CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of AT
Hearing dates:	10 September 2026
Date of findings:	10 September 2026
Place of findings:	Coroners Court, Lidcombe
Findings of:	Judge Hosking, Deputy State Coroner
Catchwords:	S 23(1)(c) *Coroners Act 2009* (NSW) Death in police operation, police response to mental health episode
File number:	2026/83142
Representation:	Assisting the Coroner: Kathleen Zielinski, Solicitor Advocate and Lara Shepherd, Solicitor, NSW Crown Solicitor's Office
Cases cited:	*Inquest into the death of AX,* 11 October 2024 *R v London Coroner; Ex parte Barber* [1975] 1 WLR 1310
Findings:	I find that AT died on 6 February 2025 at his residential unit block in Leichhardt, NSW from multiple injuries caused by falling from a height. AT fell in the context of a mixed mental state of delusions, general mental distress and worry about real world stress leading to impulsive escape actions.
Recommendations:	N/A
Publication orders:	A copy of non-publication orders made by Judge Hosking can be obtained from the Registry.

Introduction

1 AT was born on 17 March 1994 and died aged 30 on 6 February 2025 at his home in Leichhardt, NSW.

The role of the coroner

1 The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

2 The inquest into AT's death held on 10 September 2026 was a mandatory inquest pursuant to section 23 of the Act because AT's death occurred 'as a result of' NSWPF operations, being their attendance at his residence in response to a call for assistance by a concerned friend of AT's.

3 In accordance with s 75(5) of the Act, and subject to non-publication and orders, I make an order permitting the publication of a report of the proceedings as I find it is desirable in the public interest to do so.

Background

4 I have drawn from the opening delivered by the solicitor advocate in relation to uncontentious facts and circumstances and I am grateful for this assistance.

AT's life

5 AT is survived by his father and sister. His sister has attended the inquest in support of AT. His mother sadly died in around 2013 from pancreatic cancer. AT also had very close friends, two of whom attended the inquest with his sister.

[1] S 81 of the *Coroners Act 2009* (NSW) (**the Act**).
[2] S 82 of the Act.

6 AT's heritage is South African. He grew up in Sydney attending Cherrybrook High School and then the University of Technology, Sydney. He worked as a contract administrator in a property development company. At the time of his death, he was living alone in a rental apartment in Leichhardt.

7 AT struggled with untreated or under treated mental health issues which were exacerbated by his mother's death in 2013.

8 AT had suffered a drug-induced psychosis in around 2019-2020 and had also been hospitalised for suicidal ideation in 2021.

9 AT had difficulty with financial management accruing debt through drug use and gambling. In early 2025 AT sought assistance from family in respect of an accrued debt of around $70,000 which is believed to have increased by time of his death.

Hospitalisation in January 2025

10 In early January, AT began to approach friends about witnessing his will. He told one of his friends that he intended to kill himself so that his superannuation could be accessed and used to pay off debts he owed to another friend. On 12 January 2025, AT was taken to the Royal Prince Alfred Hospital (**RPAH**). His emergency department records note:

> [AT] appears to have been caught in crypto-currency scam/money loss - reports has now lost all his money, job and girlfriend…Feels worthless and like the whole world is ending.

11 AT was admitted to the MAU[3] as an involuntary patient under the *Mental Health Act 2007* (NSW) on the basis that he was mentally disordered.

12 On 13 January 2025, he was reviewed by psychiatrist Dr Wilson. Dr Wilson noted:

[3] Medical Assessment Unit.

> AT stated that his problems are insurmountable therefore he would like to commit suicide… owed a friend $30,000 as a result of a cryptocurrency debt and had debts amounting to $70,000 altogether… reported previous anti-depressant use which he had ceased… he had spent the last three weeks staying in his apartment and had not enjoyed life, although curiously also stated 'I almost felt a bit manic.' He also disclosed that he engaged in gambling and cryptocurrency training, and that his girlfriend had recently broken up with him.

13 A plan was made for AT's involuntary admission and he was commenced on 30mg of mirtazapine.[4]

14 On 14 January 2025, Dr Wilson reviewed AT and considered that he had schizophrenia.

15 While in the MAU, AT was regularly reviewed by psychiatrists, he largely kept to himself, he was dismissive towards nursing staff and he was keen to be discharged.

16 On 18 January 2025, Dr O'Sullivan, a psychiatric registrar, reviewed AT and spoke to his nominated next-of-kin (**NOK**)[5]. Dr O'Sullivan detected no signs of mania or depression, rather an acute stress reaction with poor coping/strategies skills and emotional instability.

17 On 20 January 2025, clinicians again spoke with AT's NOK, who told them that AT had continued to discuss suicide in text messages to him from hospital.

18 On 21 January 2025, AT spoke with a social worker who provided him with the numbers of financial counsellors. AT apparently stated he felt much better following that conversation. AT went on leave with a friend who later reported to staff that AT had told her:

> This is gonna be our last meal together.

[4] An antidepressant.
[5] A family friend.

19 That evening, AT was transferred from the MAU to the Acute Ward within the Professor Marie Bashir Centre Mental Health Unit. A note records that he told staff:

> This admission is making my issues worse. I need to be out there, solving these issues.

20 On 22 January 2025, AT was reviewed by Dr Tandon, consultant psychiatrist. AT said he was in around $100,000 debt, having borrowed money from different lenders he had found on the internet, paying interest of up to 50%. He had lost all the money he had borrowed. He no longer was in contact with his family. Dr Tandon considered that AT was experiencing suicidal ideation in the context of significant psychosocial stressors and on a background of poor impulse control and difficulty regulating emotions. He wrote that AT remained 'at chronically elevated risk of harm to himself given his underlying personality structure.'

21 Further information was sought from AT's NOK, family and friends. Dr Talwar, registrar, ascertained from AT's friend that AT appeared to have had psychotic symptoms since his first episode of drug induced psychosis, including paranoia about having HIV. AT had recently told his friend:

> I think I'm possessed. I think the devil possessed me.

22 Dr Talwar was also advised that AT had continued to gamble while in hospital and had taken out another $15,000 loan.

23 Dr Talwar informed AT that he would not be discharged and that the doctors would like to monitor his mental state 'for a further period as we need to see if there is an element of treatable mental illness underlying this presentation.' AT's use of his phone was also restricted to 30 minutes twice a day given concerns he was gambling while on the ward.

24 On 24 January 2025, AT told Dr Tandon that he was feeling well and he had time to put plans into place to get his life back on track. Dr Tandon explored with AT whether he had any 'delusional jealousy' about his girlfriend. AT was

noted to respond ‘Sometimes maybe I'd get a bit delusional. I think that happens.’

25 AT indicated that while he was having suicidal thoughts prior to admission, he could now see ‘reasons to live’ and wanted to try and ‘fix his life.’ Dr Tanwar discussed a plan with AT to be discharged on the condition that he stay with a trusted friend for a few days. Dr Tanwar spoke with two of AT’s friends, both felt that AT's mood had improved and one agreed to AT staying with her on discharge.

26 AT was discharged at 4:35pm on 24 January 2025. His discharge summary notes his treating team saw no evidence that he had an underlying mood or psychotic disorder, and AT's suicidal ideation was thought to be secondary to an acute situational crisis for which he was able to access appropriate supports during admission.

27 AT was discharged to stay with his friend in Rushcutters Bay. He accepted referrals for the SVH ACS [6]and the Wayback Service.[7]

Events after AT's discharge

28 SVH ACS sought to contact AT by phone the day after his discharge and they spoke with AT on the phone on 26 January 2025. Their records note that AT engaged well in the call.

29 The Wayback service attempted to contact AT multiple times after his discharge and received no response.

30 On 28 January 2025, AT returned to work and told a colleague that he was ‘possessed’ and ‘hearing things.’

31 On 29 January 2025, AT signed a consent form for Wesley Mission financial counselling and provided bank statements, payslips and loan agreements prior

[6] Acute Care Service of St Vincent's Hospital.
[7] A support service for people who have attempted suicide or have been in crisis.

to the session starting. He disclosed that he was feeling like his financial situation was hopeless and that he could see no other way out than bankruptcy and that he felt like his life in general was hopeless. He explained that he had taken out loans whilst in hospital and one loan just before entering hospital and they had all been lost on cryptocurrency investments. AT spoke about his tendency to chase his losses when crypto trading and that he would take out online loans to acquire the capital so that he could make new investments/purchases in cryptocurrency and that he lost his money. He provided a current list of his debts which included to 8 different lenders with an amount of approximately $75,000. They created a list of his direct debits, and living expenses and created a way forward for AT to realistically pay off his debts and so that his disposable income struck a balance between his current and future needs.

32 AT did not respond to calls by the SVH ACS on 29 and 30 January 2025. As a result, staff of the service visited the address where AT was discharged to and were informed that he had returned to live at his unit in Leichhardt. On 31 January 2025, SVH ACS spoke to AT on the phone while he was at work. He reported that things had settled, he had returned to work and was engaging with gambling support. It was recorded that AT had residual concerns about suicidal ideation, but he had mobilised his friends around him. AT stated he felt 'little need for ongoing [mental health] support at this stage' and was otherwise very reticent to engage further over the phone at work.

33 It appears that SVH ACS then handed over AT's further community follow up to the SLHD ACS[8] given his return to Leichhardt. A letter from SLHD ACS was found in AT's belongings following his death. A business card belonging to the service was also found with a handwritten annotation, 'Hi [AT], Please call us!' There is no evidence of any other contact between the SLHD ACS and AT.

34 On 3 February 2025, AT again saw a financial counsellor. AT told his friend that, as he had been told that gambling money obtained through a loan could

[8] Community Mental Health Acute Case Service based within the Sydney Local Health District.

be a criminal offence. On 5 February 2025, AT and his friend went for a walk and AT appeared paranoid including thinking his friend was recording their interactions and that his own phone was tapped.

6 February 2025

35 On 6 February 2025, AT's friend noticed that AT had not come to work. The pair sent messages to each other on Whatsapp. His friend offered to take AT to hospital. AT in turn wrote that he 'fucked up massively' and 'bro it's fucked…I can't come back from this.'

36 As a result, at around 1pm, his friend went to AT's apartment. While AT opened his front door, he did not let his friend in. AT appeared paranoid, was repeatedly picking up and dropping his mobile phone and made motions as if he were stabbing himself. Concerned for his own and for AT's safety, his friend retreated across the road from AT's building and called police at 1.31pm.

37 As a result of AT's friend's call to 000, the following messages were broadcast on the police CAD[9] system at 1.33pm:

> INFTS FRIEND [AT] IS HAVING A PSYCHOTIC EPISODE AND IS GESTURING AS IF HE HAD STABBED HIMSELF OR SOMEONE ELSE.
>
> RECENT MH HOSP
>
> POI RECENT SUICIDAL IDEATION
>
> POI KEEPS SAYING I F**** UP - AND INDICATING AS IF HE IS GOING TO JUMP OUT THE WINDOW
>
> THE POI WOULD NOT OPEN THE DOOR AND LEFT INFT IN - WOULD NOT ANSWER WHEN ASKED IF HE HAD HURT SOMEONE

38 Two NSWPF[10] officers responded to the job, arriving at 1.34pm. The officers turned off the car's lights and sirens well in advance of arriving, so as not to cause alarm to AT. Their BWV[11] was activated on arrival.

[9] Computer-Aided Dispatch.
[10] NSW Police Force.
[11] Body Worn Video.

39 The officers first spoke to AT's friend on the street for three minutes to understand the situation. They then gained access to AT's building and walked up the stairs to his apartment on the fourth (and top) floor.

40 They knocked on AT's door at 1.46pm. AT did not respond. The BWV then captures both officers' attempts to raise AT verbally. At all times they appear to deal with the situation sensitively, including saying to AT that he was not in trouble.

41 At around 1.47pm, Officer 1 is recorded going back to the ground level of the building to investigate a thud he heard, which he thought might have been AT jumping from his apartment. Before leaving, he instructed Officer 2 to step further away from the door to the stairwell, but to continue to attempt to engage AT.

42 While Officer 1 is away from the area, Officer 2's BWV captures him continuing to talk to AT over the next two minutes. Among other things, Officer 2 is recorded as saying:

> [AT] mate it's just the police. I know you don't want to see us…We just want to sight you…We're not here to hurt you…Your friends told us you're not feeling too well. That's the only reason we're here. AT please can you open the door. AT mate, can you please open the door mate. I'm begging you.
>
> AT, we're here for your safety man, we're not going to hurt you. We just want you to open the door so we can have a quick chat, alright.?

43 Officer 1, having not seen anything outside the building to suggest AT had jumped from his apartment, returned to the stairwell and both officers continued to attempt to engage AT. Officer 1 is recorded instructing Officer 2 to give AT time to respond in between attempts to speak to him.

44 At 1.50pm, Officer 1 requested that police rescue attend the scene. Two paramedics are recorded arriving at the top of the stairs. The NSWPF officers briefed them. Officer 2 is recorded telling the paramedics that AT has had previous mental health incidents.

45 Officer 1 is then recorded saying to AT through the door:

> [AT] it's [Officer 1] from the police. Mate, we spoke to your mate… he's a bit worried about you, we've got paramedics if you prefer to talk to them. I need you to speak to me mate, even if it's just through the door. Otherwise we might need to force entry.

46 Officer 2 then adds: 'You're not in trouble we just want to talk to you.'

47 At around 1.54pm, shortly after this point, a man in the unit below AT's, informed those present in the stairwell that he had seen something fall past his window.

48 As a result, the officers and paramedics rushed downstairs and found AT laying in the ground outside the building and immediately commenced to render first aid. At 2.29pm, the paramedics ceased resuscitation and AT was pronounced deceased.

49 It is believed that AT jumped/fell via the window in the bathroom.

Post-Mortem report dated 20 March 2025

50 Dr Brouwer conducted an external post-mortem examination on 11 February 2025. Dr Brouwer noted that AT had a two-centimetre stab wound to his abdomen along with a wound to the anterior aspect of his left forearm. Toxicology screening was negative for drugs and alcohol. Dr Brouwer opined that AT's cause of death was 'multiple injuries.'

51 Toxicology analysis only detected a low level of ibuprofen.

Dr Ellis, forensic psychiatrist, report dated 26 May 2026

52 As to AT's care at the RPAH during his admission, Dr Ellis opined that:

(1) appropriate information was sought from AT's friends and NOK while he was receiving involuntary treatment and their disclosures regarding AT's ongoing suicidal ideation was incorporated into his treatment planning.

(2) it appears reports of AT's psychotic symptoms were downplayed and not sufficiently explored.

(3) AT was provided with appropriate treatment regarding his gambling addiction as he was referred for financial counselling and at that stage in his treatment plan identifying the problem and establishing a future plan was appropriate.

(4) the limiting of AT's access to his phone to prevent him from gambling was undertaken at an appropriate level given it is important for people to have access to their social supports via their phone while receiving in-patient care.

53 Significantly, Dr Ellis opined that the decision to discharge AT on 25 January 2025 was appropriate. Dr Ellis stated:

> By this stage there was some evidence of improvement in mental state, and at least some time without drug or alcohol use. He had accommodation. There was a plan for the financial stress to be addressed. There was linkage with professional and social support in the community. He had been commenced on medication. He was agreeable to ongoing treatment. While there remained some unexplained factors … these could have been addressed with engaging in community care.

54 Dr Ellis considered that AT's overall discharge plan was reasonable, though could have been improved by:

(1) an additional period/s of unsupervised leave

(2) having a face to face meeting with those charged with caring for AT on discharge

(3) his discharge letter more appropriately describing the presence of psychotic symptoms and disordered mood, instability and insomnia.

55 As to diagnosis, Dr Ellis acknowledged that AT's case was complex.

(1) He noted that AT's final diagnosis was described as 'brief situational non-psychotic disorder' which is not a standard diagnosis in psychiatry.

(2) At a minimum there should have been a differential diagnosis of a mood or psychotic disorder.

(3) Further, AT would have clearly met the diagnostic criteria for substance use disorder.

(4) Dr Ellis considered there was mixed information to suggest a personality disorder and a more detailed examination of personality function including developmental history and interpersonal attitudes either during admission or planned for after discharge was warranted.

56 Having considered the available evidence, Dr Ellis considered that it would be reasonable to conclude that AT had psychotic symptoms before, during and after his admission. Given that, treatment with antidepressant medication only was a missed opportunity to manage his underlying symptoms and disorder.

57 Dr Ellis considered AT's follow up by SVH ACS and SLHD ACS's to have been excellent and well considered.

58 As to the question of whether AT was capable of informing an intention to commit suicide Dr Ellis opined:

> It is difficult to determine a clear intention to commit suicide on 6 February 2025. [AT] had previously expressed suicidal ideas (last noted on 26 January 2025 in text messages to [his NOK] and had a mental disorder (of the diagnostic possibilities described in my report) for which he was not taking treatment. He was under financial and relationship stress. He also expressed ideas in the days before, and last on 5 February 2025 (possession by the devil, phone being tapped) that would be consistent with psychosis (delusions).
>
> On 6 February his text messages to Mr Favaloro could be consistent with further persecutory delusions (questioning him whether he has been in the flat (did you come to my house? Did anyone?), despondency (I'm cooked, I'm fucked) or suicide (I can't come back from this). Mr Favaloro's observations when he arrives at the flat note that he is paranoid (checking for other people), making stabbing actions towards his stomach without holding a knife, pointing

> at a window, and having punched a wall injuring his knuckles. These actions can be consistent with both wishes to harm self and persecutory delusions.
>
> I note he stabbed himself twice before jumping from the window…
>
> It is more common for persons intending suicide to wait until they are alone, rather than suicide in the presence of others. Sometimes psychosis can drive suicidal acts by delusional beliefs. This is possible, however there is no direct evidence. General distress from untreated mental disorder coupled with stress can also drive suicidal acts. Both these factors were present. When persecutory delusions are present and a person feels trapped or cornered this may drive suicidal or impulsive escape behaviours. This factor was likely present.
>
> On this basis the most likely scenario is a mixed mental state of delusions, general mental distress and worry about real world stress leading to impulsive escape actions, last resort thinking and suicidal thoughts, rather than a single intent to suicide on the day. The self-harm behaviours occur after the arrival of a friend and the jumping from the window occurs after the arrival of police.

Statutory findings

59 The evidence clearly indicates that AT died on 6 February 2025 after he fell/jumped out of his bathroom window at a height at his unit block in Leichhardt suffering multiple injuries.

Manner of death

60 Suicide has been defined as 'voluntarily doing an act for the purpose of destroying one's own life while one is conscious of what one is doing,' or similarly, 'a suicidal act requires a voluntary and deliberate act by the deceased; and further, that the intent behind the action is for the deceased to end their own life, with the capacity at the relevant moment, to form that critical intention.'[12]

61 Evidence relating to AT's suicidal intention prior to his death included:

(1) hospitalisation in 2021 for suicidal ideation

(2) seeking assistance with will preparation and expressing suicidal intentions to friends in January 2025 leading to his hospitalisation

[12] See *Inquest into the death of AX* at [131], Baptie LCJ.

(3) his telling Dr Wilson on 13 January 2025 that his problems were insurmountable

(4) his continued text messages to his NOK regarding suicidal intention

(5) his description to his friend on 21 January 2025 that they were sharing their last meal together

(6) Dr Tandon's assessment on 22 January 2025 that AT was experiencing suicidal ideation and was at a chronically elevated risk of harm to himself, and

(7) on 31 January 2025 AT an SVH ACS team member spoke to AT and recorded a note that AT had residual concerns about suicidal ideation.

62 On the evidence adduced, it is difficult to determine the extent to which psychosis was a contributing factor in AT's death. We do know the matters that follow.

(1) Dr Ellis opined that AT's psychotic symptoms were downplayed and not sufficiently explored while he was in hospital and they could have been more appropriately described in his discharge letter.

(2) On 28 January 2025, AT told a colleague that he was 'possessed' and 'hearing things.'

(3) On 5 February 2025, AT appeared paranoid to his friend thinking that his friend was recording their interactions and that his phone was tapped.

(4) When AT's friend attended AT's apartment shortly before AT's death, AT appeared paranoid, picking up and dropping his mobile phone and making motions as if stabbing himself. Out of fear for his own safety as well as AT's, his friend retreated from AT and crossed the road to call the NSWPF.

63 As outlined by Baptie LCJ in *Inquest into the death of AX* at paragraphs 138-139:

> In determining whether a person has intended to cause their own death, the Court must apply the 'Briginshaw' standard or test. In particular, the Court must be satisfied on the balance of probabilities and have a reasonable satisfaction that there was a particular intention. It is noted that a "reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences".
>
> In *R v London Coroner; Ex parte Barber* [1975] 1 WLR 1310 at 1313, Lord Widgery CJ said: [P]erhaps one of the most important rules that coroners should bear in mind…[is] that suicide must never be presumed. If a person dies a violent death, the possibility of suicide may be there for all to see, but it must not be presumed merely because it seems on the face of it to be a likely explanation. Suicide must be proved by the evidence, and if it is not proved by evidence, it is the duty of the coroner not to find suicide, but to find an open verdict…".

64 Given the opinion of Dr Ellis to the effect that, 'It is difficult to determine a clear intention to commit suicide on 6 February 2025,' I am not satisfied on the balance of probabilities that AT had the capacity to form the requisite intention for his manner of death to be described as suicide.

65 Consistent with Dr Ellis' opinion, I find that AT's fall occurred in the context of a mixed mental state of delusions, general mental distress and worry about real world stress leading to impulsive escape actions.

Findings

66 I find that AT died on 6 February 2025 at his residence in Leichhardt from multiple injuries caused by a fall from height. Such fall occurring in the context of ongoing symptoms of psychosis.

67 While Dr Ellis has identified areas in which AT's treatment and discharge papers could have been improved, I am satisfied that these factors did not cause or contribute to AT's death.

68 I am satisfied that AT's discharge from RPAH was appropriate and that he was provided with appropriate support services within the community on his discharge.

69 I find that AT's friend and colleague who was present when AT died took appropriate steps to try and obtain help for AT on 6 February 2025 and in the period prior to his death.

70 I find that the attending NSWPF officers responded to AT with compassion and care. Their conduct was appropriate and it is tragic that they couldn't prevent his death.

Concluding remarks

71 I thank the assisting team for their support in the conduct of this inquest.

72 I thank the officer in charge, Detective Inspector Paul Grace for his work in conducting the investigation.

73 I acknowledge the first responders and recognise the impact that AT's death had on them.

74 I will close by conveying to AT's family and his friends my sympathy for their loss.

Statutory findings required by s 81(1)

75 I make the following findings:

Identity

The person who has died is AT.

Place of death

AT died at his residential unit block in Leichhardt NSW.

Date of death

AT died on 6 February 2025.

Cause of death

AT died from multiple injuries caused by falling from a height.

Manner of death

AT fell in the context of a mixed mental state of delusions, general mental distress and worry about real world stress leading to impulsive escape actions.

I close this inquest.

Judge R Hosking
Deputy State Coroner

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