given to CPR training every one or two years after weapon training by weapon trainers. Sergeant Jackson's training history records indicated his last CPR training would likely to have occurred on the 13th of May 2021 with DEFTAC.[202] Prior to that date records show CPR/first aid practical 11th July 2018.

[202] Transcript of proceedings, 11 March 2024, p 9.

213. As at June 2022, he described his CPR training as "just the general sort of ten-minute training that you get when you do your death tackle, your shoot, annually or for the training year".[203] His understanding prior to 5 June 2022 about when CPR should be commenced was that if a patient was breathing, regardless of what the breathing category was, that you were not to commence CPR.[204] He had that view as a result of the training he received whilst a serving NSW Police Officer.

214. As at June 2022, he believed he was acting in accordance with the first aid training he had received. With the benefit of hindsight, he does not believe it was adequate.[205] This opinion is based on his understanding that CPR was not to be performed while there was any type of breathing.

215. Prior to June 2022 he had undertaken training in relation to the use of force and restraint. His understanding in relation to OC spray is that he is lawfully entitled to use it in a situation where there is a violent confrontation occurring or likely to occur and if he was likely to be overpowered considering the circumstances.

216. Sergeant Jackson gave evidence that when he responded to the job and first sighted Kevin, his first thought was that he needed to get Kevin off the road otherwise he was going to get hit by a car. He slowed the car down and wound down both windows, being his driver's side and the passenger side, and yelled at Kevin to get off the road or he would get hit by a car. During their interaction, Kevin said multiple times: "I need help. I need an ambulance". Sergeant Jackson said that he would get him an ambulance if Kevin got off the road.[206]

217. Sergeant Jackson formed the opinion that Kevin was likely to be affected by drugs or alcohol and possibly had mental health issues.[207] Sergeant Jackson noted that he was there by himself, he was on a highway, that Sergeant Jackson himself was not of large stature, that he wanted to get Kevin off the road but he was not listening. The only two things Kevin said to him in the course of their interaction was: "I need help. I need an ambulance". Sergeant Jackson said that Kevin said this a number of times through his interaction with him.

---

[203] Ibid, p 8.
[204] Ibid, p 10.
[205] Ibid, p 11.
[206] Ibid, p 16.
[207] Ibid, p 17.

218. Sergeant Jackson made a radio broadcast for other cars to attend because he believed that he would never be able to restrain Kevin by himself and he needed assistance to stop or slow down the traffic. He said that he thought if he could spray Kevin, it would give him enough time to jump over the barrier, and either push him across to the shoulder of the eastbound lanes or to give him enough time to drag him over into the westbound lanes over the median strip.

219. He recalled Kevin being on the actual roadway when he deployed the OC spray. He estimated that he was between 1.5-2m apart from Kevin when he deployed the spray. He said that up until the handcuffs were applied, Kevin was struggling and resisting and that he believed there was no other option than to have him restrained and handcuffed.[208]

220. He said that Kevin became unresponsive prior to police moving him over the median strip and that he went quiet and limp. Sergeant Jackson was asked why, at 3:51:10am, when he said that the man, Kevin, had stopped breathing, he did not say to either Sergeant Roberts or Sergeant Tesoriero to commence CPR. He said he could not really give an answer. He was unable to provide any explanation as to why he did not himself commence CPR or request another office to do so. [209]

221. He agreed that he observed Sergeant Tesoriero giving Kevin sternum rubs and that it was his understanding, from his training, that one of the ways to try and get a response from a patient was to rub the sternum of the patient. He could not say why, when there was no response from Kevin to the sternum rubs, he did not then commence CPR.

222. He agreed that he was sufficiently concerned in relation to the welfare of Kevin, because he called the ambulance, but did not commence CPR. He said that he could see Kevin breathing shallow breaths. He said he was not given any training on what may be considered abnormal breathing or agonal breathing and that his understanding was that if a patient was breathing, CPR did not need to be commenced.[210] He acknowledged that in the early hours of 5 June 2022 he heard a female bystander yell out “CPR” but that he and the other officers spoke in relation to him breathing, so they were not going to commence CPR.

---

[208] Ibid, p 27.
[209] Ibid, p 30.
[210] Ibid, p 32.

223. He said that it was an oversight that they did not remove the handcuffs immediately after Kevin became unresponsive but conceded that it was part of his training that if somebody is unresponsive, they may require medical assistance, that handcuffs will be removed.[211]

224. He could not give an answer as to why he did not commence CPR after saying to Chief Inspector Tetley that Kevin looks "pretty fucked" and that there was "probably not much you can do at this stage". He said that an answer could be that his training did not enable him to recognise when CPR was perhaps indicated. Since the incident, Sergeant Jackson sought out further CPR training during which he learned that sternum rubs are no longer in place. He agreed that a reason he sought out the course was because the training he had previously received was inadequate.[212]

Sergeant Roberts

225. Sergeant Roberts attested from the Academy in 1991, having undertaken a first aid course. His training records show DEFTAC training in 2021, 2022 which included a half hour CPR component. Training records also show a CPR first aid online course and 2018 CPR reference. He described the CPR training as going for about half an hour and involving grabbing dummies and practicing compressions. In his 33 years' experience, he had never previously been called upon to give CPR.[213]

226. Prior to the inquest commencing, he had never heard the term "abnormal breathing". He described his training as "old school" where "if there's breath, there's a pulse, you leave them in the recovery position" and that is what he chose to do on 5 June 2022.

227. He believed that a pulse meant the person's heart was beating and that meant blood was circulating around their body.[214]

228. He described the scene that he arrived to on 5 June 2022, including Kevin coming over the barricade, being sprayed at close range (approx. 1 metre) with OC spray by Sergeant Jackson, letting out a roar, then charging towards Sergeant Roberts. Sergeant Roberts felt scared, said Kevin had his fists

---

[211] Ibid, p 35.
[212] Ibid, p 38.
[213] Ibid, p 46.
[214] Ibid.

clenched and that as Kevin came towards him, he punched him in the face. Shortly afterwards, he put Kevin into a headlock for about one minute and then together with Sergeant Jackson and another bystander he was handcuffed. Once Kevin was handcuffed, the struggle seemed to stop but Sergeant Roberts was unaware that Kevin was in fact unconscious at that time. He described Kevin flopping over and going limp and that as a result, Sergeant Roberts took his pulse and believed he could feel one. Accordingly, on his evidence, they decided not to administer CPR. They kept the handcuffs on in case he woke up. While monitoring him, they decided not to give him CPR on the basis of the pulse and believing they could see breath, as he could see steam coming out of his mouth. He described the breathing as shallow.[215]

229. In relation to ensuring Kevin's safety upon manoeuvring him, he said that they lost control of him and that he flopped and fell to the ground. He had not appreciated the loss of consciousness of Kevin at this point.

230. He said that he recalled a bystander yelling out "CPR, CPR" to police but that he yelled straight back to her "he's breathing".[216]

231. Prior to reviewing the brief, he had never heard the term agonal breathing. At the time, he believed the sternum rubs to be the right thing to do.

Sergeant Tesoriero

232. Sergeant Tesoriero commenced with the NSWPF on 17 December 2009 and completed a first aid program prior to joining. He remembers undertaking a first aid course in 2018, and around every year or so undertook 5-10 minutes of CPR training at the end of a pistol and qualification shoot. Sergeant Tesoriero training records shows his DEFTAC training was in March 2021 and 2022 where CPR was part of the annual shoot and again a CPR course in April 2018, and a CPR First Aid Online in May 2014.

233. His recollection of CPR training was that there were CPR dummies laid out on a mat, they were told about the correct cadence and depth for CPR compressions, they were told to start giving compressions and for a period of about two minutes an instructor walked around and gave feedback.[217]

---

[215] Ibid, p 51.
[216] Ibid, p 62.
[217] Transcript of proceedings, 12 March 2024, p 4.

234. His training prior to June 2022 was that if he came across a person that was not breathing or had no pulse, he would administer first aid immediately.[218]

235. In relation to the scene he arrived to, he stated that he was concerned for Sergeant Jackson from the beginning and that once they handcuffed Kevin, he believed the situation was under control. As soon as they moved Kevin over the barrier, he realised that Kevin was unconscious and got very worried and overwhelmed. After Kevin was placed on the westbound lane, Sergeant Tesoriero noticed that Kevin was not responsive, that there was a cut on the bridge of his nose and small amount of blood.[219]

236. Prior to June 2022, he had administered CPR upwards of 10 times, in that he assisted rather than initiated it.[220]

237. He personally applied sternum rubs to Kevin to try to rouse him ad wake him up. He sighted "fog" coming out of Kevin's mouth and saw shallow breaths coming out. Prior to June 2022, he had not been given any CPR training in relation to agonal or abnormal breathing and that because he sighted breath, albeit shallow breath, and a pulse, he determined that he was not going to commence CPR.[221]

238. In his opinion, the training he had received prior to June 2022 in respect of CPR was inadequate.[222]

Associate Professor Anna Holdgate

239. Associate Professor Holdgate, a Senior Staff Specialist in Emergency Medicine with extensive experience in teaching and examination of training doctors in Emergency Medicine, has provided an expert opinion regarding the circumstances surrounding CPR, and when it ought to have been administered to Kevin.

240. In her report, she states that from her observation of the BWV footage, Kevin was unresponsive from around 3:49:30am and that there is no evidence of normal breathing from this point onwards. She noted that the police called for

[218] Ibid.
[219] Ibid, p 20.
[220] Ibid, p 8.
[221] Ibid, p 23.
[222] Ibid, p 30.

an ambulance at 3:51:05 stating that Kevin was unconscious and not breathing.[223]

241. She noted that the current Australian Resuscitation Council CPR and Breathing guidelines state that 'rescuers must start CPR if the person is unresponsive and not breathing normally' and similarly, 'if the unconscious person is unresponsive and not breathing normally after the airway has been opened and cleared, the rescuer must immediately begin chest compressions and then rescue breathing'. Based on these guidelines, CPR should have been commenced at about 3:50am.[224]

242. In her opinion, over the next 9 minutes, despite police continuing to closely observe Kevin and say that his stomach was moving and that he was breathing, in the footage there is no visible evidence of chest movement or breathing. In her opinion, it was unlikely that any shallow breathing was described by the attending officers was 'normal breathing' and in her opinion, CPR should have been commenced or continued at this point.[225]

243. Associate Professor Holdgate opined in her report that the fact that police conducted several pulse checks and checked Kevin's pupillary response to light indicates that they did not understand the core indication to initiate CPR, that being unresponsiveness with abnormal beathing. Once Kevin met these two criteria, it is Associate Professor Holdgate's opinion that neither a pulse check or pupil check were relevant and that CPR should have been commenced.[226]

244. Associate Professor Holdgate did note that police are not primarily trained as health care workers and that assessing for breathing and a pulse in the dark on the side of a motorway is very challenging. In these circumstances, she noted that it may be very difficult to ascertain the presence of either breathing or a pulse with any certainty. She gave evidence that even experienced clinicians can find it difficult to differentiate genuine breathing and a palpable pulse from artefactual movements. It is for this reason that she says the threshold should be very low to commence CPR, i.e. where there is any suggestion that the breathing is not normal in an unresponsive patient, CPR should be commenced.

---

[223] Expert report of Associate Professor Anna Holdgate, Vol 7A, Tab 176, p 5.
[224] Ibid.
[225] Ibid, p 6.
[226] Ibid.

In her opinion, the police failure to recognise that CPR was indicated reflects a lack of training rather than any recklessness or carelessness on behalf of police.[227]

245. Associate Professor Holdgate also opined that while the provision of immediate CPR once Kevin became responsive with abnormal breathing would have improved his chance of survival to some extent, perhaps about 8%, in the context of sudden collapse with methamphetamine toxicity and vigorous physical activity, it is possible that Kevin's chances of survival were very poor from the moment he became unresponsive.[228]

Philippa Wilson

246. Ms Phillipa Wilson, Managing Director of Premium Health, a registered training organisation providing first aid training across Australia for over 35 years, has prepared two reports in these proceedings. Her initial report provides comment on the adequacy of the first aid management/treatment provided to Kevin by attending NSW police officers on 5 June 2022, including with respect to the non-administration of CPR and the use of sternal rubs, and what first aid/treatment would have been appropriate in the circumstances.

247. In her opinion, basic life support steps were not satisfactorily or safely performed by any attending members of the NSWPF.[229]

248. Ms Wilson noted that Sergeant Tesoriero indicated to move Kevin over the concrete barrier as the traffic was stopped on the opposing side and it was less of a danger. However, in her opinion, a significant danger was present in moving Kevin who, because he was unconscious and handcuffed was not able to protect his head, torso, limbs and spine in the one metre lift and drop over the concrete barrier to the other side.[230]

249. She noted that Kevin did not call or cry out before the lift, that there was no resistance to kick out at the handling of his leg and foot in the lift by the attending members of NSWPF, and that there was no call or cry out following the drop and impact of his body on the bitumen surface over the barrier. In her opinion, it is reasonable to assume that he was unconscious at this stage.[231]

---

[227] Ibid, p 6-7.
[228] Ibid, p 8.
[229] Expert report of Philippa Wilson, Vol 7B, Tab 176C, p 12.
[230] Ibid, p 13.
[231] Ibid.

250. She noted that at around 3:50:24am, Kevin was lifted roughly, then rolled over the concrete barrier where his unsupported and unprotected body and head is dropped onto the bitumen roadside by the attending members of the NSWPF and others. In her opinion, it appears that the danger of moving Kevin carefully, thoughtfully and safely was not considered.[232]

251. In relation to sternal rubs, Ms Wilson stated that the ARC phased out sternal rubs in 2015 with a new guideline in January 2016 initiating the change of responsiveness for a first aider instead of sternal rubbing to ask the ill or injured person to “open their eyes; squeeze my hand. Let it go”.[233]

252. The ARC current action for a first aider to seek a response from a person to determine consciousness or unconsciousness remains using the “talk and touch method”, where the first aider gives simple commands as well as grasping and squeezing the person’s shoulders firmly to elicit a response, a process that should take no more than a few seconds.

253. She observed that Sergeant Tesoriero used sternal rubs numerous times over a 5-minute period to determine the conscious or unconscious state of Kevin despite Kevin always displaying signs of unconsciousness. In her opinion, Sergeant Tesoriero’s fixation on determining whether Kevin was unconscious or trying to wake him up with vigorous sternal rubbing reduces time critical steps to ascertain the next action step to determine if Kevin’s airway was clear.[234]

254. In relation to breathing, Ms Wilson noted that she could not see or hear communication to others that a meaningful breathing check was ever undertaken by any attending member of the NSWPF to determine if Kevin was, or was not, breathing.[235] Agonal breathing, according to Ms Wilson, is not normal breathing and is commonly cited across the world following cardiac arrest and decreases rapidly within the event. It is not normal breathing; does not represent adequate oxygen intake and requires immediate intervention.

255. In relation to pulse checking, Ms Wilson gave evidence to the effect that pulse checking was removed from the ARC Guidelines in 2011.[236]

---

[232] Ibid.
[233] Ibid, p 14.
[234] Ibid, p 15.
[235] Ibid, p 17.
[236] Ibid, p 18.

256. Ultimately, in reviewing the evidence, Ms Wilson was of the opinion that there appeared to be a distinct lack of knowledge and performance of first aid skills, including a lack of communication, timekeeping, coordination, and teamwork by the attending members of the NSWPF.[237]

257. Finally, Ms Wilson stated that the current first aid programs described by the Sergeants and recorded by the NSWPF do not meet industry standards of workplace first aid training throughout Australia. Her assessment is that NSWPF members were poorly trained and as a result were inadequately skilled to manage Kevin and the first aid incident.

Senior Sergeant William Watt

258. Senior Sergeant William Watt also provided an opinion regarding the first aid training model employed by both Queensland Police and Victoria Police and the possible suitability of a similar model in NSW.

259. Senior Sergeant Watt outlined in his evidence the Mandatory Training that officers undertake in first aid/CPR. Prior to 2020, the package consisted of a PowerPoint presentation combined with a practical assessment of CPR and the employment of TECC related techniques. Since 2020, the practical scenario was removed, to minimise risks associated with COVID-19 transmission.[238]

260. He reviewed the Victoria Police and Queensland Police first aid training models. The primary difference between NSWPF and QPOL first aid/CPR training is that QPOL fund staff who wish to voluntarily undertake an externally provided recognised course. The model employed by Victoria Police, however, is that an external provider delivers the full nationally accredited HLTAID010 course to all staff every three years, with designated custody officers required to undertake it every year. The NSWPF does not have specifically designated custody officers who perform a custody role on a permanent or semi-permanent basis. Rather, the role of the custody manager is shared amongst suitably qualified staff who are rostered on any given shift.[239]

261. Senior Sergeant Watt opined that the VICPOL model is not appropriate for the NSWPF for a number of reasons, but for summary purposes, include the fact that a significant quantity of the VICPOL course is focused on the treatment of

[237] Ibid, p 21.
[238] Police expert statement of Sergeant William Watt, Vol 8, Tab 176E, p 18.
[239] Ibid, p 20.

conditions not commonly encountered by police; that the VICPOL model results in less frequent training than both the national recommendations and the NSWPF; that the current NSWPF performance standards for CPR are in accordance with national standards; that the NSWPF is required to balance competing priorities for training and that the primary issue in this matter and matters that have previously been examined by coroners, is the lack of recognition of when to commence CPR. To employ a model similar to that used by VICPOL would require between 6000 and 18,000 additional shifts to training across the NSWPF year which would result in a cost of up to $4 million every three years.[240]

262. Senior Sergeant Watt stated that it was clear from the material that neither Sgts Jackson, Tesoriero or Roberts accurately recalled the CPR based training that was delivered to them and that both Sgts Jackson and Tesoriero believe that the training they had received was inadequate. Sgt Jackson indicated that he did not remember "abnormal breathing being a major component", supporting Associate Professor Holdgate's view that CPR training is often focused on the mechanics of delivering CPR and less attention is paid to recognition of when there is a need to commence CPR.

263. He opined that given three experienced officers were not able to recognise the need to commence CPR in circumstances where, in hindsight, it was clearly required, indicates that the training they have received has failed to produce the desired outcome. His opinion is that this issue can best be addressed by "in-house" training, focused upon when to recognise the need to commence CPR, as opposed to an outsourced package that achieves compliance with a national training standard but does not focus on the identified issue.[241]

Submissions

264. Counsel Assisting submitted that having regard to the applicable NSWPF policies and procedures, in respect of the nature and timing of the first-aid provided (including the non-provision of CPR and the repeated use of sternum rubs), the actions of NSWPF, in this respect, were inappropriate and

[240] Ibid, p 22.
[241] Ibid, p 22-23.

demonstrate a systemic failure in the delivery of training to NSWPF officers in the recognition of when CPR is to be initiated.

265. The Edwards family submitted that the court would accept Ms Wilson's opinion that the NSWPF officers were poorly trained, and as a result, inadequately skilled to manage Kevin in the first aid incident.

266. They further submitted that, consistent with the evidence of Ms Wilson, at the time Kevin had been subdued, handcuffed and become unresponsive, the police officers at the scene did not follow the then current DRSABCD flowchart and procedure, and failed to demonstrate knowledge and skills and current first aid practice.

267. Ultimately, the Edwards family invited me to find that the three involved officers were not adequately trained and equipped to recognise the need to commence CPR in circumstances where it was required; that the training of each of those three officers received on CPR, in particular, when to commence it, failed to produce the desired outcome operationally in the field, and, there was, at the time, a systemic failure by the NSWPF to adequately train its officers in respect of CPR. They submit that CPR training and its competency-based assessment must be undertaken annually for every officer.

268. The NSWPF submitted that the expert evidence identified the real issue was the recognition (or lack thereof) by the attending officers in respect of when to commence CPR.

269. The NSWPF submitted that the mandatory training provided to officers did in fact identify what to do when a person exhibited normal breathing and abnormal breathing. It was submitted that the training materials did in fact identify that if a person was breathing abnormally, CPR should be commenced. However, it was acknowledged by the NSWPF that the recognition of abnormal breathing is not easy to identify. In making this submission, the NSWPF relied upon the evidence of Associate Professor Holdgate who said that even those who are medically trained can experience this difficulty and that in the environment the involved officers found themselves in on 5 June 2022, it would have been difficult to identify abnormal breathing.

Consideration – issue 3(d)

270. In terms of the nature and timing of the first aid provided by the involved officers (including the non-provision of CPR to Kevin and the repeated use of sternum

rubs) I find, consistent with the expert evidence, that it was inadequate in the circumstances.

271. Having regard to the fact that the involved officers, who were all experienced police officers, all believed that they had been let down by the NSWPF first-aid training, in addition to the expert evidence, I accept Counsel Assisting's submission that the actions of the officers demonstrate a systemic failure in the delivery of training to NSWPF officers in the recognition of when CPR is to be initiated. It must have been very difficult for the involved officers to realise in retrospect, following the death of Kevin, that they were not sufficiently trained to know when and how to assist Kevin in the minutes preceding his death.

Issue 4: Whether any recommendations are necessary or desirable in connection with Mr Edwards' death

Submissions

272. In the recent inquest into the death of Omar Mohammad, Deputy State Coroner Grahame made a number of recommendations to the Commissioner of the NSWPF in relation to NSWPF first aid provision and training. I set out below those recommendations.

1) As out-of-hospital cardiac arrests are one of the most common causes of death and because survival prospects are greatly improved where automatic external defibrillators (AEDs) are used, that urgent consideration be given to equipping all police response vehicles with AEDs for use as standard equipment by frontline police.
2) That as an interim measure pending the roll-out of AEDs for all police response vehicles, that urgent consideration be given to AEDs being provided to all mobile supervisor and duty officer vehicles in each Police Area Command.
3) That the NSW Police Force mandatory annual training for CPR include key emphasis upon the following messages:

   a. That CPR should be started if the person is unresponsive and not breathing normally (abnormal breathing);

   b. To assess breathing – rescuers should look, listen and feel:

      i. LOOK for movement of the upper abdomen or lower chest;

      ii. LISTEN for the escape of air from nose and mouth; and

iii. FEEL for movement of air at the mouth and nose;

c. That palpation of pulse is unreliable and should not be used to confirm the need for resuscitation;

d. That abnormal breathing can be hard to identify - it is something that is "not normal". Consider factors such as:

i. Does the breathing look irregular or irregular? Is it very slow (which suggests it may be abnormal)?

ii. Is the breathing noisy? If so, check that the airway is open.

iii. Is there a colour change (for example, is the patient blue around the lips)?

iv. Is there gasping or gulping?

e. If in doubt about whether a person is experiencing cardiac arrest or not, the rescuer should start CPR without concern about causing additional harm (rib fractures and other injuries are common but acceptable consequences of CPR given the alternative of death); that is – "If in doubt, have a go."

f. That if unsure about 'abnormal breathing,' start CPR (even if the person takes occasional gasps or gulps);

g. That agonal breathing is common in the first few minutes after a cardiac arrest – it is sudden, irregular gasps or gulps of breath. This should not be mistaken for normal breathing and CPR should be given straight away;

h. That CPR should be continued until any of the following conditions are met:

i. the person responds or begins breathing normally;

ii. it is impossible to continue (e.g. exhaustion);

iii. a health care professional arrives and takes over CPR;

iv. a health care professional directs that CPR be ceased.

i. That CPR should no be interrupted to check for response or breathing;

j. That the faster the rescuer acts, the higher the chances of survival.

4) That CPR information as set out in (3) above is provided to all members of the NSW Police Force on an urgent basis (noting that the administration of CPR can be a matter of life and death), by way of:

a. A state-wide NEMESIS message; and

b. A module provided to officers who perform frontline general duties delivered via Police Education Training Environment (PETE) that requires the officer to acknowledge their review of the material; and

c. Appropriate scenario training.

5) That having regard to (3) and (4) above, urgent consideration be given to the introduction of an external training course delivered by an appropriate organisation within the next 6 to 12 months, to ensure that there is a baseline level of understanding within the NSW Police Force as to the essentials of CPR and basic life support (after which time, the Commissioner may consider that it is appropriate to revert to an internal training delivery model);

6) That urgent consideration be given to amending the 2023-2024 Session Plan for the CPR/Tourniquet Practical to ensure specific reference to the matters outlined in (3) above, together with inclusion of appropriate scenario training and an appropriate form of assessment to ensure that the content has been understood;

7) That consideration be given to introducing the requirement for police officers at the rank of Senior Constable and above who are involved in first response general duties policing, to be retrained and certified in first-aid every three years.

273. Counsel Assisting submitted that I should give consideration to making the following recommendations to the NSW Commissioner of Police under s 82 of the *Coroners Act*:

1) The CPR/First Aid TECC PowerPoint presentation dated 2018-2019 be reviewed and updated to include the matters raised in Recommendation 3 from the inquest into the death of Omar Mohammad, with an emphasis being given to starting CPR in cases of a person who is unresponsive/unconscious and is not breathing normally.

2) That the annual mandatory CPR training be conducted in a venue with access to equipment allowing the playing of the PowerPoint presentation and any training videos (including videos which demonstrate what agonal breathing is);

3) That the CPR training materials and competency assessment (including the model and delivery) be reviewed by an independent external first aid expert

to ensure compliance with the ARC Guidelines relating to the delivery of CPR with a particular focus on the recognition of when CPR should be initiated.

4) That the CPR training materials be reviewed and updated annually to ensure the information provided to police officers is up to date.
5) That scenario based training be rolled out in relation to the identification of abnormal/agonal breathing.
6) Consideration be given to NSWPF to consider updates required to the content of NSWPF training PowerPoints (such as Professor Holdgate's opinion that there should be a low threshold for commencing CPR; ensuring content is in line with the Australian Resuscitation Council's guidelines including not putting a casualty in the recovery position if they are not breathing)

274. Kevin's family supported the six recommendations proposed by Counsel Assisting and listed above. Further, the family emphasised the significance of a recommendation that the NSWPF conduct a review of its first aid training, in particular, CPR, physical-handling of subdued and/or unconscious persons, and management of a first aid site, both in terms of academy and refresher training, which emphasises when to commence CPR and that the threshold should be very low in terms of when to commence CPR and involves competency assessments completed annually.

275. The family also commended to me all seven recommendations made in the inquest into the death of Omar Mohammad that I have extracted above.

276. In response to the Edwards' family submissions that the current annual training remains inadequate because it occurs on range days, the NSWPF submitted that under the police award, it is a requirement that all mandatory training is to be completed in one day. Furthermore, the locations where the mandatory training takes place are not always owned by the NSWPF and those locations are not always ideal. The PowerPoint presentation on CPR training is not necessarily delivered on every occasion. However, the recommendation that CPR training be conducted in a venue that permits the presentation of a PowerPoint was noted by the NSWPF.

277. The NSWPF also noted the recommendation that the CPR training materials, including the model and delivery, be reviewed by an independent expert and that they be reviewed and updated annually.

278. In relation to the recommendation that scenario based training be rolled out in relation to the identification of abnormal/agonal breathing, the NSWPF submitted that this will occur, albeit in competition with other scenario training that has arisen as a consequence of recommendations arising out of other coronial inquests.

279. Finally, the NSWPF submitted in relation to the recommendation that consideration be given to NSWPF to consider updates required to the content of NSWPF training PowerPoints, that in this particular instance, there was no evidence to suggest that had Kevin been placed on his side, that would have had any impact on his management.

280. Ultimately, the NSWPF submitted that there are significant competing training programs police are required to undertake, and that there are practical difficulties in training 17,500 officers on an annual basis in relation to mandatory aspects of their training.

281. I have considered all the submissions made to me in respect of the recommendations, and I have decided that it would be appropriate to make certain recommendations, which I set out below in the next section.

RECOMMENDATIONS

282. Pursuant to s 82 of the *Coroners Act,* coroners may make recommendations connected with a death.

283. Having considered all of the interested parties' submissions, I am persuaded to make the recommendations to the Commissioner of NSWPF which were proposed by Counsel Assisting, which are as follows:

    1) The CPR/First Aid TECC PowerPoint presentation dated 2018-2019 be reviewed and updated to include the matters raised in Recommendation 3 from the inquest into the death of Omar Mohammad, with an emphasis being given to starting CPR in cases of a person who is unresponsive/unconscious and is not breathing normally.

    2) That the annual mandatory CPR training be conducted in a venue with access to equipment allowing the playing of the PowerPoint presentation and any training videos (including videos which demonstrate what agonal breathing is);

3) That the CPR training materials and competency assessment (including the model and delivery) be reviewed by an independent external first aid expert to ensure compliance with the ARC Guidelines relating to the delivery of CPR with a particular focus on the recognition of when CPR should be initiated.
4) That the CPR training materials be reviewed and updated annually to ensure the information provided to police officers is up to date.
5) That scenario based training be rolled out in relation to the identification of abnormal/agonal breathing.
6) Consideration be given to NSWPF to consider updates required to the content of NSWPF training PowerPoints (such as Associate Professor Holdgate's opinion that there should be a low threshold for commencing CPR; ensuring content is in line with the Australian Resuscitation Council's guidelines including not putting a casualty in the recovery position if they are not breathing).

284. In my view, these recommendations operate to address the systemic failure of the NSWPF to adequately train its officers when to commence CPR as identified in the inquest. These recommendations appropriately address the issue of recognising *when* CPR should be commenced and when agonal breathing should be identified.

FINDINGS REQUIRED BY SECTION 81(1)

285. Having considered all of the documentary evidence and the oral evidence heard at the inquest, I make the following findings pursuant to s 81 of the *Coroners Act*.

The identity of the deceased

286. The person who died was Kevin Neil Edwards.

Date of death

287. Kevin died on 5 June 2022.

Place of death

288. Kevin died at Liverpool Hospital.

Cause of death

289. The cause of Kevin's death is unable to be ascertained.

Manner of death

290. Kevin died while experiencing a mental health episode, in the course of being restrained by the police who were attempting to prevent harm to Kevin and other road users on the M5 motorway.

ACKNOWLEDGEMENTS AND CONCLUDING REMARKS

291. In conclusion, I would like to recognise a particularly moving aspect of this inquest, which was the mutual compassion and understanding shown between Kevin's family and the involved NSWPF officers. I saw how affected the officers were by Kevin's death when giving evidence, and the graciousness and empathy with which Kevin's family treated them. I hope that this helps the officers to recover from the tragic events of 5 June 2022, and I commend Kevin's family for their involvement in this inquest. It has been very important to have had them in attendance.
292. I pay tribute to Kevin, clearly a very loved member of the Edwards family, and acknowledge the supportive environment in which he grew up, and the love and support his family, particularly his parents Glen and Diane, continued to demonstrate towards him every day through adulthood, often in challenging circumstances.
293. I would also like to thank the Counsel Assisting team, and the solicitors assisting, for their enormous work on this inquest, which is acknowledged and appreciated.
294. I now close this inquest.

Magistrate Teresa O'Sullivan

NSW State Coroner

17 October 2024