



Report by the NSW State Coroner

into deaths in custody/
police operations

1997

(Coroner's Act, 1980)

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State Coroner's Office

NSW Attorney General's Department

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The Honourable Jeffrey William Shaw, Q.C., B.A., LL.B.
Attorney General
Level 20, Goodsell Building
8-12 Chifley Square
SYDNEY, SMS

Dear Attorney,

In accordance with the provisions of Section 12A(4) of the *Coroners Act 1980*, I present a written report containing a summary of the details of the deaths of persons in circumstances referred to in Section 13A.

Under the provisions of Section 13A:

- 1 A Coroner who is the State Coroner or a Deputy State Coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the Coroner that the person has died or that there is reasonable cause to suspect that the person has died:
 - (a) while in the custody of a police officer or in other lawful custody, or while escaping or attempting to escape from the custody of a police officer or other lawful custody; or
 - (b) as a result of or in the course of police operations; or
 - (c) while in, or temporarily absent from, a detention centre within the meaning of the *Children (Detention Centres) Act 1987*, a prison within the meaning of the *Prisons Act 1952*, or a lock-up, and of which the person was an inmate; or
 - (d) while proceeding to an institution referred to in paragraph (c) for the purpose of being admitted as an inmate of the institution and while in the company of a police officer or other official charged with the person's care and custody.
- 2 If jurisdiction to hold an inquest arises under both this section and Section 13 (class of deaths which must be reported to the Coroner), an inquest is not to be held except by the State Coroner or a Deputy State Coroner.

As you are aware, Section 13A was inserted into the Act by the *Coroners (Amendment) Act 1993*, effective from 1 February 1994. Inquests into such deaths are mandatory and must be heard by the State Coroner, or a Deputy State Coroner. It is therefore part of the *Coroners Act* that deaths resulting from police operations, deaths in prisons, and deaths of persons proceeding to and from appropriate Institutions are to be the subject of mandatory reporting and inquest, although in practice such was always the case.

Eighty four cases in circumstances referred to in Section 13A were subject to investigation by the State Coroner and the Deputy State Coroners in 1997 and are referred to in this report. Of those eighty four cases, twenty eight were matters outstanding as at the 31 December, 1996 and fifty six were matters reported during 1997. The 1996 Report set out that twenty eight matters were outstanding as at the 31 December, 1996. This number is correct. One outstanding matter was subsequently considered not a death occurring in one of the circumstances set out in Section 13A (File No. 2195/96 in 1996 Report). One police operation death occurring in 1996 (inquest held in 1997) was not included in the 1996 Report and is included in this Report (File 1282/96).

Particulars of one death in custody matter reported and finalised in 1996 yet inadvertently omitted from the 1996 Report is included in this Report but not included in the statistical data in this report. (File No. 1138/96)

Of those eighty four cases, thirty four have been completed by way of Inquest finding and three have been terminated because a person was charged with an indictable offence in which an issue will be that the person caused the death. Seven cases have been listed for hearing in 1998 and forty are currently under investigation with a hearing date yet to be allocated.

I hereby enclose my report for 1997 into deaths in custody/police operations deaths for your information and for the information of both Houses of Parliament.

Yours sincerely

A handwritten signature in black ink, appearing to read 'D W Hand', with a stylized flourish at the end.

D W Hand

NSW State Coroner

Statutory appointments

Under the 1993 amendments to the *Coroners Act 1980*, only the State Coroner or a Deputy State Coroner can preside at an inquest into a death in custody or a death in the course of police operations. The deaths, the subject of this report, were conducted before the following Coroners:

MAGISTRATE DERRICK W. HAND: New South Wales State Coroner

- 1973 Magistrate and Coroner
- 1984 Westmead Coroner
- 1988 Deputy State Coroner
- 1995 New South Wales State Coroner

MAGISTRATE JOHN ABERNETHY: Senior Deputy State Coroner

- 1984 Magistrate and Coroner
- 1994 Deputy State Coroner
- 1996 Senior Deputy State Coroner

MAGISTRATE P.J. MOLAN: Deputy State Coroner

- 1986 Magistrate
- 1996 Deputy State Coroner
- 1997 Magistrate Molan died in July.

MAGISTRATE JANET STEVENSON: Deputy State Coroner

- 1990 Magistrate and Coroner
- 1997 Deputy State Coroner

Derrick Windsor Hand



- 1953 Joined the (then) Petty Sessions Branch of the New South Wales Department of Justice
- 1969 Admitted as a Solicitor of the Supreme Court of New South Wales
- 1973 Appointed a Stipendiary Magistrate and Coroner for the State of New South Wales
- 1984 Appointed Westmead Coroner
- 1985 Appointed a Magistrate for the State of New South Wales under the Local Courts Act 1982
- 1988 Appointed Deputy New South Wales State Coroner
- 1993 Appointed Magistrate Port Macquarie circuit
- 1995 Appointed New South Wales State Coroner

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Introduction by the New South Wales State Coroner

What is a death in custody?

It was agreed by all mainland State and Territory governments in their responses to the Royal Commission into Aboriginal Deaths in Custody recommendations, that a definition of a death in custody should, at the least, include:

- 1 the death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;
- 2 the death, wherever occurring, of a person whose death is caused, or contributed to, by traumatic injuries sustained, or by lack of proper care whilst in such custody or detention;
- 3 the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and
- 4 the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention. (*Recommendation 41, Aboriginal Deaths in Custody: Responses by Government to the Royal Commission 1992 pp 135-9.*)

Section 13A of the Coroners Act expands on this definition to include circumstances where the death occurred:

- 1 while temporarily absent from a detention centre, a prison or a lock-up; as well as
- 2 while proceeding to a detention centre, a prison or a lock-up when in the company of a police officer or other official charged with the person's care or custody.

It is important to note that in respect of those cases where an inquest has yet to be heard and completed, no conclusion should be drawn that the death necessarily occurred in police custody or during the course of police operations. This is a matter for determination by the Coroner after all the evidence and submissions from those granted leave to appear have been presented at the inquest hearing. One death reported in the 1996 Report was so determined at the hearing in 1997. (*File No. 2195/96 in the 1996 Report*)

What is a death as a result of or in the course of a police operation?

A death as a result of or in the course of a police operation is not defined in the Act. Following the commencement of the 1993 amendments to the Coroners Act 1980, New South Wales State Coroners Circular No. 24 contained potential scenarios that are likely 'deaths as a result or in the course of

a police operation' as referred to in Section 13A of the Act.

The circumstances of each death will be considered in reaching a decision whether Section 13A is applicable but potential scenarios set out in the Circular were:

- any police operation calculated to apprehend a person(s);
- a police siege or a police shooting;
- a high speed police motor vehicle pursuit;
- an operation to contain or restrain persons;
- an evacuation;
- a traffic control/enforcement;
- a road block;
- execution of a writ/service of process; or
- any other circumstance considered applicable by the State Coroner or a Deputy State Coroner

The Deputy State Coroners and I have tended to interpret the subsection broadly. We have done this so that the adequacy and appropriateness of police response and police behaviour generally could be investigated where we believed this was necessary.

It is most important that all aspects of police conduct be reviewed even though in a particular case it may be unlikely that there will be grounds for criticism of police. It is important that the relatives of the deceased, the New South Wales Police Service and the public generally have the opportunity to become aware, as far as possible, of the circumstances surrounding the death.

In general terms where a death has occurred as a result of or in the course of a police operation, the behaviour and conduct of police was found not to warrant criticism by the Coroners. One exception was an inquest conducted by myself into a death which occurred in a country police charge room. I criticised the delay and failure of police officers to properly process a person in custody.

Why is it desirable to hold inquests into deaths of persons in custody/police operations?

I agree with the answer given to that question by Mr Kevin Waller, a former New South Wales State Coroner.

"The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and it is not exacerbated by ill-treatment or privation

while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated.”

(Kevin Waller AM., Coronial Law and Practice in New South Wales, Third Edition, Butterworths, page 28)

I agree also with Mr Waller that:

“In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution. When the death is by deliberate self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an event pertaining to an individual. The focus there is far more upon the individual and that individual’s pre-morbid state. It is entirely proper that any death in custody, from whatever cause, must be meticulously examined.”

(Kevin Waller AM., Waller Report (1993) into Suicide and other Self-harm in Correctional Centres, page 2.)

New South Wales coronial protocol for deaths in custody/ police operations

Immediately a death in custody/police operations occurs anywhere in New South Wales, the local police are to promptly contact and inform the duty operations inspector (the DOI) who is situated at VKG, the police communications centre in Sydney.

The DOI is required to immediately notify the Deputy State Coroner (Westmead) if the death occurs within the jurisdiction of the Westmead Coroner’s Court which covers the western areas of metropolitan Sydney. The State Coroner or Senior Deputy State Coroner must be notified of all deaths which do not fall within that area. These three Coroners are on call twenty-four hours a day, seven days a week. The Coroner so informed, and with jurisdiction, will assume responsibility for the investigations into that death. The Coroner’s supervisory role of the investigations is a critical part of any coronial inquiry.

The DOI is also required to immediately notify the Commander of the State Coroner’s Support Section, a small team of police officers who are directly responsible to the State Coroner for the performance of their duties.

Upon notification by the DOI, the State Coroner or Deputy State Coroner will give directions that experienced detectives from the Crime Scene Unit

(officers of the Physical Evidence Section) and the local government medical officer or a forensic pathologist attend the scene of the death. The Coroner will check that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit (officers of the Physical Evidence Section) and the local Government medical officer or the forensic pathologist.

A member of the Coroner's Support Section must attend the scene that day if the death occurred within the Sydney Metropolitan area and, when practical, if a death has occurred in a country district. The Support Group Officer must also ensure that a thorough investigation is carried out. The Support Group Officer will continue to liaise with the Coroner and with the police investigators during the course of the investigation. In the course of the investigation the Coroner will, if necessary, direct investigators.

The Coroner, if warranted, should inspect the death scene shortly after death has occurred or prior to the commencement of the inquest hearing, or during it. If the State Coroner or one of the Deputy State Coroners is unable to attend a death in custody/police operations occurring in a country area, the State Coroner will request the local Coroner in the particular district, and the local Government Medical Officer attend the scene.

A high standard of investigation is expected in all coronial cases. All investigations into a death in custody/police operations are approached on the basis that the death may be a homicide. Suicide is never presumed.

In cases involving the police

When informed of a death involving the police service, as in the case of a death in police custody or a death in the course of police operations, the State Coroner or the Deputy State Coroners will request the Crown Solicitor of New South Wales to instruct independent Counsel to assist the Coroner with the investigations into the death. This course of action is considered necessary to ensure that justice is done and seen to be done.

In these situations Counsel (in consultation with the Coroner having jurisdiction) will give attention to the investigations being carried out, oversee the preparation of the brief of evidence, review the conduct of the investigation, confer with relatives of the deceased and witnesses and, in due course, appear at the mandatory inquest as Counsel assisting the Coroner. Counsel will ensure that all relevant evidence is brought to the attention of the Coroner and is appropriately tested so as to enable the Coroner to make a proper finding and appropriate recommendations.

Prior to the inquest hearing, conferences will often take place between the Coroner, Counsel assisting, legal representatives for any interested party, and relatives so as to ensure that all relevant issues have been addressed.

Apart from deaths in custody/police operations which occur in the Newcastle and Westmead Coronial districts (areas which are served by full-time pathologists), the remains of those who died in custody/police operations elsewhere in the State are transported by government contractor to the New South Wales Institute of Forensic Medicine at Glebe for post mortem examination by experienced forensic pathologists.

Responsibility of the coroner

Section 22 of the *Coroner's Act* provides:

the Coroner holding an inquest concerning the death of a person shall at its conclusion record in writing his findings as to whether the person died and if so:

- identity of deceased;
- the date and place of death; and
- the manner and cause of death.

Section 19 provides that:

1. if the Coroner is of the opinion that the evidence given at the inquest establishes a prima facie case against any known person for an indictable offence; and
2. the indictable offence is one in which the question whether the known person caused the death is in issue, the Coroner must terminate the inquest.

The inquest is terminated after taking evidence to establish the death, the identification of the deceased, and the date and place of death. The Coroner then forwards to the Director of Public Prosecutions a transcript of the evidence given at the inquest together with a statement signed by the Coroner and specifying the name of the known person and the particulars of the offence.

An inquest is an inquiry by a public official into the circumstances of a particular death. Coroners are concerned not only with how the deceased died but also with why.

Deaths in custody are personal tragedies and have attracted much public attention in recent years. A Coroner inquiring into a death in custody is required to investigate not only the cause and circumstances of the death, but also the quality of care, treatment and supervision of the deceased prior to death, and whether custodial officers observed all relevant policies and instructions (so far as regards a possible link with the death).

The role of the coronial inquiry has undergone an expansion in recent years. At one time its main task was to investigate whether a suicide might have been caused by ill-treatment or privation within the correctional centre. Now the Coroner will examine the system for improvements in management or physical surrounds which may reduce the risk of suicide in the future. In other

words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist and, if so, to ensuring, as far as possible, that remedial action is taken.

Recommendations

The common law practice of Coroners (and their juries) adding riders to their verdicts has now been given statutory authorisation in Section 22A of the *Coroners (Amendment) Act 1993*. This section indicated that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations (S.22A(2)).

Any recommendations made following an inquest hearing should arise from the facts under inquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. Coroners require, in due course, a reply from the person or body to whom a recommendation is made.

Acknowledgment of the receipt of the recommendations made by a Coroner is received from Ministers of the Crown and other authorities promptly. Some weeks are required for the inquest evidence and exhibits to be studied and consideration given to the recommendations made by the Coroner. A formal reply as to the outcome of those considerations is then received by the Coroner. Recommendations were made arising from five inquests held during 1997.

Contacts with outside agencies

During 1997 the State Coroner's office maintained effective contact with the New South Wales Institute of Forensic Medicine (Department of Health), the Division of Analytical Laboratories at Lidcombe (Department of Health), the Aboriginal Justice Advisory Committee (New South Wales Attorney General's Department) the Aboriginal Deaths in Custody Watch Committee, the Indigenous Social Justice Association, the Aboriginal Corporation Legal Service, the Aboriginal and Torres Strait Islander Commission, the Australian Institute of Criminology in Canberra, the Office of the State Commander New South Wales Police Service and the Department of Corrective Services. Close links were also maintained with Senior Coroners in all other states and territories.

Overview of deaths in custody/ police operations reported to the New South Wales State Coroner during 1997

All deaths pursuant to Section 13A of the *Coroners Act 1980*, must be investigated by the State Coroner or a Deputy State Coroner.

Deaths in custody/police operations which occurred in 1997

There were forty one cases of deaths in custody and fifteen cases of death as a result of or in the course of police operations reported to the State Coroner in 1997. Of these cases, eight deaths in custody and four police operations deaths were heard and determined with findings made. In an additional two police operations deaths, the inquest was terminated pursuant to the provisions of Section 19 of the *Coroners Act 1980*. The remainder have either been listed for hearing in 1998 or are still under investigation.

	1994	1995	1996	1997
Deaths in custody	31	23	26	41
Deaths in police operations	12	14	6	15
Total	43	37	32	56

Table 1: Deaths investigated by Coroners during 1994 to 1997

Aboriginal deaths which occurred in 1997

Of the fifty six deaths reported during 1997 pursuant to Section 13A, *Coroners Act 1980*, five of the deceased were adult aboriginal males, two aboriginal juvenile males and one an adult aboriginal female.

Four of the adult aboriginal males died in custody, one of those being on home detention, whilst the fifth died during a police operation. One of the juvenile males died in the course of a police operation and the other died whilst temporarily absent from a detention centre within the meaning of the *Children (Detention Centres) Act 1987*. The aboriginal female died in police custody (a proclaimed place).

An inquest into one of the juvenile deaths (police operation) has been terminated by me, a known person having been charged with an indictable offence related to the death. An inquest into the adult male death (police operation) has been held by me. Synopses of those deaths are contained in this report.

TERMINATED
See page 44
of this report
for report
(case 139/97)

See page 42 (case 86/97)
of this report for report
on this case.

	1994	1995	1996	1997
Deaths in custody	3	7	2	6
Deaths in police operations	0	0	0	2
Total	3	7	2	8

Table 2: Aboriginal deaths in custody during 1994 to 1997

The remaining deaths have either been listed for hearing or are being investigated at the time of writing this report.

Deaths investigated by the State/Deputy State Coroners during 1997

Sixty one cases of deaths in custody and twenty three police operation deaths required attention in 1997 (see Appendices). During the year inquests were held into twenty two deaths in custody and twelve police operation deaths. Findings were recorded as to identity, date and place of death, and manner and cause of death. In one death in custody and two police operations deaths, no findings as to the manner and cause of death were recorded. The inquest in each of these cases was terminated under the provisions of Section 19 of the Coroners Act 1980, on the basis that a known person had been charged with an indictable offence in which an issue will be that the known person caused the death.

Of the remaining forty seven cases, seven have been listed for hearing in 1998 and investigations are still proceeding in the remaining forty matters.

The following information relates to the thirty four deaths into which inquests were held and the three deaths in which the inquests were terminated.

Circumstances of death

Of the thirty seven deaths examined by me or my Deputies during 1997, twenty two persons died in the custody of the Department of Corrective Services. Of these, ten died of natural causes. Four died accidentally by ingestion of drugs. Five took their own life by hanging and, in one further case of hanging, I was unable to determine whether the death was accidental or a suicide. Two prisoners died by way of homicide.

One prisoner took his own life by hanging whilst in the custody of officers of the NSW Police Service.

Five persons died during the course of police (vehicle) pursuits. In two of these cases the inquest was terminated on the basis that a known person had

been charged with an indictable offence in which an issue will be that the known person caused the death. Two persons died from injuries received when the vehicle crashed and one person took his own life by shooting.

Nine persons died during other types of police operations. One died of natural causes, two were shot by a police officer acting in the course of duty, one was struck by a train whilst attempting to avoid lawful apprehension and five took their own life, four by shooting and one by stabbing during police operations.

Unavoidable delays in hearing cases

The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is unavoidable. There are many different reasons for delay. One 1994 death is still outstanding. The death is still being investigated as a homicide, and there is a possibility that a person will eventually be charged with causing the death.

One 1995 death is still outstanding. The inquest is part heard before the Senior Deputy State Coroner, John Abernethy who adjourned the matter generally for further investigation to be undertaken on his behalf.

Four deaths are still outstanding from 1996. Two of these deaths are still being investigated and two have been listed for hearing early in 1998.

The view taken by the State Coroner is that deaths in custody/police operations must be fully investigated. This will often involve a large number of witnesses being spoken to and statements being obtained.

It is settled coronial practice in New South Wales that the brief of evidence be as complete as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case. It has been found that an initially comprehensive investigation will lead to a substantial saving of court time in the conduct of the actual inquest.

In some cases there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services. The result of that investigation may have to be considered by the Coroner prior to the inquest as it could raise further matters for his consideration and perhaps investigation.

The post-mortem report provided to the Coroner by forensic pathologists attached to the New South Wales Institute of Forensic Medicine is presently taking up to twelve weeks to complete.

In some cases an expert medical or other opinion may be obtained. This will necessarily require the selected expert to read and assess the whole file before providing the Coroner with an independent report.

The concerns of the family and relatives of the deceased and possible other interested parties must also be fully addressed.

In the case of country deaths, delay can sometimes occur due to the unavailability of a suitable courtroom as the result of Supreme, District or Local Court commitments in a particular district.

Deaths occurring in police custody or during the course of police operations demand compliance by officers with the Police Commissioner's Instructions as they relate to such a death. The Crown Solicitor instructs independent Counsel to assist with the investigation of these types of deaths. The official police instructions are closely analysed by the Coroner.

Summaries of individual cases completed in 1997

Following are brief summaries of each of the 37 cases of death in custody/police operations which were heard by the State Coroner, Senior Deputy State Coroner and Deputy State Coroner in 1997. In addition, a summary of a death in custody which occurred on the 10 September 1996 and was omitted from the 1996 Report is included.

These summaries include a description of the circumstances surrounding the death, the Coroner's findings and any recommendations which were made.

Further information about any of these cases can be obtained from Glebe Coroner's Court.

1138/96* Male aged 38 years of age died on 10 September 1996 at Royal Brisbane Hospital, Brisbane Qld. Finding handed down on 6 December 1996 at Westmead by Derrick Hand, State Coroner.

The deceased was an inmate of the Grafton Correctional Centre. At about 7.05 am on 5 September 1996, an inmate heard a loud thud and found the deceased lying on a concrete path outside his unit. The deceased was taken to Grafton Hospital in a semi-conscious state and then to Royal Brisbane Hospital and died following surgery to relieve pressure on the brain. The cause of death was shown at autopsy to be due to "Craniocerebral injuries".

Finding

On 10 September 1996, [the deceased] died at Royal Brisbane Hospital, Brisbane, Queensland. Inquest Terminated, Section 19, *Coroners Act 1980*.

*This death was omitted from the 1996 Report. The death has not been included in statistical data for 1997.

1660/95 Male aged 29 years died on 24 August 1995 at Reception and Induction Centre, Malabar. Finding handed down 6 May 1997 at Glebe by John Abernethy, Senior Deputy State Coroner.

The brother and family of the deceased made serious allegations to the Senior Deputy State Coroner during a conference conducted in chambers at Glebe on 24 May 1996. They indicated that prison officers were involved in the assault of the prisoner and in the hanging of the prisoner. Whilst a suicide note was left, they would not identify it as having been written by the deceased.

The Coroner urged them to give full details to investigating police. He also urged them to seek legal representation. He assured them that his investigation and inquest would be impartial. The officer-in-charge of the investigation made many attempts to obtain full details of the allegation but the family declined to keep appointments with him. Without full details, the officer-in-charge of the case carefully investigated the matter.

The allegations of the family were initially supported by another prisoner who made a statement to police indicating that from his cell opposite he observed the deceased being beaten and then hung by prison officers. The investigation showed that the prisoner was not in the cell opposite on the day of the death, but two cells down on the same side of the wing. He thus would have been unable to see anything at all. Further, even if he was in the cell opposite, he was in no position to see the window of the deceased's cell (and thus the bars from which he was found hanging).

The prisoner later fully retracted his statement and indicated that he was promised money and drugs from a family member for giving the false statement. The initial retraction was made in a statement to police. The prisoner gave evidence, confirming the falsity of his initial allegations. The Coroner was satisfied with the evidence of the prisoner.

At the Inquest, the Coroner relied on the above aspect of the investigation and the evidence of the prisoner. He also relied on the forensic evidence of the examining pathologist who noted no injuries consistent with a violent assault. The forensic pathologist was satisfied that the deceased took his own life and gave cogent reasons for coming to that opinion. The Coroner relied on expert evidence to find that the note was in fact written by the deceased and had no hesitation in coming to a formal finding that the deceased hanged himself with the intention of taking his own life.

Family members did not attend a series of conferences scheduled by the Coroner, nor did they attend the Inquest.

The Senior Deputy State Coroner found that the deceased, a 29 year old caucasian male, was brought to the prison the day before his death from the Liverpool Court House Cells. He and his brother had been refused bail and remanded that day on a number of counts of "steal motor vehicle". The prisoner was thus received into the prison system on 23 August 1995 and took his own life during the evening of 24 August 1995. He was "one out" in Cell 61, 9 Wing, Reception and Induction Centre, Long Bay Complex of Prisons, Malabar.

When first received into the cells at Liverpool, the deceased indicated to a prison officer that he was suicidal and requested his shoe laces so that he could take his own life. The prison officer prepared and forwarded an "Inmate Gaol Lodgment Application". This noted that he was suicidal but gave no indication of the data relied on by the Prison Officer to form that opinion. The Coroner found the form to be deficient but noted that it had, at the time of inquest been replaced by a more appropriate form.

In due course, the prisoner was taken to the Reception and Induction Centre at Malabar. He was assessed the next morning by a welfare officer attached to the Department of Corrective Services. This officer did not have the "Inmate Gaol Lodgment Application" before her when making her assessment of the prisoner. The Coroner found that procedures at the time were deficient and that the form, even as written, may have assisted her with her assessment. The Welfare Officer indicated that had she had details of the suicidal inclination expressed to the receiving prison officer the day before, she would have discussed the case with the nurse assessor attached to the Corrections Health Service; she would also have questioned the prisoner more closely. The Coroner accepted her evidence that the prisoner, who she knew from previous admissions, presented as being non-suicidal.

The prisoner was also assessed by two registered nurses attached to the Corrections Health Service. He was initially assessed on the afternoon of his reception into the prison and by the psychiatric nurse the next morning - the morning of his death. Both nurses knew the prisoner from previous admissions. Both gave cogent reasons for forming the view that the prisoner was not suicidal. Because of the prior suicidal inclination, the prisoner was assessed as requiring psychiatric consultation. As a precaution, the second assessor read the assessment of the first assessor on completion of her own assessment, and found that it corresponded with her own. Both assessors had a copy of the "Inmate Gaol Lodgment Application" at their disposal.

The Coroner found that all three assessments were remarkably similar and accepted the evidence of the nurses and the welfare officer. He found that the prisoner actively hid his intention to take his life from the assessors. He also found clear reasons expressed in the note for his decision to take his life.

The Coroner was also satisfied that the assessors had recommended that the deceased be placed "two out" with his brother. The brother, however, became ill and was hospitalised on the night of the deceased's death, leaving the deceased "one out".

The Coroner was satisfied with evidence that improved procedures for the assessment of fresh prisoners had since been implemented at the Reception and Induction Centre. He therefore saw no reason to make a recommendation pursuant to Section 22A, *Coroners Act 1980*. Instead, he strongly suggested that the Department of Corrective Services examine its "Inmate Gaol Lodgment Application" form and the corresponding instructions to those Prison Officers charged with completing it. He was of the view that officers from the Department of Corrective Services and the Corrections Health Service, charged with assessing new inmates would greatly benefit from having access to the reasons relied on for an initial assessment such as "suicidal". Further, he suggested that the Department re-examine its present procedures to ensure that such forms, as a matter of course, go to those charged with conducting full reception medical, psychiatric and welfare assessments before such assessments occur.

Whilst he made some criticisms of the procedures which existed at the time of this death, the Coroner was satisfied that the deceased, an experienced prisoner, was committed to hiding his intention to take his life. He was satisfied that those assessing the prisoner carried out their assessments carefully and competently.

Finding

On 24 August 1995 [the deceased] died in Cell 61 of 9 Wing, Reception and Induction Centre, Long Bay Complex of Prisons, Malabar by hanging, with the intention of taking his own life.

99/96

Male aged 31 years died on 13 January 1996 at Long Bay Correctional Centre, Malabar. Finding handed down 26 June 1997 at Glebe by Derrick Hand, State Coroner.

The deceased was refused bail on 22 September 1995 after being charged with nine counts of robbery whilst armed and other offences. On that date he was received into the Remand Centre, Long Bay Correctional Centre. He was interviewed by a welfare officer and assessed by a nurse. He admitted to having attempted to take his life a week earlier by cutting his wrists but denied he still had suicidal thoughts. He was classified as a "suicide risk" but not "acutely suicidal" and was to be detained in a "two out" cell. His papers were also marked that the prisoner should see a psychiatrist.

The Medical Crisis team saw the deceased regularly up until his death and also on the day of his death. However, because of a breakdown in communication the prisoner did not see the prison psychiatrist, although it was thought that he had done so. In any event, he did not exhibit symptoms to the Crisis team of being "acutely suicidal". On the day of his death, he was seen by a psychiatrist in regard to medico-legal matters and the conclusion was that he was not "acutely suicidal".

For some time prior to his death, the deceased was harassed extensively by three or four other prisoners. Harassment included some minor assaults. He did not inform the prison officers until two days before his death and refused to make a written complaint for fear of reprisals from other prisoners. On the day before his death (12 January), he obtained a "sick in cell" certificate (as he had on some prior occasions) and was allowed to remain in his locked cell. On 13 January 1997, he was also allowed to remain in his locked cell on the same certificate. At about 3.10pm his cell was unlocked by a prison officer who found him hanging from strips of his own sheet. Protocol was followed and he was certified deceased.

On the days leading up to his death and on 13 January, nothing unusual was noticed by prison officers with regard to his behaviour. He was generally a quiet person and a bit of a "loner". Each prisoner is allocated a prison officer as a "case manager". The deceased's case manager was on extended leave

because of illness and it was not the practice for another officer to be allocated that role in those circumstances, although clearly someone should have been so allocated. Consequently, no other officer was aware that the prisoner's file had been marked "suicide risk" and that the prisoner should accordingly have been kept in a "two out" cell.

The State Coroner was very critical of the breakdown in the system of case management in the remand centre for two reasons. Firstly, the case manager would or should have been aware that the prisoner, having been harassed by other prisoners, was potentially a "suicide risk" and accordingly taken further action for his safety. Secondly, knowing this information, the case manager should or would not have allowed the deceased to be locked in a cell on his own.

The State Coroner commended the Prison Officers for giving their evidence in a forthright manner and accepting the fact that they were responsible for the system breaking down, but at the same time was very critical of their management of the deceased.

As a result of this death, the system of case management by prison officers has been overhauled and tightened to ensure that there is a Supervising Case Manager who takes over a prisoner's management whenever the appointed Case Manager is absent. The Corrections Health Service has also taken action to ensure that when a prisoner is referred to a psychiatrist, a system is in place to check that the psychiatrist has seen the prisoner. In light of the above actions, the State Coroner did not see a need for any recommendations to be made in this case.

Finding

On the 13 January 1996 [the deceased] in Cell 13, Wing 13, Remand Centre, Long Bay Correctional Centre, Malabar hanged himself with the intention of taking his own life.

675/96

Male aged 27 years died on or about 8 April 1996 at Lifestyles Unit, Special Care Centre, Long Bay Complex of Prisons, Malabar. Finding handed down on 8 April 1997 at Glebe by John Abernethy, Senior Deputy State Coroner.

This sentenced prisoner died on or about 8 April 1996 of opiate intoxication. He was HIV positive. He was housed in the Special Care Centre and undertaking a program in the Lifestyles Unit of that centre. The Coroner was satisfied that he was looking forward to his release. The Coroner was also satisfied that his death was accidental.

The family of the deceased did not believe that he was using prohibited drugs whilst in prison and therefore felt that he may have undergone "forced" ingestion by others. The Coroner carefully considered the evidence of the forensic pathologist, investigating police, particularly the "crime scene" officer.

The bile level of morphine was at >40mg/l and therefore indicated recent prior usage by the prisoner. There was no indication that the death was other than accidental and the Coroner found accordingly.

After hearing the evidence, the family accepted that the death was accidental.

The Coroner carefully considered the systems in place in the Unit at that time and came to the view that such systems were adequate. He was unable to ascertain how the deceased came to obtain the heroin which caused his death.

He heard evidence from the Governor of the Centre, a number of prison officers, a prisoner and several persons who visited the deceased just before his death. Whilst it is possible that the deceased was given the drug which led to his death by a visitor, the Coroner was of the opinion that it was equally possible that he received it from another prisoner.

The Senior Deputy State Coroner, in concluding his inquest, felt it timely to remind those responsible for the housing of prisoners to continue to be most vigilant in combating contraband, especially prohibited drugs, in prisons.

Finding

On or about 8 April 1996, [the deceased] died in Cell 3, Lifestyles Unit, Special Care Centre, Long Bay Complex of Prisons, Malabar, of opiate intoxication, another condition contributing to the death but not relating to the condition causing it being Human Immunodeficiency Virus Infection. I further find that such opiates were self administered, but not with the intention of taking his own life

503/96

Male aged 53 years died on 8 May 1996 at Liverpool Hospital, Liverpool. Finding handed down on 1 December 1997 at the Downing Centre, Sydney, by Janet Stevenson, Deputy State Coroner.

On 6 May 1996, the deceased (who resided with his spouse) received a letter from her solicitor advising that she wanted a divorce. The deceased called his family together that night and indicated that he was not going to divorce his wife as he did not believe in divorce. Early the next morning an altercation occurred between the parties and a rifle was produced. The deceased's spouse ran from the house but was fatally wounded by the deceased. The deceased returned to his house and neighbours called the police.

When police arrived, the deceased remained in the house and a "command post" was set up near the premises. Police telephoned the house but calls were unanswered. A daughter of the deceased arrived at the scene and asked to be allowed to either attend the premises or talk to her father. This was not permitted. A loud hailer was used to call to the deceased but he did not respond. Shortly after, a shot was heard from the house. Police entered the house, found the occupant shot and transported him to hospital where he later died.

The daughter of the deceased who attended at her parents home on the 7 May 1996 expressed the belief that if she had been permitted by police to speak to her father he would not have taken his own life. Further she was concerned that when she first attended Liverpool Hospital, police prevented her from seeing her father.

Documents supplied prior to the Inquest titled "Third Party Intervention" and a report from Dr R Milton, Psychiatrist, indicate worldwide acceptance of not using/permitting non trained negotiators, especially family, to negotiate except in unusual circumstances.

Nothing emerged during the Inquest to suggest police had acted contrary to accepted practice. As to the initial reluctance by police for family members to attend the bedside of the deceased, this stemmed from him being "in custody", reliance on police procedures, concerns by the hospital for other patients who were at that time in the Intensive Care Unit. When it was ascertained the family would not attempt to harm the deceased, or disrupt other patients, family members were permitted access to the deceased.

Finding

On 8 May 1996 [the deceased] died at Liverpool Hospital, Liverpool, of a self inflicted gunshot wound to the abdomen.

1083/96

Male aged 30 years died on 11 June 1996 at Remand Centre, Long Bay Complex, Malabar. Finding handed down on 9 May 1997 at Glebe by John Abernethy, Senior Deputy State Coroner.

The deceased, a 30 year old prisoner was being housed "one out" in Cell 37, Wing 12, Remand Centre, Long Bay Complex, Malabar. He had earlier been housed at the Goulburn Correctional Centre, but was transferred to the Remand Centre as a high security risk. He was serving a sentence of 23 years, with an earliest release date of 29 February 2004. Prior to his death he had enjoyed reasonable health. He was not a known regular drug user.

The Senior Deputy State Coroner, however, accepted evidence that he was a user of heroin whilst in prison.

The deceased died of morphine intoxication. He was found by a prisoner, dead in his cell at "breakfast knock up" at 7am on 12 June 1996. The evidence disclosed that he was last seen alive at 8.30 pm on 11 June 1996 during a cell check by prison officers at "lock up". The Coroner was satisfied that he died before midnight on 11 June 1996.

The evidence clearly suggested that the deceased decided to inject himself with heroin using a syringe and a black coloured cord as a tourniquet. There was nothing to suggest that the deceased took his own life, or to suggest that he was given a "hot shot".

The Coroner relied heavily on the forensic evidence of the pathologist and physical evidence police. Toxicology showed a high level of morphine in the blood consistent with an accidental overdose. Further, the bile level at .35 mg/l was consistent with recent prior usage of the drug. This in turn was totally consistent with the two venipuncture marks found, one very recent and the other one to two days old. Another prisoner who was a close friend of the deceased agreed that the deceased was a "careful" user of heroin whilst in prison. No witness knew of any fears held by the deceased, or any reason why some person might want to kill him. The Coroner accepted evidence that the deceased related well to other prisoners and had no problems with prison authorities.

The police investigation, as is common, was unable to ascertain how the deceased came to receive heroin whilst in prison. Prison authorities gave evidence as to procedures in force to attempt to locate contraband, including heroin.

The Senior Deputy State Coroner indicated that he continued to be concerned at the apparent ease with which prisoners are able to obtain heroin and the implements for its administration. He stressed, however, that he had no evidence before him to indicate that prison authorities had not been diligent in their continued attempts to minimise the use of such drugs in prison.

Finding

On 11 June 1996 [the deceased] died in Cell 37 Wing 12, Remand Centre, Long Bay Complex of Prisons, Malabar of morphine intoxication, self administered but not with the intention of taking his own life.

2268/96

Male aged 27 years died on or about 12 June 1996 at Lithgow Correctional Centre, Lithgow. Finding handed down on 14 May 1997 at Lithgow by John Abernethy, Senior Deputy State Coroner.

Despite the inquest being terminated pursuant to Section 19, *Coroners Act 1980*, the Senior Deputy State Coroner considered the appropriateness of the actions of all those involved in the custody of the inmate at or about the time of his death.

He found that the alertness of one prison officer in noting the deceased to be "laughing and joking" at 7 pm and injured to the face at about 7.45 pm to be of great assistance in his consideration of the criminal issues arising in the case. Further, he found that prison officers acted most appropriately in discussing those injuries with the prisoner and then arranging for his examination by a registered nurse.

He found that the registered nurse also conducted a careful examination and that her assessment of the condition of the prisoner was reasonable in all the circumstances.

The Coroner found that one prison officer, on finding the deceased dead in his cell at "let go", should have locked the cell. He noted however, that this did not in any way affect this particular death in custody. He also acknowledged that that officer acted correctly in immediately returning all "let go" prisoners to their cells, thus ensuring preservation of the crime scene.

The deceased was allegedly punched by another prisoner on the night of 11 June, 1996 in C2 Unit, Lithgow Correctional Centre. After hearing evidence, the Senior Deputy State Coroner terminated the inquest pursuant to Section 19, *Coroners Act 1980*. He forwarded a transcript of the evidence and exhibits tendered in the case to the Director of Public Prosecutions.

Finding

On or about 12 June 1996 [the deceased] died in Cell 142, C2 Unit, Lithgow Correctional Centre. Inquest terminated, Section 19, *Coroners Act 1980*.

1310/96

Male aged 62 years died on 6 July 1996 at Morton Street, Queanbeyan. Finding handed down on 19 March 1997 at Queanbeyan by Derrick Hand, State Coroner.

The deceased was living in a block of units. He became agitated when two young intoxicated males were skylarking and making a lot of noise outside on the stairway. He came out of his unit in a highly agitated state shouting at them and holding a large knife and a small axe in his hands. At 8.43pm the police were called and when they arrived, the deceased was still holding the weapons and advancing towards the police officers. They called on him to drop the weapons, at the same time manoeuvring him into a corner of the stairs. After a number of calls by the police, the deceased dropped the weapons and was immediately handcuffed by the police and placed in the back of a police van.

After being placed in the van the deceased began having trouble breathing. Police officers immediately removed him from the van, took off the handcuffs and placed him in a recovery position on the roadway. He was gasping and gurgling and had a faint pulse, so the police officers (in accordance with police protocol) did not administer CPR. The ambulance was called at 8.57pm and arrived at 9.02pm. Despite the efforts of the ambulance officers the deceased failed to recover and a doctor who arrived on the scene pronounced him dead. That doctor was in fact the deceased's general doctor. He gave evidence at the Inquest that the deceased had a serious heart condition and becoming agitated as he had would have aggravated the condition to the point where he could have collapsed walking down the street. The doctor described the deceased as living on an edge.

Civilian witnesses corroborated the police version of events and stated that the police officers at all times treated the deceased in a proper manner, doing all they could to defuse the situation and later care for the deceased. The State Coroner was of the opinion that the police officers acted properly and handled the matter in a very professional manner.

Finding

On 6 July 1996 [the deceased] died in Morton Street, Queanbeyan, from a natural cause, namely, an acute myocardial infarction.

821/96

Male aged 49 years died on 15 July 1996 at Parramatta Correctional Centre, Parramatta. Finding handed down on 4 August 1997 at Westmead by John Abernethy, Senior Deputy State Coroner.

The deceased was a recently sentenced prisoner. He was sentenced on 5 July, 1996 and taken to Parramatta Correctional Centre. He underwent the usual reception assessments by both the Department of Corrective Services and the Corrections Health Service. He did not complain to his assessors of any medical condition. He was not, therefore, seen by a medical practitioner on reception into the prison system.

The deceased was sharing a cell with his friend and partner in crime. He left his cell at about 9.30 am on 15 July 1996 to make a telephone call. His cell-mate noted that he was breathing more heavily than usual, but said that he was "OK". He collapsed in a quadrangle of the prison. He informed a prison officer who went to his aid that he had felt dizzy and had fallen. He told his cell-mate "I just tripped on the stairs." He sustained a graze to his head and did not have chest pain. He was lying on his side, conscious, clammy, with weak pulse. Oxygen was quickly administered by nursing staff. His condition deteriorated and CPR was attempted by prison officers, nursing staff and, later, ambulance officers. CPR ceased at 10.20am and he was pronounced dead at 11.07am.

The Senior Deputy State Coroner found that the prisoner died of massive pulmonary thrombo-embolism due to deep venous thrombosis, a natural cause. The cause of death was not in dispute.

The Coroner also found that those who attended the deceased on his collapse did all that they reasonably could to save his life.

The deceased had indicated to his wife on the Wednesday before his death, that he had pulled a muscle in his leg. He complained to his cell-mate of gout and a "sore foot". His cell-mate urged him to go to the clinic. He was reluctant to do so but did on Saturday 13th July 1996. He described gout in his hand to the registered nurse on duty and she prescribed Indocid for the gout and another medication for constipation. The following day he again attended the clinic where another nurse gave him more Indocid, this time for gout in his foot. He made no other complaint to the nurses and certainly did not describe symptoms consistent with a pulmonary embolism.

The nurses, on each occasion were unable to make contact with the "on call" medical practitioner, despite a number of attempts, so gave the prisoner the Indocid which is a restricted substance, without reference to a medical practitioner. He was booked to see a medical practitioner on the day he died.

The Senior Deputy State Coroner found that the nurses failed to comply with Corrections Health Service Standing Orders in giving the prisoner the medication without making contact with a medical practitioner, but after hearing the evidence of the reviewing specialist physician, found that there was no causal link between the medication and the condition which caused the prisoner's death. In fact, he found that the Indocid may have slightly lessened the chance of death.

The issue of medication being given to the prisoner without the authority of a medical practitioner, and the related issue of a medical practitioner not being contacted/contactable by staff, was addressed by the Coroner, who was satisfied that there was and is an adequate protocol in place within the Corrections Health Service. He also noted that all staff have been reminded of the need to comply with that protocol. He was of the view that the nurses involved, having been counselled by the Corrections Health Service, should face no further criticism.

The Coroner concluded that the deceased, an articulate prisoner, had not complained to any person about symptoms consistent with the condition which caused his death. To the contrary, he presented to the nurses with symptoms of another condition which was duly treated.

The widow of the deceased gave evidence and was of the view that the prisoner should have been examined by a medical practitioner on entry into the prison system. The Senior Deputy State Coroner noted that the existing assessment system involves assessment by a registered nurse who, in the "triage" fashion, will arrange for examination by a medical practitioner in all cases where the need may arise. He saw no need to recommend change at this stage.

Finding

On 15 July 1996 [the deceased] died in the Parramatta Correctional Centre, Parramatta, of a natural cause - massive pulmonary thrombo-embolism due to deep venous thrombosis.

1048/97

Male aged 48 years died on 29 July 1996 at Prince of Wales Hospital, Randwick. Finding handed down on 18 November 1997 and 19 November 1997 at Lithgow by Janet Stevenson, Deputy State Coroner

On 15 April 1996, the deceased was working out in the prison gymnasium. A number of other inmates were using the equipment at the time. Two prison officers were supervising inmates from an office which is above the gymnasium. Two inmates, one with a removable bar from a "Nautilus" type gym, and another with a pin from weight stacks attacked the deceased, causing an injury to the head. A third prisoner may have assisted as "lookout".

Finding

On 29 July 1996 (the deceased) died at Prince of Wales Hospital, Randwick. Inquest terminated, Section 19, *Coroners Act 1980*.

Recommendations

1. That the Department of Corrective Services install surveillance cameras in the gymnasium and boxing areas of Lithgow Correctional Centre and that such installations be considered for other Correctional Centres.
2. That the modifications made to the gymnasium equipment undertaken at Lithgow Correctional Centre following this incident be considered for other Correctional Centres.

1578/96

Male aged 41 years died on 8 August 1996 at Reception and Induction Centre, Long Bay Complex of Prisons, Malabar. Finding handed down 21 January 1997 by John Abernethy, Senior Deputy State Coroner.

The prisoner died in the early hours of 8 August 1996. He died of ischaemic heart disease, a natural cause. Death occurred prior to 6.30am.

The mother of the deceased was concerned that she had not been notified that the deceased underwent major surgery several years earlier, until well after the procedure had been carried out. The Senior Deputy State Coroner was of the view that the issue of doctor/patient confidentiality meant that it was for the patient to inform his next of kin, should he choose to do so.

The prisoner had complained of chest pains the afternoon prior to his death and was seen by the nursing unit manager and another registered nurse. Both nurses formed the view that he may be suffering from reflux and gave appropriate medication. The registered nurse again spoke to the deceased later that night and was informed that the pain had lessened. Arrangements were made for the prisoner to see a medical practitioner the next morning.

The Coroner requested the forensic pathologist to review the nursing notes. He was of the view that the nurses acted appropriately in all the circumstances. The Coroner accepted that opinion.

Of concern to the Senior Deputy State Coroner, was the fact that the "break-fast let go" had not been carried out according to instructions to prison officers. It was clear that the prisoner had died by the time of "let go" but no attempt was made to elicit a verbal response from him, or on failure to obtain such a response to rouse the prisoner.

The Coroner noted that the Department's own investigation had focused on this deficiency and so stopped short of making a further recommendation. He did, however, remind the Department of the importance of its officers correctly following "let go" procedures.

Finding

On 8 August 1996 [the deceased] died at Reception and Induction Centre Long Bay Complex of Prisons, Malabar, of ischaemic heart disease.

1585/96

Male aged 68 years died on 8 August 1996 at Junee Correctional Centre, Junee. Finding handed down on 11 April 1997 at Wagga Wagga by John Abernethy, Senior Deputy State Coroner.

The deceased was a 68 year old sentenced prisoner. He was due for release, subject to parole on 24 March 1997. He was a minimum security prisoner, under strict protection because of the nature of his criminality. The deceased was transferred from Maitland to Junee Correctional Centre, arriving on 6 April, 1996.

The Senior Deputy State Coroner found that the deceased had been a “model” prisoner, who kept largely to himself but had good relationships with both prisoners and prison officers. There was regular dialogue between the deceased and his case management officers and his few requests were granted by prison authorities.

The deceased’s general health was poor. He suffered his first heart attack in January 1986 and his second in July 1992. The Coroner received evidence as to his poor ventricular function and mitral regurgitation secondary to his myocardial infarctions. He also received evidence as to a coronary artery bypass in June 1994 and then heart failure that October. His doctors indicated to the sentencing judge that he would require a special diet.

The Senior Deputy State Coroner heard evidence from the medical officer who attends the Junee facility. He confirmed the deceased’s poor health and that, other than by way of medication and diet, little could be done for him. The Coroner was satisfied that the medical treatment the deceased was receiving in prison was adequate. He was offered a special diet but declined the offer.

The deceased collapsed on the morning of 8 August 1996 in an exercise yard in the prison. The Senior Deputy State Coroner found that prisoners, nurses, ambulance officers and the medical officer who attended him behaved entirely appropriately. The alarm was immediately raised by prisoners and assistance arrived within minutes. The Coroner accepted evidence from the medical practitioner, that the resuscitation efforts of both nurses and ambulance officers were of the highest standard.

The Coroner found that prison officers acted appropriately in quickly securing the area. He also noted the high standard of the police investigation, and that the family of the prisoner had no concerns about the death. The Coroner formally commended those who attempted to revive the prisoner.

Whilst the Coroner was satisfied as to identification, he noted that police were

not permitted to attend at the NSW Institute of Forensic Medicine, Glebe in order to identify the body to the mortuary assistant. He was told that financial constraints prevented that. He also noted that the body bag was unsealed and indicated that it was the responsibility of police to ensure that body bags are sealed prior to removal. The Coroner indicated that he felt that police ought to attend at autopsy in certain types of deaths including homicides and "Section 13A" deaths such as this one.

The Coroner also noted that the body was not transported to Sydney in a refrigerated vehicle. He heard evidence from the contracting undertaker that refrigerated vehicles are now utilised in all cases.

The Senior Deputy State Coroner heard evidence from the ranking physical evidence police officer for the region and accepted that there may be no standardised body tags; no standardised instruction as to what is to be written on such tags; and no standardised seals for body bags. He also felt that the bags themselves could be improved.

The Senior Deputy State Coroner was of the view that, just as it was important that he clearly criticise where criticism is warranted, he should equally clearly indicate when those involved in matters such as this carry out their duties properly and with maturity as in this case. He made a number of constructive "machinery" recommendations.

Finding

On 8 August 1996 (the deceased) died at the Junee Correctional Centre, Junee of ischaemic heart disease.

Recommendations

That the NSW Police Service considers:

1. Standardising body tags throughout the State;
2. Ensuring that all physical evidence kits issued to physical evidence police contain standardised tags;
3. Standardising relevant data to be written on such tags;
4. Improving standard issue body bags by placing eyelets adjacent to the zipper ending so that a seal can more easily be placed through such eyelets and then through the eyelet in the zipper, and that handles be placed on such bags; and
5. Numbering the seal and cross referencing this "numbered seal" on the body tag.

Male aged 22 years died on or about 19 August 1996 at Metropolitan Remand Centre, Malabar. Finding handed down on 18 November 1997 at Glebe by John Abernethy, Senior Deputy State Coroner.

The deceased was an inmate of the Remand Centre, Long Bay Complex of Prisons, Malabar. He entered the prison system on 22 April 1996 and was housed in the Remand Centre whilst awaiting court proceedings for armed robbery. He was found dead in his cell at "let go" by prison officers on the morning of 19 August 1996. He was "two out" in his cell.

The deceased was 22 years of age. He spent the day of or before his death with his fiancée, who visited him in prison. According to his fiancée, prison officers and his cell mate he was in good spirits. The Senior Deputy State Coroner was satisfied that the deceased did not intentionally take his own life.

The Senior Deputy State Coroner was satisfied that the deceased died accidentally during the night of 18-19 August, 1996, after ingesting heroin. A syringe was located in the cell and he was seen to inject himself by his cell mate. As is usually the case, the Senior Deputy State Coroner was unable to ascertain how the deceased came to possess the heroin or syringe. He accepted, though, that the drug is not difficult for prisoners to obtain.

The Coroner found that the deceased had a virulent drug habit. He admitted to his cell-mate before taking his last dose that he had not long before taken a dose of the drug. He admitted similar behaviour to his brother on an earlier occasion. The bile level of morphine indicated recent use of the drug before the fatal dose. The relatively high blood level may have been consistent with two doses in reasonably quick succession.

The Senior Deputy State Coroner noted that the officer-in-charge of the case, the forensic pathologist who conducted the autopsy, and the crime scene specialist could not point to any sign of foul play. All were well satisfied that death was accidental.

The family of the deceased were satisfied that the matter had been carefully and thoroughly investigated by police on behalf of the Coroner.

The Senior Deputy State Coroner was satisfied, on hearing evidence from the Governor of the Prison that the facility was being satisfactorily run.

Finding

On or about 19 August 1996 [the deceased] died in Cell 34, 12 Wing, Metropolitan Remand Centre, Long Bay Complex of Prisons, Malabar, of morphine toxicity, another significant condition contributing to the death but not relating to the condition causing it being coronary artery atheroma.

2359/96

Male aged 75 years died on 28 August 1996 at Cessnock Correctional Centre, Cessnock. Finding handed down on 12 March 1997 at Raymond Terrace by Derrick Hand, State Coroner.

The deceased had been sentenced to two years imprisonment for assault occasioning actual bodily harm from 4 November 1994, and was transferred to Cessnock Correctional Centre on 22 December 1994. He had a heart condition for which he was receiving medication. His blood pressure was monitored weekly. He had received treatment from the prison doctor for an unrelated medical condition on 27 August 1996. Around 7.30pm on 28 August 1996, the deceased was speaking to his wife on the prison telephone. After completing the call, other inmates saw him fall to the ground. Officers were called immediately and CPR was administered by a nurse. Ambulance officers arrived at 7.40pm and continued CPR as well as electric shock treatment. There was no response and he was pronounced dead at 8.05pm.

The deceased had complained to his wife of dizziness the week before and had been treated by the prison doctor. He did not complain to his wife during the telephone call of any problems. Evidence was given by the prison doctor and the forensic pathologist at the Inquest regarding the deceased's long standing heart condition and the fact that such a condition could cause sudden death without symptoms of pain etc. being evidenced beforehand.

The State Coroner was satisfied that the deceased had been properly treated whilst in prison and that no criticism could be made of the prison officers or the medical staff at the prison.

Finding

On 28 August 1996, [the deceased] died in Wing 3, Cessnock Correctional Centre, of a natural cause, namely acute myocardial ischaemia due to coronary atherosclerosis.

1085/96

Male aged 16 years died on 9 September 1996 at Arundle Road, Horsley Park Finding handed down on 22 and 23 July 1997 by John Abernethy, Senior Deputy State Coroner.

The deceased was an inexperienced, unlicensed driver. On the early morning of 9 September 1996, police were patrolling in a Nissan Patrol 4WD truck. The driver, a probationary constable, held a "bronze" certificate whilst the observer, a constable, held a "silver" certificate. The vehicle was classed as "Category 4", meaning the driver can not engage in a pursuit of any kind and that the vehicle is not to be used in a pursuit.

At the time, the deceased was driving a stolen motor vehicle. A friend was driving another stolen vehicle. The vehicle being driven by the deceased had been stolen several days earlier whilst the vehicle being driven by the friend had been stolen from the Marconi Club car park, Bossley Park, the night before.

The vehicles were observed about 1am entering The Horsley Drive just west of Cowpasture Road. They entered from an industrial area, close together and at some speed. The tail lights of the deceased's vehicle (second vehicle) were not illuminated and neither was one headlight. Police followed them and came upon them stationary on The Horsley Drive just past the intersection of Wallgrove Road. Police stopped behind them and activated the revolving lights of the police vehicle. The observer carried out a "stolen vehicle inquiry" on the deceased's vehicle via police radio. The inquiry revealed that the vehicle of the deceased was stolen, but this fact was not immediately confirmed.

As the observer was exiting the police vehicle to speak to the deceased, both cars drove west quite quickly. The first vehicle turned left into Horsley Road whilst the vehicle being driven by the deceased turned right into Arundle Road. Police followed the vehicle of the deceased. The Coroner found that the police vehicle did not exceed 90 kph and probably reached no greater speed than 80 kph. The vehicle of the deceased was estimated as travelling at 110-120 kph on Arundle Road.

The deceased lost control of his vehicle which hit a culvert and then a telegraph pole. It caught fire immediately. Because of the flames, police were unable to assist the deceased who died of incineration, smoke inhalation and head injury. The head injury was probably non-survivable. The deceased was trapped in the wreckage of the vehicle and could not have been removed by police even if the vehicle had not caught fire.

Neither police officer at any time believed that police were engaged in a pursuit. They believed that they were merely following the vehicle.

The distance between commencement of the pursuit and the crash was 1.6 km and the whole event took only about two minutes.

The Senior Deputy State Coroner heard an audio tape of the radio transmissions between police and VKG. The radio operator did not believe that a police operation was being undertaken and did not notify the Duty Operations Inspector. The radio conversations provided valuable evidence at inquest. In essence, they showed that the speed of the police vehicle was given by the police observer; that the observer remained at the radio after the crash giving and receiving relevant information; and that police continued to follow the deceased's vehicle whilst awaiting confirmation that his vehicle was stolen. The officers were unable to locate the vehicle's fire extinguisher which was loose on the floor of the vehicle behind the rear seats, instead of being in a bracket specially provided for it. The fire was eventually extinguished by a tanker of the NSW Fire Brigades.

Police investigating the matter on behalf of the Coroner correctly identified several issues. Firstly, they were of the opinion that this was in fact a police pursuit, rather than a drive to "catch up" the vehicle of the deceased. Secondly, the driver was not, pursuant to instructions, permitted to engage in a pursuit. Thirdly, the vehicle being used by police was of a type not permitted to be used as a pursuit vehicle. Fourthly, police had not complied with

Commissioner's Instruction 106.04 in physically checking that the fire extinguisher was in place and ready to use.

The Senior Deputy State Coroner agreed with the opinion of investigating police. The Coroner accepted their view that, in following the car, police were engaged in pursuit because they had identified themselves as police by activating the revolving lights, and because they had wanted to speak to the driver, even though no attempt was ever made to catch him or apprehend him.

Accordingly, he accepted the general submission that the operation amounted to a most technical example of a police pursuit. He also found that the behaviour of police had no bearing on the death of the deceased, who would have still driven at speed had the police vehicle remained stationary. He accepted also that the police officers themselves had suffered considerable trauma and that a careful de-briefing by a Senior Commissioned Officer would be an appropriate way of finalising the matter of police involvement.

Finding

On 9 September 1996 [the deceased] died at Horsley Park, of incineration, smoke inhalation and head injury sustained when the motor vehicle he was driving left the carriageway of Arundle Road, hit a telegraph pole and caught fire whilst being pursued by officers of the New South Wales Police Service.

Recommendations

1. The NSW Police Service should give urgent consideration to re-wording the definition of "pursuit" so that it makes better grammatical sense and can be more clearly understood; that the amended definition be carried to the appropriate meeting of all Australian Police Services with a motion that it replace the present definition.
2. The NSW Police Service should take steps to educate all police on:
 - a) the objective circumstances which may constitute a pursuit; and
 - b) the inherent dangers of a pursuit to police, the community and the person pursued.
3. All police should be reminded of the provisions of Police Commissioner's Instruction 106.02 "Cleanliness and on-road maintenance", with particular emphasis to the tasks to be undertaken on commencing and finishing duty.
4. Consideration should be given to the adequate training of all police in the best use of fire extinguishers.
5. Consideration should be given by the NSW Police Service to the creation of one comprehensive set of guidelines or instructions dealing with all aspects of safe driving including pursuits and urgent duty driving.

Male aged 65 years died on 15 September 1996 at Kirkconnell Correctional Centre, Bathurst. Finding handed down on 9 October by John Abernethy, Senior Deputy State Coroner.

The deceased was sentenced at the Sydney District Court on 15 March 1996 to 9 months hard labour (minimum term) with an additional term of 3 months. He was sent to Cooma Correctional Centre, but later transferred to Kirkconnell Correctional Centre on 31 July 1996. He was due for release on 14 December 1996. His classification was C2. He was in strict protection.

Around 1.30 pm on 15 September, the deceased was seen "power walking" around the facility, as was his usual practice. A short time later, he returned to the common room of his unit and spoke with fellow inmates. He then went to the ablutions block within the unit where he was discovered approximately 20 minutes later by an inmate. At the time he was located, the deceased was in the locked toilet cubicle with his head face down on the floor, slightly under the cubicle wall. His legs were under the other side of the cubicle wall near the urinal.

Prison authorities were notified and attended. He was moved into a position where staff could administer first aid, but no pulse could be found. A registered nurse from the centre's medical unit attended, as did ambulance officers. He was pronounced dead at 3.20 pm.

A post mortem examination was conducted by a forensic pathologist at the NSW Institute of Forensic Medicine, Glebe. He found the cause of death to be severe coronary artery disease, causing insufficient blood to reach the heart muscle. This condition was further aggravated by the presence of mitral and aortic valve disease. Minor injuries to the body, including a bloody nose, were consistent with the collapse of the deceased.

Prison protocols covering resuscitation and security of the area were observed. Crime scene and detectives attended and carefully inspected the area of death.

A careful, competent and comprehensive investigation was conducted by police who found no evidence of suspicious circumstances. To the contrary, investigating police found the deceased to be a quiet man who kept to himself. He was liked by both prisoners and staff and simply wanted to serve his sentence and get on with his life. The investigation also disclosed that the deceased was, at the time of his death, receiving appropriate medication. He had had chest x-rays and an electro-cardiogram prior to his transfer to Kirkconnell, but no abnormality was detected. He attended the facility's clinic regularly for medication but made no complaints of chest pain, shortness of breath or other symptoms of heart disease. His family doctor indicated to investigators that he last saw the deceased in relation to his heart disease on 1 November 1993. He had undergone a comprehensive series of tests at that time and was found to have signs of acute coronary insufficiency. He was seen by a cardiologist who advised no treatment at that time.

The family of the deceased raised no issues to either investigating police or

the Coroner. The Senior Deputy State Coroner was satisfied that the prisoner died of natural causes and that he was being adequately treated for any physical problems he may have had prior to his death.

Finding

On 15 September 1996, [the deceased] died at Unit 3, Kirkconnell Correctional Centre, via Bathurst, of a natural cause, namely ischaemic heart disease due to combined effects of calcific coronary atherosclerosis and calcific aortic and mitral valve disease, a significant condition contributing to the death, but not relating to the condition causing it, was generalised atherosclerosis.

2026/96

Male aged 25 years died on 20 September 1996 at John Hunter Hospital, Newcastle. Finding handed down on 6 March 1997 at Newcastle by Derrick Hand, State Coroner.

Around 9am on 20 September 1996, Drug Enforcement Agency Police Officers involved in an undercover drug operation code named "Abingdon" attended premises at 15 Hubbard Street, Islington to arrest a male person involved in the supply of marijuana. At the same time, other police were on their way to the deceased's property at Merriwa in an endeavour to locate drug crops. At Islington, plain clothes police officers announced their presence to the house occupants and entered. Two officers were confronted by the deceased holding a shortened shotgun at his waist.

The deceased cocked the shotgun and aimed it at Detective Senior Constable B, who took evasive action while firing his service revolver. Another officer, Senior Constable H, also fired his service revolver. B fired 6 shots whilst H fired five shots. The deceased was hit, staggered back into the bedroom from which he had earlier emerged and dropped the shotgun onto the floor. He then staggered around the bedroom and came back to the doorway where he collapsed face down. The shooting occurred from a distance of 2 to 3 metres.

Detective B then went to the deceased to check his condition, saw that he was still breathing and called for an ambulance to be contacted. This was done by two other detectives, one of whom had a mobile phone. As Detective B went to the aid of the deceased, another male person was seen by other police officers to run from a hallway on the opposite side of the living room and into a bedroom at the front of the house.

Police called to this person to come out but there was no reply. Police outside the premises were informed that the person was possibly armed. The police inside the house then attempted to form a barricade between themselves and the front room using lounges. Another officer then went into the living room and dragged the deceased into the hallway where it was thought he could be safely treated by ambulance officers. A female was also taken from the living room.

Whilst this was occurring the second male attempted to leave via the front window of the premises and was arrested. There was some confusion at this point as to whether police inside the premises were aware of the arrest or if they still feared other persons might still be in the premises. A few minutes later police entered the front bedroom and declared the premises safe. The Ambulance received the 000 call at 9.19am and arrived at the scene about 9.22am. They connected their equipment to the deceased at 9.32am. The delay in connecting the equipment was due to fears that there may still have been another armed person in the premises.

The deceased was treated by paramedics and taken to the John Hunter Hospital and was pronounced dead on arrival at 9.54am

The female who was taken from the premises was interviewed on ERISP shortly after the incident. She stated that she heard the police identify themselves and order the occupants to lie on the floor. She saw the deceased come out of the bedroom and point the shotgun at the police officers. She further stated she heard a 'clacking noise' and thought the deceased fired. The State Coroner was satisfied that the 'clacking noise' was caused by the deceased injecting a bullet into the chamber of the shotgun. He found that the shotgun had not been fired.

Prior to the police attending Islington, there was no information that would have led to police to suspect that the deceased was at the premises. Evidence was given by another female who was staying at the premises, but who was out shopping at the time of the incident, that there was to be a drug deal between the arrested person and another male (who was in reality an undercover police officer) at the premises on the morning of the 20th September 1996. She also stated that the deceased was there as 'back up' in case it was a drug rip off. Apart from the shotgun, police located a loaded .22 rifle and a loaded pistol at the premises

The deceased was under investigation regarding the cultivation of drugs in the Merriwa area. He had a prior criminal history of drug and other offences.

Police procedures in the setting up and carrying out of the operation were investigated by a Superintendent of Police. He came to the conclusion that, in accordance with the Commissioner's recommendations, the operation should have been classified as 'high risk' and the Special Protection Group of the police service should have been consulted prior to the attendance at Islington. The operation was considered to be 'low risk' by its officer in charge. The Superintendent made a number of recommendations to the Commissioner of Police which will lead to the tightening of control over such operations. Some have already been implemented.

The State Coroner urged the Commissioner of Police to adopt those recommendations if he had not already done so.

There was overwhelming evidence from four civilian witnesses that there was only the initial quick volley of shots heard, corroborating the police officers

statements that, after firing at the deceased when he was pointing the shotgun at Detective B, no further shots were fired.

The State Coroner found that the delay in the ambulance officers attending to the deceased had no bearing on the survival of the deceased. Evidence was given by two experienced medical practitioners that the chest wound was fatal and that medical intervention would not have saved the deceased.

The State Coroner was satisfied that the raid went wrong because of the intervention of an unknown factor in that police officers were confronted by the deceased holding a loaded shotgun at the waist high position and pointing it at Detective Senior Constable B. He also found that the shotgun was cocked by the deceased inserting a bullet into the firing chamber.

The State Coroner further found that, in those circumstances, any person (whether a police officer or not) would have been justified in taking appropriate action to protect himself. In this case, the two police officers fired their service revolvers and the deceased was shot in the chest, arm and buttock and subsequently died. The State Coroner further found that the actions of the two police officers in firing their revolvers to prevent at least Detective Senior Constable B from being shot and probably killed were justified.

Finding

On 20 September 1996, [the deceased] died at the John Hunter Hospital, Newcastle of the effects of a gunshot wound to the chest. The wound was inflicted on that date at 15 Hubbard Street, Islington, by either Detective Senior Constable B or Senior Constable H, police officers who were acting the course of their duty, such killing being a justifiable homicide.

1194/96

Male aged 49 years died on or about 4 October 1996 at Parramatta Correctional Centre, Parramatta. Finding handed down on 14 April 1997 by John Abernethy, Senior Deputy State Coroner.

The deceased had been in prison since 19 June 1996, awaiting sentencing on drug related matters. Around 9.10am, he was found hanging from the bars of his cell window by a bed sheet which had been tied around his neck. Notes written by the deceased, indicating his intention to take his own life were located in the cell.

The Senior Deputy State Coroner was satisfied that all statutory issues were clear. He found that the deceased chose to take his own life rather than put his family, and in particular, his son, through any stigma that may have occurred from an intensive police investigation into other alleged criminal activities. He found that such police investigation was warranted in all the circumstances.

The Coroner found that the deceased learned shortly before his death that police were to attend the prison on 4 October 1996 to further interview him

in relation to a number of serious crimes, and that the deceased thereupon decided to take his own life.

The Senior Deputy State Coroner accepted that the deceased was a "sweeper" and therefore entitled to be "one out" in his cell; that he was in fact a "model" prisoner and that he had no enemies within the prison. His relationships with both prison officers and prisoners were good. There was no prior indication to any person that the deceased intended to take his own life.

The Coroner found nothing in the behaviour of the Department of Corrective Services or its officers that warranted any criticism at all. He found the police investigation to be thorough and competent.

In his opinion there was nothing to indicate foul play, but abundant evidence to indicate that the deceased took his own life.

Finding

On or about 4 October 1996, [the deceased] died in Cell 184, Wing 5, Parramatta Correctional Centre, Parramatta by hanging himself with the intention of taking his own life.

1282/96

Male aged 53 years died on 24 October 1996 at Great Western Highway, Werrington. Finding at inquest held at Westmead on 10 April 1997 by P.J. Molan, Deputy State Coroner

The deceased was involved in a relationship with a person who had sought a domestic violence restraining order against him. That order had not been served on him. On the 23 October 1996 that other person left a friend's house and got into her car. The deceased approached that car and shot and killed the other person with a shotgun. The deceased then left the scene.

The next day police were notified by neighbours of the deceased of the whereabouts of the deceased who was driving his vehicle. One Police vehicle took up a position behind the vehicle being driven by the deceased. They were shortly after joined by another police vehicle. Both police vehicles then activated their sirens and warning lights. The deceased pulled into the breakdown lane and slowed his vehicle. He was seen to pull a shotgun over to himself and shoot himself as he accelerated the vehicle he was driving. His vehicle then collided with a stationary police vehicle which had stopped in front of the deceased. The deceased was dead by the time police reached the vehicle.

Finding

On the 24 October, 1996 [the deceased] died at Werrington of the effects of a shotgun wound to the head, self inflicted with the intention of taking his own life

2193/96

Male aged 48 years died on 29 October 1996 at Goulburn Correctional Centre, Goulburn. Finding handed down on 21 January 1997 at Glebe by Derrick Hand, State Coroner.

On 23 August, 1996 the deceased was sentenced to six months imprisonment, for various drug offences. He was received into Goulburn Correctional Centre on that date. He had suffered heart problems prior to being sentenced and this fact was included on his prison assessment form. The prison medical officer continued the medical treatment the deceased had been receiving outside prison. Around 8.30am on 29 October 1996, the deceased was jogging in the prison wing when he collapsed. Other inmates ran to his aid and called for medical attention. Despite efforts by the medical team he could not be revived. The deceased had been spoken to by an inmate earlier and was advised not to run so hard, but he continued to run 'flat out'. No issues were raised by the family as to his treatment while in prison and the State Coroner was satisfied that he had been receiving proper medical treatment for his ailment while in prison.

Finding

On 29 October 1996, [the deceased] died at the Goulburn Correctional Centre of the effects of a natural cause, namely valvular heart disease.

2315/96

Male aged 35 years died on 16 November 1996 at Port Macquarie Base Hospital, Port Macquarie. Finding handed down on 22 July 1977 at Port Macquarie by Derrick Hand, State Coroner.

The deceased was arrested by police at 11.32pm on 12 November 1996 following complaints by residents that he was going around the streets overturning garbage cans. He was taken to Port Macquarie Police Station and was placed in the charge room dock at 1.57pm. Before identifying and charging him, the arresting officers decided to attend a complaint received earlier that someone was driving erratically in a cul-de-sac in the town. Apart from being moderately affected by alcohol, the deceased showed no signs of being mentally disturbed and no signs of being suicidal. Whilst in the dock, the deceased was checked about every two minutes by one of the two officers on duty in the station. He was last checked at 12.25am.

At 12.30am, police entered the charge room and observed that the deceased had tied his shoelaces together, placed them around his neck, tied one end to the upper door hinge of the dock and hanged himself. He was immediately cut down and CPR was commenced, as he was not breathing. An ambulance was summoned and arrived eight minutes later. The prisoner was attached to a heartstart machine and a pulse and breathing were detected. He was then conveyed to the Port Macquarie Base Hospital intensive care unit and placed on life support. On 16th November 1996, relatives requested that life support be removed and he passed away at 6pm on that date.

The State Coroner was critical of the police officers for not carrying out the Commissioner's Instructions relating to the charging of a person at a police station. In effect, the police were required to immediately check the prisoner for any identification and then to carry out a computer (COPS System) check to ascertain whether the deceased was previously known to police.

If that check had been made, the officers would have ascertained that the deceased had attempted suicide before and was classed as a suicide risk. Appropriate action could then have been taken to ensure he did not harm himself. The deceased had only been a resident in Port Macquarie for a few months and was not previously known to police at that centre. The two arresting officers and the other two officers on duty in the station were aware of the Commissioner's Instructions and accepted that they were not followed.

Since this incident, the dock at the police station has been modified to reduce the areas from which persons could hang themselves. The State Coroner took evidence from various senior police officers as to the design of the dock. He also inspected it himself and was of the opinion that there were still areas of concern in the design of the dock. He made appropriate recommendations.

Evidence was given that, when designing the dock (which in 1994 replaced the traditional style docks), it was considered that docks were not 'cells' and therefore were not required to be suicide proof. The State Coroner disagreed strongly with this thinking on the basis that, once a person is taken into police custody, there is that high duty of care placed on the police service and its personnel.

Once that point was raised, the State Coroner made inquiries regarding safety in police vehicles used for transporting prisoners and inspected such vehicles at the police station. He came to the conclusion that there were opportunities for someone to take their life in such a vehicle. There was also action that could be taken to minimise these risks and the State Coroner made appropriate recommendations.

Finding

On 16 November 1996, [the deceased] died in the intensive care unit of the Port Macquarie Base Hospital, Port Macquarie, of the effects of a self-inflicted hanging on the 13 November 1996 in the charge room dock of the Port Macquarie Police Station, such hanging being inflicted by the deceased with the intention of taking his own life.

Recommendations

To the Commissioner of Police:

1. re-consideration be given to the design of the charge room docks in police stations;
2. consideration be given to the design of police vehicles used for the conveyance of prisoners; and

3. consultation should be held with Senior Officers attached to selected Police Stations in considering the above recommendations.

2575/96

Male aged 36 years died on 25 December, 1996 on the Wee Waa - Narrabri Road, near Wee Waa. Finding handed down on 21 November 1997 at Narrabri by John Abernethy, Senior Deputy State Coroner.

The deceased and his spouse separated on 8 November 1996. There were two children from the relationship. Over a long period of time, the marriage had deteriorated to the point where the wife left the matrimonial home and moved to a refuge in another town. She did so suddenly and unexpectedly. The relationship had been punctuated by incidents of abuse against her, and she sought and obtained Apprehended Violence Orders against the deceased. The deceased was permitted access to the children but his wife made it clear to him that the relationship was over. On the evidence, the situation in the family home was worsening and becoming more dangerous for her. During most of the marriage the wife did not involve the authorities with her domestic problems.

During 1996, the deceased had become quite depressed, was abusing alcohol and sought medical assistance. During December, his general practitioner became concerned about his depression and referred the deceased to a psychiatrist. The GP felt he may have been both suicidal and homicidal. When the deceased was examined by the psychiatrist, the latter found him to be only mildly depressed and advised the GP to treat with appropriate medication.

Between the time of the wife leaving and his death, police gave great assistance to the deceased, who appeared not to have accepted that the marriage was at an end. He regularly attended the police station for a variety of reasons and police were unfailingly helpful and careful as negotiators and even counselors. They urged him to seek professional advice, but he never did. He was breached under the *Firearms Act 1989* after his wife left him and all known firearms were confiscated. Police did not know that he also owned a .410 shotgun which was returned to the deceased just prior to his death. The Coroner found that local police and particularly the Officer-in-Charge, developed a significant rapport with the deceased. He did not appear depressed on 24 December 1996 when he attended the police station for the last time.

The Christmas arrangement was that the deceased would have the children on Christmas eve and morning. The wife was to attend at the opening of gifts on Christmas morning and she did so at about 9.30 am. By arrangement she was to collect the children in the early afternoon. At 2 pm her daughter telephoned and told her to "hurry" as her father had been drinking but still wanted to drive the children to the home of the wife's parents. As the wife was driving to collect the children she saw her husband driving towards her. They stopped their vehicles and spoke briefly.

When the wife indicated that she was not going to discuss the marriage the deceased got out of his vehicle with a firearm. He pointed the gun at his wife and told her to get into his vehicle. She persuaded him to go in separate vehicles to the cemetery where their son was interred, but once mobile went directly to the home of the Officer-in-Charge of police. She burst into that person's home, extremely distressed and briefed him.

The Officer-in-Charge left his home at about 2.30 pm. He collected another police officer and located the deceased in his vehicle. The deceased ignored police attempts to have him pull over. A pursuit commenced, and police advised by radio the fact of pursuit, the location, direction being travelled, the registered number of the vehicle and the fact that police believed the deceased to be armed.

The pursuit continued at speeds below 100 kph for about two kilometres. Just outside the town the deceased slowed down and pulled to the edge of the road. The police vehicle was stopped about 10 - 15 metres behind, but on the bitumen. Police alighted and approached the deceased with service revolvers drawn. The Officer-in-Charge called out in a loud voice:-

“(name of deceased) I want you to get out of the car. Get out of the car.”

There was no response and he saw no movement in the deceased's vehicle. He again called out several times:-

“(name of deceased) I want you to get out of the car.”

At this time police heard a muffled noise from within the vehicle of the deceased. They then saw him slump to the centre of the vehicle. It was clear that he had shot himself.

On reaching the vehicle they noted the gunshot wound to the head and requested assistance by radio. On returning to the deceased's vehicle, police noted a shortened .410 shotgun on the deceased's lap. Several minutes later at 2.35 pm ambulance officers attended and attempted to assist the deceased who was still alive. At 2.50 pm a medical practitioner arrived and pronounced him dead. In due course, police retrieved three unused shotgun cartridges. The Senior Deputy State Coroner found this to be most significant as it supported the theory of the GP that the deceased may have been both suicidal and homicidal.

The scene was appropriately secured and the matter was investigated by an independent “shooting” team. The Senior Deputy State Coroner found that the investigation was carried out thoroughly and competently. He found that the Police Commissioner's Instructions had been adhered to.

The Coroner also found that various members of Wee Waa police, but particularly the Officer-in-Charge at all times acted appropriately and with empathy in dealings with the deceased. He found their work to be an example of community policing at its best. He formally commended the Officer-in-Charge and his staff.

The Coroner was of the opinion that the police operation had been carried out appropriately, and found expressly that the Officer-in-Charge (a trained police negotiator) was attempting to persuade the deceased to exit the car so that he could commence to negotiate with him. The Coroner also commented:-

“The public must understand that in situations like this, there is always an actual and potential danger to the life and safety of police. Despite the rapport that had been built up, they could never afford to be confident that he would not attempt to harm them. Knowing that he had a firearm in his possession and the allegation that he offered it at (the wife) they had no option except to attempt to apprehend and disarm him.”

The Coronal investigation was found to be of high calibre. The Coroner commented that the deceased may have had it in his mind either to shoot his family and then himself or to shoot himself in front of them.

Finding

On 25 December, 1996 the deceased died on the Wee Waa - Narrabri Road, near Wee Waa, of a shotgun wound to the head, inflicted by him with the intention of taking his own life.

2598/96

Male aged 54 years died on 29 December 1996 at 179 Moorall Creek Road, Strathcedar, Via Wingham. Finding handed down on 30 September 1997 at Forster by John Abernethy, Senior Deputy State Coroner.

The deceased was a 54 year old man with financial and other problems. He and his spouse had argued on the night of 28 December 1996. The following morning, as his spouse was about to leave the family property, he indicated that he intended to shoot her greyhound dog. The spouse contacted police and in due course they attended at the family property.

The son of the deceased indicated to police that he believed that he had hidden all ammunition on the property. The police officer, Sergeant A, together with the spouse and son searched for the deceased, locating him in a shed on the property. He was seated on a chair with a .22 calibre rifle between his knees. One hand was gripping its barrel and the other was on the trigger. Behind him on a bench was an opened box of cartridges. Also on a bench near him was a shotgun.

Sergeant A ordered the civilians to leave the shed and at about 10am began to attempt to dissuade the deceased from taking his own life. In the meantime the deceased's spouse telephoned friends who alerted police at Taree. In due course a number of police arrived, including trained negotiators.

It was extremely hot in the shed and Sergeant A “negotiated” with the deceased over a period of two hours. The conditions were most unfavourable. At times another police officer (Constable B) also assisted with these negotiations.

Some time after 11am, police negotiators arrived. They immediately obtained background information from the spouse and son of the deceased. They also obtained further information from Constable B before deciding that one of them, Constable C, would enter the shed and commence "face to face" negotiations. At about 11.45 am Constable C entered the shed. Sergeant A was still negotiating with the deceased. Constable C introduced himself, whereupon the deceased said "fuck you" and discharged the firearm, falling backwards onto the floor.

Police and Ambulance Officers attempted to revive him but he died just after midday.

Police service revolvers were examined and all police ammunition was accounted for. Later, ballistics determined that the gun the deceased was holding killed him. Physical evidence police attended the scene and comprehensively examined it.

A most thorough investigation was carried out by police on behalf of the Coroner. The Senior Deputy State Coroner found that all relevant police instructions, procedures and protocols had been carried out correctly.

Sergeant A, an untrained negotiator had spent almost two hours attempting to persuade the deceased not to end his life. He acted thoughtfully, sensitively and most appropriately at all times in very difficult conditions. Following the events of this operation he has been on sick leave. He is unlikely to be able to resume his employment as a police officer.

The Coroner commended the officer-in-charge of the investigation for its thoroughness. He also commended Sergeant A and wrote to his Commander, requesting that his efforts be formally noted.

At the conclusion of the Inquest, the son of the deceased indicated in open court his family's appreciation to the officer-in-charge of the case for the sensitive manner in which he communicated with the family. He also thanked Sergeant A for the efforts made to persuade the deceased not to end his life.

Finding

On 29 December 1996 [the deceased] died at 179 Moorall Creek Road, Strathcedar, Via Wingham, of a gunshot wound to the head, self inflicted with the intention of taking his own life.

Male aged 27 years died on 30 December 1996 at Prince of Wales Hospital, Randwick. Finding handed down on 6 August 1997 at Glebe by Derrick Hand, State Coroner.

The deceased and his girl friend stole a motor vehicle in Woollahra in the early hours of the morning of 27 December 1996. They drove through Double Bay and at 12.37am came under police notice for disobeying a 'stop' sign. Police activated the blue light and siren. Instead of pulling over and stopping, the deceased accelerated. A high speed pursuit ensued. The deceased drove at speeds well in excess of the speed limits of 60 and 70 kilometres per hour and police evidence was that he reached a speed of 120 kph on one road. Generally the speed varied between 80 and 100 kph for both vehicles. Although the streets are usually densely populated, there was very light traffic due to the time of the morning.

The road conditions were good, weather was fine with dry bitumen driving surface at all times. The deceased drove through several 'stop' signs and red traffic lights. On at least one occasion he swerved to the incorrect side of the carriageway, narrowly missing another vehicle. The deceased was not previously known to either of the two police officers in the pursuing vehicle. The pursuit lasted for approximately 4 minutes and 30 seconds and covered a distance of approximately 7.5kms.

At the intersection of Todman Avenue and South Dowling Street, Kensington, the deceased drove through a red traffic light and collided with another vehicle which was proceeding through the intersection with a green traffic light. The three males in the other vehicle were only slightly injured. The deceased's vehicle overturned. The deceased was not wearing a seat belt and was thrown clear of the vehicle. His female passenger was wearing a seat belt and was only slightly injured. Police quickly summoned the ambulance service and the deceased was transferred to Prince of Wales Hospital where he died on 30 December 1996.

The deceased had numerous convictions both for criminal and driving offences. His first offence occurred when he was 12 years of age. Included in his offences were stealing a motor vehicle and driving in a manner dangerous to the public. The pursuing police were suspicious of the vehicle in the first instance because many vehicles of the same make are stolen in that area and the deceased did not stop when first signalled to do so.

At the conclusion of the evidence the State Coroner was satisfied that

1. In all the circumstances the police pursuit was lawful and justified;
2. The police did consider the issue of public safety and in all the circumstances acted and responded appropriately;
3. The two police officers exercised their discretion correctly in pursuing the vehicle driven by the deceased and that proper consideration was given, by all police concerned, to the safety of the public;

4. There was no breach of any official guidelines in relation to high-speed pursuits by police vehicles or in relation to any other matters.

The State Coroner was, however, critical of the actions of a newspaper reporter who photographed the deceased and his passenger a second or so before the accident occurred. He raised concern that the reporter was at the scene at all and said the only inference he could draw was that the reporter or someone with whom he was associated was monitoring police radio and, upon hearing that a pursuit was in progress, went to a location where he was able to take the photograph which appeared the next day on the front page of the Daily Telegraph.

The State Coroner further stated that the photographing of the car may well have been a contributing factor in the accident, as doubtless the deceased would have been startled by the camera flash momentarily disturbing his concentration. The collision occurred immediately after the photograph was taken and the State Coroner was concerned about members of the press engaging in this type of activity for the sole purpose of getting a story. He stated that he considered the action of the reporter, at the least, to be extremely irresponsible. He did not however, believe that the actions of the reporter contributed significantly to the collision because of the dangerous driving of the deceased.

The State Coroner issued a general warning to the press and all media to act responsibly in the course of their fact finding. He said they and the public generally should not unnecessarily interfere with the police carrying out their duties.

Finding

On 30 December 1996 [the deceased] died at the Prince of Wales Hospital, Randwick, of the effects of a head injury sustained on 27 December 1996 at the intersection of Todman Avenue and South Dowling Street, Kensington, when, whilst trying to elude a pursuing police vehicle, he entered the intersection against a red traffic light and collided with a motor vehicle being driven by Bruce Douglas Jenkins.

7/97

Male aged 42 years died on or about 31 December 1996 at Industrial Training Centre, Long Bay Complex of Prisons, Malabar. Finding handed down on 24 June 1997 at Glebe by John Abernethy, Senior Deputy State Coroner.

This 42 year old sentenced inmate was being housed in Cell 182 of Four Wing at the Industrial Training Centre, Long Bay. He died of epilepsy, a natural cause, during the night of 31 December 1996 - 1 January 1997. He was "one out" in his cell and was located by a Prison Officer when a response was not obtained at "let go".

The next of kin of the deceased raised no concerns relating to the death.

While under protocol, epileptics are generally housed "two out", they may be housed "one out" with the concurrence of a medical practitioner. The Senior Deputy State Coroner was satisfied that this protocol was followed by the Department of Corrective Services.

The Coroner was satisfied that the inmate had been receiving adequate medical care, and died unexpectedly. Further, he was satisfied that all officers of the Department of Corrective Services followed settled procedures once he was found deceased.

The Coroner found no other issue that needed addressing.

The Senior Deputy State Coroner was satisfied that the prisoner died suddenly and unexpectedly from his epilepsy and that no criticism was warranted of either the Department of Corrective Services or the Corrections Health Service. He felt it timely to remind all who may be interested in the incidence of deaths in custody, that a percentage of these, like this one, may be from natural causes.

Finding

On or about 31 December 1996, [the deceased] died in Cell 182, Four Wing, Industrial Training Centre, Long Bay Complex of Prisons, Malabar of epilepsy, a natural cause.

86/97

Aboriginal male aged 19 years died on 10 January 1997 at railway line, Lidcombe. Finding handed down on 4 September 1997 at Glebe by Derrick Hand, State Coroner.

Around 11.10pm on 10 January 1997, police were called to a disturbance at a local hotel. It was alleged that the deceased had been involved in an assault on another person. The deceased was spoken to by a police officer and, while that officer was distracted by something else, ran off. The officer chased him for about 150 metres, then returned to speak to other persons involved in the incident.

A few minutes later, the attending police received a radio message that a person had been hit by a train. They attended the railway line and found the deceased to be the person who had run from police. The train driver stated that he suddenly saw a flash of yellow (the deceased's T-shirt) on the tracks in front of him. He applied all brakes but the deceased was too close for the train to be stopped in time.

The deceased had been drinking alcohol that evening and his blood analysis showed a reading of 0.182 grams per 100ml of blood. He was on probation and the State Coroner was satisfied that the fear of being arrested whilst on probation was the reason for him running to try to avoid arrest.

The State Coroner was also satisfied that the police acted properly and that it was impossible for the train driver to stop in time to avoid the deceased.

Finding

On 10 January 1997 [the deceased] died on the railway line west of the Lidcombe Railway Station of the effects of multiple injuries sustained then and there, when, whilst trying to avoid apprehension by a police officer acting in the course of his duty, he was struck by a moving train as he was attempting to cross that rail line.

122/97

Male aged 46 years died on or about 16 January 1997 at Goulburn Correctional Centre, Goulburn. Finding handed down on 26 November 1997 at Goulburn by John Abernethy, Senior Deputy State Coroner.

This 46 year old man hanged himself in his cell, Number 41 of C Wing at the Goulburn Correctional Centre on the night of 15-16 January 1997. He was on remand for serious criminal matters and was, at the time of his death, serving a "balance of parole" sentence. He had, in the past, served a number of prison sentences and during his life had obviously engaged in a great deal of serious criminal activity.

The deceased left a note clearly setting out his intentions. The Senior Deputy State Coroner was satisfied that he made a very rational decision to end his life, and in fact canvassed any other alternatives he felt may have been open to him. The relevant part of the note is set out in full:-

"Dear Governor, I apologise for the inconvenience in leaving my disposable costume behind. I in leaving bear no grudge or hard feeling toward prison staff, nor police. At 47 years of age I am embarrassed at still being a burden on my country, and the taxpayers of my country. It seems to be the most honourable thing to do at this time. As escape was an avenue I used before and it was then I learned that to stay out there in my own country I would most probably have to kill or maim police to survive. Police too are just other Aussies doing a necessary service and I cannot kill just to serve my own selfish needs. That ruled out escape and another prison term would not only be unfair, but too much for me to tolerate. I've had enough and go this way, please excuse me for this..."

The cell call alarm was functioning correctly. Corrective Services personnel acted appropriately at all times, as did Corrections Health personnel.

The family of the deceased raised no issue with investigating police. The Department of Corrective Services saw no issue to raise either. The police investigation was thorough. The Senior Deputy State Coroner saw no issue to canvass at inquest.

Toxicological analysis showed a very high level of morphine (heroin) in the blood of the deceased. Also found were codeine, methadone, diazepam and nordiazepam. A forensic pathologist conducted a thorough post mortem examination and found that the deceased died by hanging. He could not quantify the possible contribution of the multiple drug toxicity.

The Coroner could find no issue worthy of criticism in respect of any person or authority concerned with the incarceration of the prisoner, or of the police

investigation into his death on his behalf. He commented:-

"Drugs in prisons are unfortunately a fact of life. Contact visits, while necessary and desirable, have made it all the more difficult for prison authorities in their attempts to minimise drugs in prison."

Finding

On or about 16 January 1997, [the deceased] died in Cell 41, C Wing, Goulburn Correctional Centre, Goulburn, by hanging, self inflicted with the intention of taking his own life. Another significant condition contributing to the death, but not related to the condition causing it, was multiple drug toxicity.

139/97

ABORIGINAL

Male aged 17 years died on 19 January 1997 at Royal Prince Alfred Hospital, Camperdown. Finding handed down on 21 March 1997 at Glebe by Derrick Hand, State Coroner.

The deceased was a passenger in a stolen motor vehicle which was involved in a police pursuit. The vehicle collided with an ambulance during the pursuit before colliding with a power pole at an intersection. The vehicle reached speeds in excess of 120 kph in a 60 kph area during the pursuit.

A known person was subsequently charged with an indictable offence in which an issue will be that the known person caused the death.

Finding

On 19 January 1997, [the deceased] died at Royal Prince Alfred Hospital, Camperdown. Inquest Terminated, Section 19, *Coroners Act 1980*.

209/97

Male aged 50 years died on 29 January 1997 at Wee Jasper. Finding handed down on 11 September 1997 at Yass by Derrick Hand, State Coroner.

On 28 January 1997, the deceased appeared at the Yass Local Court to answer allegations of breaches of bail and of an Apprehended Domestic Violence Order made in favour of his spouse. He was granted further bail, on the condition that he not approach the complainant or their home. He then drove to the family property at Wee Jasper and set fire to both a shed and house. The shed was completely destroyed and the house was partially damaged. He then went to another home and stayed there.

When police arrived, he refused to come out of the house and police set up a perimeter. Despite being spoken to on the telephone by police negotiators, he refused to come out. He was last seen alive near a window at 11.10am on 29 January 1997. At 7.50pm that night, the police gained entry to the house and located the deceased, locked in the bathroom, with a shotgun wound to the head. The shotgun was located next to the deceased. During the time the deceased was in the house, he had fired two shots at the police without injur-

ing anyone. No shots were fired by police.

Around 9.11am on 29 January 1997, the police negotiator had believed that the deceased was ready to come out. The deceased, however, informed the negotiator that he had heard a news bulletin on the radio giving the circumstances of the siege and his personal details. This upset him and he stated that he would not be coming out. During the prolonged negotiations by telephone, the deceased spoke of his problems and made threats against his wife and two particular police officers who had been involved in arresting him in relation to the domestic violence matters. He said on a number of occasions that he was going to shoot the two officers. In a previous telephone call to a friend he had made the same threats.

The family raised the following concerns with the State Coroner:

1. Why had he been granted bail?
2. Why, despite their requests, had the police not allowed his wife to speak to the deceased on the telephone during the negotiations?

On the issue of bail, there was evidence before the State Coroner that the wife feared for her life and wanted the deceased to be ordered to stay away from her. Bail was allowed with that condition. On the issue of the police not allowing the deceased's wife to talk with him, evidence was given by the chief police negotiator that there were concerns that if the deceased was allowed to speak to his wife, the situation might be further inflamed and there was the possibility of the deceased taking his life during such a conversation. In any event, the negotiator considered that negotiations were effective until the time of the radio broadcast.

Medical evidence was given that the deceased had attempted suicide on two previous occasions and that he suffered from a personality disorder. His behaviour towards his wife became violent from about June 1996 and she had been both physically and verbally assaulted on a number of occasions, resulting in the Local Court making orders against him.

When the deceased set fire to the shed and house, he was seen (by a 72 year old female neighbour) walking away, carrying a shotgun. The neighbour ran to the house and put out a number of small fires which had been set inside it, so there was only minor fire and smoke damage to the premises. When she first saw the deceased, he pointed the shotgun in her direction before turning and walking away. She gave evidence that she had a fear of fires. The State Coroner was satisfied that she showed outstanding bravery in the circumstances and adopted the recommendation by the investigating police officer that her bravery be recognised in a more appropriate manner.

An area of concern was the broadcast on radio of the circumstances of the siege and information about the deceased whilst the siege was ongoing and negotiations still taking place. A former Inspector of Police disobeyed the Police Commissioner's Instruction relating to media releases about sieges which state that before any media release is made there must be consultation

with the Officer in charge of the State Protection Group as to what information is to be released. Usually only the fact that a siege is in progress is for media release. The State Coroner was highly critical of the actions of the former officer (since retired) and directed that the Commissioner be requested to reinforce those very clear instructions to his Commanders.

The State Coroner was satisfied that the Police protocol relating to sieges was properly carried out by those officers (apart from the above media release) and no criticism of them was warranted.

Finding

On 29 January 1997, [the deceased] died at Sawyers Creek Road, Wee Jasper, of the effects of a shotgun wound of the head, self inflicted then and there with the intention of taking his own life.

149/97

Male aged 24 years died on 7 February 1997 at Parramatta Correctional Centre, Parramatta. Finding handed down on 22 May 1997 by John Abernethy, Senior Deputy State Coroner.

The deceased was a 24 year old unsentenced prisoner. He was a caucasian male who had never been in prison before, and he had a virulent substance abuse problem. He entered police custody on 5 February 1997 charged with a number of offences of break, enter and steal, goods in custody, implements in possession, assault police and resist arrest. He may have sustained minor physical injuries on arrest. He appeared before Waverley Local Court on 5 February 1997 and again on 6 February 1997, where he was remanded to appear again at Waverley on 12 March 1997. Bail was refused.

The Senior Deputy State Coroner found that police observations of him in custody on the night of 5-6 February 1997 were close and that his behaviour was unremarkable.

Following his appearance at court on 6th February, he was transferred to Corrective Services custody and transported to Parramatta Correctional Centre. He spent an uneventful night there on 6-7 February and the following day at the institution. On the evening of 7 February, he was locked "two out" in Cell 205, Wing 5, with another young prisoner.

The Coroner found that the deceased and his cell mate chatted in a desultory way and at 7pm the cell mate fell asleep. At about 9.30pm he awoke and found the deceased hanging by his prison clothing from the cell window. He was dead. The cell mate raised the alarm by way of the cell call alarm buzzer.

Prison officers quickly attended and cut the deceased down. They sealed the cell pending arrival of the police. In due course crime scene officers and investigating police attended and a full investigation was carried out.

The Coroner was satisfied that the deceased gave no indication on reception that he was contemplating suicide. He was satisfied that a competent and thor-

ough reception assessment was carried out by an experienced registered nurse (Corrections Health Service). Similarly, he was satisfied that a thorough reception assessment was carried out by a welfare officer attached to the Department of Corrective Services.

Prison authorities knew that the deceased was in prison for the first time and placed him appropriately in a "two out" cell. Arrangements had been made for him to see the visiting medical officer about physical injuries, and to see the psychologist, as he had indicated to one assessor that he had attempted suicide several times in the past. He was placed on appropriate medication to enable him to cope with withdrawal from any substance habit he may have had.

Accordingly, the Coroner was satisfied that an appropriate standard of care was exercised by Police, Corrective Services officials and Corrections Health officials. He found that the prisoner's suicide could not reasonably have been foreseen.

Finding

On 7 February 1997, [the deceased] died in Cell 205, Wing 5, Parramatta Correctional Centre, Parramatta by hanging done with the intention of taking his own life.

762/97

Male aged 28 years died on 22 February 1997 at Cooma Correctional Centre, Cooma. Finding handed down on 15 October 1997 at Cooma by Janet Stevenson, Deputy State Coroner.

The deceased was "two out" in a cell at Cooma Correctional Centre. He was last seen alive at 7.15pm on 21 February 1997 and was found lying face down on his bed at 7.35am on 22 February 1997. No marks of physical violence or obvious cause of death were observed on the body. The deceased was known to be addicted to drugs and had been prescribed various drugs by the prison medical staff. He had attempted suicide in the past and just days before his death had made another attempt. He was not on the methadone program. Toxicology studies indicated a therapeutic level of methadone in the deceased's blood sample. Nothing was found during the post mortem to indicate death by other than a natural cause.

The deceased was well known to nursing staff at Cooma Correctional Centre because of previous incarcerations. They were aware of his suicidal tendencies and associated family problems. It was quite clear during the Inquest that an attempt by nurses was made to address every concern, real or perceived, of the deceased. It was obvious their level of care was sensible and compassionate; this was acknowledged and appreciated by the family of the deceased.

Concerns were raised by nursing staff that methadone may have been readily used as a "currency" by prisoners, possibly following a change in prison policy regarding supervision of prisoners after methadone had been dispensed.

The existing Departmental guidelines for the dispensing of methadone were perused by the Deputy State Coroner and found to be adequate to the circumstances. Accordingly, recommendations were not necessary.

The Deputy State Coroner found the methadone was not acquired by the deceased through formal channels in the gaol and had obviously been obtained through inmate-to-inmate transactions. The level of methadone in the deceased's body was in the therapeutic range and it did not appear to have caused the prisoner's death.

Finding

[The deceased] died at Cooma Correctional Centre, Cooma on the 22 February, 1997 of natural causes, the origin of which is unknown.

418/97

Male aged 34 years died on 5 March 1997 at Wollongong Hospital, Wollongong. Finding handed down on 24 September 1997 at Wollongong by Derrick Hand, State Coroner.

On 4 March 1997, the deceased attended the home of his de facto wife and , after an argument with her, stabbed himself in the stomach. He pulled the knife in and out of the wound indicating that he was going to kill himself. The wife immediately rang the ambulance and the police at 11.25pm. Police arrived at the premises at 11.33pm shortly after two ambulance officers. The deceased was seen to continually push the knife in and out of his stomach and despite pleas from both the police and ambulance officers, refused to stop and put the knife down.

At 12.25am he stabbed himself twice in the chest and collapsed. Ambulance paramedics immediately attended to him and he was taken to Wollongong Hospital, where he was pronounced dead just after 1am.

The deceased had been treated by a psychiatrist since 1981. He had been diagnosed as a chronic schizophrenic and was on prescribed medication. He had on more than one occasion appeared to have attempted suicide but on at least two occasions had rung someone to help him. On each occasion he was hospitalised. His treating psychiatrist gave evidence that he had not seen him for a month prior to his death, but was not surprised that he had taken his life. A blood analysis carried out post mortem indicated that the deceased had not taken his prescribed medication in the days shortly before his death.

The State Coroner was satisfied that the police and ambulance officers acted properly in their efforts to have the deceased give himself up and no criticism was warranted of their actions.

Finding

On 5 March 1997, [the deceased] died at Wollongong Hospital, Wollongong, of the effects of stab wounds to the chest, self inflicted on that date at Denise Street, Lake Heights, with the intention of taking his own life.

509/97

Male aged 51 years died on 19 March 1997 at Long Bay Gaol Hospital Annex, Malabar. Finding handed down on 22 September 1997 at Glebe by Derrick Hand, State Coroner.

On 11 July 1989, the deceased was sentenced to ten years imprisonment after a conviction for sexual assault on a child under the age of ten years. He was serving his term at Kirkconnell Correctional Centre and was due for release in 1999. He suffered from asthma and, following an attack, was transferred to the Long Bay Gaol Hospital on 3 March, 1997. He was treated at that hospital and remained there until his death. On 18 March, 1997 the deceased was examined by the prison doctor who found his chest to be clear and directed that he not use a nebuliser but an inhaler.

During the night of 18 March 1997, the deceased was checked at approximately 15 minute intervals by nursing staff. All patients are checked at such intervals by the nurse who looks through the window insert in each door. The deceased was spoken to at about 2.30am on 19 March 1997 when he asked for the nebuliser, but was told by the attending nurse the doctor said he was to use his inhaler. The deceased had earlier in the evening complained of a headache but at 2.30am he stated to the nurse that he was much better. The deceased was last checked at about 5.45am when he was observed propped up on his pillow in bed.

No conversation took place between the deceased and the nurse. Around 6.30am, two nurses attended to hand out medication to the hospital patients. The deceased was still propped up on his pillow but could not be roused. An ambulance officer attended and confirmed the nurse's opinion that he was dead. The prison doctor later attended and pronounced life extinct. A post mortem examination showed the cause of death to be bronchopneumonia. The forensic pathologist gave evidence that, while it is not usual for such a death to occur without the symptoms being previously obvious, it can occasionally happen.

The State Coroner was satisfied that no criticism was warranted of the Corrections Health Staff at the Hospital.

Finding

On 19 March 1997, [the deceased] died at Long Bay Gaol Hospital Annex, Malabar of the effects of a natural cause, namely bronchopneumonia.

566/97

Male aged 36 years died on 29 March, 1997 at Miller Street, Villawood. Finding handed down on 2 September 1997 at Glebe by Derrick Hand, State Coroner.

The deceased was directed by police to stop at a roadside breath testing station. There was a passenger in his vehicle at the time. When the officer checked the deceased's license it was found to have a hole in it, indicating that it had been cancelled. The officer instructed the deceased to wait while he

checked the license particulars and he walked back to his patrol vehicle to do so. The officer ascertained that the vehicle the deceased was driving was in fact stolen so he called for other police assistance. Whilst the officer was in his vehicle the deceased's vehicle moved off and turned left into Miller Street. The officer followed, with another officer in a separate patrol car also following.

A police caged truck caught up to the stolen vehicle and pulled across it at an angle at the same time as the first patrol car pulled in at an angle on the driver's side of the stolen vehicle. An officer in the caged truck (Constable B) immediately ran to the passenger's side of the deceased's vehicle, opened the door and tried to get the passenger out. He then heard the words "get your hand off your gun" and saw that the deceased had exited his vehicle and moved to the driver's side door of the first patrol car. He then ran around to that area and saw that the deceased had a pistol in his hand pointing it at the driver of the patrol car (Constable M).

The deceased looked at Constable B and moved back a couple of steps across the roadway, at the same time wielding his pistol in two hands and pointing it at him. Constable B immediately drew his pistol, pointed it at the deceased and called out to him a number of times to drop his gun. In the meantime, Constable M had alighted from his vehicle, drawn his pistol and pointed it at the deceased, also calling out for him to drop his gun. When the deceased continued pointing his gun at Constable B, both Constables made the decision to fire at the deceased. Constable B fired four rapid shots and Constable M fired two rapid shots at the deceased who was hit by four bullets.

The deceased dropped his gun and fell to the ground. The officers attended the deceased to check his condition. He was still breathing and an ambulance was immediately called. The ambulance arrived within a few minutes, but an examination by the paramedics confirmed that the deceased was dead. The area was immediately sealed off and senior police officers called.

The uncontested evidence by Constable M was that the deceased, whilst still seated in the driver's seat of the stolen vehicle, had pointed a cocked pistol at him through the car's window at the same time telling the constable to leave his pistol alone. The constable stated in evidence that at that stage he thought he was going to be taken as a hostage. The deceased had then alighted, run around to the driver's side door where Constable M was seated and stood between the open door and the constable. He had pointed the cocked pistol at and within two inches of the constable's head. Showing remarkable coolness in a very dangerous situation, the constable told the deceased to put his gun down and walk away. It was then that Constable B appeared. The deceased had then backed off and pointed his gun at him.

Constable B gave evidence that when the deceased pointed his gun at him and wouldn't put it down he was of the opinion that he (Constable B) was going to be shot so he fired. Constable M was also of the opinion that Constable B was going to be shot prompting him to fire.

Three civilians witnessed the events from the time the deceased backed away

from Constable M's vehicle and all corroborated the police version. Other civilians also gave evidence that they heard the police call out on a number of occasions for the deceased to drop his gun.

The deceased's gun was examined immediately after the shooting by police and found to be cocked and fully loaded. Five rounds of ammunition were also found in the deceased's pocket.

The post mortem report and the ballistics examination showed that a shot to the chest was the lethal wound and that shot came from Constable M's pistol.

The State Coroner was satisfied that the deceased drove off from the breath testing site because he was driving a stolen car, his license had been previously cancelled and, as he was currently on parole, his parole was likely to be revoked should he be apprehended.

The State Coroner commended the two Constables for the cool and professional manner in which they tried to defuse the situation. Their behaviour was an indication of the training they had received in the Police Service. They showed considerable restraint in the circumstances. Constable M had been in the service for nine years and Constable B for only ten months. Both Constables received counselling after the event but it was obvious when they were giving evidence that they have been very much affected by the shooting.

Finding

On 29 March 1997, [the deceased] died at Miller Street, Villawood of the effects of a gunshot wound to the chest inflicted there and then by [Constable M] a constable of police acting in the course of his duty such killing being a justifiable homicide.

702/97

Male aged 27 years died on 12 April 1997 at Parklea Correctional Centre, Parklea. Finding handed down on 17 December 1997 at Glebe by Derrick Hand, State Coroner.

The deceased (a police officer) failed to attend the Royal Commission into the NSW Police Service in April 1996 and a warrant was issued for his arrest. He was eventually located in New Zealand and was arrested and lodged in Rimutaka Prison, Wellington. On 15 August, 1996 an order for extradition to Australia was made by the Wellington District Court and on 16 August 1996 he was escorted back to Sydney.

The escorting police officer had received information that the deceased might harm himself and may be worried about people "getting at" him. The deceased told the officer that this was "rubbish" and there was no way he would even think about committing suicide. On 19 August 1996, he appeared at Central Local Court to answer charges relating to drug trafficking, and bail was refused. He appeared before the Royal Commission on 8 November,

1996 and was sentenced to eight months imprisonment for contempt of the Commission. The hearing for the drug related matters was later fixed for 1 September 1997 at the Downing Centre District Court, Sydney.

The deceased was held at the Metropolitan Reception and Remand Centre in special protection. Numerous requests were made by his solicitor for him to be moved to Berrima Gaol, to be placed in the prison hospital or to be removed to a special purpose centre on the basis that he was being harassed by other prisoners and that he should not have been classified as maximum security. In addition, on two occasions the Supreme Court recommended he be classified to either Berrima or a Special Purpose Centre. In November 1996, the Classification Committee, in a dissenting decision, recommended that he be transferred to Berrima. However, because the decision was not unanimous, it was reviewed by the Director of Classification, who rejected the recommendation for the following reasons:

1. In October, 1996, a visitor was arrested and charged with trying to smuggle amphetamines in to the deceased;
2. The charges he was still facing were grave;
3. He had previously fled overseas and it was inappropriate for him to be housed in a low or medium classified prison; and
4. Security at Berrima is generally based on trust and the prison hospital was not an appropriate place for a person in his situation being under Special Protection.

On 10 April 1997, a prison officer approached the deceased and some other prisoners at the Reception and Remand Centre with a view to ascertaining their wishes regarding placement when the Centre closed down in July 1997. It was suggested to the deceased that he might wish to go to Parklea Correctional Centre where he could continue in Special Protection. This was agreed to by the deceased and arrangements were made for his transfer. On 11 April 1997, he was taken to Parklea where he was screened and classified 'strict protection'. He was taken to his cell where he was locked in at about 4.30pm. He had a number of boxes in his possession and, after they were searched, he was allowed to take one box into his cell. This box contained a TV and what appeared to be a blue towel. The other boxes were stored in another place.

Before the deceased was locked in the cell, prison officers checked the alarm and found it to be in working order. At 8.45am on 12 April 1997 officers opened his cell door during normal 'let go' and found the deceased hanging by the neck from a ventilation window bar at the front of the cell by means of a skipping rope. He had placed a 'sloppy joe' jumper around his neck then the rope. His feet were touching the ground and his knees were bent to within about thirty centimetres of the floor. He was checked by one of the officers and found to be apparently deceased.

Evidence was given by an inmate that when the prison officers were in the office for a very short time, he saw the deceased take the skipping rope out of a box and secrete it around his waist under his clothes. This occurred before the officers searched the boxes.

Normal procedures were then put into operation. No cell alarm had been heard during the night. Prisoners in adjoining cells had not heard anything unusual during the night.

When the deceased arrived in Sydney from New Zealand he had been interviewed by his solicitor who noticed a mark around his neck which was described in evidence as appearing to be 'a classic ligature mark'. His solicitor asked the deceased about what had happened. He was evasive, distressed and his eyes filled with tears. He replied that there was "nothing to it" and when pressed stated he had done it in the New Zealand prison because he was scared of going into the general prison population and thought if he appeared suicidal he would not be placed there. He stressed to the solicitor that he was not to tell the deceased's family or anyone what he had done. That mark had also been noticed by his girl friend who saw him in the police cells on Friday 16 August 1996. When she asked about the mark he said it was "nothing" and he didn't want to talk about it.

When screened at the Remand centre, the deceased was asked about the mark and he said it was sustained during a fight. He was also asked if he was suicidal and whether he had any fears that he would harm himself. He answered in the negative. The mark was not noticed by any police officers nor by any person involved in his imprisonment in New Zealand. An acceptable reason for this can be found in the fact he wore a high-necked 'skivvy' at all times he was in custody of the NSW Police and from his conversation with his solicitor when returned to Sydney, he certainly took precautions to try and ensure that no one knew anything about what he had done.

The evidence did not show that, at any stage after his arrest, he had any suicidal or self-harm tendencies and in fact the evidence showed that he had a positive attitude that he would successfully defend the drug charges. These facts, coupled with his explanation to his solicitor about the prior ligature mark and the fact that he had used a jumper to soften the effect of the rope around his neck, prompted the State Coroner to say that he could not accept that the high standard of proof required to find that a person had wilfully taken his own life had been reached.

The State Coroner expressed concern at the length of time taken by the Police Service to notify the family of the death, and that the media were the first to do so.

Finding

On 12 April 1997, [the deceased] in Cell 5108, F Section, Area A, Parklea Correctional Centre, hung himself but whether this was done with the intention of taking his own life, the evidence does not enable me to say.

Male aged 31 years died on 3 May 1997 at Westmead Hospital, Westmead. Finding handed down on 14 October 1997 by John Abernethy, Senior Deputy State Coroner.

The deceased was a 31 year old sentenced caucasian male. He was an inmate at Silverwater Correctional Centre. He had been granted weekend leave and, at 4pm on 2 May 1997, was picked up at the gaol by his mother. She took him to her house at Blackett, where he stayed the night with her.

The two went to bed around 11pm. At 11.15pm his mother heard him snoring. Around 3.45am the mother went past the bedroom of the deceased and could see that he was asleep. At about 5.30am she again went past his bedroom and saw him in bed. At 7am, the deceased got up, sat on the lounge and had a cigarette. He did not have breakfast but took a shower around 7.45 am. Around 8am, his mother noticed that he was sweating and he told her that he had a really severe headache. He had two Panamax tablets and began to vomit in the front yard of the house. He came inside and lay on the lounge for a short time. He suddenly got up and ran to the toilet and continued to vomit, and locked the door. His mother heard a loud thud, and he did not answer when she called to him. She managed to unlock the door and with the help of a neighbour, opened it. An ambulance attended and conveyed him to Mount Druitt Hospital and then to Westmead Hospital. A CAT scan revealed an intracranial haemorrhage.

He died at 6.15pm on 3 May, 1997.

The Senior Deputy State Coroner was satisfied that this death was caused by a massive haemorrhage into the substance of the brain. No tumour was found in the brain and there were no pathological changes in the organs indicative of high blood pressure. The spontaneous rupture of a small blood vessel in the brain was the most likely cause of the haemorrhage. There were no findings of injuries or marks of violence on the body.

The Coroner was further satisfied that nothing found in the toxicology was likely to have contributed to the death of the prisoner. He found that, whilst it was unexpected in such a young man, there was no doubt at all that the death was a natural cause.

The police investigation was thorough and there was no issue at all involving either the Department of Corrective Services or the Corrections Health Service. Death was sudden and entirely unexpected.

Finding

On 3 May 1997, [the deceased] died at Westmead Hospital, Westmead, of an intracranial haemorrhage, a natural cause, whilst on weekend leave from the Silverwater Correctional Centre, Silverwater.

Male aged 37 years died on 9 June 1997 at Parramatta Correctional Centre, Parramatta. Finding handed down on 15 September 1997 at Westmead by Janet Stevenson, Deputy State Coroner.

The deceased was an inmate of Parramatta Gaol. He was both a drug user and an alcoholic prior to his incarceration. He was taken into custody on the 2 June 1997 as he was unable to meet Local Court bail. On 3 June 1997, he was transferred to Parramatta Gaol. The deceased was assessed as depressed and was known to have attempted suicide whilst in prior custody, so he was placed on several prescription medications in an attempt to deal with his depression and alcohol withdrawal. It was considered in the prisoner's best interest he be placed with a mature, reliable inmate.

On the evening of the 5 June, the prisoner was found unconscious in his cell, treated by medics and taken to Westmead Hospital. After being treated as an inpatient at the hospital, he was returned to Parramatta Gaol the following day and placed in a cell with another prisoner.

At 4pm on the afternoon of 8 June, the prisoners were in their cell after having their evening meal. A news item on the evening news related to a young boy the deceased knew and he appeared to become depressed after watching this. The deceased, whilst talking to the other prisoner, was playing with a match box in which he kept his medication. A short time later the deceased was seen to be swaying and slurring his words. His cellmate told the deceased to go to bed.

About ten minutes later, his cellmate heard the deceased snoring. During the night, he woke around 3am and heard the deceased still snoring. Around 6am when he woke, he found the deceased dead. He pushed the "knock up" button but there was no response. Around 9am, as prisoners were being released from their cells, prison officers were informed of the death.

There were no injuries to the body. The deceased died of a drug overdose of medication he had not been prescribed.

The two issues for the Inquest were the non-response to the "knock up" button and whether there was any evidence as to the genesis of drugs found in the deceased's body.

As to the "knock up" button, there was evidence of problems with the computer system relating to this alarm. The computer print out was out of synchronisation as to time and date. The evidence was that the button was working when tested by police and prison staff shortly after the cell was secured.

As to the non-prescribed medication, there was no evidence of foul play in the actions of the other prisoner; in fact, the evidence was the reverse. There was no evidence as to where the drugs ingested by the deceased were obtained and it is presumed these were obtained in the gaol from other prisoners in the not uncommon "usual manner".

Finding

On the 9 June 1997, [the deceased] died at Parramatta Correctional Centre, Parramatta of acute toxicity due to carbamazepine and doxepin.

920/97

Male aged 19 years died on 4 August 1997 at Westmead Hospital, Westmead. Finding handed down on 2 October 1997 at Westmead by Janet Stevenson, Deputy State Coroner.

The deceased was a passenger in the rear of a stolen Holden Commodore sedan. Police attended the vicinity of Hudson Street, Seven Hills in response to a call from police radio that persons were attempting to steal a maroon car. On arrival, police saw the vehicle in which the deceased was a passenger double parked next to a maroon car. Police made certain inquiries with the Police radio and the vehicle in which the deceased was a passenger moved off. Police followed the vehicle while waiting on details from the radio. The vehicle in which the deceased was a passenger did not stop at a stop sign intersection and turned into Grantham Road. Police at this stage activated the siren and flashing blue and red lights and called in a "pursuit" to VKG.

The stolen vehicle at this time had already moved slightly to the left of the road, giving the appearance that it was going to pull over. The vehicle then accelerated and a short distance down the road failed to negotiate a tight right hand bend. The rear of the vehicle "slid out" and the vehicle impacted a pole. The driver and a front seat passenger ran from the scene leaving the deceased in the back seat. The deceased was not wearing a seat belt. An ambulance conveyed the deceased to Westmead Hospital where he died shortly after of injuries received in the collision.

The driver was later arrested and charged with an indictable offence in which the question in issue will be that the driver caused the death.

Finding

On 4 August 1997, [the deceased] died at Westmead Hospital, Westmead. Inquest Terminated, Section 19, *Coroners Act 1980*.

Appendix 1:

Summary of inquests heard or terminated in 1997

File number	Date of death	Place of death	Date of finding	Age at death (years)	Manner of death	Circumstances	Place of Inquest
1660/95	24/08/95	Long Bay	06/05/97	29	Hanging	Prison	Glebe
99/96	13/01/96	Long Bay	26/06/97	31	Hanging	Prison	Glebe
675/96	07/04/96	Long Bay	08/04/97	27	Drug overdose	Prison	Glebe
503/96	08/05/96	Wetherill Park	01/12/97	52	Gunshot	Police Operation	Westmead
1083/96	6/06/96	Long Bay	09/05/97	30	Drug overdose	Prison	Glebe
2268/96	11/06/96	Lithgow	14/05/97	27	Inquest terminated	Prison	Lithgow
1310/96	06/07/96	Queanbeyan	19/03/97	62	Natural causes	Police operation	Queanbeyan
821/96	15/07/96	Parramatta	04/08/97	49	Natural causes	Prison	Westmead
1048/97	29/07/96	Randwick	19/11/97	48	Assault injuries	Prison	Lithgow
1578/96	08/08/96	Long Bay	21/01/97	41	Natural causes	Prison	Glebe
1585/96	08/08/96	Junee	11/04/97	68	Natural causes	Prison	Wagga Wagga
1673/96	18/08/96	Long Bay	18/11/97	22	Drug overdose	Prison	Glebe
2359/96	28/08/96	Cessnock	12/03/97	78	Natural causes	Prison	Raymond Terrace
1085/96	09/09/96	Horsley Park	23/07/97	16	Multiple injuries	Police operation	Westmead
1884/96	15/09/96	Kirkconnell	09/10/97	65	Natural causes	Prison	Glebe
2026/96	20/09/96	Islington	06/03/97	25	Gunshot	Police operation	Newcastle
1194/96	03/10/96	Parramatta	14/04/97	49	Hanging	Prison	Westmead
1282/96	24/10/96	Werrington	10/04/97	53	Gunshot	Police operation	Westmead
2193/96	29/10/96	Goulburn	21/01/97	48	Natural causes	Prison	Glebe
2315/96	16/11/96	Port Macquarie	22/07/97	35	Hanging	Prison	Port Macquarie
2575/96	25/12/96	Wee Waa	21/11/97	36	Gunshot	Police operation	Narrabri
2598/96	29/12/96	Strathcedar	30/09/97	54	Gunshot	Police operation	Forster
2600/96	30/12/96	Kensington	06/08/97	27	Multiple injuries	Police operation	Glebe
7/97	01/01/97	Long Bay	24/06/97	42	Natural causes	Prison	Glebe
86/97	10/01/97	Lidcombe	04/09/97	19	Multiple injuries	Police operation	Glebe
122/97	16/01/97	Goulburn	26/11/97	46	Hanging	Prison	Goulburn
139/97	19/01/97	Newtown	21/03/97	17	Inquest terminated	Police operation	Glebe

Appendix 1: (con't)

Summary of inquests heard or terminated in 1997

File number	Date of death	Place of death	Date of finding	Age at death (years)	Manner of death	Circumstances	Place of Inquest
209/97	29/01/97	Cavan via Yass	11/09/97	50	Gunshot	Police operation	Yass
149/97	7/02/97	Parramatta	22/05/97	24	Hanging	Prison	Westmead
762/97	22/02/97	Cooma	15/10/97	28	Natural causes	Prison	Cooma
418/97	05/03/97	Lakes Heights	24/09/97	34	Self inflicted knife wound	Police operation	Wollongong
509/97	19/03/97	Long Bay	22/09/97	51	Natural causes	Prison	Glebe
566/97	29/03/97	Villawood	02/09/97	36	Gunshot	Police operation	Glebe
702/97	12/04/97	Parklea	17/12/97	27	Hanging	Prison	Glebe
492/97	03/05/97	Silverwater	14/10/97	31	Natural causes	Prison	Westmead
642/97	09/06/97	Parramatta	15/09/97	37	Drug overdose	Prison	Westmead
920/97	04/08/97	Westmead	02/10/97	19	Inquest terminated	Police operation	Westmead

Appendix 2:

Summary of other deaths in custody/police operations before the State Coroner in 1997, and for which inquests are not completed.

File number	Date of death	Place of finding	Age at death (years)	Circumstances
581/94	21/03/94	Long Bay	48	Death in custody
948/95	22/05/95	Long Bay	24	Death in custody
396/96	27/02/96	Gold Coast	26	Death in custody
1278/96	03/07/96	Bathurst	27	Death in custody
1760/96	30/08/96	Long Bay	44	Death in custody
19/97	02/01/97	Goulburn	29	Death in custody
261/97	09/02/97	Long Bay	31	Death in custody
513/97	19/03/97	Lithgow	23	Death in custody
668/97	10/04/97	Lithgow	51	Death in custody
778/97	30/04/97	Orange	20	Police operation
823/97	08/05/97	Camperdown	17	Police operation
869/97	13/05/97	Goulburn	26	Death in custody
893/97	17/05/97	Maitland	47	Death in custody
931/97	22/05/97	Junee	29	Death in custody
986/97	31/05/97	Goulburn	26	Death in custody
1073/97	08/06/97	Goulburn	46	Death in custody
<i>Hanging Suicide</i> 1262/97	14/06/97	Muswellbrook	28	Death in custody
1157/97	19/06/97	Waterloo	15	Death in custody
1228/97	28/06/97	Bondi	33	Police operation
753/97	01/07/97	Parramatta	20	Death in custody
1375/97	13/07/97	Lithgow	24	Death in custody
1376/97	13/07/97	Newcastle	28	Death in custody
<i>Hanging Suicide</i> 1409/97	18/07/97	Junee	54	Death in custody
1423/97	19/07/97	Dubbo	28	Death in custody
1532/97	01/08/97	Long Bay	62	Death in custody
<i>Natural Causes</i> 1533/97	01/08/97	Long Bay	22	Death in custody

Appendix 2 (con't):

Summary of other deaths in custody/police operations before the State Coroner in 1997, and for which inquests are not completed.

File number	Date of death	Place of finding	Age at death (years)	Circumstances
1672/97	17/08/97	Long Bay	52	Death in custody
1739/97	23/08/97	Lithgow	24	Death in custody
1816/97	01/09/97	Bathurst	33	Death in custody
2011/97	29/09/97	Grafton	25	Police operation
1256/97	15/10/97	Parklea	54	Death in custody
2165/97	20/10/97	Long Bay	54	Death in custody
2197/97	25/10/97	Silverwater	22	Death in custody
2022/97	26/10/97	Muswellbrook	29	Death in custody
2209/97	27/10/97	Cessnock	19	Death in custody
2217/97	29/10/97	Gouburn	43	Death in custody
2276/97	05/11/97	Bulli Tops	24	Police operation
1354/97	11/11/97	Fairfield	17	Police operation
2343/97	12/11/97	Tamworth	32	Death in custody
1382/97	20/11/97	St Marys	47	Death in custody
2458/97	29/11/97	Belrose	36	Police operation
2483/97	01/12/97	Silverwater	32	Death in custody
2528/97	06/12/97	Kanwal	31	Police operation
69/97	14/12/97	Wagga Wagga	29	Police operation
2595/97	17/12/97	Randwick	45	Death in custody
1509/97	20/12/97	Liverpool	32	Death in custody
2675/97	26-27/12/97	Silverwater	41	Death in custody

