New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of MQ
Hearing dates:	24 & 25 November 2025
Date of Findings:	17 December 2025
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – time of death, cause and manner of death, clinical progression of pneumonia, concern for welfare, New South Wales Police Force Computer Aided Dispatch system, capacity and timeframe for response at St George Police Area Command
File number:	2023/00074236
Representation:	Ms S McGee, Counsel Assisting, instructed by Ms A Thorne (Crown Solicitor's Office) Mr S De Brennan for the Commissioner, New South Wales Police Force, instructed by Mr S Davis (New South Wales Police Force Office of the General Counsel) Ms I Hogan for Constable C Rogan instructed by Mr W Anderson

Findings:

MQ died on 2 or 3 March 2023 at Peakhurst NSW 2210.

The cause of MQ's death was acute necrotising bronchopneumonia.

MQ died of natural causes following the clinical progression of community-acquired pneumonia in the days preceding 2 March 2023. MQ's death occurred in circumstances where at 8:29pm on 2 March 2023, a concern for her welfare was first reported to the New South Wales Police Force with no appropriate response initiated until a follow up concern was reported at 8:05am on 3 March 2023. However, it is not possible to conclude whether MQ's death likely would have been prevented if an appropriate response had been initiated when the concern for MQ's welfare was first reported.

Non-publication orders:

Pursuant to section 74 of the *Coroners Act 2009* (the Act), or the incidental powers arising under the Act, the Court orders:

1. For the purposes of the publication of any evidence or other information relating to the above matter, the deceased person is to be given the pseudonym of "MQ".

2. Order 1 does not operate to prevent the person referred to being named or referred to in any evidence tendered or adduced in the inquest hearing (including reference to that person's name in open Court) or require the use of a pseudonym in documentary evidence in lieu of that person's name in the material tendered in the proceedings.

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1. Introduction

1.1 At around 8:29pm on 2 March 2023, Kerry Hayes made a phone called to Hurstville police station which was answered by a New South Wales Police Force (**NSWPF**) officer. Mrs Hayes told the NSWPF officer that she was concerned about the welfare of her friend, MQ, and she had not heard from MQ for a period of time. Mrs Hayes was aware that MQ had been unwell in the several days prior to making her call.

1.2 The NSWPF officer who answered the call noted what Mrs Hayes reported but did not create a job on the NSWPF communication system about the report. Such a job would have requested other NSWPF officers to acknowledge and action it, which would have allowed for a check to be done to make sure that MQ was alive and well.

1.3 Instead, at around 8:05am the next morning, Mrs Hayes called Hurstville police station again and spoke to a different NSWPF officer to follow up her call from the previous evening. At this time a job was created which resulted in NSWPF officers attending MQ's home a short time later. After being unable to raise MQ, the NSWPF officers entered her home and found MQ lying on the ground, unresponsive and showing no signs of life. MQ was later tragically pronounced life extinct at the scene.

2. Why was an inquest held?

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

2.2 Some examples of reportable deaths are where the cause of a person's death is not due to natural causes, or where the cause or manner of a person's death may not immediately be known. In MQ's case, her death was a reportable death because there was reasonable cause to suspect that she died as a result of a police operation. In other words, if MQ was still alive by 8:29pm on 2 March 2023, and if an appropriate job relating to the concern for her welfare had been created, and if NSWPF police officers had responded to this job, it is possible that medical treatment might have been instituted which may have prevented her death.

2.3 Section 23(1)(c) of the Act makes it mandatory for an inquest to be held in such circumstances. This is primarily because NSWPF officers are bestowed with unique powers not available to ordinary members of the community, in order to allow them to discharge their duties. The exercise of such powers or, in MQ's case, where such powers were not exercised, have important implications for the wider community. This in turn requires transparent and independent scrutiny when such powers ought to have been exercised but were not. Doing so serves a number of purposes, including ensuring that such powers are exercised appropriately and responsibly.

2.4 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the coronial jurisdiction and inquest process into what

is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will wish to attempt to cope with the consequences of such a traumatic event in private. The sense of loss experienced by family members and other loved ones does not diminish significantly over time. Therefore, it should be acknowledged that both the coronial process and an inquest by their very nature unfortunately compel a family and loved ones to re-live distressing memories and to do so in a public forum.

3. MQ's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. It is hoped that what is set out briefly below acknowledges MQ's life in a meaningful way.

3.2 MQ was born in 1967 and came from a large family. She began working for NSW Health in 2008 and was most recently employed as an administration manager in the emergency department of a large Sydney hospital. Throughout her career MQ excelled at every role she held and was well respected by her colleagues for her intelligence, determination and capability.

3.3 MQ's sisters described her as a vibrant and joyful presence in their large family. There are many treasured memories of MQ during significant family events. She was a flower girl at the wedding of one of her sisters, and a bridesmaid at the weddings of her niece and another sister. MQ adored her nieces and nephews and was a loving godmother to one of her nephews. For his christening, MQ embroidered a beautiful blanket that embodied the love and care she constantly showed. MQ's sisters emphasised the deep affection that MQ had for her family and how it was so apparent in every moment that she shared with them.

3.4 One of MQ's greatest dreams came to fruition when she became a mother to her son who was the absolute love of her life. MQ felt boundless happiness and showed limitless love for him.

3.5 MQ also shared a deep bond and love for her father with whom she had a special connection. When MQ's father became gravely ill, she did her utmost to ensure that he was as comfortable and as well cared for as possible. That MQ was able to look after her father so well in his time of need brought both her and her father great comfort in otherwise difficult circumstances.

3.6 The other special love in MQ's life was her rescue cat, "Georgie Boy". After MQ's passing, her sisters found a wonderful home with a new family to ensure that "Georgie Boy" is loved and well cared for just as MQ would have wanted.

3.7 MQ had a deep love of music and a great passion for some her favourite artists, including David Bowie, Pink Floyd, and the Rolling Stones. She was a regular concert goer and enjoyed losing herself in the music that brought her so much joy.

3.8 Equally, MQ brought much joy, light, laughter and love to the lives of others. She was known for her contagious laugh, radiant smile and signature dimples. MQ had a remarkable determination and a beautiful soul.

3.9 There is no doubt that MQ's passing is profoundly felt by her family and loved ones. MQ is missed every day and nothing can fill the void left by her loss. But the memories that MQ's family and friends have of her spirit, radiance and loving and joyful presence will never diminish.

4. Summary of relevant background[1]

4.1 MQ had no known significant medical issues other than asthma for which she had been prescribed an inhaler.

4.2 On 21 and 22 February 2023, MQ reported to some of her colleagues that she was feeling shoulder pain. She was a regular swimmer and attributed the pain to a swimming injury on 20 February 2023.

4.3 On 22 February 2023, one of MQ's colleagues noted that she appeared distracted. MQ reported that she had been on painkillers and was feeling "*a bit spaced out*". MQ's colleague suggested that she see a doctor, with one of her colleagues offering to go with her to a different hospital to the one where she worked.

4.4 On 24 February 2023, MQ did not attend work. That morning, she had a telehealth appointment with a general practitioner (**GP**) and reported a torn rhomboid muscle while swimming on 20 February 2023, as diagnosed by her "boss" in the emergency department. MQ also reported asthma symptoms and that she had been taking mersynofen (pain relief medication) with some improvement. MQ asked for a medical certificate which was issued with no specific reason recorded. The GP prescribed further analgesia if required and recommended a face-to-face appointment so that MQ's symptoms could be assessed. Later that evening, MQ did not attend a scheduled concert.

4.5 Over the weekend, MQ's precise movements are unknown but she communicated via phone calls and text messages with several friends including Kerry Hayes.

4.6 On 27 February 2023, MQ did not attend work again. She phoned a colleague and reported feeling unwell with pain in her back and shoulder and only eating crackers over the weekend. MQ also joked that she would be okay "*so long as [she didn't] breathe*".

4.7 At 2:51pm, MQ had a further telehealth appointment with a different GP. She reported pain in the left arm, left shoulder and upper back, and difficulty breathing. However, she also indicated that her symptoms were improving. MQ reported feeling not well enough to attend work and requested a medical certificate which was issued, again with no specific reason recorded. The GP advised MQ to attend a face-to-face appointment to assess her symptoms, particularly if they worsened or if she developed any shortness of breath or had difficulty managing her pain. MQ was advised to take deep breaths to expand her lungs and avoid atelectasis.

[1] This has been drawn from the helpful opening submissions of Counsel Assisting.

4.8 On 28 February 2023, MQ returned to work. Although MQ reported feeling better after the weekend, a colleague noted that she looked unwell and offered to take her to the emergency department to be assessed, anonymously if she wished to do so. MQ's colleague expressed concern that she could have a serious illness, such as a lung clot, pneumonia or a cardiac issue and that she should seek medical assessment as soon as possible. Although MQ reported that she would "*be right*", the colleague noted that MQ appeared very pale and breathless even whilst sitting.

4.9 Other colleagues noted that MQ referred to shoulder pain, expressed the belief that it was related to swimming, and that she indicated she had made an appointment to see her GP. During the day, MQ replied to an email indicating that she felt "*80%*" that day and that she had to "*breathe in deeply to my lungs so they don't collapse*".

4.10 At around 1:30pm or 2:00pm, MQ spoke to Mrs Hayes' daughter who was one of MQ's work colleagues. MQ reported feeling "*extremely unwell*" and asked her colleague to buy her a heat pack and decongestant cough suppressant from a chemist. After obtaining the items and delivering them to MQ's office, the colleague noted that MQ "*looked sicker than anyone [she had] seen in the [emergency department]*".

4.11 Throughout the day, other colleagues observed that MQ's face looked grey, her breathing was laboured, she had a tremor in her hand, and there was a terrible smell emanating from her.

4.12 On 1 March 2023, MQ did not attend work and was recorded as absent on sick leave. At around 10:53am, a work colleague called MQ and noted she did not sound well and was breathing heavily. MQ complained of muscle pain in the top of her back and shoulder. The colleague offered to take MQ to a different hospital but MQ declined and indicated that she had an appointment booked with a GP the next day.

4.13 At around 12:20pm, Mrs Hayes called MQ and they spoke for about four minutes. MQ reported that she was sick at home and had not eaten all week. Mrs Hayes asked MQ to call her later that evening.

4.14 Phone records indicate that MQ sent a multimedia message at 7:49pm and at 8:48pm she made a 48 second phone call to a colleague. MQ left a voicemail indicating that she was unwell and that she thought she would be in hospital by Friday. At 9:02pm, the colleague called MQ back and offered to pick her up. MQ replied that she was fine and that she was going to see a GP the next day.

5. The events of 2 and 3 March 2023

5.1 At around 10:00am on 2 March 2023, Mrs Hayes called MQ's mobile phone and reached her voicemail. Mrs Hayes subsequently called MQ's workplace and was told that MQ was not at work. Phone records indicate that MQ received SMS messages at 10:32am, 11:19am and 1:46pm.

5.2 MQ's neighbour made phone calls to MQ between 3:59pm and 5:27pm followed by a SMS message sent at 5:39PM. At around 5:30pm or 6:00pm, MQ's neighbour (who was also her landlord) heard MQ coughing and walked up to MQ's window and called out to her. MQ responded indicating that she was fine although the neighbour thought that MQ sounded weak.

5.3 Between 5:53pm and 7:34pm, Mrs Hayes called MQ's mobile phone three times with each call going unanswered.

5.4 One of MQ's colleagues called her at 3:30pm and again later that night when she returned home from work. MQ did not answer on either occasion. The colleague sent MQ a message asking if she was all right and whether she had seen a doctor. MQ reportedly replied with a message indicating yes. Although these calls and messages are not reflected in MQ's phone records, they may have been sent and received over Wi-Fi or mobile data using an application such as Messenger which MQ was known to use.

5.5 At 8:29pm, Mrs Hayes called Hurstville police station which is located within St George Police Area Command (**PAC**). The call was answered by Probationary Constable Chelsea Rogan.[2] According to Mrs Hayes, she told Probationary Constable Rogan that she was concerned for MQ's welfare because she was "*so sick*". Mrs Hayes provided her address and MQ's address to Probationary Constable Rogan and asked for a NSWPF officer to check on MQ. Probationary Constable Rogan told Mrs Hayes that the NSWPF were very busy and that a welfare check may not be done straight away.

5.6 After the call ended, Probationary Constable Rogan did not create a job regarding Mrs Hayes' call on the NSWPF Computerised Aided Dispatch (**CAD**) system. This is an online system used by NSWPF radio (known as **VKG**) to coordinate and prioritise deployment of NSWPF resources in the field. As a result, no NSWPF resources were made aware of Mrs Hayes's concern for MQ's welfare and able to respond accordingly.

5.7 On 3 March 2023, Mrs Hayes called MQ's phone at 6:53am and 7:34am with both calls going unanswered.

5.8 At 8:05am, Mrs Hayes called Hurstville police station to follow-up on her call the previous night. She spoke to Constable Zachariah Barker who confirmed that there was no record of any welfare check for MQ having been requested. Constable Barker created a concern for welfare job on the CAD system and asked Constable Kassia Woodcock and Constable Yarran Quint to attend MQ's home as a priority.

[2] For convenience and clarity, the ranks of the NSWPF officers as they were at the time of these events have been used. No disrespect is intended.

5.9 The two NSWPF officers arrived at MQ's address at around 8:30am. On approach they heard an alarm sounding indicating that the door to a fridge or freezer had been left open. They knocked on MQ's door and called her phone but were unable to raise her. The NSWPF officers spoke to MQ's neighbour who reported her interaction with MQ the previous afternoon. After confirming that MQ was not at work, Leading Senior Constable Handley, the external supervisor was contacted. Leading Senior Constable Handley arrived on scene at around 9:03am and entered MQ's unit with Constable Woodcock and Constable Quint.

5.10 MQ was found lying on her back on the floor next to the fridge. She was cold to touch and showed no signs of life. The fridge was open with its alarm sounding. A bucket containing what appeared to be vomit, water bottles and towels were found next to MQ. Various medications (ibuprofen, paracetamol, antihistamine and a cough medicine) were found around MQ's bedroom and on her bed.

5.11 Paramedic services were contacted and attended the scene a short time later. However, MQ was subsequently later sadly pronounced life extinct at the scene.

6. The post-mortem examination

6.1 On 10 March 2023, Dr Jennifer Pokorny, forensic pathologist, performed a post-mortem examination at Forensic Medicine, Sydney. The significant findings from the examination can be summarised as follows:

(a) areas of consolidation involving both lungs with multifocal areas of necrosis/abscess formation;

(b) areas of acute necrotising bronchopneumonia in the lungs;

(c) areas of subendocardial and interstitial fibrosis in the heart;

(d) liver cirrhosis; and

(e) toxicological analysis of post-mortem blood detected a low level of paracetamol.

6.2 In the post-mortem examination report dated 12 May 2023, Dr Pokorny opined that the cause of MQ's death was acute necrotising bronchopneumonia.

7. What issues did the inquest consider?

7.1 Prior to the commencement of the inquest a list of issues was circulated amongst the sufficient interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

(1) MQ's condition in the days prior to her death.

(2) The circumstances in which no CAD job was created in response to Mrs Hayes' call to Hurstville police station concerning MQ at 8:29pm on 2 March 2023.

(3) Whether the failure to create a CAD job, or to take any other steps in response to Mrs Hayes' call on 2 March 2023, was a breach of any relevant NSWPF policy or procedure.

(4) The capacity, from 8:29pm on 2 March 2023, of the NSWPF officers working in the St George PAC to attend to a concern for welfare job in respect of MQ, with the features of reported illness and uncharacteristic lack of response to communication attempts.

(5) The time by which such a job would likely have been attended to if a CAD job was created in response to Mrs Hayes' call at 8:29pm on 2 March 2023.

7.2 As part of the coronial investigation, Professor Deborah Yates, consultant thoracic physician, was instructed to provide an independent expert report addressing a number of questions regarding the circumstances surrounding MQ's death.

8. MQ's condition in the days prior to her death

8.1 Professor Yates explained that pneumonia is an acute illness representing an infection of the lung tissue (air sacs or alveoli). Symptoms can develop over a period of 24 to 48 hours. Without appropriate treatment, severe sepsis may result with death occurring within a few days.

8.2 Professor Yates gave evidence that it is impossible to know the cause of MQ's shoulder pain that she reported from 21 February 2023 onwards. Although MQ attributed her pain to a soft tissue injury from swimming, Professor Yates gave evidence that it is plausible that the pain originated from an existing pneumonia. This is because pneumonia affects the pleura, or the lining of the lung. The pleura is very sensitive and lies adjacent to the diaphragm. When there is irritation at the bottom of the lung, this can cause referred pain in the shoulder. Professor Yates explained that pleurisy is often the first feature of pneumonia.

8.3 Professor Yates explained that MQ initially would have become breathless and experienced chest pain. This is consistent with the symptoms that MQ reported to her colleagues and during her telehealth GP appointments from 27 February 2023 onwards. Later, MQ would have felt very unwell and coughed repeatedly, as noticed by her neighbour, and eventually succumbed to the effects of bacterial sepsis. Professor Yates also explained that MQ's flu-like symptoms, cough and pain in the left shoulder are all compatible with a diagnosis of pneumonia, most likely community-acquired and

caused by bacterial pathogens. Professor Yates noted that the timeframe in which MQ became so unwell that she had to leave work and then deteriorated at home is compatible with severe bronchopneumonia.

8.4 Professor Yates gave evidence that anaerobic pathogens which cause necrotising pneumonia as in MQ's case can originate in the teeth and be aspirated into the lungs. These pathogens characteristically generate an unpleasant odour producing halitosis. Professor Yates expressed the view that this was the cause of the smell that MQ's colleagues noticed when she returned to work on 28 February 2023.

8.5 **Conclusions:** MQ's clinical course between 21 February 2023 and 2 March 2023 was consistent with the development of community-acquired necrotising pneumonia caused by bacterial pathogens. These pathogens can create an unpleasant smell which was noticed by MQ's colleagues. MQ's initial symptom of shoulder pain was consistent with diaphragmatic irritation causing referred pain in the shoulder. MQ's subsequent symptoms of breathlessness, chest pain (most likely a result of pleurisy), malaise, flu-like symptoms and repeated coughing were all consistent with progression of her pneumonia.

9. The circumstances in which no CAD job was created on 2 March 2023

Probationary Constable Rogan's responsibilities on 2 March 2023

9.1 Probationary Constable Rogan was working the night shift at Hurstville police station on 2 March 2023. She was performing duties as the station constable: attending to front counter enquiries, answering phone calls, dealing with persons reporting on bail, preparing statements and briefs of evidence, and other administrative duties. The only other person working in the station at the time was Acting Sergent Darren McDiarmid, the internal supervisor.

9.2 At this time, Probationary Constable Rogan was in the fifth and final session of her year as a Probationary Constable and two days away from attesting as a Constable. As a Probationary Constable progresses through each session they require decreasing levels of supervision from more senior NSWPF officers so that by session 5 a Probationary Constable's work is only checked upon completion.

9.3 Probationary Constable Rogan gave evidence that when Mrs Hayes called Hurstville police station at 8:29pm on 2 March 2023, she was attending to taking a statement regarding an alleged domestic violence incident from a complainant who had walked into Hurstville police station earlier in the evening. Probationary Constable Rogan also gave evidence that she could not recall whether she was in the middle of having the complainant sign the statement, or whether the complainant had already left and she was attending to some administrative matters associated with the taking of the statement.

9.4 Probationary Constable Rogan explained that before commencing to take the report:

(a) she had already requested that a car crew return to Hurstville police station to take the statement but none was available to attend;

(b) she had informed Acting Sergeant McDiarmid of this and had been instructed to take the statement herself;

(c) it would have been regarded as "*unacceptable*" for her to decline to take the statement or indicate that she was unable to do so without supervision; and

(d) the complainant had already been waiting for about an hour and was becoming impatient.

9.5 Probationary Constable Rogan also gave evidence that she had "*a little level of discomfort*" in taking the statement because:

(a) she had never before taken a statement from a domestic violence complainant whilst unsupervised;

(b) she was not in the same team as Acting Sergeant McDiarmid and had only worked with him "*a handful of times*" prior to 2 March 2023; and

(c) she "*didn't want it to be wrong*".

9.6 As to the first of these matters, Probationary Constable Rogan gave this evidence:

> It was, it's a well-known thing that - I don't know where it's come from but it's known that probationary constables can't do domestic violence incidences to be [Officer-in-Charge] and unsupervised when, when there has been an offence.

9.7 Probationary Constable Rogan also gave evidence that from speaking to other constables, the practice of probationary constables taking statements from complainants in alleged domestic violence matters did not appear to be a common practice in other teams. Notwithstanding the above, Probationary Constable Rogan agreed that Acting Sergeant McDiarmid was in the station with her on 2 March 2023 and, although he was working in a different part of the station, was performing duties as the internal supervisor.

9.8 Acting Sergeant McDiarmid gave evidence that as at 2 March 2023, Probationary Constable Rogan was approaching the end of her probationary period and it would be expected that she could lead a basic investigation into an alleged domestic violence matter or take a report of it. Acting Sergeant McDiarmid gave evidence that it was his understanding that there were guidelines (as opposed to rules) about what probationary constables can do in each session of their probationary year:

> And it's always depending on the competency of the officer, but a [session] 5 probationary constable would be expected to lead basic domestic violence assaults and lower, basically.

9.9 Acting Sergeant McDiarmid was asked about whether, in his experience, it was common for car crews to be unable to return to a police station during a shift to take an alleged domestic violence report because they were attending to other jobs. He gave evidence that anecdotally "*almost every day it would happen at some stage*".

Constable Rogan's phone call with Mrs Hayes

9.10 Probationary Constable Rogan gave evidence that when speaking with Mrs Hayes on the phone, Mrs Hayes indicated that her friend was very sick, that Mrs Hayes had not heard from her "*in a number of hours*", and that Mrs Hayes was requesting that a welfare check be conducted. Probationary Constable Rogan also gave evidence that although she had no specific recollection of asking how unwell MQ was, it would have been her usual practice to do so.

9.11 Probationary Constable Rogan gave evidence that whilst she was on the call, she made some brief notes on a piece of paper. Probationary Constable Rogan assessed the report as a Priority 3 job which is an incident that involves a non-urgent response where the NSWPF is required to attend as soon as possible. In contrast, a Priority 2 job involves an immediate response where there is a serious threat to life or property occurring at the time.

9.12 As Probationary Constable Rogan believed that the matter warranted a Priority 3 response, she considered that she would finish her current task and return later to put the concern for welfare job relating to MQ on the CAD system. Probationary Constable Rogan gave evidence that she had seen "*other senior officers who [she had] worked with during the whole course of [her] probationary year*" follow this practice. Probationary Constable Rogan also gave evidence that she "*pretty much […] saw them do it*" and that she "*just followed suit*".

9.13 Probationary Constable Rogan was asked by Counsel Assisting whether her focus on the alleged domestic violence incident diverted her attention so that she could not give Mrs Hayes' phone call the usual attention that she ordinarily would have. Probationary Constable Rogan gave this answer:

> I can imagine there would be no issues with taking the phone call, as a phone call like that takes, like, a minute or two, getting what I need. And then that's a matter of picking up a phone and writing down some things and then in between that, I've gone somewhere, done something and come back and gone back to do whatever I was doing. And it's, yes, I was immersed in what I was doing, the, the, that, not having that bit of paper there as a reminder has slipped my mind, then.

Systems relevant to the entering of jobs on the CAD system

9.14 Acting Sergeant McDiarmid gave evidence there is no specific NSWPF policy or guideline which provides for the creation of a CAD job by a station constable in Probationary Constable Rogan's position on 2 March 2023. However, Acting Sergeant McDiarmid described the challenges a station constable might face when receiving multiple calls in a row whilst having to deal with multiple people at the counter at the same time.

9.15 Acting Sergeant McDiarmid gave evidence that he had seen examples of situations where junior constables make a note of a phone call if they are in the middle of a task and then complete the task before putting the job on the CAD system. He gave evidence that this was a matter of concern and that he had definitely had discussions with these junior officers about prioritising work. Acting Sergeant McDiarmid described two difficulties with the approach of delaying entry of jobs onto the CAD system: keeping call makers waiting and overwhelming car crews with multiple jobs at once when the jobs are eventually entered on the CAD system.

9.16 Acting Sergeant McDiarmid described his own method of writing down all the relevant details of a job, entering the job onto the CAD system at the time of, or immediately after, taking a report, crossing out each job as it is entered, and reviewing the list of jobs at the end of a shift to ensure each job for that shift had been entered on the CAD system.

9.17 Acting Sergeant McDiarmid gave evidence that the type of system being used was of less importance than having an actual system to use. Acting Sergeant McDiarmid also gave evidence that it would be "*better across the board for a junior officer working by themselves*" to at least have some system in place for the entering of jobs on the CAD system. Acting Sergeant McDiarmid described the absence of formal guidelines and the absence of specific training in this way:

> [T]his is a constant conversation in all matters of policing. Any [skills] degradation is being passed down the chain which is probably a story for another time but it's just a constant theme is [sic] that we've got junior officers training just junior officers, that the seniority levels are not there and a lot of experience has been lost over the years that people are now just doing the best they can with very little, you know, best practice.

9.18 In contrast, Chief Inspector Sean Daley, the Duty Officer for the night shift on 2 March 2023, gave evidence that he has seen all methods of recording a job before it is entered on the CAD system: using a Post-it note, notepad, an official police notebook or placing a call directly onto the CAD system. Chief Inspector Daley also gave this evidence regarding the timing of when jobs are placed on the CAD system:

> My observations have always been that they've taken the job and they've put it directly onto the CAD system. There's no time delay from my observations.

9.19 In addition, Acting Sergeant McDiarmid gave evidence that there can be a wide variety of concern for welfare jobs with differing priorities. In this context, it is important for station constables, especially when they are more junior officers, to not make their own assessment of the relative importance of a job. Acting Sergeant McDiarmid gave evidence that they instead ought to put jobs on the CAD system as soon as possible so that a more senior officer can review the type and priority of response required.

9.20 Chief Inspector Daley similarly gave evidence that once a job is in the CAD system it is viewable by the Duty Officer, and also the internal and external supervisors, all of whom can upgrade or downgrade the priority of a particular job.

Changes in practice

9.21 Ultimately, Probationary Constable Rogan gave evidence that she ought to have entered the job on CAD immediately and that the matter she was attending to was not so important as to have taken priority over Mrs Hayes' call.

9.22 Probationary Constable Rogan gave evidence that since March 2023 she has made a number of changes to her own work practices:

(a) she always has a notepad in which she writes down every single job;

(b) after writing down the job she enters the job on CAD immediately, regardless of whether it is a Priority 2 or Priority 3 job;

(c) she strikethroughs each job in her notepad to indicate that it has been completed; and

(d) she keeps the notes until the end of the shift to make sure that every job has been actioned.

9.23 The omission by Probationary Constable Rogan appears to have been out of character. The inquest received evidence that in 2023 she had received letters of commendation from members of the community, complimenting her on her policing work. Further, Acting Sergeant McDiarmid gave evidence that prior to the night shift on 2 March 2023 he had spoken with other senior officers who regarded Probationary Constable Rogan as a competent NSWPF officer who "*showed promise*".

9.24 **Conclusions:** The evidence establishes that there were several contributing factors to the failure to create a job on the CAD system in relation to Mrs Hayes' call on 2 March 2023. First, Probationary Constable Rogan was performing a task, namely the taking of a statement regarding an alleged domestic violence incident whilst unsupervised, for the first time. Probationary Constable Rogan's unfamiliarity with this task likely resulted in her giving less attention to Mrs Hayes' call than she otherwise would have. There does not appear to have been any strict rule regarding what tasks a NSWPF officer in Probationary Constable Rogan's position is able to perform unsupervised. However, it is evident that Probationary Constable Rogan was two days short of completing her probationary period and that Acting Sergeant McDiarmid was available if Probationary Constable Rogan required any assistance or supervision. It therefore appears that the task that Probationary Constable Rogan was undertaking was within the scope of her duties.

9.25 Second, Probationary Constable Rogan did not have a robust system in place for the creation of jobs on the CAD system. Rather, Probationary Constable Rogan was simply following the actions of other NSWPF officers in deferring the creation of a job on the CAD system until some time after the report of the job was given. The evidence indicates that a common sense and unsophisticated method of writing down all relevant details of a job, creating a job on the CAD system at the time or immediately after a report is made, and marking off such a task as being completed would have avoided the omission which occurred on 2 March 2023. Despite the apparent simplicity of such a method being followed, it was not done in relation to Mrs Hayes' phone call.

9.26 Third, the workload on 2 March 2023 distracted Probationary Constable Rogan from the job at hand and meant that she simply forgot to create the concern for welfare job regarding MQ on the CAD system. This issue is dealt with in more detail below.

9.27 The evidence of Acting Sergeant McDiarmid and Chief Inspector Daley indicates that as at March 2023 and currently there were, and are, varying practices used by NSWPF officers of different seniority regarding when and how jobs are created on the CAD system within St George PAC. There are obvious benefits in having a consistent approach in such a process to ensure that it is reliable and repeatable. Such an approach would likely avoid the type of omission that occurred on 2 March 2023. Accordingly, it is necessary to make the following recommendation.

9.28 **Recommendation:** I recommend to the Commissioner of the New South Wales Police Force that consideration be given to having the St George Police Area Command review its practices, procedures and training regarding the taking of phone calls of matters which require a job to be created on the CAD system. This review should ensure that such processes are sufficiently robust and reliable, and that the New South Wales Police Force may respond appropriately to such jobs in accordance with its polices and standard operating procedures.

10. Breach of any NSWPF policy or procedure

10.1 The NSWPF *PoliceCAD Usage Procedures* (Version 2.5) provides:

> PoliceCAD is an incident and resource management system that provides the ability to communicate effectively with front line police, which is crucial to enabling a timely response by police to calls for service from the public.

10.2 The *NSWPF Handbook* provides:

> Police CAD is to be used to record all requests for assistance and service related telephone calls. COPS is the principal computer system to record relevant telephone calls and action items.
> […]
> Decide which telephone messages, both incoming and outgoing, are to be recorded.

10.3 As to this last matter, the NSWPF Handbook goes on to provide that any calls where police attention, action or enquiries are required, or where some form of subsequent follow-up will be required, will be recorded. The NSWPF Handbook also provides that, as a minimum, the following information will be recorded: the name of the person making the call and their phone number, the time and date of the call, the name of the NSWPF who receives the call, a brief summary of the nature of the message, and a brief summary of any proposal pending actions.

10.4 The NSWPF *PoliceLink Radio Operations Group Telephony Dispatch Standard Operating Procedures* (Version 67, 20 February 2023) (**Telephony SOP**) did not apply to the station constable role that Probationary Constable Rogan was performing on 2 March 2023. Notwithstanding, the Telephony SOP provides some useful comparative information about the role of a telephonist regarding a concern for welfare job. For these types of jobs, the Telephony SOP provides that a telephonist "*must commence a PoliceCAD incident*" and obtain information such as the location of the person for whom concern has been expressed, the type of incident or situation, name and description of the person, and the location and time they were last seen.

10.5 **Conclusions:** Mrs Hayes' call on 2 March 2023 requesting that a concern for welfare check be conducted in relation to MQ required the NSWPF to take action or make enquiries. Accordingly, the NSWPF Handbook provides that a CAD job ought to have been created. For avoidance of doubt, if Mrs Hayes' call had been received by a dispatch telephonist then the Telephony SOP required such a concern for welfare job being created on the CAD system. Therefore, the omission by Probationary Constable Rogan amounted to a breach of the NSWPF Handbook.

11. Capacity on 2 March 2023 to attend a concern for welfare job

11.1 In March 2023, St George PAC consisted of three police stations at Hurstville, Kogarah and Riverwood. NSWPF resources across each of these stations were effectively pooled for the purpose of responding to jobs broadcast on the CAD system. Chief Inspector Daley gave evidence that across the St George PAC on 2 March 2023, there were:

(a) 16 NSWPF officers available to respond to a job between 6:00pm and midnight;

(b) 12 NSWPF officers available between midnight and 3:00am; and

(c) 10 NSWPF officers available between 3:00am and 6:00am.

11.2 Apart from the numbers of NSWPF officers rostered on duty, the following evidence was given regarding specific aspects of the workload at Hurstville police station, and across the St George PAC more broadly, on 2 March 2023:

(a) Probationary Constable Rogan described the night shift as being "*particularly busy*" but also gave evidence that the volume of work at Hurstville police station has effectively remained unchanged since 2023;

(b) Acting Sergeant McDiarmid gave evidence that in his experience in the day shift at Hurstville police station, which ran from 6:00am until 6:00pm, was generally the busiest time. However, Acting Sergeant McDiarmid still described the workload until 10:00pm to be "*constant*" and "*overwhelming*";

(c) Chief Inspector Daley gave evidence that at the start of the night shift there were 26 jobs broadcast on the CAD system that had not been responded to yet which meant that the rostered NSWPF officers were "*walking into a very busy shift*";

(d) Chief Inspector Daley also gave evidence that the custody facilities at Kogarah police station were closed at 9:50pm due to capacity and only re-opened at 3:00am, which was an uncommon occurrence because Kogarah is the main custody area for the St George PAC;

(e) Chief Inspector Daley gave evidence that he was the only NSWPF officer available to respond to a high risk missing person report involving a 12-year-old child which was a job that someone in his position as the Duty Officer would not usually attend to; and

(f) Chief Inspector Daley also gave evidence that NSWPF officers on proactive duties were called back to attend to general duties, again an uncommon practice.

11.3 **Conclusions:** The available evidence indicates that the workload within St George PAC was consistently busy in March 2023 and remains similarly busy presently. However, there were certain features about the workload during the night shift on 2 March 2023 which suggest that it was particularly busy necessitating a departure from usual practices. Overall, the evidence establishes that there was limited capacity within St George PAC during the night shift on 2 March 2023 to attend to a concern for welfare job, and also other jobs of similar priority more generally.

12. Response timeframe if a CAD job had been created

12.1 In general terms, a NSWPF telephonist or station constable will perform an initial triage of any call received and allocated a response priority when a job is created on the CAD system. Once a job is in the CAD system ii can be viewed by the Duty Officer and the internal and external supervisors who can upgrade or downgrade the priority of particular jobs.

12.2 Chief Inspector Daley gave evidence that if a NSWPF car crew is available they are "*expected to respond to a job no matter what the priority*". Typically, when responding to a Priority 3 job a car crew will attend to the job that has been in the queue in the CAD system for the longest period of time. However, there may be instances where a car crew may respond to a job that is not the oldest in time if, for example, the car crew is already at a location near a job in the CAD queue.

12.3 Chief Inspector Daley gave evidence that if Probationary Constable Rogan had created a concern for welfare job on the CAD system in relation to Mrs Hayes' call regarding MQ at around 8:29pm on 2 March 2023, it is likely the NSWPF response to this job would have taken at least four to five hours. The following matters are relevant to the calculation of Chief Inspector Daley's estimate:

(a) Chief Inspector Daley gave evidence that there were two high risk missing person reports made on 2 March 2023 that would have utilised "*a lot of resources*";

(b) there were several alleged domestic violence incidents which could typically occupy a car crew for up to four or five hours;

(c) although it would depend on what was contained in the narrative for any concern for welfare job created in relation to MQ, Chief Inspector Daley gave evidence that he expected that a car crew would respond to an alleged domestic violence incident of equivalent priority first. This is because of the NSWPF's proactive strategy of attending to alleged domestic violence incidents and taking action as soon as possible. Chief Inspector Daley explained the effect of this proactive strategy: "*[I]t will slow [NSWPF officers] down getting to other jobs because they're attending to the domestic job*".

(d) By way of example, a Priority 3 job relating to a domestic violence incident involving an alleged assault by one housemate against another housemate was created on the CAD system at 8:58pm with a car crew assigned at 9:55pm and on scene at 10:48pm; and

(e) By way of further example, another job relating to a domestic violence incident involving alleged verbal abuse with no physical injuries, but with persons who may require an interpreter, was created on the CAD system at 4:39pm with a car crew assigned at 4:33am on 3 March 2023.

12.4 As to this second example, counsel for Probationary Constable Rogan suggested to Chief Inspector Daley that the approximately 12 hour response timeframe meant that a similar timeframe was likely if a concern for welfare job had been created on the CAD system regarding Mrs Hayes' call about MQ. However, Chief Inspector Daley considered that to be "*too long a time period*" and explained:

> I think at the end of the four to five hour period that I mentioned, a lot of car crews were becoming available to do jobs. So, I'm still staying with that four to five hour period from when the initial call was made, that police would have been able to respond to this job, to the job we're referring to.

12.5 The estimated response time provided by Chief Inspector Daley indicates that if a concern for welfare job regarding MQ had been created on the CAD system at around 8:29pm on 2 March 2023, it most likely would have been attended to between around 12:30am and 1:30am on 3 March 2023. This is particularly relevant given the following opinions expressed by Professor Yates:

(a) if medical treatment had been sought for MQ on 2 March 2023, it is likely that she would have been admitted to hospital and treated with appropriate intravenous antibiotic and oxygen therapy; and

(b) if medical treatment had been provided to MQ "*on 2 March 2023 or shortly thereafter, then such treatment might have materially altered the progression of her bronchopneumonia*" [emphasis added].

12.6 The available evidence indicates that MQ was last known to be alive between around 5:30pm and 6:00pm on 2 March 2023 when her neighbour heard her coughing and had a brief verbal exchange to ask about her welfare. Other evidence indicates that MQ exchanged messages with a colleague (which do not appear in any call charge records but may have occurred over Wi-Fi or mobile data using Messenger) at some unspecified time later that night. The evidence therefore indicates that it is likely that MQ was still alive at around 8:29pm on 2 March 2023 when Mrs Hayes spoke to Probationary Constable Rogan. It is therefore possible that MQ was still alive between around 12:30am and 1:30am on 3 March 2023 when NSWPF officers are likely to have attended her home in response to a concern for welfare job if one had been created on the CAD system.

12.7 **Conclusions:** Given the number and nature of other outstanding jobs that were already on the CAD system during the night shift on 2 March 2023, even if a concern for welfare job had been created regarding MQ it is most likely it would not have been attended to by the NSWPF for four to five hours. This estimated response timeframe is largely based on the number of NSWPF resources, having completed earlier jobs, that were becoming available from around 12:00am onwards on 3 March 2023.

12.8 Having regard to this estimated response timeframe, it is possible that if MQ was still alive when NSWPF officers are likely to have attended her home in the early hours of the morning on 3 March 2023 (if a CAD job had been created) and if medical treatment had been instituted shortly afterwards, then it is possible that MQ's death might have been averted. On the available evidence each of these occurrences rise no higher than a possibility.

12.9 The evidence does not allow for a conclusion to be reached that MQ's death would have been prevented if a concern for welfare job had been created on the CAD system at around 8:29pm on 2 March 2023. However, this does not in any way detract from the importance of ensuring that concern for welfare jobs of the kind involving MQ are entered onto the CAD system in a timely manner so that the NSWPF may respond appropriately to such jobs.

13. Findings pursuant to section 81(1) of the Act

13.1 I gratefully acknowledge the significant contributions of both Ms Sian McGee, Counsel Assisting, and her instructing solicitor, Ms Annabelle Thorne of the Crown Solicitor's Office, to the coronial investigation and inquest process. The Assisting Team has ensured that a thorough investigation has been conducted and provided tremendous assistance at each stage of the coronial proceedings. I am extremely grateful for their meticulous approach, and for the compassion that they have shown throughout.

13.2 I also thank Detective Senior Sergeant Richard Broome, the Officer-in-Charge, for his efforts in conducting the NSWPF investigation and compiling the initial brief of evidence.

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

Identity
The person who died was MQ.

Date of death
MQ died on 2 or 3 March 2023.

Place of death
MQ died at Peakhurst NSW 2210.

Cause of death
The cause of MQ's death was acute necrotising bronchopneumonia.

Manner of death
MQ died of natural causes following the clinical progression of community-acquired pneumonia in the days preceding 2 March 2023. MQ's death occurred in circumstances where at 8:29pm on 2 March 2023, a concern for her welfare was first reported to the New South Wales Police Force with no appropriate response initiated until a follow up concern was reported at 8:05am on 3 March 2023. However, it is not possible to conclude whether MQ's death likely would have been prevented if an appropriate response had been initiated when the concern for MQ's welfare was first reported.

14. Epilogue

14.1 On behalf of the Coroners Court of New South Wales and the Assisting Team, I offer my deepest sympathies, and most sincere and respectful condolences, to MQ's family, loved ones and many friends for their most painful and tragic loss.

14.2 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
17 December 2025
Coroners Court of New South Wales