Report by the NSW State Coroner

into deaths in

custody/police operations

for the year 2017.

A report Prepared pursuant to s23 of the *Coroners Act 2009* (NSW)
NSW Office of the State Coroner
NSW Department of Attorney General and Justice
ISSN No: 1323-6423

Report by the NSW State Coroner

into deaths in

custody/police operations

for the year 2017.

The Hon. Mark Speakman SC, MP
Attorney General and Minister for Justice
Level 15, 52 Martin Place
Sydney NSW 2000

2nd April 2018

Dear Attorney General,

Section 37(1) of the Coroners Act 2009 ('the Act') requires that I provide to you annually, a summary of all deaths in custody and deaths in a police operation that were reported to a coroner in the previous year. Inquests are mandatory in such cases but many of those deaths that occurred last year have not yet been finalised. I have also included a summary of those deaths which were reported in previous years but only finalised last year.

I attach a hard copy and an electronic copy of the 2017 report.

Section 37(3) requires that you cause a copy of the report to be tabled in each House within 21 days of receipt.

The deaths in question are defined in Section 23 and include deaths that occur while the deceased person is in the custody of a police officer or in other lawful custody, or while the person is attempting to escape. Also included are deaths that occur as a result of police operations, or while the person is in or temporarily absent from a child detention centre or an adult correctional centre.

As you would appreciate, deaths in prisons have for centuries been recognised as sensitive matters warranting independent scrutiny. Similarly, deaths occurring as a result of police operations which include shootings by police officers, shootings of police officers and deaths occurring as a result of a police pursuit, also attract public and media attention.

The inquest findings referred to are available on the Coroners Court webpage at: http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx for inquest findings. Please do not hesitate to contact me if you wish to discuss any of the matters contained in the report or would like further details of any of the matters referred to.

Yours faithfully,

Magistrate Teresa O'Sullivan
(Acting NSW State Coroner)

2017- Overall Summary in Brief

- A total of forty seven (47) deaths subject to s.23 of the Coroners Act were reported to the State Coroner in the calendar year 2017. This figure represents an increase of ten (10) deaths from the previous annual report for the year 2016.

- In 2017, the State Coroner and Deputy State Coroners completed a total of twenty six (26) s.23 inquests. A further inquest was suspended following the charging of a person with the death.

- As at the 31st December 2017 there are one hundred and five (105) unfinalised s.23 deaths compared to seventy six (76) unfinalised matters from the previous report in 2016.

- Twelve (12) of the forty seven (47) deaths reported in 2017 were as a result of natural causes compared to 2016 where fourteen (14) of the deaths reported were as a result of natural causes.

- Deaths as a result of natural causes still remains the highest manner of death followed by motor vehicle collision of which ten (10) deaths were recorded of this type in 2017.

- Five (5) Aboriginal deaths were recorded in 2017, an increase of one (1) death from 2016. Four (4) of these deaths occurred in custody and one (1) as a result of police operation. Two (2) as a result of hanging, one (1) as a result of natural causes, one (1) as a result of a motor vehicle collision and one (1) is yet to be determined.

- Forty five (45) of the forty seven (47) overall deaths were male.

- One (1) of the deaths in custody was as a result of alleged homicide by another inmate.

- One (1) person died in detention at the Villawood Immigration Detention Centre.

- The death occurring at Villawood Detention Centre was by way of natural causes.

- Of the forty five (45) male deaths, thirty three (33) of them were over the age of thirty (30) years.

- Of the two (2) female deaths, both died in a Police Operation as a result of a fall or jump and both were over the age of forty (40).

- Of the twenty seven (27) persons who died in custody fourteen (14) were on remand and thirteen (13) were serving a sentence.

STATUTORY APPOINTMENTS

Pursuant to Section 22(2) of the *Coroners Act 2009*, 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 inquests detailed in this report were conducted before the following Senior Coroners:

NSW State and Deputy Coroners 2017

His Honour Magistrate MICHAEL BARNES

NSW State Coroner (Resigned, December 2017)

1982- 1987	Solicitor in private practice
1987 -1990	Principal Solicitor, Aboriginal Legal Service
1990-1993	Principal Legal Officer, Criminal Justice Commission
1993-1999	Chief Officer, Complaints Section, Criminal Justice Commission
2000-2003	Head, School of Justice Studies, Queensland University of Technology
2003-2013	Queensland State Coroner
2013	Appointed NSW Magistrate
2014	Appointed NSW State Coroner

Her Honour Magistrate TERESA O'SULLIVAN (A/State Coroner from December 2017)

Deputy State Coroner

1987	Admitted as solicitor of Supreme Court of QLD
1987-89	Solicitor, Legal Aid QLD
1989-90	Solicitor, Child Protection, Haringey Borough, London
1990	Admitted as solicitor Supreme Court of NSW
1990-97	Solicitor, Marrickville Legal Centre, Children's Legal Service
1998-03	Solicitor, Central Australian Aboriginal Legal Aid Service, Alice Springs
2003-08	Solicitor, Legal Aid NSW, Children's Legal Service
2008-09	Solicitor, Legal Aid NSW, Coronial Inquest Unit
2009	Appointed Magistrate Local Court NSW
2015	Appointed NSW Deputy State Coroner

Her Honour Magistrate HARRIET GRAHAME

Deputy State Coroner

1993	Admitted as a solicitor of the Supreme Court of NSW
1993-2001	Solicitor at Redfern Legal Centre, Western Aboriginal Legal Centre & NSW Legal Aid Commission
2001-2006	Barrister
2006-2010	Lectured in Law (Various Universities)
2010	Appointed a Magistrate in NSW
2015	Appointed NSW Deputy State Coroner

His Honour Magistrate Derek Lee

Deputy State Coroner

1997:	Admitted as a solicitor of the Supreme Court of NSW
1998-2002:	Solicitor, Office of the Director of Public Prosecutions (ODPP)
2002-2005:	Senior Solicitor, ODPP Special Crime Unit
2005-2007:	Solicitor, Legal Aid (Inner City Local Courts)
2007-2012:	Barrister
2012:	Appointed NSW Local Court Magistrate
2016:	Appointed NSW Deputy State Coroner

Her Honour Magistrate Elizabeth Ryan

Deputy State Coroner

1986	Admitted as solicitor of Supreme Court of NSW
1986-1987	Solicitor, Bartier Perry & Purcell Solicitors
1988-2003	Litigation Lawyer, Commonwealth Director of Public Prosecutions
2003-2009	Managing Lawyer, Commonwealth Director of Public Prosecutions.
2009	Appointed a Magistrate, NSW Local Court
2017	Appointed a NSW Deputy State Coroner.

CONTENTS

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 recommendations of the Royal Commission into Aboriginal Deaths in Custody 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, police custody, detention as a juvenile or detention pursuant to the Migration *Act 1958* (Cth);
- 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;
- 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
- 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.

Section 23 of the *Coroners Act 2009* (NSW) expands this definition to include circumstances where the death occurred:

- while temporarily absent from a detention centre, a prison or a lock-up; and
- 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 relation to those cases where an inquest has yet to be heard and completed, no conclusion can be drawn that the death necessarily occurred in custody or during the course of police operations.

This is a matter for determination by the Coroner after all the evidence and submissions have been presented at the inquest hearing.

Intensive Correction Orders

Where the death of a person occurs whilst that person is serving an Intensive Correction Order, such death will be regarded as a death in custody pursuant Section 23 of the *Coroners Act 2009* (NSW).

Corrective Services NSW has a policy of releasing prisoners from custody prior to death, in certain circumstances. This generally occurs where such prisoners are hospitalised and will remain hospitalised for the rest of their lives.

Whilst that is not a matter of criticism it does result in a "technical" reduction of the actual statistics in relation to deaths in custody. In terms of Section 23, such prisoners are simply not "in custody" at the time of death.

---

[1] *Recommendation 41, Aboriginal Deaths in Custody*: *Responses by Government to the Royal Commission 1992 pp 135-9*

Standing protocols provide that such cases are to be investigated as though the prisoners are still in custody.

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

A death which occurs 'as a result of or in the course of a police operation' is not defined in the *Coroner's Act 2009*. Following the commencement of the 1993 amendments to the *Coroners Act 1980*, New South Wales *State Coroner's Circular No. 24* sought to describe potential scenarios that are likely deaths 'as a result of, or in the course of, a police operation' as referred to in Section 23 of the *Coroners Act 2009*, as follows:

- **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**
- **any other circumstance considered applicable by the State Coroner or a Deputy State Coroner.**

After more than twenty years of operation, most of the scenarios have been the subject of inquests.

The Senior Coroners have tended to interpret the subsection broadly. This is so that the adequacy and appropriateness of police response and police behaviour generally will be investigated where we believe this to be necessary. It is critical that all aspects of police conduct be reviewed notwithstanding the fact that for a particular case it is unlikely that there will be grounds for criticism of police.

It is important that the relatives of the deceased, the New South Wales Police Force and the public generally have the opportunity to be made aware, as far as possible, of the circumstances surrounding the death. In most cases where a death has occurred as a result of or in the course of a police operation, the behaviour and conduct of police is found not to warrant criticism by the Coroner's.

We will continue to remind both the NSW Police Force and the public of the high standard of investigation expected in all Coronial cases.

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

In this regard, I agree with the answer given to that question by former New South Wales Coroner, Mr Kevin Waller, as follows:

> *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*[2]*.*

I also agree 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*[3]*.*

Coronial investigations into deaths in custody are an important tool for monitoring standards of custodial care and provide a window for the making and implementation of carefully considered recommendations.

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

As soon as a death in custody/police operation occurs in New South Wales, the local police are to promptly contact and inform the Duty Operations Inspector (DOI) who is situated at VKG, the police communications centre in Sydney.

The DOI is required to notify immediately the State Coroner or a Deputy State Coroner, who are on call twenty-four hours a day, seven days a week. The Coroner so informed, and with jurisdiction, will assume responsibility for the initial investigation into that death, although another Coroner may ultimately finalise the matter. The Coroner's supervisory role of the investigations is a critical part of any coronial inquiry.
Upon notification by the DOI, the State Coroner or a Deputy State Coroner will give directions for experienced detectives from the Crime Scene Unit (officers of the Physical Evidence Section), other relevant police and a coronial medical officer or a forensic pathologist to attend the scene of the death.

The Coroner will check to ensure that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Where aboriginality is identified, the Aboriginal Legal Service is contacted.

---

[2] *Kevin Waller AM. Coronial Law and Practice in New South Wales, Third Edition, Butterworth's, page 28*

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

Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit and the Forensic Pathologist. 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 the inquest.

If the State Coroner or one of the Deputy State Coroner's is unable to attend a death in custody/police operations occurring in a country area, the State Coroner may request the local Magistrate Coroner to attend the scene.

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

In cases involving the NSW Police

When informed of a death involving the NSW Police, 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 Coroner's may request the Crown Solicitor of New South Wales to instruct independent Counsel to assist the Coroner with the investigation 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 investigation 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 and direction hearings will often take place between the Coroners, Counsel assisting, legal representatives for any interested party and relatives so as to ensure that all relevant issues have been identified and addressed.

In respect of all identified Section 23 deaths, post mortem experienced Forensic Pathologists at Glebe or Newcastle conduct examinations.

Responsibility of the Coroner

Section 81 of the *Coroners Act 2009* (NSW) provides*:*

> **81 Findings of Coroner or jury verdict to be recorded**
>
> (1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so:
>
> (a) the person's identity, and
>
> (b) the date and place of the person's death, and
>
> (c) in the case of an inquest that is being concluded—the manner and cause of the person's death.
>
> (3) Any record made under subsection (1) or (2) must not indicate or in any way suggest that an offence has been committed by any person.

Section 78 of the *Coroners Act 2009* (NSW) provides:

78 Procedure at inquest or inquiry involving indictable offence

This section applies in relation to any of the following inquests:

(a) an inquest or inquiry held by a Coroner to whom it appears (whether before the commencement or during the course of the inquest or inquiry) that:

(i) a person has been charged with an indictable offence, and

(ii) the indictable offence raises the issue of whether the person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.

(b) an inquest or inquiry if, at any time during the course of the inquest or inquiry, the Coroner forms the opinion (having regard to all of the evidence given up to that time) that:

(i) evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, and

(ii) there is a reasonable prospect that a jury would convict the known person of the indictable offence, and

(iii) the indictable offence would raise the issue of whether the known person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.

(2) If this section applies to an inquest or inquiry as provided by subsection (1)(a) the Coroner:

(a) may commence the inquest or inquiry, or continue it if it has commenced, but only for the purpose of taking evidence to establish:

(i) in the case of an inquest—the death, the identity of the deceased person and the date and place of death, or

(ii) in the case of an inquiry—the date and place of the fire or explosion, and after taking that evidence (or if that evidence has been taken), must suspend the inquest or inquiry and, if there is a jury, must discharge the jury.

(3) If this section applies to an inquest or inquiry as provided by subsection (1)(b) the Coroner may:

(a) continue the inquest or inquiry and record under section 81(1) or (2) the Coroner 's findings or, if there is a jury, the verdict of the jury, or

(b) suspend the inquest or inquiry and, if there is a jury, discharge the jury.

(4) The Coroner is required to forward to the Director of Public Prosecutions:

(a) the depositions taken at an inquest or inquiry to which this section applies, and:

(b) in the case of an inquest or inquiry referred to in subsection (1) (b) - a written statement signed by the Coroner that specifies the name of the known person and the particulars of the indictable offence concerned.

Role of the Inquest

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 and Police Operations 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 in physical surroundings, which may reduce the risk of suicide in the future.

Similarly in relation to police operations and other forms of detention the Coroner will investigate the appropriateness of actions of police and officers from other agencies and review standard operating procedures. In other words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist and, if so, ensure, 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 been given statutory authorisation pursuant to Section 82 of the *Coroners Act 2009*. This section indicates that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations.

Any statutory recommendations made following an inquest should arise from the facts of the enquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. The Coroner requires, in due course, a reply from the person or body to whom a recommendation is made.

Acknowledgment of receipt of the recommendations made by a Coroner is received from Ministers of the Crown and other authorities promptly.

Unavoidable delays in hearing cases

The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is at times unavoidable and there are many various reasons for delay.

The view taken by the State Coroner is that deaths in custody/police operations must be fully and properly 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 comprehensive 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 results of those investigations may have to be considered by the Coroner prior to the inquest as they could raise further matters for consideration and perhaps investigation.

Table 1: **Deaths in Custody/Police Operations, for the period to 2017.**

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32
2007	17	11	28
2008	14	10	24
2009	12	18	30
2010	23	18	41
2011	20	9	29
2012	20	21	41
2013	26	17	43
2014	14	13	27
2015	26	15	41
2016	16	21	37
2017	28	19	47

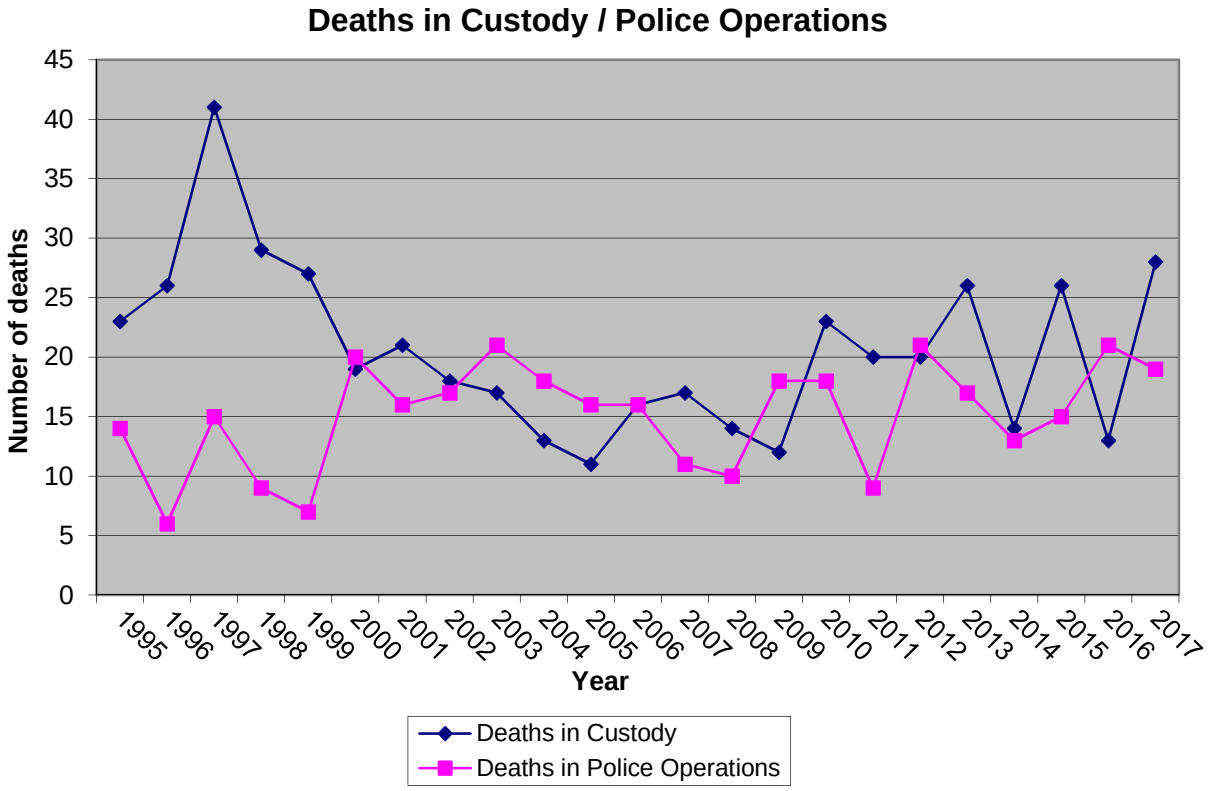
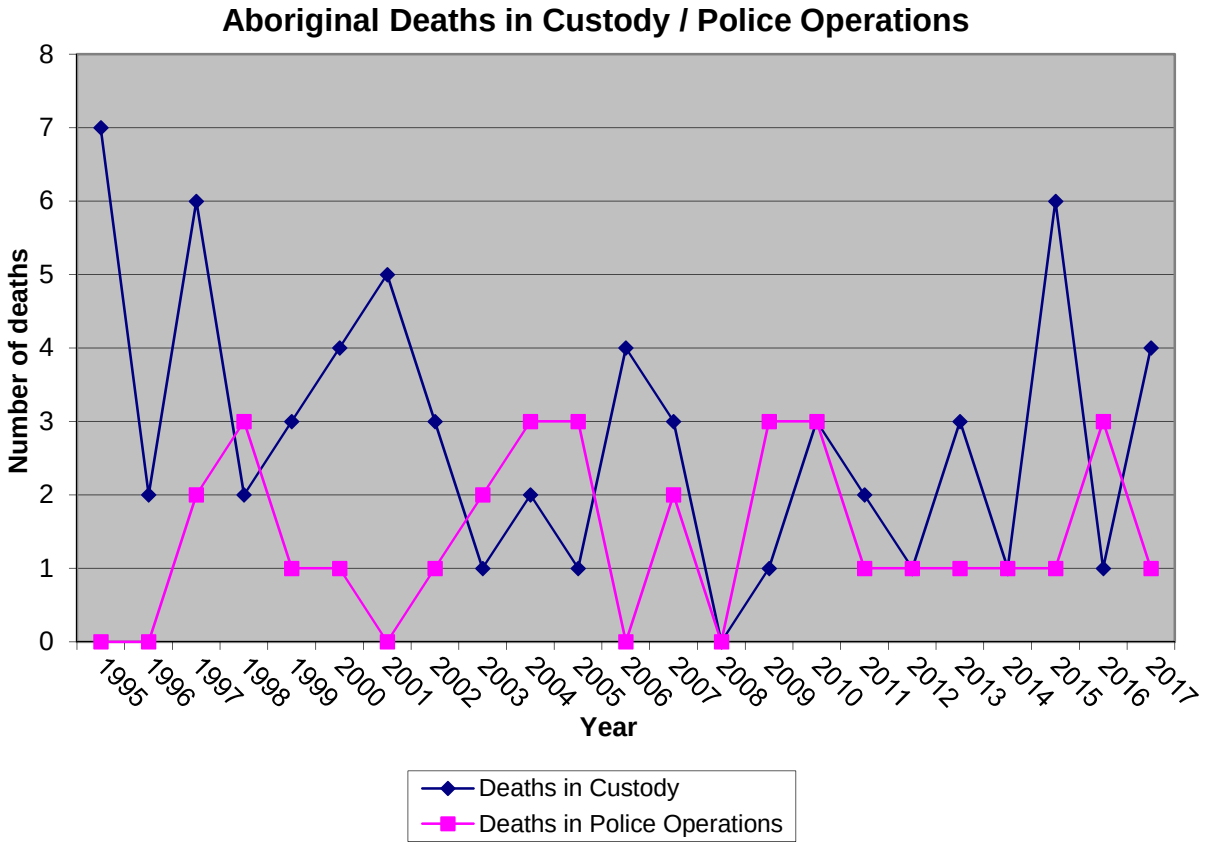


Table 2: Aboriginal deaths in custody/police operations 2017

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	7	0	7
1996	2	0	2
1997	6	2	8
1998	2	3	5
1999	3	1	4
2000	4	1	5
2001	5	0	5
2002	3	1	4
2003	1	2	3
2004	2	3	5
2005	1	3	4
2006	4	0	4
2007	3	2	5
2008	0	0	0
2009	1	3	4
2010	3	3	6
2011	2	1	3
2012	1	1	2
2013	3	1	4
2014	1	1	2
2015	6	1	7
2016	1	3	4
2017	4	1	5



Circumstances of deaths of persons who died in Custody/Police Operations in 2017:

12 x Natural Causes

5 x Fall/Jump

4 x Gunshot/Firearm

10 x Motor Vehicle Collision

1 x Unknown

8 x Hanging

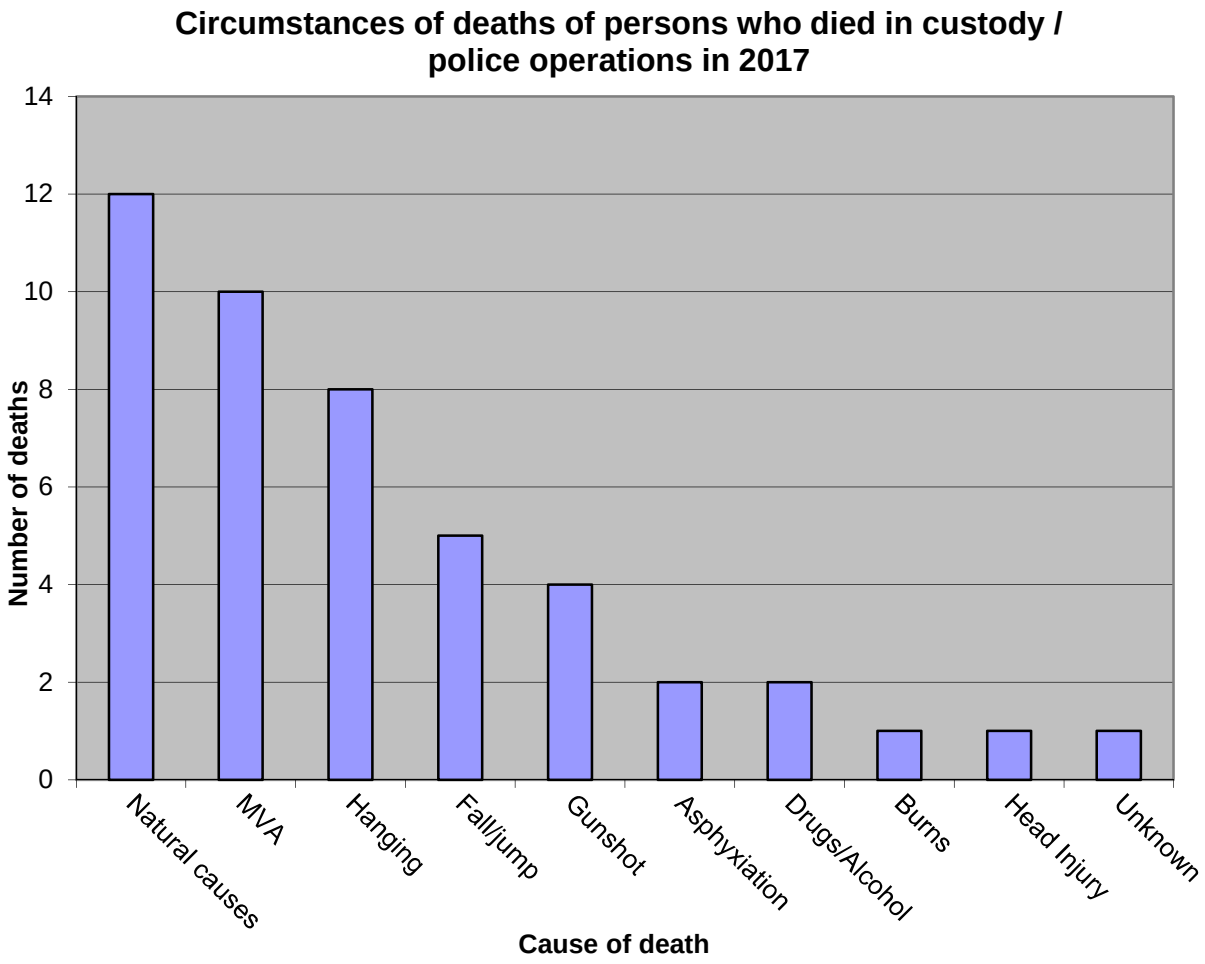
2 x Asphyxiation

1 x Head Injury

1 x Burns

2 x Drugs/Alcohol

1 x Assault



SECTION 23 INQUESTS UNDERTAKEN IN 2017

Following are the written findings of each of the cases of deaths in custody/police operations that were heard by the NSW State Coroner or Deputy State Coroner in 2017. These findings include a description of the circumstances surrounding the death and any recommendations that were made. **Please note:** Pursuant to Section 75(1) & (5) of the *Coroner's Act 2009* the publication of the names of persons has been removed where the finding of the inquest is that their death was self inflicted, unless the Coroner has directed otherwise*. **The deceased names will be referred to as a pseudonym.***

	Case No	Year	Name	Coroner
1	189678	2012	Paigh Bartholomew	DSC Barry
2	114526	2013	DW	SC Barnes
3	162787	2013	Keith Howlett	DSC Grahame
4	177495	2013	Edward Haenga	DSC Lee
5	173338	2014	Benjamin Gilligan	DSC Grahame
6	59894	2014	PM	DSC Grahame
7	261690	2014	David Lobejko	SC Barnes
8	286081	2014	John Inman Bale	DSC Grahame
9	307093	2014	Garry Weigand	DSC Lee
10	315543	2014	Ronald Brizzolora	DSC O'Sullivan
11	368701	2014	Tori Johnson	SC Barnes
12	368881	2104	Katrina Dawson	SC Barnes
13	369898	2014	Man Haron Monis	SC Barnes
14	11170	2015	Kevin Norris	SC Barnes
15	24641	2015	Donald McKinnon	DSC Ryan
16	59013	2015	Warren Maguire	DSC Barry
17	64099	2015	MC	DSC Grahame
18	254391	2015	KE	DSC Grahame
19	377772	2015	Bruce Thomas	DSC O'Sullivan
20	11257	2016	LP	DSC Barry
21	131207	2016	RP	DSC Grahame
22	26063	2016	Kerry Forrest	DSC Lee
23	234818	2016	Bruce Burrell	DSC Lee
24	259112	2016	BJ	DSC Grahame
25	314488	2016	Colin Hay	DSC Lee
26	94667	2016	Glennon Johnstone	DSC Grahame

1. 189678 of 2012

Inquest into the death of Paigh Bartholomew. Finding handed down by Deputy State Coroner Barry at Glebe on the 25th July 2017.

On 16 June 2012, Paigh Bartholomew was found unresponsive by Corrective **Services staff, supine on a mattress in the house she shared with nine other inmates** of the minimum security complex at Emu Plains Correctional Centre (EPCC). She had received a quantity of drugs the previous evening she took the drugs via injection and later manifested into decreasing consciousness. She was found deceased by staff at approximately 7.30am. She was only 21 years old.

Paigh Bartholomew:

Counsel representing Paigh's family read a statement to the Court from Ms Kerrie Bartholomew, Paigh's aunt. In that statement Kerrie described how she had raised Paigh from the age of 13 months to 18 years. Paigh was described as a happy child and full of energy, who had a loving relationship with Kerrie and her, other daughters.

Regrettably Paigh's father died whilst he was in custody and her mother exhibited scant interest in her. For the rest of her life Paigh struggled to come to terms with the fact that her parents were not part of her life.

Paigh loved drama, music and art and was described as a "social butterfly". She was thoughtful and compassionate, baked for the local Sunday school and attended church regularly. As she entered into her teens Paigh found it more difficult to reconcile the fact that her mother had no involvement with her. In her statement, Kerrie described Paigh as going "off the rails". By the age of 18, Paigh was pregnant and already addicted to drugs. Her baby was taken from her and this exacerbated her deteriorating behaviour.

Kerrie loved her very much as did a large number of the Glebe community where Paigh had grown up. She is very much missed by Kerrie and her daughters and by the members of the Glebe community.

The Inquest:

The role of the Coroner as set out in s.81 of the *Coroner's Act 2009* (the Act") is to make findings as to:

(a) the identity of the deceased
(b) the date and place of the person's death;
(c) the physical or medical cause of death; and
(d) the manner of death, in other words, the circumstances surrounding the death.

The focus of this inquest is the manner of Paigh Bartholomew's death and the actions of those persons whose duty it was to supervise her at Silverwater Women's Correctional Centre (Silverwater) and Emu Plains Correctional Centre (EPCC).

Paigh's death was reported to the Coroner as it occurred whilst she was an inmate at EPCC. In these circumstances an inquest is mandatory pursuant to the combination of ss.23 and 27 of the *Coroner's Act 2009.*

"The purpose of a s.23 inquest is to fully examine the circumstances of a death…in order that the public, relatives and the relevant agencies can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."(Waller, Coronial/ Law and Practice in New South Wales, p.106).

The Evidence:
The Autopsy

An Autopsy Report was prepared by Forensic Pathologist, Dr Rebecca Irvine. Dr Irvine reported that the cause of death was **"Mixed Heroin and Alprazolam Toxicity**".

Paigh was found to have a 0.4cm area of red ecchymosis on her right arm, containing an apparent recent puncture site. Toxicology detected a therapeutic concentration of alprazolam and a therapeutic concentration of morphine, as well as a sub-therapeutic concentration of paracetamol.

Morphine is the immediate metabolite of heroin in the body, and urine tests indicated heroin was the parent drug of morphine in this case.

The Autopsy Reports records that *"Although the morphine and alprazolam are both in the therapeutic or non-toxic range, their combined depressive effects on the central nervous system would be expected to be greater than the simple addition of their effects. Further, examination of the suspected injection site* shows *an early inflammatory response and the lungs had developing pneumonia; these changes would take* a *few hours to become apparent. The pneumonia suggests a period of several hours of decreased responsiveness."*

The events at Silverwater Women's Correctional Centre:

Between 26 March 2012 and 12 April 2012, Paigh was in custody, on remand at Silverwater. She had been charged with breach of bond, supplying a prohibited drug and possession of a prohibited drug. She was released on bail on 12 April 2012 and readmitted to custody on 27 April 2012, for breaching her bail conditions and further offences. On 27 April 2012 she had been travelling (with two men) in a vehicle that was stopped by NSW Police and when searched, it was found that she had over 9 grams of brown powder (which, when tested was found to contain heroin) in her possession. She remained in custody, on remand, until her death.

On 2 May 2012, at Silverwater, a random search of inmates was conducted by the State Emergency Unit (a unit within Corrective Services NSW) and Silverwater staff in the induction area. Paigh was observed to drop a package to the ground by Silverwater staff.

As a result, she was strip searched and admitted to dropping the package and to possessing another smaller package in her underpants. Paigh claimed to have picked up the packages in her cell, where they had been hidden behind the television. She claimed not to know what was in the packages. During the search, Senior Correctional Officer (SCO) Renee Craft, an officer with the K9 Unit (part of the State Emergency Unit), opened the packages and found them to contain a brown" dough-like" substance. From her work with the K9 unit, SCO Craft had had some experience in identifying drugs.

In her oral evidence, she described the substance as looking like" cookie dough". She broke the "dough ball" apart and found it to be a 'wet type of texture'. It did not have any smell. The larger package was wrapped in CSI (Corrective Service Industries) type wrapping with black plastic around it and bound by sticky tape. Despite requesting the dog handler to 'run' past the drugs again, the dog gave no indication that the package contained drugs.

SCO Craft gave evidence that she had completed a 13 week canine course where she had been shown pictures and actual samples of drugs. She had been shown various types of heroin and knew that there were a number of different types and colours of heroin. On training days, the K9 Unit was kept informed of any new type of heroin in circulation.

Her evidence was that she had" not seen any drug like this". The relevant Corrective Services policy at the time (part of the Corrective services Operations Procedures Manual) stated:

"Drugs are unknown substances until analysed. Correctional centre staff must operate on the premise that the suspected substance is a *prohibited drug"*

SCO Craft sealed the substance in an exhibit bag and in compliance with the policy, treated it as though it was a drug. She entered the packages in the exhibit safe at Silverwater. SCO Craft spoke with Acting Manager of Security (MOS), at the time SAS Diane O'Donoghoe, and told her that she did not know what was contained in the packages.

SCO Craft gave evidence that she formed the view, after discussion with SAS O'Donoghoe that she could not charge Paigh because she did not know what she would be able to charge her with. SCO Craft then prepared a synopsis report and an Incident Reporting Module (IRM). Those reports were emailed to the General Managers at Silverwater and for the State Emergency Unit and the Acting MOS at Silverwater.

SCO Craft understood that her synopsis report would be read by the General Manager at Silverwater who would see that the packages had been seized and entered into the exhibit safe. Within that report it was recorded that the two packages weighed 17.8g for the larger package and 1.6g for the smaller one. SCO Craft recorded in that document that the packages contained a "brown unknown substance". It was not until after Paigh died that those packages were, in fact analysed. It was revealed that the substance in the larger package was 14.7g of heroin (at 15.5% purity) and a further 1.1g of heroin (purity not tested) in the smaller package.

SAS O'Donoghoe was the Acting MOS at Silverwater on 2 May 2012. After the packages were located, she attended the induction unit and spoke with SCO Craft. She recalls being told by SCO Craft that some "stuff' had been found on an inmate but that it was not known what it was. At that time SAS O'Donoghoe dismissed the incident. She stated that this was because SCO Craft had told her that she didn't think the item was anything in particular and it was not known what the substance was.

SAS O'Donoghoe stated that she recalled seeing the substance which she described as being, "like a balled up piece of bread". She had not seen any substance like that before and she told the court that she had little knowledge in relation to the identification of drugs. She stated that if SCO Craft couldn't identify the substance, as a member of the K9 Unit with experience handling drugs, the she did not feel she would be able to either. She did not think to check the exhibit safe to see if in f*act* the item had been deposited there.

In her oral evidence SAS O'Donoghoe stated that she did not recall seeing the report that SCO Craft had emailed to her nor did she recall seeing the incident details contained within the IRM. However, she did not dispute that it was likely that SCO Craft sent her the report via email and stated, "If she (SCO Craft) said that she did, then she did". When the relevant Corrective Services policy was drawn to SAS O'Donaghoe's attention, she agreed that the policy indicated that any unknown substance must be treated as a drug until the unknown substance is analysed. A report by Officer Wayne Taylor, MOS of Silverwater from 2012, dated 25 June 2012, states:

"I have formed the opinion that procedures relating to the discovery of drugs and other contraband were not followed by staff after the search of inmate Bartholomew and regardless of personal opinions the seized items should have been treated as a *drug and comprehensive reports should have been submitted by all staff involved in the search and appropriate actions should have been implemented to have the matter investigated and dealt with internally or handed over to New South Wales Police which I believe would have been the more prudent option."*

In her oral evidence, SAS O' Donoghoe accepted those conclusions and agreed that she "should have alerted police to the presence of the package". She further stated. "It was reported to me so I should have called the police" She agreed that she did not follow policy in relation to the packages. Regrettably, SAS O'Donaghoe's late concessions as to her failure to follow policy in relation to the discovery of the packages on 2 May 2012 did not assist SCO Craft, who faced disciplinary action for her role in the matter, notwithstanding the fact that SCO Craft had indeed followed procedure by preparing an IRM and placing the unknown substance in an exhibit bag and depositing it in the exhibit safe.

As a result of the failure of staff at Silverwater to properly follow procedure in relation to the discovery of the two packages in Paigh's possession, there was no assessment or review of her classification prior to her transfer to the minimum security facility EPCC.

SAS O' Donoghoe stated that, given the amount of drugs located in the two packages had there been a police investigation then that may well have had an impact on Paigh's classification and subsequent movement between correctional centres. She was unable to say that it certainly "would" have had an impact, but she said those factors would have been taken into consideration in a review of Paigh's classification and or placement and Paigh may not have been sent to a minimum security centre. Silverwater is a maximum security centre, but if Paigh had retained a minimum security classification after a review of her classification, it was possible she would not have been moved to EPCC.

The Events at Emu Plains Correctional Centre

(EPCC) is a minimum security correctional centre for females. It is a working dairy farm utilising the services of inmates to perform dairy farm duties. The centre has 11 accommodation houses in the main centre and a further 9 accommodation houses in what is known as the Jacaranda Centre which is an area outside the main confines of the gaol. Each residential house in the main centre has up to 10 inmates at any one time.

Each house has its own bathroom, kitchen and laundry with each bedroom positioned around a central lounge room of the house. All accommodation houses are positioned in the north eastern corner of the facility. The corner in which these accommodation houses are located is bounded on the northern side by a paddock. The eastern side is also bounded by a paddock and orchard, both of which form part of the EPCC external grounds.

The boundary fence of the Centre consists of a tall barrel roll fence which is unable to be scaled due to the barrel roll being positioned on the top of the fence. The area between the barrel roll fence and the internal fence surrounding the accommodation houses is what is known as the "sterile zone". The sterile zone is an area where inmates are prohibited from entering unless under supervision. This zone is designed to maintain a secure area between the accommodation houses and the other areas of the Centre. The zone is approximately five metres wide being measured from the barrel roll fence to the rear of the accommodation houses. The rear of each accommodation house backs onto the sterile zone and each bedroom has an external window which can be partially opened. These windows are secured by security mesh grille on the outer side of the window.

On 18 May 2012, Paigh was transferred to EPCC. She was accommodated in house 3, in a room with a window facing towards the external sterile zone.

The Anonymous Note

On 9 June 2012, Paigh received a visit from Nicholas Vossos. He was her only visitor on that day. On 11 June 2012, Senior Assistant Superintendent (SAS) Angelika Sassenberg received an "anonymous handwritten note initially given by an inmate to another officer. The information contained in that note suggested that Paigh had received heroin during the visit on 9 June 2012 and had been using drugs with other inmates in house 3. All inmates in House 3 had been "target" urine tested on 10 June 2012. The urine test results did not become available until after Paigh's death (Paigh did not test positive for any illicit drug in the sample taken on 10 June 2012).

As at 11 June 2012 SAS Sassenberg was acting as the Intelligence (Intel) Officer at EPCC. Following receipt of the anonymous note, SAS Sassenberg put in place the following management plan:

- She listened to telephone calls received by Paigh the previous week. It was clear to her that the substance of those telephone calls were to the effect that Mark Younis (who was listed as a "friend" on Paigh's list of permitted contact telephone numbers, and was listed in Corrective Services records as Paigh's next of kin) was arranging a delivery of an illicit drug to Paigh.

- SAS Sassenberg interviewed Paigh about the allegation contained in the anonymous note. Paigh denied the receipt of heroin, but when asked if her urine would come back clean she replied: "I don't know." SAS Sassenberg viewed this as an admission by Paigh in relation to the use of heroin.

- Paigh was told by SAS Sassenberg that she would be watched closely. Arrangements were made for Paigh to be monitored during any forthcoming weekend visit.

- SAS Sassenberg advised Paigh to make an appointment with the drug and alcohol counsellor regarding her addictions.

Following her discussion with Paigh, SAS Sassenberg spoke with another inmate, T, from House 3. Inmate T confirmed that Paigh had received "a drop of heroin and pot". SAS Sassenberg spoke to inmate T about any concerns with Paigh and the other residents in the house. Inmate T stated that there were concerns that some of the other residents might expect Paigh to try and collect more drugs, and that she, inmateT, would monitor this and look after Paigh. SAS Sassenberg gave evidence that she had known inmate T for a length of time and felt that she could relate to her and that T would tell her what was going on.

At that time, SAS Sassenberg did not believe she had sufficient evidence to consider an alteration to Paigh's housing arrangement.

Regrettably, SAS Sassenberg was not rostered to work on 14 and 15 June 2012 and there was no replacement for her as Intel Officer. Essentially, any intelligence that could have been gathered in those two days and any monitoring of Paigh, especially her telephone calls, could not be pursued...

On 17 June 2012, (the day after Paigh's death) SAS Sassenberg listened to telephone calls made by Paigh on the afternoon of 15 June 2012. Paigh had again contacted Mark Younis and Nicholas Vossos. Another inmate from the house, inmate A, can be heard speaking in one of those conversations. Five telephone calls were made by Paigh to the drug syndicate responsible for the delivery of drugs to Paigh. It was arranged that Mr Vossos and a female were to pass the heroin and syringes to Paigh that night. It was apparent to SAS Sassenberg, from the content of those telephone calls that the drugs were to be transported to the jail on the evening of 15 June 2012 and to be delivered at around 10:30 PM.

14 June 2012

There was evidence from several of the inmates in House 3 that Paigh had attempted to exit the house via a window on 14 June 2012; that is the night before the drug delivery. The evidence was that Paigh had kicked at the grille attached to the outside of the window and had dislodged it from the bottom of the frame. She was able to exit through that opening. Inmate T initially told police in a record of interview that this occurred on 14 June 2012.

However in her oral evidence inmateT insisted that this activity had taken place on 15 June 2012 only. Other inmates, inmates Pand L stated that an attempt had been made by Paigh on 14 June 2012 to escape by climbing through the window into the sterile zone.

That attempted escape cannot be confirmed one way or the other. Officer Angela West, who was the Manager of Security at the centre at that time, gave evidence that the relevant records indicated that perimeter checks by officers, which included the sterile zone, had been completed as per the standard protocols on the 14 June 2012 and until the evening of 15 June 2012.

In fact the records indicated that on 15 June 2012 there were two sterile zone checks during the course of one shift. All those officers involved (with the exception of Officers Duggan and Walker, whose evidence is considered below)) attested to the fact that they had correctly completed the checks of the sterile zone on that day.

In her oral evidence, MOS West expressed doubt that the attempt by Paigh to exit the house via the window had been made on 14 June 2012, as it would be expected that any damage to the window would have been discovered during those checks. On the one hand it would be surprising that the inmates would manufacture the information concerning 14 June 2012. These inmates did not give evidence and their statements could not therefore be tested.

On the other hand, if the officers, as they attest in their statements, performed their duty according to protocol and successfully completed the checks of the sterile zone, then over those five occasions between the evening of 14 and 15 June 2012, it is unlikely that the breach would have remained undiscovered. These officers did not give oral evidence and as such their written statements cannot be tested.

On the material before me, there is no evidence that the checks on the sterile zone on 14 June 2012 or on 15 June 2012 (until the night shift) were defective. In the circumstances I am unable to make a finding as to the events relating to the possible escape attempt by Paigh on 14 June 2012.

The Window Grilles

The windows of the houses facing the sterile zone are covered in a light alloy mesh grille. There is in place an EPCC standard operating procedure pertaining to the inspection of those grilles. At the time of these events that procedure entailed a requirement for the grilles to be visually and physically inspected on a daily basis at the commencement of each shift using either a hammer or another tool.

There was evidence that because of the nature of the material of the grille, the use of a hammer was considered to be inappropriate. Instead, it was generally the accepted practice that officers inspected the integrity of the grilles by physically grabbing the mesh and shaking it.

At the commencement of each shift two officers were directed by the Officer in charge to complete a perimeter check of the Centre which includes the inspection of the grilles.

Once the officers had completed the inspection they were to return to the main office and report any findings to the senior officer of the day. From time to time random checks (including the sterile zone) were conducted throughout the shift. As with the routine checks, these are recorded in the Security Compliance Journal by the senior officer on duty.

Correctional Officer (CO) Robert Hanigan, in his oral evidence, agreed that a check of the window grilles was usually completed by grabbing the mesh and shaking it. He also gave evidence that whilst there was always a check at the beginning of each shift, from time to time there was a second random check conducted on the night shift.

Corrections Officers West and Felstead also gave evidence of second random checks being carried out during a single shift from time to time. They confirmed that the usual practice of ensuring the grilles were secure was to physically grab the grille by hand and shake it.

I find that the accepted procedure for checking the window grilles was the physical grabbing of the mesh. The evidence suggests that this practice was sufficient to ensure the security of the grilles notwithstanding the written procedure. MOS West conducted 'validation' checks to ensure compliance with Corrective Services and EPCC policy and procedure. This included validation checks of the perimeter checks (including the sterile zone) and the results were entered into the Journal.

Prior to Paigh's death, the last time a validation check of perimeter checks had been performed by MOS West was 10 June 2012. On that day, MOS West physically attended the inspection of the sterile zone being undertaken by correctional officers and observed them to ensure that the checks were being correctly conducted. All windows facing the sterile zone were found to be secure on that day.

15 June 2012

On the evening of 15 June 2012, Mr Vossos and a female travelled to EPCC. At about 10pm they delivered an unknown quantity of heroin and syringes to Paigh through the boundary fence. Mr Vossos has been convicted of an offence of supplying a prohibited drug relating specifically to the supply of heroin at EPCC on 15 June 2012.

There are varying accounts from the inmates in House 3 in their statements (given on 16 June 2012) as to the events of the evening of 15 June 2012.

Inmate A heard a man's voice yelling from the outside fence.

Inmate C heard a loud bang from Paigh's room at about 10pm. She entered Paigh's room and helped her climb back in through the window. The mesh screen had been bent out. Inmate M stated that at about 10pm inmate A said "my baby is getting a drop". About 10 minutes later, Paigh emerged from her room and appeared white in colour and blue around the mouth.

Inmate D saw Paigh and inmates T and A emerge from Paigh's room at about 1Opm. They were all affected by drugs.

Inmate T was in Paigh's room with Paigh and inmate A. All three took heroin. There are conflicting accounts of the amount of heroin consumed.

Inmate A claimed in her recorded interview with police, to have consumed only a small amount orally, after which, she claims she left the room and fell asleep on the couch.

Inmate T stated to police that she observed Paigh holding a syringe full of dark brown liquid. She told Paigh there was too much in the syringe and that she should not inject that much. She saw Paigh inject about 40 lines on the syringe. According to inmate T's account, she injected about 10 lines on the syringe and inmate A consumed about the same amount as Paigh.

Following the consumption of the drugs, there are a number of accounts as to Paigh's appearance and demeanour.

Inmate J saw Paigh emerge from her room about 10.30pm. Her lips were blue, she could not open her eyes properly nor walk in a straight line. Inmate J said that Paigh looked like she was "ODing" and did not appear to be breathing properly.

Inmate C saw Paigh come out from her room and heard her chest making a rattling sound, which this inmate recognised from experience as being the sound of a person overdosing.

Inmate M stated she and a few other inmates walked Paigh around the house until about 1am. She further stated that inmate T obtained a mattress from Paigh's room and placed it on the living room floor.

Some inmates laid Paigh down on the mattress and rubbed her legs trying to keep her awake until about 1 or 2am. Inmate D stated that she was the inmate who laid Paigh on the mattress and that Paigh remained in the same position for about 40 minutes.

Inmate D stated that Paigh was still alive and breathing but "gasping" for air. Inmate D laid on the lounge and fell asleep, finally going to bed between 1 and 1:30am. She stated that Paigh was still breathing when she left the room.

Inmate C said she tried to help Paigh until about 2:30am. Initially Paigh had been sitting beside her on the lounge and she tried to keep Paigh's head propped up because she kept falling forward and backward.

The evidence from all the inmates is that they all eventually fell asleep.

Buzz Up - Knock up

The "buzz up" or “knock up" is a duress alarm system whereby inmates at EPCC can depress a button which alerts staff to a problem in the house. A number of inmates in their statements spoke of wanting to" buzz up" when they observed Paigh's poor condition. Inmate C stated that she wanted to 'buzz up' because to her it was obvious that Paigh was "going and she was overdosing and not in a good way".

In her statement, she spoke of a number of other inmates who wanted to 'buzz up. ‘She states that they were told not to “buzz up" by inmates A and T, because inmates A and T did not want staff to “ruin their stone". In her oral evidence, inmate T denied she had said this. Inmate T claimed that she told Paigh she was worried about her and wanted to 'buzz up' but it was Paigh who rejected that idea. Inmate T splashed water on Paigh's face and claimed to have stayed with her until about 2:30am.

In response to the suggestion by several of the inmates that they 'buzz up', inmate T stated in her oral evidence that it was inmate A who" went crazy" saying "if anyone buzzes up, I'll swear….". Inmate T claims this was said in a threatening manner and she also claims that Paigh was also insistent that there be no' buzz up' Inmate T agreed that she knew that if there had been a 'buzz up' then medical help would have been forthcoming.

What is clear is that none of the inmates 'buzzed up'

16 June 2012

On the morning of 16 June 2012, an officer conducting a check of the sterile zone shortly after 7am observed the grille on the window of room number 7, Paigh's window. The grille was not secured and appeared to have been kicked out from the inside.

SAS Sassenberg was notified. SAS Sassenberg attended the house and opened the door to Paigh's room, observing the room to be empty with no mattress on the bed. She then saw the mattress on the floor in the lounge room and observed Paigh lying on the mattress.

In her evidence, SAS Sassenberg stated Paigh's arm was blue, her eyes were open like slits and her face was blue around the mouth and eyes. Paigh was not breathing and SAS Sassenberg commenced CPR. CO Hanigan relieved SAS Sassenberg and continued CPR. An ambulance arrived at 7:27 am and CPR was discontinued at 7:30am.

Officers Duggan and Walker

Corrective Services Officers Kerry Walker and Kieran Duggan were on duty on the night shift of 15-16 June 2012 at EPCC. They were instructed to complete a perimeter check of the centre which included checking all doors, grilles, locks and gates, in between the houses and the sterile zone. On this evening Cos Walker and Duggan only checked the doors of the houses and the windows of the houses that did not face the sterile zone. They did not enter the sterile zone or check any of the windows facing the sterile zone.

Their evidence was that perimeter checks were to be conducted at the commencement of each shift. CO Walker stated he had never been on night shift when 2 checks were conducted in the sterile zone. CO Duggan acknowledged that sometimes there had been a second random check. The shift commenced at 10 pm. Each officer gave similar evidence to the effect that had they had conducted the check as required, the check would have commenced at about 10:05pm.

By the time they had completed checking the internal areas it was usually 20 to 25 minutes before they would have entered the sterile zone; thus they would have been in the sterile zone at approximately 10:30pm. In relation to the mode of checking the windows, CO Walker stated that each officer had their own method. His method was to grab hold of the mesh on the windows and shake it, although this was not done by him on every window.

Officer Duggan stated it was not his normal practice to physically check every window but to inspect them visually and only physically check them if he noticed something unusual. He told police in August 2012 that he would have seen the damage to Paigh's window on 15 June 2012 if he had done a visual check. His oral evidence was that he could have missed seeing the damage when performing a visual check of Paigh's window.

Officer Walker stated: "If I had done the check at 10pm and done a physical I would have discovered the breach"

By a remarkable coincidence, CO Walker said that this night shift, being 15 June 2012, was the only night he had failed to perform the check as ordered. CO Duggan acknowledged that there had been one prior occasion when he had not performed this duty as directed. CO Duggan in response to a question as to why he did not complete the checks on this occasion stated: "Complacency. Made an error. That's all I can think of. We just didn't do it."

Had the officers completed the check and observed the breach that would have triggered an examination of the inside of the house and Paigh and her deteriorating condition would have been discovered.

Changes Made

SAS Felstead gave evidence of changes made at EPCC, following the death of Paigh. A device called a Digi-tool has been installed. This is an electronic recording system that records proof positive movements of officers conducting security checks. Following oral evidence given by SAS Felstead in camera, a number of improvements to this system have been suggested and I have included these as recommendations.

In addition, changes have been made to the duress alarm. Earlier evidence from MOS West indicated that if a duress alarm had been pressed in the house then a red flashing light outside the house (visible from the inside) would have signalled that the alarm had in fact been activated. That duress alarm is now a silent alarm, so that any inmate who in the future may feel intimidated and reluctant to 'buzz up' will be able to do so without alerting others in the house to that action.

I have also made a recommendation that involves better information for new inmates at EPCC about the duress alarm or 'knock up' system.

Conclusion

The last few months of Paigh's life can be characterised as a series of system failures and missed opportunities.

First, there was the failure to follow procedure on 2 May 2012, when Paigh was found in possession of contraband at Silverwater.

Had procedures been followed, and the police been notified and Paigh's classification or placement reviewed as a result of a police investigation, there is a possibility that Paigh would not have been moved to EPCC. Apart from the failure by Corrective Services staff to follow correct procedures, one of the issues arising in this inquest is the paucity of training available to Corrective Services staff concerning the identification of prohibited drugs.

It is acknowledged by staff that drugs in correctional centres are a major issue. SAS Sassenberg, in her written statement said "it is a common occurrence for illegal drugs to be inside gaols". For this reason I propose to make a recommendation which should enable Corrective Services staff to receive update briefings on the identification and current concealment methods of heroin and other drugs

Second, there was the missed opportunity to follow up the information contained in the anonymous note received by SAS Sassenberg on 11 June 2012. Whilst SAS Sassenberg put in place a management plan for the purpose of monitoring Paigh, her position as Intel Officer was not filled on 14 and 15 June 2012 when she was rostered off work. There was no procedure in place for staff to follow up that management plan and significantly there was no one available to listen to the telephone call made by Paigh on 15 June 2012 which disclosed information concerning a drug drop. Had there been an Intel Officer available to listen to that telephone call on 15 June 2012 there was a very real potential to interrupt the drug drop.

Third, the failure by Cos Duggan and Walker to conduct the sterile zone check on the evening of 15 June 2012 was a significant failure of their duty and a missed opportunity to discover the security breach by physically checking the grille on Paigh's window. Both officers agreed that had they completed the check as directed, they would have likely discovered the breach if it had occurred before 10.00pm.

On CO Walker's own evidence they would probably have discovered the breach if it had occurred at 10.15pm or 10.30pm.As set out above, the officers' evidence was that they normally commenced the perimeter checks at about 10.05pm and on their evidence it was about 20 to 25 minutes before they entered the sterile zone.

Although there is some contest as to the frequency of a second random check of the sterile zone, the real possibility remains that had these officers conducted a second random check during their night shift on 15-16 June 2012 then the breach would have been discovered and Paigh's condition discovered.

Of course the eventuality of discovering the security breach is connected to the timing of the exit by Paigh from the window. There are varying accounts as to when Paigh exited the window.

Inmates K and J stated that they observed Paigh about 10.30pm and her lips were blue which would infer that Paigh had already consumed the drugs. Inmate M saw Paigh emerge from her room at about 10.10pm- following inmate A's claim that Paigh was getting a drop.

Inmate C saw Paigh's legs and body outside the window about 10.00pm. Inmate D saw Paigh and inmatesT and A emerge from Paigh's room about at 10.OOpm and they all seemed affected. Inmate T told police in 2012 that she saw Paigh and inmate A coming out of Paigh's room to get water at about 5 minutes to 10.00pm and they then went back to Paigh's room and called inmate Tin to take drugs 10 to 15 minutes later.

Therefore, there would appear to be ample evidence to suggest that Paigh exited the window sometime between 10.OOpm and 10.15pm, well before it would have been expected that Cos Duggan and Walker would have entered the sterile zone. That leaves the real possibility that had the perimeter check been properly done, the damaged window would have been detected and an opportunity for Paigh to receive medical assistance -would have arisen.

Fourth, there was available to inmates in the house the option of depressing the duress alarm, which would have activated a flashing light outside the house, or of using an intercom button to seek assistance for Paigh on the night. It is possible that some inmates may have felt intimidated by inmates A or T and for this reason did not 'buzz up'. Inmate T denied that she intimidated anyone and nominated inmate A as being the one who went "crazy" and acted in an intimidating fashion. It was not possible to examine inmate A as she could not be located.

I am unable to make a finding as to why there was no 'buzz up' on this night, but to avoid the future possibility that inmates may feel intimidated into not using the duress alarm in similar circumstances I have included recommendations to address this issue.

Paigh Bartholomew

Paigh Bartholomew was a vibrant young woman, who was struggling to manage her addiction to drugs. Notwithstanding a childhood in which she was very much loved by her aunt and cousins, Paigh was unable to reconcile herself to the fact that her parents were not in her life and, in relation to her mother, that she had been virtually abandoned.

At the time of her death she was only 21 years old. The tragedy of this matter is that, apart from the failings by Corrective Services staff on the night of her death, had any of the other inmates in House 3 chosen to "buzz up" there seems little doubt that Paigh could have been saved.

Formal Finding:

I find that Paigh Bartholomew died 16 June 2012 at House 3 Emu Plains Correctional Centre, Old Bathurst Road, Emu Plains. The cause of death was mixed heroin and alprazolam toxicity. The manner of her death was the consumption of drugs illegally delivered to the Correctional Centre.

Recommendations

Recommendation to the Commissioner of Corrective Services

1. That the induction process for any new inmate to the Emu Plains Correctional Centre and any information provided (in writing and orally) during that process should specifically note:

a) The presence of the duress alarm within each house.
b) If the alarm is pressed it will sound in the Administration Centre to alert Corrective Services staff who will attend the house.
c) Pressing the alarm will not cause an alarm to sound nor a light to flash within or around the house.

2. That the Commissioner of Corrective Services give consideration to approaching the Commissioner of the New South Wales Police Force to request update briefings on current concealment methods and packaging for heroin, so as to assist in detecting contraband within New South Wales Correctional facilities and training Corrective Services staff.

2. 114526 of 2013

Inquest into the death of DW. Finding handed down by State Coroner Barnes at Newcastle on the 31st August 2017.

The Coroners Act in s.81(1) requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of DW.

Introduction

DW died at the John Hunter Hospital on 14 April 2013, nine days after he had been transferred there from the Cessnock Correctional Centre where he had been found in his cell with a ligature around his neck on 5 April 2013. He was 31 years of age.

The inquest

Section 81 of the *Coroners Act 2009* requires a coroner presiding over an inquest to confirm that the death occurred and make findings as to:-

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

Pursuant to the combined operation of ss. 21(1)(a), 22(2) and 23(d)(ii) of the Act, a Senior Coroner has exclusive jurisdiction to hold an inquest concerning the death of a person if it appears that the person has died while an inmate of a correctional centre. Under s. 82 of the Act a Coroner may make such recommendations considered necessary or desirable in relation to any matter connected with the death, including in relation to public health and safety.

In this case, there is no doubt that DW died at the John Hunter Hospital on 14 April 2013. The focus of this inquest has been upon whether better management of the risks arising from his mental health condition while an inmate of Cessnock Correctional Centre could have avoided the death, the medical cause of his death and whether any recommendations should be made under s.82.

Social history

DW was born on 13 December 1981 in Newcastle. He was aged 31 when he passed away. DW was an Aboriginal man. He was the much loved son of DW Senior and SW, and a brother to six sisters and one brother. At the time of his death, DW was the de facto partner of CM and stepfather to CM's three children. DW Senior described DW as a "bit of a wild child" when he was growing up. DW completed his schooling in year 6. He had a history of substance abuse, having started using methyl amphetamines when he was about 14 years old.

When DW was about 18, he moved to Tasmania with some friends and family members and lost contact with his parents. After some time, however, DW Senior bought DW a ticket to bring him back home. DW had developed serious mental health problems that may have been exacerbated by drug use. On his return to Newcastle, he lived with his parents for several years and initially made a significant recovery, with his parents' help.

However, he began to use drugs again and during a psychotic episode, slashed his throat with a pen knife and nearly died. After DW was released from hospital, he spent a lengthy period as an inpatient of the James Fletcher Mental and Rehabilitation Centre and then the Morisset Hospital, a specialist psychiatric hospital. When DW was discharged from Morisset Hospital, he was in good health and started a course at TAFE in Aboriginal art, numeracy and literacy. The mental health team at the hospital assisted DW in finding a 2 bedroom unit in Merewether in which to live.

DW and C met in about late 2006 while DW was at Morisset Hospital and C was visiting a friend. C moved into DW's Merewether apartment in about 2010 and they lived together until DW's incarceration in 2012.

Criminal justice history

Between 1995 and 1999, DW committed a number of offences as a juvenile, which are not relevant for present purposes. On 14 March 2011, DW was charged in relation to an incident involving the wounding of a person. He was taken into custody at the Metropolitan Remand and Reception Centre, Silverwater ("MRRC") that day. DW was subsequently transferred to the South Coast Correctional Centre and Cessnock Correctional Centre ("Cessnock") before being released on bail on 29 November 2011.

On 25 April 2012, DW was charged with aggravated break and enter. He was arrested and taken back into custody at the MRRC.

On 31 August 2012, DW was sentenced for the offences of recklessly wound any person and aggravated break and enter (the 2011 and 2012 charges respectively). His aggregate sentence was 3 years and 8 months expiring on 9 April 2015, with a non-parole period of 2 years and 6 months concluding on 9 February 2014.

Medical history

DW was diagnosed with schizophrenia in about 2002. As set out above, DW was an inpatient at the Morisset Hospital for an extended time and other mental health facilities including the Mater Mental Health Hospital.

DW was taken into custody on 14 March 2011. Soon afterwards, DW slashed his throat in a suicide attempt on 16 April 2011 which he attributed to withdrawing from methamphetamine use.

Then DW was taken back into custody on 25 April 2012, his intake assessment identified a range of health concerns including illicit substance abuse, hepatitis C and serious mental illness with a history of self-harm and suicide attempts. He was treated with fortnightly antipsychotic injections to treat schizophrenia as well as being prescribed diazepam.

Events preceding the death

DW was arrested and returned to custody at the MRRC on 29 April 2012 when he was charged with aggravated break and enter. After subsequent transfers to Cessnock, Parklea and Bathurst Correctional Centres, he was transferred back to Cessnock on 11 August 2012 and then sentenced on 31 August 2012.

At Cessnock, DW was initially housed with the prison's general population. He reported on reception there that he was prescribed fortnightly antipsychotic depot medication and diazepam (Valium) which he had recently stopped taking.

The existence of psychosis was queried on a psychiatric review on 10 May 2012, but DW was maintained on antipsychotic medication Ripseridone 50mg injections. A subsequent psychiatric review in September 2012 documented that DW was stable and that there were nil signs of psychosis.

On 17 October 2012 DW was reviewed by Dr Bench, Psychiatrist, who continued the Risperidone injections.

On 27 November 2012, DW was reviewed by a mental health nurse who noted that he was irritable and refused his regular depot injection, claiming that it had been increased in dose (to 50mg) when it had not in fact been.

On 5 December 2012 DW was reviewed by Dr Bench and denied any mental illness and said in effect that all past signs and symptoms were secondary to substance abuse. No recent behavioural concerns were noted.

"*Ongoing compliance*" issues were noted on 9 December 2012.

On 18 January 2013 Dr Bench and Nurse Kibble reviewed DW and noted that he was refusing medication, denied schizophrenia but was assessed as having schizophrenia but not showing any signs of psychosis.

On 8 March 2013, when DW was reviewed by a drug and alcohol counsellor he disclosed that he had been using buprenorphine, an opiate.

On 14 March 2013, Nurse Kibble again reviewed DW. She observed various concerning signs including psychomotor agitation. He alleged that Corrective Services staff were poisoning his food and he wouldn't sleep for fear of being murdered. He said he was armed with a shiv to protect himself and was ambivalent about taking medication, saying he was not sick. He surrendered the shiv, a sharpened screwdriver, to Senior Assistant Superintendent ("SAS") MacGregor.

He was admitted to Cessnock's then Mental Health Unit ("MHU") on Nurse Kibble's recommendation and agreed to take medication prescribed by Dr Bench including diazepam at 10mg 4th hourly to a maximum of 30mg daily and a reduced dose of risperidone.

The Mental Health Unit at Cessnock was a separate part of the jail comprising 8 to 12 cells which in the first part of 2013 housed a number of inmates with diagnosed mental health issues. It was adjacent to the Justice Health Clinic.

DW asked to be referred to the Mental Health Screening Unit ("MHSU") at Silverwater where he had been treated in the past. This is a purpose built mental health facility designed to enable multidisciplinary assessment and treatment. It provided these services to prisoners from across the state. There was often a waiting list for admission to the unit.

On 15 March 2013, Dr Bench reviewed DW and noted "*decompensation of mental illness*". DW alleged his cell was being poisoned via the toilet and that he was not eating and drinking for fear of being poisoned. He had reportedly lost 7kg whilst off his medication. He reported Buprenorphine abuse. DW reluctantly accepted the new medication of diazepam and risperidone 4mg but adamantly refused to go back onto the risperidone injections. He denied suicidal ideations or a desire to harm others.

Dr Bench decided DW should be referred to the MHSU at Silverwater. In the meantime, Dr Bench recommended that DW remain in the MHU at Cessnock under a Risk Intervention Team ("RIT") Protocol. Dr Bench expected that the form seeking a bed for DW in the MHSU would be completed and forwarded to Silverwater on 15 March 2013.

The transfer was urgent because in Dr Bench's view the Cessnock MHU was not a suitable facility for treating acutely psychotic prisoners such as was DW.

However, for reasons which were not adequately explained, the form was not completed until 21 March 2013. Nurse Kibble indicated that she cannot now recall if the referral was to be given priority but she absent from work from 16-19 March 2013 inclusive and attended to this administrative task two days after she returned to work.

DW could not be compelled to take his medication as he was not on a community treatment order under the *Mental Health Act 1990.* Dr Bench considered it was not necessary to have DW scheduled under that Act because he could be monitored in the MHU while he waited for admission to the MHSU.

Progress notes record DW as "*extremely agitated*" and refusing to take medication at 10.30pm on 15 March, but DW accepted his prescribed medication on 16, 17 and 19 March.

He was reviewed again by Dr Bench on 20 March and found to be partly medication-compliant with risperidone and psychotic with the same delusions as previously described.

On 21 March various sharpened items were found in his cell and removed.

On 22 March DW returned a positive test to buprenorphine and had some privileges withdrawn as a consequence.

On 24 March DW missed a visit from his partner Ms M and sister SW, who had arrived at the correctional centre outside visiting hours.

DW became upset and self-harmed with a glass that he smashed in his cell. An incident report was prepared by Correctional Officer ("CO") Harcourt, who was on duty in the Mental Health Unit at the time. CO Harcourt noted that he had observed DW cover the camera in his cell and went to check on his welfare, which is when the self-harm incident happened.

The practice of inmates covering cameras in their cells appears to have been known amongst correctional officers. The RIT review by Nurse Kibble and SAS Hamilton concluded that DW was threatening to cut his own throat and threatening to kill staff.

SAS MacGregor ordered all cells in the MHU to be searched for sharp objects and a mandatory notification to the RIT was made.

DW was placed in a cell with constant camera monitoring on 24 March.

On 26 and 28 March, Nurse Kibble reviewed DW, who reported the same delusions. He would not rule out further self-harm. An RIT assessment was carried out on 28 March by Nurse Kibble and SAS MacGregor and a Dianna Eberzy, Corrective Services psychologist.

DW was recorded as "*distressed, confused, angry, cannot say he will not hurt himself again*" and was to have ongoing camera monitoring. A further RIT review was scheduled for 2 April. Nurse Kibble made a progress note about the review, noting DW's belief that he was being poisoned.

Psychologist Ms Ebzery recorded on 28 March 2013 that

Mr W was co-operative and engaging. He appeared remorseful for his actions and was able to identify more appropriate methods of coping and resolving internal conflict. Although he continues to deny having any thoughts or plans for self-harm, his behaviour exhibits high impulsivity and poor consequential thinking. He appears to have greater insight into his mental health issues, but is still quite paranoid about discussing symptoms or particulars with anyone other than the mental health nurse. Mr W continues to be of the belief that his clozapine injections are attempts to poison him, but has been compliant with other anti-psychotic medication.

On 30 March DW remained paranoid and is recorded as refusing medication the night of the 29 March. No record appears to exist of any administration of diazepam after 29 March.

DW saw his de facto partner and his sister on 31 March 2013 and talked about how the guards were trying to kill him. Ms M told him that she thought he was being paranoid.

Nurse Kibble reviewed DW at 12.15pm that day and recorded that he "*remains very preoccupied with officers poisoning him*" (he could "*see needle marks on his fruit*") and was very anxious to go to the MHSU.

On 1 April, Nurse Kreft saw DW, noting that he was eating and there was nil talk of food tampering. She also saw him on the morning of 2 April when he seemed suspicious of his food and appeared calm but wanting to go to the MHSU.

A further RIT review was conducted on 2 April with Correctional Officers Harrower and Belcher and Nurse Kreft present, at which DW again said that he believed he was being poisoned but he is recorded as not at risk self-harm, and to have "*CCTV medical 1 out*". He was moved to cell 8 and permitted to have his cell light off at night and access to cigarettes and matches. A RIT review was scheduled for 5 April.

There is no progress note on the file for 4 April. On 4 April DW's acceptance to the MHSU (dated 3 April) apparently came through on the fax, dated at about 10.15am. However, the Metropolitan Transport truck had already departed when the approval was received and processed. The next truck was not due until 6 April.

A Drug and Alcohol progress note from 5 April 2013 records a request for "OST" (Opioid Substitution Treatment program) being reissued, stating "*reports he is currently injecting bup daily in custody*".

The events of 5 April

On 5 April Correctional Officers Harrower and Slingsby were on duty at F Wing (the MHU) from 8:00am. Nurse Kibble saw DW briefly in the morning and reported that he did not give her any immediate concerns.

RIT review at 2.15pm conducted by Nicole Buchanan, Corrective Services psychologist, CO Harrower and SAS MacGregor noted that he was still delusional. DW was informed that his transfer to the MHSU had been approved and he is recorded as seeming happy, being scheduled to leave the following day. Ms Buchanan later told investigators that DW appeared to show some insight in that he acknowledged that his belief that he was being poisoned was "*not right*" She said that nothing he said or did gave her any concern that he might self-harm.

After the RIT assessment, DW was taken to the phone located in the Mental Health Unit common room to make a phone call to Ms M. She later told investigators that she recalled speaking to him about 2.27pm and DW saying words to the effect that "*I'm ready to go. I'm ready to do it now*". Ms M told investigators later that she asked him what he meant and he said "*nothing, see you later*".

The recording of the phone call that was made as standard procedure did not bear out that portion of the conversation as recalled by Ms M. On the contrary, DW sounded happy and there is no indication of imminent self-harm. It is likely that she has mistaken DW telling her he was ready to go to the MHSU as an indication of an intent to self-harm.

DW was returned to his cell by SAS MacGregor at about 2.45pm. Before that occurred another officer gave DW some tobacco and cigarette papers at his request and spoke to DW as he rolled a cigarette. That officer said DW seemed calm and compliant.

At about 3.06pm, DW began trying to cover the lens on the camera in his cell with what appears to be wet toilet paper. Those attempts were renewed at about 3.14pm, this time with paper covering the central portion of the lens, which had the result of concealing/preventing a view of the inside of the closed door to his cell.

At about the same time an adjoining cellmate, Mr Ingram, was recorded as 'knocking up' on the cell alarm. The reason recorded in the Monitor Room journal was for a phone call. A further 'knock up' by Mr Ingram at 3.29PM was recorded as wanting a shower.

At around 3.25pm CO Harrower rang CO Jenny Archer, who was on duty in the central Monitoring Room, about an allocation list. The central Monitoring Room had banks of television screens showing camera feeds from various locations around the jail, including the safe cells in F wing (MHU). The images relayed from each of the MHU cell cameras were all contained on the one big screen as 64 separate images.

CO Archer told the investigators that she did not notice the paper covering the lens in DW's cell until just before DW was found by the officers delivering meals. At the inquest she sought to assert that she had in fact seen DW attempting to cover the camera in his cell but had not reported it to the officer in the wing because the attempts were unsuccessful. For the reasons set out in counsel assisting's submissions I conclude that this evidence is unreliable.

An officer stationed in the Monitor Room at that time had to monitor the 64 sections of monitor screen, take phone calls from all over the complex and answer cell call alarms.

When an inmate is on 24 hour CCTV monitoring, responsibility for the monitoring falls to the monitoring officer whenever the officers in the MHU are away from their work stations. At around the time at which DW is shown on the CCTV as starting to put paper on the camera lens, Senior Correctional Officer ("SCO") Harrower and CO Slingsby began meal distribution to the F wing inmates.

While occupied in this task they were not able to monitor the cameras in the F Wing cells. Video of DW's cell subsequently retrieved showed him moving around just before 3.20pm, and then officers appeared at the door of his cell at 3.35pm. It was only when SCO Harrower went to deliver DW his meal that he was found, apparently unconscious.

Looking through the door window, CO Slingsby could see DW seated on the floor by the door. He called out and got no reply and then saw DW's head tilted to one side and his tongue hanging out of his mouth. He asked SCO Harrower to open the cell door and as he did so DW slid down onto the floor.

CO Slingsby ran to the officers' station to get a cut down knife. A few seconds later, when he got back to DW's cell, he saw SCO Harrower attempting to free something from around DW's neck.

SCO Harrower described finding DW "*slumped against the grill on the inside of the cell door*" with a cord that had been put over the bolt latch on the door, thus creating resistance when he tried to open the bolt.

SCO Harrower found the other end of the cord "*wrapped round his* (DW's) *throat*" and removed it by placing his finger under it and pulling the noose free, which he described as a "*truckies slip knot*".

SCO Harrower began chest compressions and called for CO Slingsby to radio a medical emergency

CPR was continued with a face mask. Dr Bench arrived with a defibrillator, followed by nursing staff with oxygen. CPR was continued until a pulse was detected. A Justice Health emergency response form records CPR at 3.40pm and ambulance arriving at 4.11pm.

A heart rate appears to have been monitored/detected from at least 3.50pm. DW's pupils were described at that time as "*fixed/large*".

Ambulance records show that on the arrival of paramedics, DW had a Glasgow coma score of 3, a pulse of 60 beats per minute, and normal and reactive pupils. Multiple doses of morphine were administered.

Events after the fatal incident

Hospital treatment

At 4.45pm DW was taken to John Hunter Hospital by ambulance where cerebral hypoxia was diagnosed by an EEG and MRI. By the early hours of 6 April, DW had been diagnosed with irreversible brain damage.

He remained intubated, sedated and hydrated in the ICU but over the following 10 days he did not regain consciousness. Hospital records showed the following drugs as having been therapeutically administered, midazolam, morphine and adrenaline.

Ante mortem blood samples taken on DW's admission on 5 April 2013 at a time recorded in the toxicology certificate as 6.00pm showed the presence of Nordiazepam 0.01mg/L; Midazolam 0.10mg/L; morphine (free) 0.05mg/L; Morphine-3-glucuronide 0.22mg/L; Morphine-6-glucuronide 0.03mg/L.

On 12 April the family made a decision after medical advice to withdraw assisted ventilation. DW passed away at 11.50am on 14 April.

Family notification

Ms M told investigators that at some point in the afternoon of 5 April she received a call from DW's sister S, who told her that her boyfriend had heard over a police scanner that something had happened to DW.

Ms M rang Cessnock and spoke to Officer Guy Sim, the Manager of Security, who told her that DW had been taken to hospital. A report noting that "Next of kin informed" is time stamped 4.49pm.

Autopsy order

In accordance with established procedures, the duty pathologist at the Department of Forensic Medicine in Newcastle sought and obtained an autopsy order in relation to DW's body. That process followed the following steps.

A copy of the initial police report of the death to the coroner, the form P79A, and a summary of the circumstances of death and the treatment provide by the hospital, the form A, were provided to the duty pathologist at the Newcastle Department of Forensic Medicine, Professor Timothy Lyons.

After reviewing the available material, Professor Lyons forwarded to the office of the Newcastle Deputy State Coroner a form headed "Request for Coronial Direction" in which he set out some details of the circumstances of DW's death and made the following recommendation:

Given the time difference (between the fatal incident and death) *and the known cause of death I cannot see the benefit in an autopsy as the cause is already known. I suggest an ext + review of records.*

1. He also noted, "*We will try and obtain ante mortem bloods."*

2. Professor Lyon's recommendation was accepted and an autopsy order consistent with it was made by the Newcastle Deputy State Coroner.

Autopsy evidence

On 15 April an autopsy in accordance with the coroner's order was undertaken by an experienced forensic pathologist, Dr Allan Cala.

He examined the external surfaces of DW's body and reviewed the medical records from John Hunter Hospital. He noted that there was a faint ligature mark on the right side of the neck and numerous scars on both forearms consistent with previous attempts at self-harm. There were no other injuries and no external signs of disease. Based on the hospital records which included scans of DW's head and upper body, analysis of his blood when he was admitted to hospital and progress notes detailing the observations and conclusions of the specialists who treated him, Dr Cala concluded that the cause of DW's death was hypoxic encephalopathy, due to neck compression, due to hanging. He issued an autopsy report detailing those findings and conclusions.

Family's pathologist

The family retained a former NSW Health Pathology forensic pathologist to review some of the material. Professor Johan Duflou prepared two reports relating to the question of DW's cause of death.

In his first report Professor Duflou agreed that if the circumstances as outlined in the P79A were correct, the mark on DW's neck could reasonably be attributed to a ligature and hanging. He conceded that if this were the case, the cause of death as found by Dr Cala was reasonable.

However, Professor Duflou queried whether the morphine and nordiazepam found in ante mortem blood taken on admission to the John Hunter Hospital may have been the result of illicit use of heroin and diazepam. He suggested such drugs could in combination cause respiratory arrest.

In a second report prepared after Professor Duflou had reviewed the medical records from the John Hunter Hospital he repeated his concerns about the drugs found in DW's ante mortem blood sample.

In both reports Professor Duflou also questioned the appropriateness of Dr Lyons not recommending an internal autopsy in view of DW dying as a result of an in custody event. I shall return to that issue below.

Independent toxicology

An independent clinical toxicologist, Professor Alison Jones was briefed by those assisting me to respond to the concerns raised by Professor Duflou. She advised that the diazepam administered to DW in prison is likely to have resulted in the presence of nordiazepam found in his ante mortem blood sample. The level of the drug was at a sub therapeutic level and unlikely to have contributed to his death.

Further analysis of the blood sample showed an absence of the metabolite 6-Monoacetylmorphine excluding heroin as the source of the morphine and confirming it was a result of the morphine administered by the ambulance officers who responded to the incident.

It is regrettable that Professor Duflou would raise these baseless concerns when their only effect was to unnecessarily distress DW's family.

Death investigations

Because of the serious nature of the injury suffered by DW it was reported to police soon after he left the correctional centre in the ambulance.

Two general duties officers attended and spoke to the correctional officer who had found DW hanging and the security manager.

They inspected the cell and instructed that it be secured.

Crime scene officers attended, photographs were taken and relevant exhibits were seized.

When DW died on 14 April 2013, an identification statement was obtained from his mother and a P79A was prepared to report the death to the coroner. Responsibility for the investigation was delegated to Detective Inspector Garry James of the Corrective Services Investigations Unit.

Inspector James interviewed all relevant witnesses and obtained all relevant records. He undertook a comprehensive investigation and produced a detailed report.

He identified a number of factors that may have contributed to opportunities to prevent the death being missed. These included: inadequate staffing of the monitoring room; the availability of a ligature to an at risk prisoner; and a hanging point in the cell of an at risk prisoner.

An internal investigation was also undertaken by Acting Assistant Superintendent Graham Kemp of the Corrective Services Investigations Branch and referred to the Corrective Services Deaths in Custody Management Committee.

Both investigation reports were tendered into evidence at the inquest.

Review of psychiatric care

The court was assisted by a review of the psychiatric care provided to DW while he was in Cessnock Correctional Centre undertaken by Associate Professor Michael Robertson, a consultant psychiatrist.

Associate Professor Robertson observed that it was likely that DW suffered from schizophrenia complicated by poly substance abuse including illicit substances obtained while he was in prison. He considered it likely that DW's psychiatric problems were also exacerbated by intermittent or non-adherence with his antipsychotic medication.

He concluded:

Having reviewed the brief of evidence, I am satisfied that the best standard of care was provide in the circumstances, but that the deceased's transfer to a more specialized health care setting, specifically the Mental Health Screening Unit, would have enabled more assertive management and precluded the exacerbating effects of illicit drug use.

He considered it likely that DW was suffering from paranoid psychosis when he took the action that resulted in his death.

In Associate Professor Robertson's opinion, more assertive attempts to gain medication compliance were warranted, with resort of the Mental Health Act scheduling regime if necessary. Indeed, he considered the Mental Health Act should have been used to ensure DW was consistently medicated when it became clear he was psychotic and resisting treatment in early 2013.

He also queried why DW was not moved to the MHSU more promptly where he is more likely to have received regular medication and less likely to have had access to illicit drugs. In Associate Professor Robertson's opinion that was the appropriate setting in which to compel medication compliance.

Associate Professor Robertson suggested clinicians providing care in a correctional setting would benefit from clearer guidelines as to the utilization of the Mental Health Act in a custodial setting.

Analysis regarding issues of concern

Particulars of death

On 5 April 2013, correctional officers delivering meals to inmates at the Cessnock Correctional Centre found DW in a locked cell unconscious with a ligature around his neck. He was given appropriate emergency first aid and life sustaining measures and transferred to a tertiary hospital where despite the best care he died when life support was removed nine days later.

Investigations in the hospital established that DW had suffered irreversible hypoxic brain injury.

Investigations in the prison established that in the 25 - 30 minutes before he was found, DW, who had made previous attempts on his life, had made repeated attempts to obscure the view of the surveillance camera in his cell; no other person had entered the cell in the relevant period; and the ligature found around DW's neck was a draw string from his pants.

An external examination of his body and a review of the scans taken in the hospital enabled the forensic pathologist who undertook the autopsy on DW's body to exclude any trauma related injury as contributing to the death.

Toxicological analysis of blood taken when he was admitted to hospital eliminated illicit or prescribed drugs as possible contributors to the death.

Conclusion

The autopsy report confirmed the hospital diagnosis of hypoxic encephalopathy as a result of neck compression due to hanging as the cause of death.

There is no doubt that DW did not appear suicidal when he was locked in his cell less than an hour before he took the actions which led to his death. This caused me to consider whether he was at the time so psychotic that he didn't understand what he was doing. He appeared to be acting rationally when he asked for and was given the makings of a cigarette just before being locked in and his persistence in masking the observation camera does not suggest a loss of comprehension. I conclude that DW must have undergone a sudden mood change that led to him deciding to take his own life.

Accordingly, the manner, cause, date and place of DW's death are readily apparent. The inquest focused on a number of aspects of his care and management that may have contributed to his death occurring or which could be reformed to improve the quality of care provided to correctional inmates. These are my conclusions in relation to those issues.

Adequacy of mental health care

As outlined above, the independent psychiatrists who reviewed the mental health care given to DW in the months before his death were generally of the view that it was adequate and appropriate.

Dr Bench a psychiatrist who provided mental health care to prisoners at Cessnock as a Visiting Medical Officer raised concerns about the time prisoners in the MHU were kept locked in their cells and the requirement that assessment and therapy was on occasions necessarily only able to be undertaken while the therapist stood in a corridor and the prisoner/patient remained locked in his cell. He alluded to prisoners being locked in their cells for up to 23 hours per day and having very limited access to natural light and fresh air.

Conclusion

The inquest did not undertake a review of the provision of mental health care to prisoners generally. I will therefore refrain from making general comments about the quality of that care.

However, it is notable that two of the practitioners who sought to provide care to DW while he was in the MHU withdrew from their respective roles as a result, it seems, of their dissatisfaction with the circumstances in which care was expected to be provided. While the independent experts who reviewed the care provided to DW were not critical of it generally, there were obvious problems with aspects of it that are dealt with below.

Compulsory medication

One aspect of his care which was questioned was why DW was not compelled to take the antipsychotic medication that he obviously needed but which he inconsistently accepted.

Assuming that a medical practitioner could have concluded that DW was a danger to himself or others, in order for him to be compelled to take the necessary medication he would either have had to have been made the subject of a Community Treatment Order by the Mental Health Review Tribunal or to have been made the subject of a Forensic Community Treatment Order. In both cases he would have had to have been transferred to a declared mental health facility as the mental health unit at the Cessnock Correctional Centre did not meet the necessary criteria. Those orders can only be made if there is no less restrictive care that would address the prisoner's mental health care needs.

In this case it was clear that DW was keen to go to an appropriate declared mental health facility – the MHSU at Silverwater. Accordingly, there was no basis to seek to compel him to attend the facility for treatment. If he had been transferred there and he had continued to refuse medication, the steps necessary to administer it compulsorily could have been taken.

Conclusion

There was no need or authority to resort to the provisions of the Mental Health Act which enable compulsory treatment until DW had been transferred to a declared mental health facility, an arrangement he would have voluntarily agreed to. The problematic delay from a treatment perspective was the failure to decide to transfer him to the MHSU until 15 March by which time he was he was in crisis. The evidence and expert opinion indicates DW's mental health deteriorated without sufficiently prompt and active intervention.

Transfer to the MHSU

When it was eventually decided on 15 March to transfer DW to the MHSU at Silverwater, for reasons that were not adequately explained but seem to be attributable to an administrative error, there was further unnecessary delay in giving effect to that decision.

Conclusion

The failure to transfer DW to the Silverwater MHSU in the three weeks from when his treating psychiatrist ordered that to occur until the fatal incident was a significant omission by those responsible within Justice Health.

Adequacy of accommodation in the MHU

The major flaw in the cell in which DW was housed was that it contained a hanging point. I accept that the hanging point was obscure and difficult to detect despite the cells being inspected with a view to identifying such defects when they were converted for use by at risk prisoners.

I accept that the presence of a hanging point in the cell was due to a human oversight rather than a deliberate refusal to make the cells safe. It has now been rectified.

A second observation camera has now also been added to the cells used to house at risk prisoners which should make them safer if the monitoring issue described below is addressed.

Conclusion

The presence of a hanging point in the cell in which DW was housed and the inadequacy of the monitoring equipment were hidden defects that have since been addressed.

The ligature

Various excuses were made as to why DW was allowed to have ligatures in his cell. It was variously suggested that he was transferred to the MHU because he was a risk to others, rather than himself and that the on-going RIT would continue to review whether an inmate involved in that regime should have items that could be used to self-harm removed.

Reference was made by some witnesses to the need to not undermine a prisoner's dignity by removing normal clothing from him. A smock is less dehumanizing than no clothes and allowing a prisoner to wear his own clothes is better still. It was also suggested that the clinicians who had regular contact with DW could have caused his shoe laces and pants drawstring to be removed had they concerns.

The belief that there were no hanging points in the MHU cells may have given false comfort about this issue.

It was also suggested that DW had a history of self-harming through cutting rather than the use of ligatures and that as there were other items such as bedding in the cell that could be used by a prisoner intent on hanging himself there would be no point in just removing shoe laces or pant draw strings.

There was a deal of uncertainty as to whether an earlier local order continued to apply and changes have been made since DW's death.

Conclusion

DW was transferred to the MHU because he was assessed as being psychotic. He was known to regularly refuse to accept psychotropic medication. He was clearly not stable and was very likely to undergo mood changes. He had a recent history of self-harming and making threats of self-harm.

In the circumstances the level of risk he posed to himself could not be precisely defined.

The management of such inmates requires balancing the risk they pose to themselves and others against the detrimental effect of minimising those risks by intensive observation and the withdrawal of access to personal items that can be used to self-harm. That careful assessment did not occur in this case. No one made a considered assessment that the risk of allowing DW to have access to ligatures was justified. This was a failure of the correctional officers and Justice Health officers responsible for managing the MHU.

Since DW's death the policies in place at the Cessnock Correctional Centre have been amended to prohibit cords or drawstrings being allowed to inmates on RITs within the MHU or Multi-purpose Unit as it is now called. Accordingly, no further recommendation is required.

Monitoring of the cell camera

A review of the vision recorded by the camera in DW's cell showed that on the day he fatally self-harmed, he commenced efforts to obscure the camera with wet toilet paper at 3.06pm. The first attempt was unsuccessful. He made further attempts. The camera was partly obscured from about 3.15pm and remained so until DW was found unconscious in his cell 3.35pm.

For the reasons detailed earlier in this report I conclude that contrary to her inquest evidence, the officer monitoring the cells did not notice this activity until moments before DW was found.

That is not surprising: the officer was expected to watch a wall of monitors showing up to 64 different views. That officer also had to take phone calls from all over the complex and respond “knock ups’ from prisoners.

The officer on duty in the Monitor Room on the day in question was undertaking her first shift in that role. She told the inquest she had a small number of sessions watching another officer perform the function and helping out in the weeks before this incident.

The inadequacy of her training was highlighted when she was unable to activate the electronic locks to allow a senior officer who was finishing his shift to leave the centre. He came to the Monitoring Room and gave the officer further instruction in the technical aspects of her role.

The limited proficiency of the officer in the Monitoring Room was made significant at the material time because the MHU officers were in the process of delivering meals to the prisoners in the unit. As a result, they were away from their work station and thus unable to monitor the observation cameras as they would normally do at other times.

Conclusion

The responsibilities of the Monitor Room officer were unduly burdensome and the officer attempting to discharge them on the day in question had been inadequately trained.

Since earlier this year, two officers have been posted in the monitor room from 8.30am till 10.30pm. The second officer on the afternoon/night shift is a senior correctional officer who provides increased training for the junior staff and generally oversees the operation of the Monitor Room.

Further, a Monitor Room Standing Operating Procedure has been developed which includes a direction that staff initiate effective responses to alarms and incidents, including covered cameras. It also identifies that control room has the primary responsibility for monitoring assessment cells and staff in the control room are to alert unit officers of any need to intervene.

Provided that counsel assisting’s suggestion that instructions be given as to what matters are to be recorded in a log kept in the Monitor Room is adopted, I am of the view that these changes adequately address the shortcomings highlighted in this case.

Contacting next of kin

Mr W Senior expressed his concern to investigators that he had not been rung by Corrective Services and told about what had happened to his son that afternoon.

Corrective Services policy requires that the "Emergency Contact" person nominated by an inmate at reception or as updated subsequently be contacted when an inmate is taken to hospital for admission. In this case Corrective Services records showed Ms M as the Emergency Contact.

Conclusion

So far as can be established, authorities contacted neither DW's partner nor his parents when he was taken to hospital. However, his partner heard of the incident from a friend monitoring police radio broadcasts and she called the jail very soon after DW was placed in the ambulance and before he had arrived at the hospital. She was apprised of what had transpired.

I accept that a parent does not have a definitive right to be advised of welfare and health issues if a prisoner has nominated somebody else as his contact person, as had happened in this case. I assume that the authorities would have contacted DW's partner if she had not called first.

In any event, DW's parents became aware of his situation. One would hope that adherence to bureaucracy would not have prevented Corrective Services from alerting them to their son's location had they not otherwise have been notified.

Accordingly, no adverse comment should be made and no recommendations for change are necessary.

Extent of the autopsy

There was no dispute as to the manner and cause of DW's death among those who were aware of the facts until a forensic pathologist in private practice, Professor Johan Duflou, raised questions about those issues in a report he provided to solicitors acting for DW's family.

The evidence has shown that those questions were baseless and indeed under close questioning from counsel assisting, Professor Duflou conceded that the manner and cause of death had been established to the requisite standard.

It became apparent that the on-going concern of Professor Duflou was the ordering of an external examination and a medical records review rather than the three cavity internal examination that he considered should have been undertaken in this case because the material events occurred while the deceased was in custody.

I am aware that some forensic pathologists do not agree with the move away from performing three cavity autopsies in almost all cases apparently involving an external cause of death.

However, the law in New South Wales reflects the more enlightened perspective that when it comes to examining and or dissecting the bodies of those whose deaths have been reported to a coroner, the dignity of the deceased is to be respected and the least invasive procedure that will enable the manner and cause of death to be established should be utilized.

Although conceding in his second report that intentionally self-inflicted hanging was "very likely" the manner of DW's death, Professor Duflou continued to assert that a three cavity autopsy should have been performed because a NSW Health policy directive stipulated it should occur in relation to all deaths in custody cases. He also pointed out that was consistent with a protocol published by the International Red Cross.

The *Coroners Act 2009* in s.88 stipulates that a person conducting an autopsy to establish the cause and manner of death "*is to endeavour to use the least invasive procedures that are appropriate in the circumstances."*

The provision is somewhat misconceived because the person conducting the autopsy can only examine the body to the extent authorized by the Coroner who issues the autopsy order. The direction should perhaps also be directed to the Coroner. Certainly in my experience, in accordance with the spirit of the law, Coroners throughout NSW adopt this approach.

In this case the Newcastle Deputy State Coroner ordered an external examination of the body; analysis of ante mortem blood and a review of the hospital medical records, consistent with the recommendation made by the duty pathologist, Dr Lyons.

Dr Lyons explained the reason he made the recommendation in those terms. He said:

- As the death occurred 9 days after the fatal incident he expected that subcutaneous bruising would be apparent on external examination without the need for dissection.

- An MRI of Mr. W's body had been performed at the hospital and was available to the case pathologist.

- The time between admission to hospital and death gave police far longer than usual to investigate the circumstances before the autopsy decision had to be made. Specialist death in custody detectives had been involved. They had no suspicions, labeled the death a suicide and indicated that police did not intend attending the autopsy all of which indicated police considered no third party was involved.

- The P79A contained significant detail.

- Old scars on Mr. W's body suggested a history of suicide attempts.

- He was known to be suffering from mental illness.

- The medical records provided adequate information as to the cause of death.

The CCTV vision demonstrated that Mr W was alone in a locked cell when the fatal incident occurred and his actions in covering the cell camera were in the circumstances only explicable by an intention to self-harm. When the scene information was coupled with the information available from the hospital records, an external examination and toxicology, the manner and cause of death were readily apparent. No more invasive autopsy would have assisted the inquest reach the findings it was required to make.

A NSW Health Policy Directive (PD2012_049) entitled "Forensic Pathology – Code of Practice and Performance Standards in NSW" (the Code of Practice) acknowledges that *"There may be circumstances where departure from these standards is appropriate. The reasons for this should be clearly documented..."*

Appendix 9 of the Code of Practice is headed *Standard Guidelines: Deaths in custody.* It provides that in such cases *"The post mortem examination should be performed as for a homicide or suspicious death, with appropriate investigating police personnel and police photographers in attendance."*

The other instructions make clear that it is envisaged an internal examination will usually be undertaken. However the Code of Practice also recognises the imperative of using the least invasive procedure to satisfy the needs of the Coroner to make findings.

A NSW Health policy directive cannot override the Coroner's autopsy order. Dr Cala, the forensic pathologist who undertook the autopsy, could not rely on the Code of Practice to undertake a more invasive autopsy than had been ordered. However, it calls into question whether Professor Lyons, the pathologist who recommended that the Coroner issue the order in the terms that it was made, inappropriately failed to comply with the intent of the policy directive.

Conclusion

I am of the view the recommendation made by Professor Lyons was appropriate in the circumstances and was consistent with the legislative requirement to respect the dignity of the deceased and undertake the least invasive autopsy necessary to establish the manner and cause of death.

Professor Lyons' explanation for departing from the usual practice is set above. I consider the reasons he has given justify the departure from the policy as the policy allows.

Furthermore I consider his notation on the "Request for coronial direction" form adequately records his reason for the recommendation. While a literal reading of the Code of Practice would indicate that it is the autopsying pathologist who needs to record the reasons for departure from its guidelines that simply reflects the failure of that document to reflect the reality of practice.

In my view, it will rarely be appropriate to make a blanket ruling requiring the undertaking of any investigative step in every case within a category of coronial cases without considering the circumstances of each case. In my view the sound approach can be summed up by the maxim, "Do everything that is necessary but only what is necessary."

The policy directive is due to be reviewed later this year. That is timely. I assume the Coroners will be consulted as part of that process and so I will refrain from making a formal recommendation as to how it might be updated.

Formal Finding:

DW died on the 14th April 2013 at the John Hunter Hospital from injuries sustained nine days before his death when he deliberately tied a ligature around his neck and attached the other end to the door locking mechanism in his prison cell and suspended his weight from it with the intention of ending his life.

3. 162787 of 203

Inquest into the death of Keith Howlett. Finding handed down by Deputy State Coroner Grahame at Glebe on the 31st March 2017.

REASONS FOR DECISION

This inquest concerns the death of Keith Howlett

Introduction

Keith Howlett was 49 years of age at the time of his death. He was serving a term of imprisonment at Junee Correctional Centre. That gaol is privately operated by the GEO Group, through a contractual agreement with the Commissioner of Corrective Services. Junee is a medium/minimum security prison located about 40 kilometres from Wagga Wagga in Southern NSW.

Mr Howlett had entered custody on 18 April 2013, having been sentenced by the NSW District Court, sitting at Wagga Wagga. His earliest release date was 17 April 2015. He had indicated that he wished to appeal his sentence and was apparently awaiting a Supreme Court Bail application at the time of his death.

Mr Howlett was married to Lisa Marie Howlett (Liza Turner). He kept in close contact with her during his incarceration. Mr Howlett had numerous health issues, which had been taken into account at the time of his sentence. He had been recently treated for lung cancer in the community and was HIV positive.

On the morning of 24 May 2013 Mr Howlett began coughing up blood and sought help from other inmates. He collapsed and appeared unresponsive. Officers immediately called for medical back-up. Around 9.37 medical staff arrived, but resuscitation was not commenced and Mr Howlett was pronounced dead at the scene.

An autopsy was conducted which identified Mr Howlett's cause of death as complications of non-small cell carcinoma of the lung. The examination revealed a destructive lesion in the upper lobe of the right lung, which appeared to have eroded into the trachea and right bronchus. The haemoptysis Mr Howlett suffered was massive and unexpected. While Mr Howlett had recorded in his diary that he had coughed up "a piece of lung cancer" on 17 May 2013, there is no record which indicates this event had been specifically reported to Dr Baguley or medical staff at the Junee clinic.

The role of the coroner

The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.

In this case there is no dispute in relation to the identity of Mr Howlett, or to the date and place of his death. For this reason the inquest focussed on the manner and medical cause of Mr Howlett's death. It was also necessary to consider whether or not his death was in any way avoidable and if so what mechanisms, if any, could be put in place to help prevent such a situation recurring. Issues relating to the manner of his death, touching upon his level of comfort and the adequacy of his care in the lead up to his death were also considered.

Where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is detained in custody the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice, it is especially important that the care they receive is of an appropriate standard. Even where the death appears to have been naturally caused, it is essential that any medical treatment provided is reviewed independently and that its quality is carefully assessed.

The legal representative for the family noted that it has been said "you can judge a society by how well it treats its prisoners". There is undoubtedly great truth in that statement. While there are recognised challenges in delivering quality health care services across the range of custodial institutions that exist throughout regional NSW we must nevertheless strive to maintain high standards for those incarcerated and thus unable to choose their own care. Notwithstanding the recognised difficulties, in compliance with NSW Health and Justice Health policy and procedure, the GEO Group are required to provide a standard of care comparable to that provided in the public health system, with special regard to the unique health needs of patients who are inmates. In other words, at the time of his death Mr Howlett's level of care should have resembled the care any citizen would expect within the public system in the community.

Section 81 (1) of the *Coroner's Act* (2009) NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Keith Howlett.

Scope of the inquest

A list of issues relevant to Mr Howlett's death was circulated prior to the inquest commencing. The following questions were posed:

- **Did Mr. Howlett have a terminal illness at the time of his incarceration?**
- **Did Mr. Howlett receive appropriate medical treatment at Junee Correctional Centre?**
- **Was Mr. Howlett exhibiting symptoms at Junee Correctional Centre consistent with the progression of his lung cancer?**
- **Should Mr. Howlett have been referred for a palliative care assessment prior to his death whilst at Junee Correctional Centre?**
- **Did medical staff at Junee appropriately consult Mr. Howlett's specialists in the treatment of his complex medical conditions?**
- **Should Mr. Howlett have been transferred to a hospital facility to appropriately manage his serious medical conditions prior to his death?**
- **Did staff at Junee appropriately manage his level of anxiety and depression associated with his medical illness?**
- **What type of palliative care services are provided to persons in custody with life limiting illnesses?**

The inquest proceeded over four sitting days. A large number of statements were tendered, as were expert reports, medical records and policy documents. Oral evidence was also received, including from Mr Howlett's wife, and from medical and nursing practitioners involved in Mr Howlett's care both in the community and in custody.

Comprehensive submissions were received from all parties and oral submissions were taken. I was greatly assisted by the detailed summaries of the evidence provided to me and do not intend to restate those chronologies in detail.

I have considered all the material and the questions initially posed very carefully but a hearing can tend to crystallize the issues and I intend to distil my reasons fairly briefly under a small number of very broad headings.

Background

When Mr Howlett entered custody on 18 April 2013 he had a complex medical history. He had been diagnosed with lung cancer in May 2012 and was still being monitored after initial treatment.

Mr Howlett also had a number of chronic and long standing conditions which had previously been documented by Justice Health for his sentencing proceedings. These conditions included HIV, peripheral vascular disease, chronic nausea, depression, anxiety, insomnia, gastro-oesophageal disease, hypocholesteremia.

The inquest received detailed evidence in relation to Mr Howlett's lung cancer status and diagnosis. I do not intend to restate each of the expert opinions. In my view it is established that Mr Howlett had a potentially life threatening disease which had been treated initially in the community with curative intent. There were indications that radiotherapy had produced some positive effect and the tumour which had been identified had shrunk in size to some degree. Whether or not Mr Howlett had active disease on the 18 April 2013 cannot be definitively established at this point. However, in my view it is most likely. It is clear that Mr Howlett had a disease which had the capacity to recur and may have already been progressing from the time just prior or just after his entry into custody. Mr Howlett certainly had some physical symptoms which were at least consistent with the possibility of ongoing or recurrent disease. I accept Professor Chye's view that there were concerning symptoms which needed further investigation.

Various opinions were given as to Mr Howlett's projected life expectancy and real chance of survival. It is important to note that such predictions are inherently unreliable, particularly for individuals like Mr Howlett who have other complex health risks. Dr Yap estimated a patient in Mr Howlett's condition in the community would, at the time he entered custody, have had a 1 in 6 chance of survival after 5 years. Dr Sullivan who had treated Mr Howlett in the community, was of the view that on the information available to her that "given there had been some response to treatment, and more importantly no progression, his prognosis would have been measured in years with a median survival of approximately 1.5-2 years."

Whatever the case, Mr Howlett believed that his disease was incurable. This certainly appears to have been the way it was presented to the court at his sentencing proceedings on 18 April 2013. Her Honour Judge English remarked that it is "not an easy task to send a dying man to gaol" It was also Dr Baguley's evidence that at the first consultation Mr Howlett specifically stated that "his cancer was not cured and that he would die from it". Further Dr Baguley said that Mr Howlett had clearly told him "that there were no further treatment options."

In contrast, Mr Howlett's wife had an understanding that prior to him going into custody Keith had been told "there may be another bout of radiation and chemo; however, that wasn't actually documented. It was just, it, it was, a day by day, see how he's going sort of basis".

Mr Howlett's entry into custody and his relationship with Dr Baguley

On his entry into custody, Mr Howlett was seen by Nurse Blight who completed the "Reception Screening Tool". It was immediately clear that Mr Howlett was "seriously ill" and a review with the doctor was organised for the following day. Mr Howlett spent that night in the medical unit.

Mr Howlett saw Dr Baguley for the first time 19 April 2016. A very brief record exists of this consultation. Dr Baguley notes the lung cancer and that Mr Howlett's treatment was "not curative". He notes the HIV and severe PVD and writes "to be weaned off opiates as appropriate". He ordered a chest X-ray. I am struck by the brevity of the note and the lack of detail recorded. When questioned about the need to obtain further information about Mr Howlett's treatment options and prognosis from his medical practitioners in the community rather than just accepting Mr Howlett's assessment, Dr Baguley reported that the nurses would have sent out a number of letters, "that's done automatically on admission to the gaol". Dr Baguley suggested that there was no real point in directly contacting the practitioners now that Mr Howlett was in custody, it seemed that it was his practise to start again and if necessary use local specialists.

Mr Howlett was kept on the medical ward for the first few days of his incarceration. However, there was confusion about the reason for this. While Dr Baguley suggested at some point that it may have been a "suicide watch", there is no firm documentary evidence that supports this contention. In evidence Dr Baguley suggested that it was due to Mr Howlett's vomiting and "to get a handle on how sick he was" as well as his "risk of self-harm". RN Workman's evidence was that he was kept to monitor his physical health. Unfortunately very little appears to have been done in this respect. Formal observations were not recorded or only in a partial or sketchy manner. The reason for his release back to the unit is not recorded.

Mr Howlett saw Dr Baguley again on 26 April 2013 and 10 May 2013. At the inquest Dr Baguley had no clear recollection of whether he had seen any material from any of the treating specialists during these later consultations. The appointment on 10 May 2013 was organised in response to Mr Howlett informing the nursing staff that he had been vomiting. Dr Baguley recorded "vomiting ++ on and off still" and changed his medication.

At the inquest Dr Baguley expressed the view that this vomiting was likely to have been caused by anxiety. He stated that Mr Howlett "did not look ill" and suggested that Mr Howlett's diary entries in relation to this matter may have been exaggerated.

While Dr Baguley saw Mr Howlett on three occasions, it is in my view quite clear that a meaningful therapeutic relationship did not develop between doctor and patient. There appears to have been no reassurance given that contact would or had been made with relevant specialists.

As far as any plan was made by Dr Baguley for Mr Howlett's future it consisted of him seeing Mr Howlett on a monthly basis and responding to health problems that he was specifically alerted to.

It is difficult to understand why further investigations were not put in train. The review of the chest X-ray obtained was cursory at best and involved no comparison to past scans or reports. While Mr Howlett's HIV needs were seen to by an outside specialist, there was in my view no systematic or appropriate review of his lung cancer.

Mr Howlett was certainly concerned about the lack of care he was receiving. When he saw Dr Bourne on 17 May 2013, by video link in relation to his HIV, he took the opportunity to state that he was not happy with the health services he had been provided with. He expressed concern that he was "missing the next round of therapy" for his lung cancer. This seems completely at odds with Dr Baguley's contention that he had been told "nothing could be done".

I am of the view that the transfer of care for Mr Howlett from the community to the custodial setting was well below best practice. He was known to have complex medical conditions and had established therapeutic relationships with medical providers in the community. Sending off form letter requests to providers was not enough. Dr Baguley's approach seemed to be to "take things as they came". According to the process that should have been followed, a Comprehensive Health Assessment Plan (CHAP) should have been created. Dr Baguley believed this was the nurse's responsibility and appeared quite unconcerned about it. It did not appear to have been a useful document to him. For a patient known to have anxiety, this lack of a coordinated approach must have been very stressful.

As the evidence emerged, it was clear that there was room for improvement in the transfer of care for inmate patients such as Mr Howlett, with a cancer diagnosis.

There appeared to be some recognition of this issue within Justice Health. Dr Donnelly, the Director of Medical Programs within Justice Health and the Forensic Mental Health Network, gave evidence in relation to the establishment of a new position in July 2016 within Justice Health, the Cancer Care Coordinator. With the increase in the prison population, there is of course a corresponding increase in the number of patients with cancer. Dr Donnelly explained the new role as,

> *"a person with clinical expertise in management of cancer patients and their main role is to be aware of all patients who have a diagnosis of cancer in custody, to assist in coordination of their care, such as…*

chasing up previous medical reports and make sure that that information is available to the relevant clinicians, and to assist in coordinating getting acute care to that patient if they require, for example further surgery, chemotherapy or radiotherapy. They also will have a role in transition to palliative care for appropriate patients with cancer"

Dr Donnelly spoke of this position as an improvement to make sure "no-one slips through the cracks".

My understanding of the position is that it would involve co-ordination for inmates in a GEO run prison in the same way as in a prison where Justice Health administered the health service. In my view this position is a positive step which may improve care for patients such as Mr Howlett.

Planning for future patient care

The Inquest heard that the medical management of patients in NSW gaols is "nurse led". Doctors are not on site 24 hours in all correctional centres. The system is designed so that nurses provide ongoing care and refer to medical staff when required, firstly to a general practitioner or to specialist nursing staff such as a mental health nurse or drug and alcohol nurse. Referral can apparently also be made to a specialist if circumstances require.

At the time of Mr Howlett's incarceration, nurses had responsibility for gathering information and completing the Comprehensive Health Assessment Plans within 30 days. No CHAP was completed in relation to Mr Howlett by the time of his death. Counsel for GEO pointed out that it was by then only days late of the target time-frame. This is correct, but what seems of greater interest is the lack of concern this caused. It may be that practitioners felt the document was of little value. Dr Baguley showed little familiarity with it and RN Phillips seemed unsurprised that it was late.

It appeared to be the type of task which fell to the bottom of a priority list. One can only wonder at its value for treatment in these circumstances. Certainly Mr Howlett would have benefitted from knowing that there was a plan in place, but it does not appear to have been remotely important to Dr Baguley.

In any event the document has now been replaced with the Chronic Disease Screen. It is important that tools such as this, if required, are undertaken in accordance with the guidelines in place. Failures to meet formal deadline requirements of this nature should not be easily dismissed. It is important that there are meaningful ways to measure compliance in a complex health system reliant on well-known policies and standards.

More comprehensive auditing may be necessary to see if targets are being systematically met. If they are not, it may be that further compliance checks are needed.

On the other hand if the non-compliance occurs because the tools do not gather useful information, then revision is certainly called for. The evidence of Dr Donnelly demonstrated that the number of files actually audited each year is very few.

Mental Health

Mr Howlett saw nurses on a number of occasions. On 6 May he undertook a mental health assessment with RN Workman. She noted that he had a history of Chronic PTSD and anxiety. He described chronic pain, nausea and vomiting. He had reduced appetite, fatigue and insomnia. He told RN Workman that he was "entitled to better care". Shockingly, it appears she did not know more than that he had a "serious medical condition". She gave evidence that at some stage after this assessment she discussed Mr Howlett's mental health with a visiting psychiatrist Dr Matthew Jones and it was decided that they would continue to "monitor" Mr Howlett. Unfortunately, even with his known issues, Mr Howlett was never seen by a psychiatrist.

Mr Howlett also saw a psychologist employed by Corrective Services on one occasion. It was recorded that he was "coping as well as possible in the circumstances". Dr Donnelly described an historical arrangement whereby Justice Health employed only psychiatrists and mental health nurses and the Department of Corrective Services employed psychologists. He was unable to comment on the scope of psychology services the Department offered. It is well beyond the scope of this inquest, but this arbitrary division between mental health professionals seems unhelpful.

It is apparent and unfortunate that no positive rapport was developed between Mr Howlett and any mental health practitioner. While an assessment took place, little else was achieved. It is unfortunate that a man with known mental health fragilities was not seen by a psychiatrist within the five weeks he was at Junee.

What was Mr Howlett's quality of life in the period leading up to his death?

In my view there is overwhelming evidence that Mr Howlett was suffering greatly in the lead up to his death. He had discussed his vomiting with nursing staff and with Dr Baguley. He had told Dr Bourne about it. There is ample evidence that his vomiting and diarrhoea was also well known to custodial officers. He was seen vomiting as he returned to the unit after morning medication. Other inmates had complained about his constant diarrhoea and the smell of faeces in the cell. He had trouble attending for his medication. He spoke to his wife and mother-in –law about it and recorded the extent of it in his diary.

GEO submitted that Dr Baguley treated Mr Howlett's nausea in an appropriate manner and drew the Court's attention to Dr Baguley's evidence that Mr Howlett's appearance was not consistent with vomiting at the level he described in his diary. Nevertheless I am persuaded by the weight of the evidence that there was a significant problem with nausea and diarrhoea and that it required further attention. In addition, Mr Howlett described being in pain. The breakthrough pain medication he had been prescribed in the community was not made available to him in custody.

There appears to have been no clear reason for this decision, except that Dr Baguley thought he was already "getting enough".

There is evidence that Mr Howlett was very thin and not coping with the prison diet. He was fatigued and found moving around the gaol difficult. All of these issues should have been explored by a practitioner skilled in recognising palliative care needs. The issues needed to be explored by a practitioner capable and open to developing rapport with a seriously ill patient.

Dr Baguley's approach appears to have been that when Mr Howlett "began to deteriorate" he would be sent to Sydney. Dr Donnelly explained that in Sydney, inmates could be treated at the Long Bay Prison Hospital or treated at the secure ward at Prince of Wales. What Dr Baguley did not seem to entertain was that palliative care strategies could have been commenced and planned for while Mr Howlett was still at Junee.

The need for palliative care

Palliative care is a multi-faceted approach that aims to improve the quality of life of patients facing the various problems that can be associated with life limiting or life threatening illness. It can involve a focus on pain relief and symptom management, as well as psychological care and support.

The palliative care needs of prisoners are currently managed in a variety of ways within the NSW Correctional system. Patients may be admitted to Long Bay Prison Hospital and managed in the Medical Sub-Acute Unit, or more rarely in the Aged Care Rehabilitation Unit. Those with higher clinical needs are transferred for care to Prince of Wales Hospital. However, this is apparently rare. Palliative care provided at Long Bay is by arrangement with the Sacred Heart Hospice and involves assessment if necessary by visiting staff from that institution.

Importantly Dr Donnelly stressed that palliative care patients may also be managed in other correctional facilities by local clinical staff. In cross-examination he identified the importance of treating patients close to their families and avoiding acute admissions where possible. He explained that the thrust of the Ministry's policy direction in this area is to educate all primary health providers. He stated

> *"For us to pick up on that would be to continue educating our GPs and nurses in appropriate recognition and pain management in the peripheral facilities and only escalate acute palliative care for particular patients…I think the resources are better spent continuing with the education of GPs rather than trying to set up a network of palliative care consultation across the state."*

Dr Donnelly gave evidence of a session on palliative care at the 2014 Annual General Practitioners conference, which had been attended by Dr Baguley and others who work in the country and rural areas. There was also evidence that Professor Chye had given training on palliative care to nurses around August 2016. There was no evidence of a co-ordinated or comprehensive training package which had been regularly or systematically rolled out.

Mr Howlett was clearly a candidate for a comprehensive palliative care assessment.

Was Mr Howlett's death predictable or expected ?

Mr Howlett was only in custody for about 5 weeks. His quality of life appeared to be deteriorating and he was initially reluctant to be transferred to Sydney, away from his wife. Whether there was ultimately anything that could have been done to prevent the fatal haemotysis, had staff been aware of an incident of prior haemotysis is now pure conjecture. I accept his cancer took a rapid and unexpected turn and that it would have been most unlikely that anyone could have accurately predicted the fatal events which caused his death. However, one can easily imagine that the enormous discomfort of his last days could have been eased somewhat by greater attention to his palliative care needs.

On the morning of his death Mr Howlett filled out a request to see a doctor. He wrote "Haven't been able to keep any food or liquid down for 28 days. I'm getting weaker by the day". After his death, the autopsy showed the progress of his disease and indicated the way it was likely to have been affecting his day to day functions.

Conclusion

Mr Howlett's last weeks were full of despair and dissatisfaction in relation to his medical care. His palliative care needs had not been adequately assessed and no clear plan had been identified in relation to possible further treatment, palliative or otherwise. The lack of an appropriate therapeutic relationship with either nurse or doctor at Junee was particularly unfortunate.

The evidence does not support a clear finding that his death was caused or hastened by the treatment (or lack of treatment) he received. What is established is that the opportunity to properly assess some of his pressing needs was missed by those responsible for his care.

This caused great discomfort and pain for Mr Howlett and his wife in what turned out to be the last days of his life.

Formal Finding:

I find that Keith Howlett died at on 24 May 2013. He died at Junee Correctional Centre. The medical cause of his death was complications of non-small cell carcinoma of the lung. Keith Howlett's death was the result of natural disease.

Recommendations pursuant to section 82 of the *Coroner's Act* (NSW) 2009

Lessons can often be learnt from the close examination of a single death, and while it is prudent to acknowledge the limited scope of the inquiry, it is equally important to identify areas of possible improvement as they emerge.

A number of recommendations were circulated at the conclusion of the inquest for comment. It is fair to say they received little support from either Justice Health, the GEO Group or from the Commissioner of Corrective Services. Mrs Howlett was largely supportive of the draft recommendations.

I note that Justice Health was of the view that no recommendations in relation to palliative care training were necessary. It was submitted that Justice Health can already access NSW Health's state wide program for development and training which includes relevant educational modules. It was also submitted that there had been a session on palliative care at a 2014 Justice Health Medical Officer conference, which GEO doctors were welcome to attend. Even though issues of training were directly addressed with Dr Donnelly in evidence,

Justice Health appeared surprised that training was an area of concern for the Court. Given the importance of palliative care in the context of an aging prison population, it was somewhat disappointing that Justice Health did not embrace recommendations with the real potential to improve the quality of life for a growing group of prisoners.

The evidence established that Mr Howlett's last days were unnecessarily uncomfortable. The Court accepts his death was sudden and somewhat unpredictable. However, in the weeks preceding his death Mr Howlett was anxious and dispirited about his future care. There had been no real recognition of the urgent need to screen his palliative care requirements.

His nausea and diarrhoea were inadequately controlled. He was fatigued and without breakthrough pain medication. He was without adequate mental health support and had not been provided with any information about when he may be seen by a lung cancer specialist for review.

Dr Baguley and other medical staff appear to have been of the view that the need for a palliative care review had not yet arisen, notwithstanding the fact that Mr Howlett had already been receiving palliative care in the community. Given the facts of this case it appears quite obvious that further training for medical staff on the early recognition of a prisoner's palliative care needs would be an appropriate intervention.

Similarly giving inmate patients more information about what might be available to them within the system makes sense.

The Court accepts that it may be that modules in relation to palliative care, already developed by the NSW Health Education and Training Institute, may be useful in developing programs for a custodial context, but particular issues arise for patients who are inmates. These require specific attention.

Justice Health could also see no benefit in allowing all prisoners with cancer the option of being reviewed by the Cancer Care nurse, a position recently created by Justice Health. The main difficulty appeared to be that those with lesser conditions such as skin cancer may cause too great a demand. It was an unhelpful response. Given that Justice Health has created a position of "Cancer Care Nurse", I am confident that the organisation would have the ability to manage the definitional issue appropriately. Overall I was surprised by the resistance displayed by Justice Health in this regard.

Equally disappointing was the response of the Commissioner of Corrective Services, who wanted any recommendations made limited to the Junee Correctional Centre. Dr Donnelly's evidence was helpful and wide ranging and I am of the view that wider opportunities for improvement emerged. There was nothing in the evidence to suggest that the care offered at Junee was below that offered in other regional settings or that the need for increased awareness of palliative care issues was only relevant to GEO staff.

It is important that health care options are uniform for prisoners, whether their care is provided by a private operator or by Justice Health itself. Equally I was not persuaded by the Commissioner's arguments that strengthening the evaluation and audit process of providers such as GEO was unnecessary.

Submissions received by the GEO Group did not support any of the recommendations and appeared to express the view that each was largely unnecessary or did not fall within its area of responsibility.

Given the interwoven responsibilities for the provision of health services to prisoners, especially in a privately run correctional facility, consideration of implementing the recommendations will require ongoing cooperation between all of the agencies involved.

A co-operative approach is required and for that reason, these recommendations will be addressed jointly to those with the capacity to drive change. Where there is a will to implement, the mechanics of service delivery will fall into place.

Rather than quibble about exactly who has final responsibility for implementation, a more co-operative approach is called for.

The over-arching policy framework must include commitment to equal health service whether an inmate finds him or herself in a custodial setting run by a private operator or a Government entity. Turf wars become irrelevant where there is a genuine motivation to improve current practise. Given that evidence received at this inquest suggested that palliative care for prisoners should and can be improved, it was disappointing that a more open and proactive approach was not adopted.

Recommendations pursuant to section 82 of the Coroner's Act (NSW) 2009

Arising from the evidence taken and for reasons set out in these findings I make the following recommendations. Clearly implementation will require co-operation and so I have taken the unusual course of directing each of the recommendations to the following persons for their joint consideration.

To The NSW Minister for Corrections

The NSW Minister for Health

The Chief Executive Officer of GEO Group

I recommend that:

Consideration is given to developing and implementing a palliative care training package for all nursing and medical staff within Justice Health, and including all other providers of medical services contracted to Corrective Services.

In particular training should address the early recognition of palliative care intervention for all inmates diagnosed with serious and life threatening illnesses and/or illnesses that may require opiate/analgesic relief.

Immediate consideration is given to creating a designated position and central location to resource and support medical staff across NSW in relation to palliative care options for all inmates.

Immediate consideration is given to mandating that all inmates identified with cancer be given the option of being reviewed by the Cancer Care Nurse (who shall be provided access to the necessary medical information and support systems) within an appropriate and fixed time frame.

A brochure is developed for inmates in relation to the palliative care and cancer support services available within the NSW custodial system, (including the part of that system which is privately operated).

Annual auditing of GEO Health Services (or any similar contract providers) includes a face-to-face interview component with a percentage of randomly selected inmates currently receiving health services.

Annual auditing of GEO Health Services (or any similar providers) should include mandatory checking compliance with tools such as the Chronic Disease Screen.

I direct the Registry to send a copy of these findings to the Chief Executive Officer of Justice Health and the Forensic Mental Health Network and to the NSW Commissioner for Corrective Services.

4. 177495 of 2013

Inquest into the death of Edward Haenga. Finding handed down by Deputy State Coroner Lee at Glebe on the 6th November 2017.

Introduction

Mr Edward Haenga was serving a custodial sentence at the time of his death. He had been in custody for almost 16 years and was due to be released in December 2013. During the evening of Saturday 8 June 2013 Mr Haenga spoke to his father on the phone and told him that he was looking forward to starting a new work program on the following Monday. Tragically, Mr Haenga was never able to start that program or be released from custody. On the morning of Sunday, 9 June 2013 Mr Haenga was found in bed, unresponsive, inside his cell. Despite resuscitation attempts he could not be revived and was pronounced deceased.

Why was an inquest held?

A Coroner's function and the purpose of an inquest are provided for by law as set out in the *Coroners Act 2009* (the Act). All reportable deaths must be reported to a Coroner or to a police officer.

Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. This is because when a person is imprisoned or held in lawful custody as a result of breaching a law, the State, by depriving that person of their liberty, assumes responsibility for the care of that person. It is necessary to ensure that the State discharges its responsibility appropriately by independently and transparently examining the circumstances surrounding that person's death.

Once a person's death is reported to a Coroner, the Coroner has an obligation to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to fulfil his or her functions. A Coroner's primary function is to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it.

In Mr Haenga's case, ample evidence was gathered during the investigation following his death to allow the questions about his identity and where and when he died to be answered. The inquest was primarily focused on the cause and manner of Mr Haenga's death. In other words, what happened in the months and days leading up to 9 June 2013 and how did events during this period of time impact upon Mr Haenga and his death?

In the course of investigating the cause and manner of Mr Haenga's death several issues were identified. Many of these issues concerned the care and treatment that Mr Haenga received whilst he was in custody. Specifically, the issues related to the last 3 years of Mr Haenga's life when he was housed at Junee Correctional Centre (**Junee**). Unlike most correctional centres in New South Wales, Junee is privately operated by the GEO Group Australia Pty Ltd (**GEO**) under a management agreement with Corrective Services New South Wales (**CSNSW**).

As Mr Haenga suffered from a number of physical and mental health conditions he had contact with a number of health care practitioners who worked at Junee and who were employed by GEO. Mr Haenga also had contact with a number of visiting medical officers who worked at Junee. Although Junee was a privately operated facility it still had an obligation (pursuant to the management agreement between GEO and CSNSW) to provide health care facilities and services to inmate patients to the standards of the public health care system.

Furthermore, in providing these facilities and services GEO was under an obligation to comply with relevant policy directives, guidelines and procedures established by both the NSW Ministry of Health and the Justice Health and Forensic Mental Health Network (**Justice Health**). Justice Health is ordinarily responsible for the provision of health care services and facilities to inmate patients in correctional centres operated by CSNSW. In the last days of Mr Haenga's life he was housed at one such centre, the Metropolitan Special Programs Centre (**MSPC**) at Long Bay Correctional Complex in Matraville. Whilst there Mr Haenga was under the care of clinical staff employed by Justice Health as well as visiting medical officers.

The coronial investigation gathered evidence about these issues from various health practitioners directly involved in Mr Haenga's care in order to consider whether the care provided to him was adequate and appropriate. The inquest carefully examined this evidence and heard evidence from a number of independent experts who were asked to provide opinions concerning a number of issues central to the inquest. The inquest also reviewed the systems, processes, and applicable documentary policies and guidelines which governed the care and treatment provided to Mr Haenga. This review was done to consider whether any aspect of the systems and policies was deficient and, if so, whether any aspect, or aspects, could be improved upon.

Mr. Haenga's life

Before going on to discuss the evidence and issues which the inquest examined it is important at this point to say a few brief words about Mr Haenga's life. As mentioned above inquests are often concerned with systems and processes and how they may be improved for the community at large. With such far-reaching intentions that may impact positively upon the broader community it is, perhaps, sometimes easy to forget that there is a single person at the centre of the inquest.

Inquests are often concerned with the circumstances of a person's death. These circumstances usually occupy the last few weeks, days, hours, and, sometimes, minutes, of a person's life. Usually a great deal of documentary evidence is gathered about these circumstances. However, those documents very rarely tell us much about the person who died, or the, often years, of life which preceded their death.

That is why it is extremely important, at the beginning of these findings, to acknowledge Mr Haenga's life and to recognise the impact that his death has had on his family.

Mr Haenga was born in New Zealand to his father, Pepe, and mother, Charlotte. He had 2 younger siblings, William and Rachel. In 1988 Mr Haenga and his father moved to Australia and they were joined a short time later by the rest of Mr Haenga's family. Mr Haenga went to school at Bankstown Primary School and, later, Liverpool Public School. In the early 1990s he formed a relationship with Morena Aparicio and moved to south-west Sydney. Mr Haenga and Morena had 3 children together: Amelia, Manuel, and Diego.

Tragically, Mr Haenga was involved in house fire in 1993 and suffered third degree burns to 70% of his body. He spent about a year in hospital and, after being discharged, regularly returned to hospital for burns treatment in the following years. According to William, this incident changed Mr Haenga as he found it difficult to readjust to life after being discharged from hospital. Mr Haenga and Morena separated a short time later and Mr Haenga lost contact with his children.

Sadly, around the same time Mr Haenga's mental well-being began to decline. He had been taking pain relief medication for his burns and later began to abuse illicit drugs. Mr Haenga also became involved in criminal activity and, as a result, spent some time in custody. Mr Haenga later formed another relationship. Sadly this relationship ended with the death of Mr Haenga's partner and he was charged in relation to the death.

Mr Haenga's father described his son as having a passion for playing rugby league, which he had started doing at an early age, and for music. Mr Pepe Haenga said that his son was soft-spoken and loved his mother enormously; at a young age Mr Haenga would constantly follow his mother around and watch her cook in the kitchen. Mr Haenga was devoted to, and loved his, 3 children. He missed them enormously following the breakdown of his relationship and whilst he was in custody.

Mr Pepe Haenga described his son as someone who was more like a best friend to him, than a son. It was abundantly clear during some moving and heartfelt words spoken by Mr Pepe Haenga at the end of the evidence in the inquest how much he misses Mr Haenga. This fact, and the love that Mr Haenga had for his children, makes Mr Haenga's death at the young age of 37 particularly distressing.

Mr Haenga's custodial history

In December 1997 Mr Haenga was taken into custody after being charged with offences of murder and assault. It was not his first time in custody. In July 1999, following the outcome of the criminal proceedings, Mr Haenga was convicted and sentenced. In June 2000 Mr Haenga was convicted and sentenced for a number of armed robbery offences. Ultimately, the overall effect of these sentences meant that Mr Haenga would not be eligible for release to parole until December 2013.

After being sentenced in 1999 Mr Haenga was housed at a number of different correctional centres at Goulburn, Lithgow, Parklea, Bathurst and the MSPC. The first 13 years of Mr Haenga's sentence are not relevant to the issues considered by the inquest. Instead, the inquest focused on the last 3 years of Mr Haenga's sentence after he was transferred to Junee on 8 September 2010. Mr Haenga remained at Junee until 26 May 2013 when he was transferred back to the MSPC (via Bathurst Correctional Centre) arriving there on 27 May 2013. Mr Haenga remained at the MSPC and was discovered to be in his cell, deceased, on the morning of 9 June 2013.

What happened on 8 and 9 June 2013?

On 8 June 2013 at about 5:45pm Mr Haenga was given his prescribed medication by a Justice Health Nurse and CSNSW correctional officer. This was the last time that Mr Haenga was seen alive.

At about 7:15am on 9 June 2013 a CSNSW correctional officer was performing a head check in the wing where Mr Haenga was housed. The officer noticed that Mr Haenga was in bed and not moving.

The officer called out to Mr Haenga and, after not receiving a response, shook the bed mattress in an attempt to wake Mr Haenga, believing him to be still asleep. When Mr Haenga did not respond the officer noticed that Mr Haenga did not appear to be breathing and an emergency radio call was made for immediate assistance.

A number of Justice Health nurses and CSNSW officers responded to the call. Cardiopulmonary resuscitation was commenced in an attempt to revive Mr Haenga but he remained unresponsive. NSW Ambulance paramedics were called and they arrived at the scene at about 7:32am and continued the attempts to revive Mr Haenga. However this was also unsuccessful and Mr Haenga was pronounced deceased at 7:35am.

What was the cause of Mr Haenga's death?

After being discovered in his cell on the morning of 9 June 2013, Mr Haenga was later taken to the mortuary at the Department of Forensic Medicine in Glebe where an autopsy was performed by Dr Kendall Bailey on 12 June 2013. Following her examination Dr Bailey prepared a report dated 4 February 2014.

Autopsy Findings

In her autopsy report Dr Bailey noted that Mr Haenga had an enlarged heart (cardiomegaly). That is, Mr Haenga's heart weighed more than would normally be expected for someone of his height. Dr Bailey explained that heart enlargement increases the risk that a person will develop cardiac failure (the failure to adequately move blood around the body) and sudden potentially fatal cardiac arrhythmias (abnormal heartbeats). Dr Bailey also explained that Mr Haenga was obese which increased his risk of developing cardiac disease, such as high blood pressure (hypertension), and metabolic disturbances, such as diabetes and increased cholesterol levels. Dr Bailey ultimately concluded in her report that the cause of Mr Haenga's death was cardiomegaly, with obesity being a significant condition which contributed to his death.

In evidence during the inquest Dr Bailey said that if she had written her autopsy report in 2017 she might have recorded the cause of death as being complications of morbid obesity. This is because what Dr Bailey could demonstrate from the clinical findings at autopsy was that Mr Haenga had a body mass index (**BMI**) of over 60 and that his heart weight was outside what would be expected for someone of his height.

Dr Bailey also pointed to other significant findings such as the fact that Mr Haenga had a large fatty liver, Hepatitis C, and early cirrhosis (all of which pointed to some level of liver dysfunction), along with some respiratory dysfunction. All of these findings would have impacted upon Mr Haenga's metabolic processes. But Dr Bailey was unable to point to any clinical finding which confirmed what this impact was. This is because, as she explained, these physiological processes cannot be demonstrated at autopsy.

In her report Dr Bailey referred to the toxicological testing that was conducted on a blood sample taken from Mr Haenga. That testing revealed the presence of a number of prescription drugs such as escitalopram, amisulpride, codeine, quetiapine and methadone. The therapeutic effect of these drugs, their side effects, and the reasons why they had been prescribed to Mr Haenga will be discussed in more detail later in these findings. Dr Bailey found that the concentration levels of these drugs in Mr Haenga's blood sample were consistent with what Mr Haenga's medical records indicated he had been prescribed.

Toxicology results

As part of the police investigation a forensic toxicologist. Dr William Allender, was asked to provide an opinion on the concentration levels of the drugs detected in the post-mortem toxicological testing. In a report Dr Allender concluded that the concentrations of both citalopram and codeine were outside the therapeutic ranges expected for these drugs.

Given Dr Allender's conclusions, Dr Bailey was asked in November 2016 to clarify a number of aspects of her report. Dr Bailey explained that cardiac failure or cardiac arrhythmia, or a combination of the two, might have been the mechanism of death. However, because both of these are physiological phenomena it was not possible to point to any clinical findings to demonstrate either of them at autopsy.

Dr Bailey was also asked a number of further questions in relation to the toxicology results from the autopsy. Dr Bailey explained that whilst the levels of some medication found in the blood tests indicated, according to academic literature, that they were within the reported non-toxic range, she would defer to the opinion of an expert in toxicology.

As a result, Associate Professor Naren Gunja, a specialist medical practitioner in clinical toxicology, was asked to consider the toxicology results and provide a report. Associate Professor Gunja noted that the blood concentrations of both amisulpride and escitalopram were elevated. That is, they were higher than therapeutic levels.

In Mr Haenga's case a amisulpride concentration of 0.85 mg/L was detected where, according to Associate Professor Gunja, the therapeutic range is usually well under 0.5 mg/L. Associate Professor Gunja also explained that a escitalopram concentration of 0.66 mg/L was detected in circumstances where the usual therapeutic level is under 0.1 mg/L.

Associate Professor Gunja explained that these concentration levels could have been due to 2 things. Firstly, they could have been the product of post mortem redistribution. Secondly, they could represent doses that were more than the ordinary expected dose for treatment of a medical condition (a supratherapeutic dose).

Post mortem redistribution is the phenomenon where drugs may shift from their original tissue compartment to a different tissue compartment. This can have the effect of increasing drug concentrations in the blood leading to a result that does not accurately indicate the true blood concentration at the time of death.

Associate Professor Gunja thought it was more likely that the elevated level of amisulpride was due to post mortem redistribution. This is because amisulpride is lipophilic, meaning that it is capable of being dissolved in, or of absorbing, lipids (fats). This in turn means that it has a large volume of distribution and is more susceptible to post mortem redistribution. On this basis, Associate Professor Gunja also thought that it was more likely that the elevated level of escitalopram could represent a supratherapeutic dose.

Prolongation of the QT interval

Associate Professor Gunja explained that Mr Haenga had been prescribed a number of medications that carry the risk of prolonging the QT interval. In order to understand the cause of Mr Haenga's death, and the other issues which the inquest examined, it is necessary to briefly explain what is meant by QT interval prolongation.

With each person's heartbeat an electrical signal travels from the top to the bottom of the heart. As the signal travels it causes the heart to contract and pump blood. An electrocardiogram (**ECG**) is a test that records the heart's electrical activity and these signals as they move through the heart. Data from an ECG is mapped on a graph in 5 distinct electrical waves identified with the letters: P, Q, R, S and T. The QT interval is the measure of electrical activity between the Q and T waves in the heart's electrical cycle and shows activity in the heart's lower chambers, the ventricles. Normally the QT interval is about a third of each heartbeat cycle.

When the QT interval is prolonged it can upset the timing of the heartbeat and cause dangerous arrhythmias (irregular heartbeats).

An abnormally prolonged QT interval is associated with an increased risk of ventricular tachycardia, a fast heart rate caused by improper electrical activity in the ventricles, especially a condition known as Torsades de Pointes (**TdP**). Drugs which carry the risk of prolonging the QT interval are therefore known as *torsadogenic* drugs.

Associate Professor Gunja identified that Mr Haenga was taking:

- 3 drugs (amisulpride, escitalopram and methadone) that had a high risk of prolonging the QT interval;
- 1 drug (quetiapine) that had a low to moderate risk of prolonging the QT interval; and
- 1 drug (pericyazine) that had a low risk of prolonging the QT interval.

Associate Professor Gunja explained that the risk of developing TdP is often multi-factorial and can depend on factors such as abnormal heart size and shape, the use of torsadogenic drugs, and electrolyte abnormalities such as low potassium or magnesium. In evidence during the inquest he described this as a "*Swiss cheese effect*". That is, if each of these risk factors coincided at a particular point in time it could lead to the risk materialising. In other words, in Mr Haenga's case, it could result in him suffering a fatal cardiac arrhythmia.

Associate Professor Gunja said that, from a toxicological perspective, it is recommended that drugs which prolong the QT interval not be prescribed concurrently. During the inquest two independent psychiatrists gave evidence and expressed a similar view. This issue will be discussed in more detail below. Associate Professor Gunja also expressed concern that Mr Haenga had been prescribed 3 highly torsadogenic drugs where he was known to be obese.

In evidence, both Dr Bailey and Associate Professor Gunja agreed that even if one were to ignore the evidence of what medication had been prescribed and the toxicology results, the clinical findings still showed that Mr Haenga was at risk of sudden cardiac death. There is no evidence that Mr Haenga was suffering from QT prolongation.

This is because the last time he had an ECG performed on him was in 2011, well before he was placed on the medication regime that he was on at the time of his death. Further, as explained by Dr Bailey, a fatal arrhythmia could not be demonstrated by any clinical findings at autopsy.

Given the agreement amongst all the experts, in pathology, toxicology, and psychiatry, as to the increased risk of QT prolongation from torsadogenic drugs, particularly when taken concurrently, it is not possible to ignore this as a factor which probably contributed to Mr Haenga's death.

Dr Bailey said in evidence that it was reasonable to consider this as a factor in causing Mr Haenga's death and was not one which she was able to exclude. Associate Professor Gunja explained that QT prolongation, morbid obesity, and heart enlargement were all risk factors and that they were additive.

CONCLUSION: Complications from Mr Haenga's morbid obesity, including cardiomegaly, could have led to a cardiac arrhythmia which caused his death. Equally prolongation of the QT interval from the concurrent use of 5 torsadogenic drugs could also have led to a cardiac arrhythmia. There is no other evidence to suggest any other possible cause of death. The expert evidence established that both morbid obesity and QT prolongation are additive risk factors. It is therefore more probable than not that both of these sets of risk factors contributed to Mr Haenga suffering a fatal cardiac arrhythmia which caused his death.

Was Mr Haenga hoarding medication?

The elevated levels of amisulpride and escitalopram identified by Associate Professor Gunja raised a further question.

That is, could these elevated levels be due to the fact that Mr Haenga had been hoarding medication he had been prescribed, and consuming them in larger doses than were intended by the prescribers of this medication?

In examining this question I will only concentrate on the level of escitalopram as Associate Professor Gunja thought that it was more likely that this, rather than the amisulpride, possibly represented a supratherapeutic dose**.**

Mr Haenga's medication charts reveal that he received doses of escitalopram 30mg each day between 5 June 2013 and 9 June 2013. Mr Haenga was transferred from Junee to the MSPC (via Bathurst) arriving on 27 May 2013. After his transfer, in accordance with CSNSW guidelines his cell was searched 3 times: on 30 May 2013, 2 June 2013 and 4 June 2013. Hoarded prescription medication is deemed to be contraband. If found by CSNSW officers the medication is seized and reported to Justice Health. In Mr Haenga's case no hoarded medication was found during any of the 3 searches.

It is theoretically possible for Mr Haenga to have been given his escitalopram on any day between 5 June 2013 and 9 June 2013 and to have not taken it, with the intention of hoarding it.

As escitalopram is not a type of drug which requires Justice Health staff to supervise a patient taking it, Mr Haenga could have not taken it on one day and then taken it, along with another dose, on another day. However, there is no evidence to establish, or even suggest, that Mr Haenga had ever hoarded any medication he had been given, either at Junee or after he arrived at the MSPC in May 2013.

CONCLUSION: The elevated levels of escitalopram and amisulpride detected during post-mortem toxicological testing were due to post-mortem redistribution. There is no evidence that Mr Haenga hoarded either medication and took supratherapeutic doses of them to explain the elevated levels.

When did Mr Haenga die?

The medical evidence does not allow for a conclusive answer to this question. As Dr Bailey explained in evidence at the inquest, the onset of rigor mortis after a person's death is variable and very inexact. Dr Bailey said rigor mortis had been documented in ranges between minutes up to 24 hours. Due to this high degree of variation, Dr Bailey said that it is not possible to give an estimated time of death based on rigor mortis. However, the toxicology results may shed some further light on this issue. Mr Haenga was given 2 tablets of Panadeine Forte, along with his other medication, at about 5:45pm on 8 June 2013. Panadeine Forte consists of both paracetamol and codeine. Associate Professor Gunja explained that the toxicology testing did not detect any paracetamol, meaning that it had been metabolised by the time of Mr Haenga's death.

What the toxicology testing did detect was peak concentrations of codeine and its metabolites. Associate Professor Gunja explained that he would expect it would take at least 4 hours for the paracetamol to have been metabolised after the Panadeine Forte was taken.

CONCLUSION: Mr Haenga died sometime between about 10:00pm on 8 June 2013 and 7:15am on 9 June 2013.

Issues examined by the inquest and a Coroner's power to make recommendations

The inquest primarily focused on examining the care and treatment that Mr Haenga was provided with whilst in custody between June 2011 and the time of his death. Because of the way in which Junee was operated, this care was provided by clinical staff employed by both GEO (at Junee) and Justice Health (at the MSPC), as well as visiting medical officers.

This examination was done to identify any inadequacies or shortcomings in care so that they might be eliminated or improved upon for the future benefit of, in this case, other persons held in custody.

From a Coroner's perspective, the power to make recommendations which might lead to such improvement is an extremely important one. This power is provided for by section 82 of the Act. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

The coronial investigation into the death of a person is one that, by its very nature, involves much grief and anguish. The emotional toll that such an investigation, and any resulting inquest, places on families and friends of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any inadequacies or shortcomings, whether by an individual or an organisation, with respect to any matter connected with a person's death. It seeks to identify them not to assign blame or fault but, rather, so that lessons can be learnt from mistakes and so that, hopefully, these mistakes are not repeated in the future.

The mere assigning of blame or fault rarely produces a positive outcome and often only serves to add to the anguish that a family member may be experiencing. If families of deceased persons must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be some hope for some positive outcome. The recommendations made by Coroners are made with the hope that they will lead to some positive outcome by improving general public health and safety.

In this inquest Dr Andrew Ellis, an independent consultant forensic psychiatrist, was engaged to examine a number of different aspects of the care and treatment provided to Mr Haenga, and to provide an expert report for the Court. The aspects of care which the inquest and Dr Ellis focused on related to the types of medication that Mr Haenga had been prescribed, how that medication was administered to Mr Haenga, the effects of that medication on him, and whether other medical investigations were performed. These issues can be summarised as follows:

Whether Mr Haenga's medication regime, particularly in the last 6 months of his life, was appropriate, particularly having regard to Mr Haenga's comorbidities;

Whether, during the period from June 2011 to May 2013, Mr Haenga was provided with adequate health care at Junee, and whether metabolic monitoring and cardiac monitoring was, or should have been, provided to him;

Whether the recording and monitoring of Mr Haenga's medication regime was adequate.

I will deal with each of the issues below. In some cases shortcomings have been identified. Where necessary or desirable, I have made recommendations in the hope that systems and procedures can be improved upon.

The general management of Mr Haenga's physical and mental health

The management of Mr Haenga's health by CSNSW and Justice Health prior to his arrival at Junee in September 2010 is largely not relevant to the issues which the inquest examined. It is therefore not necessary to recount this period of time in any great detail.

What is important to note is that during his time in custody, both at Junee and at other centres operated by CSNSW, Mr Haenga received care and treatment from a number of different health services: general physical health care, drug and alcohol services, and mental health care. Mr Haenga's care by these various health providers was due largely to events in his life which occurred before he entered, and whilst he was in, custody. The different types of health care provided to Mr Haenga were:

Mental health care: When Mr Haenga first entered custody on 30 December 1997 (after being arrested and charged for the offences that he was later sentenced for in 1999) he was diagnosed with post-traumatic stress disorder (**PTSD**) as a result of the severe injuries he sustained in the 1993 house fire. Whilst in custody Mr Haenga also disclosed that he was dealing with unresolved grief issues and had previously attempted self-harm. At various times whilst in custody Mr Haenga was found to have symptoms of paranoia, low mood, anger, depression and poor sleep. He was also diagnosed with a number of conditions including PTSD (as referred to above), bipolar disorder and antisocial personality.

Drug and alcohol issues: Mr Haenga had a history of alcohol and illicit drug use before entering custody in 1997. After reporting further illicit drug use whilst in custody, Mr Haenga was placed on the methadone program in March 1998. Apart from a brief period in 2009, Mr Haenga remained on the methadone program during his entire time in custody up until his death.

Primary or general physical, health care: During his time in custody Mr Haenga was noted to be overweight and obese. Much of this weight gain may have been due to medication that he was taking, which will be discussed in more detail later. Mr Haenga also suffered from a number of different health conditions including chronic back pain, osteoarthritis in his knees, oedema in his legs and, at one point, pneumonia (for which he required hospitalisation).

The period of time which the inquest focused on was between June 2011 and May 2013. This is because it was on 9 June 2011 that Mr Haenga first saw Dr Matthew Jones, a psychiatrist who worked at Junee as a Visiting Medical Officer (**VMO**). At that time, Mr Haenga was also under the care of Dr Richard Baguley, the General Practitioner (**GP**) at Junee, who had first started seeing Mr Haenga some 9 months earlier on 17 September 2010. Supporting Dr Jones and Dr Baguley were a number of mental health, drug and alcohol, and primary health care nurses.

Dr Jones' involvement in Mr Haenga's care was prompted by a consultation that Mr Haenga had with Dr Baguley on 2 June 2011. Dr Baguley saw Mr Haenga on that day for a review as Mr Haenga had recently been hospitalised for pneumonia. Dr Baguley noted that Mr Haenga's mood was down and so referred him for a psychiatric review by Dr Jones.

Complexities and challenges

All of the medical practitioners who gave evidence at the inquest who were either directly involved in Mr Haenga's care, or had been asked to review and comment on the adequacy of it, agreed on two facts. Firstly, Mr Haenga was a complex patient to care for, and was described by Dr Ellis as "*more complex than most*" other patients in custody. Secondly, because of this complexity and the environment that Mr Haenga was in, his health care management presented a number of particular challenges. These complexities and challenges are summarised below:

In general, there are particular constraints to providing psychiatric care to a patient within a prison environment. Dr Ellis made the general observations that drug use and exposure to violence is prevalent within gaols and that dislocation from community supports is common. He explained that security takes primacy over health care, which in turn limits time that medical practitioners can spend with patients. These time limitations are further constrained by the need to triage and prioritise the most urgent cases, leaving little time for patients that do not fall within this category.

Dr Jones worked at Junee one day per week. This allowed for approximately 4 hours per week for patients to be clinically assessed. Due to the fly in, fly out nature of Dr Jones' position, his available time was spent not only on reviewing existing patients, but also seeing new patients, checking medical test results, and writing prescriptions. In evidence Dr Jones said that on average he saw 10 patients each day he was at Junee, spending between 10 to 15 minutes with them. Between June 2011 and May 2013 Dr Jones had 10 consultations with Mr Haenga. It was not uncommon for there to be a period of several weeks between each of these consultations.

The infrequency of these consultations, made it difficult for Dr Jones to develop a therapeutic alliance with Mr Haenga. Dr Jones estimated that in 2013 there were between 200 to 300 patients on the mental health wait list at any given time, and that many of these patients have complex and chronic mental health issues.

Information provided by Justice Health from their Patient Administration System (**PAS**) establishes that in May 2013 between 309 and 329 patients were on the wait list. However, it was acknowledged in evidence during the inquest that not all of these patients were waiting for psychiatric review by Dr Jones; some of them may have been entered on the PAS for future appointments or follow up with a mental health nurse.

Mr Haenga had a history of violent behaviour. Because of his physical size and sometimes threatening demeanour Mr Haenga could be, at times, an intimidating person to deal with. When he first started seeing Dr Jones, Mr Haenga was fixated on the medication regime that he had been on and was reluctant to change it. Indeed, Dr Jones reports that Mr Haenga threatened him with violence when it was suggested that it should be changed. Mr Haenga may also have been seeking to secure sedating medication.

Mr Haenga presented as someone with diagnostic complexity. Dr Ellis noted that previous diagnoses of PTSD, substance abuse disorder, bipolar disorder, pain disorder and personality disorder had all been considered for Mr Haenga and that because these conditions have overlapping symptoms they could have been easily confused with each other. Dr Ellis also noted that Mr Haenga could well have had all of these conditions.

Arriving at a certain diagnosis would have required a comprehensive review of Mr Haenga's clinical records and past history. Features such as Mr Haenga's mood symptoms, behavioural disturbances and how his changing medication regime affected these factors would have been required. In particular, there was limited access to potentially relevant medical investigations (such as cerebral imaging) and to collateral information from Mr Haenga's family about his background and past history. Time and resource constraints also did not allow for this type of comprehensive review to be performed.

Due to these constraints, management of Mr Haenga's condition or conditions was done primarily through pharmacology, that is, the prescribing of various types of medication. However, Dr Ellis pointed out this alone was unlikely to result in remission of Mr Haenga's symptoms or more stable behaviour. Whilst medication could assist with things such as mood stabilisation and improved sleep and concentration, it was unlikely on its own to bring about improved insight, motivation and interpersonal skills.

The added difficulty was that there was an absence of alternatives to pharmacological treatment, and that Mr Haenga had a number of presumed conditions which could have benefited from it.

Was Mr Haenga's medication regime appropriate?

In order to examine whether Mr Haenga's medication regime was appropriate it is first necessary to provide some detail about that regime and the prescribing rationale behind it. Apart from its appropriateness, Mr Haenga's medication regime also raised other issues which are discussed below.

What psychotropic medication was Mr Haenga taking?

During his first consultation on 9 June 2011 Mr Haenga told Dr Jones that he had previously been diagnosed with bipolar disorder and PTSD. As a result Mr Haenga was already taking medication that had been prescribed by another psychiatrist in the 9 months before he first met Dr Jones. The relevant medication that Mr Haenga was taking by 9 June 2011 is summarised below:

Sodium valproate (also known as valproic acid), an anti-epilepsy drug used as a mood stabiliser for the treatment of bipolar disorder;

Quetiapine, an antipsychotic drug used for the treatment of psychotic disorders like schizophrenia. This had been prescribed to Mr Haenga to treat his diagnosed bipolar disorder and PTSD;

Gabapentin, an anticonvulsant that is also used to treat nerve pain which had been prescribed to Mr Haenga for his chronic back pain; and

Methadone, as part of the methadone program Mr Haenga had been on for several years.

Following this initial meeting Mr Haenga continued to take each of the above medications. In addition Dr Jones prescribed a new medication for Mr Haenga, ***escitalopram*** at a dose of 10mg daily. Escitalopram is an anti-depressant drug of the selective serotonin reuptake inhibitor class and is used to treat depression and anxiety disorders.

Apart from the new prescription of escitalopram, over time both Dr Jones and Dr Baguley made a number of other significant changes to Mr Haenga's medication regime.

These are detailed below:

On **26 July 2012** Dr Baguley decreased Mr Haenga's dose of quetiapine from 900mg to 800mg to help with his weight loss, pending psychiatric review.

At the same time Dr Baguley replaced gabapentin with another type of analgesic medication, ***pregabalin***. This is a nerve-conduction blocking drug used to treat neuropathic pain syndromes.

On **4 December 2012**, Dr Baguley commenced Mr Haenga on 1 tablet of ***Panadeine Forte*** 3 times per day for pain relief.

On **7 February 2013** Dr Jones increased Mr Haenga's dose of escitalopram to 20mg. Dr Jones noted that whilst Mr Haenga was thinking positively about his release at the end of the year, he was still reporting that he felt depressed.

Sometime between **14 February 2013 and 14 March 2013** Dr Baguley increased Mr Haenga's dose of Panadeine Forte to 2 tablets 3 times daily.

On **14 March 2013** Dr Jones increased Mr Haenga's dose of escitalopram to 30mg as Mr Haenga continued to report that he still felt depressed. Dr Jones reduced Mr Haenga's dose of quetiapine from 700mg to 400mg. Dr Jones also prescribed a new medication, ***amisulpride*** (200mg), as a trial. Amisulpride is also an antipsychotic drug like quetiapine. Dr Jones prescribed this for Mr Haenga's bipolar disorder, to help him with his agitation, thinking and in an attempt to motivate him.

On **11 April 2013** Dr Jones prescribed Mr Haenga with another new drug, ***pericyazine*** (20mg) at night. Like quetiapine and amisulpride, pericyazine is also an antipsychotic drug. It appears that the pericyazine was prescribed to offset the side effects that the reduction in quetiapine was having; it had been causing Mr Haenga to have trouble sleeping.

On **2 May 2013** Dr Jones saw Mr Haenga for the final time. Dr Jones believed that the pericyazine was having a good effect and increased the dose to 30mg at night.

All of the above means that by **11 April 2013** Mr Haenga was taking 3 different types of antipsychotic medication: quetiapine, amisulpride, and pericyazine. He remained on this medication, and the others described above, up until 8 June 2013. At this point it is important to point out that Mr Haenga should not have been taking quetiapine up until 8 June 2013.

This occurred due to a series of events in late April and early May 2013. On 29 April 2013 Mr Haenga did not take his quetiapine, although he did take his other medication. Mr Haenga continued to not take his quetiapine for the next 2 days. The reason for this is unknown. However, what is known is that Mr Haenga had a consultation with Dr Jones on 2 May 2013 and told Dr Jones that he had stopped talking quetiapine.

Despite being told this, Dr Jones did not stop Mr Haenga's prescription of quetiapine. After his consultation with Dr Jones, Mr Haenga continued to not take his quetiapine in the following days until 5 May 2013 when he took it again.

The effect of all this is that on 6 May 2013 Dr Baguley recharted (that is, re-prescribed) the quetiapine, after noting that Mr Haenga had not taken it for 6 days since 28 April 2013 but then resumed taking it on 5 May 2013. The recharting by Dr Baguley resulted in Mr Haenga being given quetiapine on 6 May 2013 which he then continued to take up until 8 June 2013. This sequence of events will be discussed in more detail below.

The appropriateness of the medication regime will be considered in this context. That is, whilst Mr Haenga was *actually* prescribed 3 different antipsychotics (amisulpride, pericyazine, and quetiapine) at the time of his death, the *intention* of Dr Jones was that he only should have been prescribed 2 antipsychotics (amisulpride and pericyazine). The prescription of quetiapine was due to inadvertent error. This error will also be discussed further below.

Mr Haenga's history on the methadone program

The fact that Mr Haenga was on the methadone program is relevant to the question of whether his medication regime was appropriate. This is because, as already noted above, methadone had a high risk of prolonging the QT interval.

When Mr Haenga arrived at Junee in September 2010 he was taking 120mg of methadone daily. This remained consistent until January 2011 when there was a gradual increase of the dosage up to 150mg. The dosage remained at this level until 12 January 2012 when a gradual reduction began. By the end of August 2012 the dosage had been reduced to 50mg and it remained at this level until February 2013 when there was a further slight reduction to 45mg. This reduction continued for the next few months reaching a lowest dose of 20mg on 30 April 2013. The dose remained at this level until 24 May 2013 when it was increased to 25mg and then gradually increased to 50mg, this last dose being given on 8 June 2013.

Dr Baguley saw Mr Haenga for the last time on 24 May 2013. At this time Dr Baguley began a gradual increase in Mr Haenga's methadone after noting that Mr Haenga had tried to reduce his dosage too quickly. Dr Baguley ordered the dose to increase from 25mg up to 80mg, but this increase was planned by Dr Baguley to occur incrementally over a period of time with a gradual series of 5 mg increases.

It was Dr Baguley's eventual plan to reduce Mr Haenga's dose of Panadeine Forte as the methadone dose increased, but this plan never eventuated as Mr Haenga was transferred away from Junee two days later on 26 May 2013.

Expert opinion

One of the matters which Dr Ellis was invited to consider was whether Mr Haenga's medication regime was appropriate. Another consultant forensic psychiatrist, Dr Anthony Samuels, was engaged by the legal representatives for Dr Jones to also consider this issue, and others.

In evidence during the inquest both Dr Ellis and Dr Samuels agreed that generally where it is not possible to be certain about a diagnosis for a patient, such as in Mr Haenga's case, it is acceptable to treat and manage that patient's symptoms with medication and attempt to refine a diagnosis over time. With this in mind, both experts also agreed that there was a clinical rationale for Dr Jones to have prescribed the medication which he did.

Dr Ellis thought that there was no indication that 3 antipsychotics were required, accepting, as described above, that the quetiapine was prescribed inadvertently. Dr Ellis even queried whether a single, or even no, antipsychotic medication should have been prescribed as Mr Haenga had no obvious history of psychosis associated with mood disorder. However, Dr Ellis acknowledged that it was difficult to arrive at a certain diagnosis for Mr Haenga, and that Mr Haenga himself had pressured clinical staff to not change his medication and asserted that it was helping him.

In evidence during the inquest Dr Ellis was asked whether there was any indication for the 2 intended antipsychotics (amisulpride and pericyazine) to have been prescribed. Dr Ellis agreed with Dr Jones' intention to rationalise Mr Haenga's medication regime, that is, reduce the number of different medications that Mr Haenga was taking. In this regard, Dr Ellis noted that it was Dr Jones' intention to eventually replace the quetiapine with amisulpride and that, by introducing pericyazine, Dr Jones was effectively cross-tapering it with the quetiapine (along with helping Mr Haenga's difficulties with sleeping).

Whilst Dr Ellis indicated that it was not outside proper medical practice to engage in such cross-tapering he reiterated that polypharmacy should generally be avoided. Dr Ellis did qualify this opinion by noting the complexities and challenges which Mr Haenga's management presented, as already described above, and that there are circumstances where polypharmacy is required.

Dr Samuels agreed with Dr Ellis that, in general, polypharmacy (particularly using multiple antipsychotics) is "*not considered optimal practice*". Dr Samuels did note though that Dr Jones was working with Mr Haenga to rationalise his medication and that he had successfully convinced Mr Haenga to stop taking quetiapine temporarily (before it was inadvertently recharted).

In evidence Dr Samuels noted that the doses of amisulpride and pericyazine were both low, meaning they would have been readily metabolised but agreed with Dr Ellis that, ideally, polypharmacy is not a good idea.

Both Dr Ellis and Dr Samuels agreed that it would have been unwise to suddenly stop Mr Haenga's antipsychotic medication. To do so may have placed Mr Haenga at risk of physical withdrawal, it may have caused him to act out against medical and correctional staff, and it may have adversely affected his mental state. Both experts therefore agreed with Dr Jones intention to rationalise Mr Haenga's medication.

Dr Jones himself in evidence during the inquest appeared to accept that polypharmacy was not ideal. When asked by his own counsel whether he could think of any recommendations of his own which he could make following Mr Haenga's death, Dr Jones referred to a need to be more aware and mindful of the use of polypharmacy in practice.

Dr Jones went on to explain that he believed that vigilance was required in this regard and made the frank concession that, at times, such a situation may be due to complacency.

CONCLUSION: Mr Haenga's medication regime was, in general terms, not clinically optimal. This is because he was prescribed more than one type of psychotropic medication. Antipsychotic medications were part of this regime. The intended use of 2 antipsychotics, and the unintended use of a third antipsychotic, meant that Mr Haenga was placed at increased risk of adverse side effects. The most significant side effect was prolongation of the QT interval which carried the risk of causing a fatal cardiac arrhythmia. However it is acknowledged that Dr Jones was working therapeutically with Mr Haenga with the intention of rationalising Mr Haenga's medication regime over time.

Was the dose of escitalopram as at 8 June 2013 appropriate?

The second issue to consider in relation to Mr Haenga's medication regime is the dose of escitalopram. At the time of his death Mr Haenga's dose was 30mg. Dr Jones had increased it to this level on 14 March 2013. Associate Professor Gunja described the usual dose as being 10-20mg daily and described 30mg as an "*uncommon dose used in intractable or severe cases*". He also described it as "*particularly high*" in view of the other medication (pericyazine, methadone, amisulpride and quetiapine) that Mr Haenga was taking, all of which carried risks of QT prolongation.

Dr Ellis describes the increase in escitalopram to 30mg on 14 March 2013 as being "*above the usual maximum recommended dose*".

Somewhat in contrast, in his report Dr Samuels describes the 30mg dose as "*not an excessively high dose*" and referred to a prescribing manual which indicates that there are some instances where doses can go as high as 40mg. However, even Dr Samuels acknowledged that caution would have to be exercised when prescribing a dose of 30mg given the multiple other medications that Mr Haenga was on. Later in his report, Dr Samuels stated that the 30mg "*possibly was too high*" in combination with the other medications that Mr Haenga was on.

CONCLUSION: The dose of 30mg escitalopram was probably too high on its own, and too high in conjunction with the other medication that Mr Haenga was on. This is because it was one of 4 intended medications that Mr Haenga had been prescribed, all of which carried the risk of QT prolongation.

Was it appropriate for escitalopram to have been prescribed on 4 June 2013?

The third issue to consider is whether it was appropriate for the escitalopram to have been prescribed on 4 June 2013. In his report Dr Ellis indicated that doctors who gave phone orders for the continuation of Mr Haenga's medication should also have queried nurses who requested such orders about whether physical investigation had been performed because of Mr Haenga's unusual medication regime.

Mr Haenga's transfer from Junee to the MSPC did not interrupt his administration of escitalopram. He continued to take it up until his departure from Junee and after his arrival at the MSPC up until 3 June 2013.

However on that day Justice Health nursing staff recognised that the medication chart for the escitalopram was reaching the end of the page which meant that it was required to be recharted. As Mr Haenga had not yet been reviewed, and was not due to be reviewed, by one of the psychiatrists who worked at the MSPC, it was recognised that a new chart would have to be re-written.

This led to a request for an interim order for the prescription to be resumed. That request was made via phone call, by a Justice Health nurse at the MSPC, to Dr Samson Roberts the VMO psychiatrist at the MSPC at the time. At 2:00pm on 4 June 2013 Dr Roberts gave an order for the dose of escitalopram to be continued until Mr Haenga could be reviewed by him. This order resulted in Mr Haenga's prescription of escitalopram being continued each day from 5 June 2013 until 8 June 2013.

It should be made clear that the phone call on 4 June 2013 was the only occasion when Dr Roberts had any involvement in Mr Haenga's care. He had not seen Mr Haenga or reviewed his clinical file after Mr Haenga arrived at the MSPC, nor did he see Mr Haenga or review his file at any time between 4 June 2013 and 9 June 2013.

Dr Roberts explained that at the time it was his practice (and was still his practice at the time of the inquest) to continue an existing prescription for a patient for a limited time pending the writing of a new prescription. Dr Roberts also explained that he considered it would be ethically and clinically inappropriate to prevent continuation of medication for a patient without undertaking a clinical assessment of the patient. Dr Roberts did not have any recollection what information he was provided during the phone call about Mr Haenga's clinical history and, in particular, the nature of his medication regime.

However, Dr Roberts explained that even if he had such information, and this information highlighted the challenges in Mr Haenga's pharmacological management, he still would have given the order. Dr Roberts said that the risk of any side effect from continuing the escitalopram (where no side effect had been identified previously) was outweighed by the greater risk that Mr Haenga would be adversely affected if his escitalopram was abruptly stopped, in circumstances where he had been taking it for a long time.

At the time there was a specific Justice Health guideline which addressed the prescribing of medication overt the phone. ***Clause 7.1.3.7*** of the Justice Health Medication Guidelines 2012 (**the 2012 Medication Guidelines**) allowed for a medical officer to prescribe medication by phone and stipulated how such an order is to be put into effect.

Relevantly, it provided that "*as soon as practicable (and preferably within 24 hours of ordering medication but at least on the next working day)"* the prescriber must "*attempt to review the patient, or make arrangements to ensure that the patient is followed up by a local practitioner if [the prescriber] considers it appropriate in the circumstances of the case*".

Dr Roberts did not attempt to review Mr Haenga at any time after 4 June 2013. In a statement prepared before the inquest, and in evidence during the inquest, Dr Roberts said that he could not recall what information he was provided with by the nurse during the phone call. However Dr Roberts explained that when faced with a request for a prescription to be given over the phone he assumed that the patient receiving the medication had been reviewed, and that a determination had been made that the medication itself, and its dose, were appropriate. Dr Roberts went on to explain that at best he was receiving third-hand information (from the prescriber, to the medication chart or progress notes, to the nurse making the phone call) and that for him to second guess the judgment of another clinician who had had face-to-face contact with the patient would have been inappropriate.

Dr Roberts explained that in his experience he had encountered many inmate patients on multiple medications. Whilst, at face value, there may be a concern regarding the multiple medications, Dr Roberts indicated that the multiplicity might also indicate that the patient was a challenging one.

Ultimately, it is not known what information was conveyed to Dr Roberts on 4 June 2013. Neither Dr Roberts, not the nurse who phoned him, were able to recall what (if anything) might have been discussed during the phone call about what other medication Mr Haenga was on.

In these circumstances and noting Dr Robert's very limited indirect involvement in Mr Haenga's care, there is no evidence to suggest that Dr Robert's should have reviewed Mr Haenga or arranged for follow up in accordance with clause 7.1.3.7 of the 2012 Medication Guidelines.

CONCLUSION: It was appropriate for Dr Roberts to give an interim order on 4 June 2013 to continue Mr Haenga's prescription of escitalopram. On the limited evidence of what information was available to Dr Roberts there was nothing to indicate that the prescription should not have been continued. There was also nothing to indicate, at that time, that Mr Haenga warranted review.

Was it appropriate for Panadeine Forte to have been prescribed on 6 June 2013?

On 6 June 2013 a different medication was prescribed for Mr Haenga by phone. On this occasion the medication was Panadeine Forte and it was prescribed by Dr Chong Kee (Tony) Chew, the staff specialist GP who was rostered on the Justice Health afterhours medical service at the time.

This occurred at about 11:20am on 6 June 2013. Dr Chew gave an order for 2 tablets of Panadeine Forte (500mg of paracetamol and 30mg of codeine) to be prescribed. Dr Chew explained that he ascertained that Mr Haenga had been on the same medication since February 2013 and that there were no apparent issues with continuing it.

On that basis, Dr Chew did so. Similar to Dr Roberts, Dr Chew explained in evidence that the nature of the phone order was not for him to query investigations performed by other clinicians. Dr Chew said that the sole purpose of the phone order was to rewrite or continue an order in circumstances where the order was interim in nature only, and to stop medication abruptly might have potentially dangerous consequences.

Neither Dr Bailey nor Associate Professor Gunja expressed any concern at the level of codeine (0.45 mg/L) in Mr Haenga's toxicology results. Associate Professor Gunja described it as a being consistent with therapeutic ingestion of Panadeine Forte (2 tablets containing 60mg codeine in total).

CONCLUSION: It was appropriate for Dr Chew to give an interim order on 6 June 2013 to continue Mr Haenga's prescription of Panedeine Forte. On the information available to Dr Chew there was nothing to indicate that the prescription should not have been continued. There was also nothing to indicate, at that time, that Mr Haenga warranted review.

Was the recording of and monitoring of Mr Haenga's medication regime appropriate?

This question is largely concerned with the circumstances which led to Mr Haenga's quetiapine being inadvertently recharted by Dr Baguley on 6 May 2013. In order to answer this question it is necessary to look at what events preceded 6 May 2013 and whether appropriate systems were in place to prevent such inadvertence.

How did the quetiapine come to be recharted?

On 29 April 2013 Mr Haenga did not take his quetiapine. However, the medication administration charts indicate that Mr Haenga did take the other medication (sodium valproate, pericyazine, amisulpride, naproxen, pregabalin) that he was prescribed on that day. Exactly why Mr Haenga did not take the quetiapine is not known. However, given that he had been concerned that the quetiapine had been contributing to his weight gain, and that he had discussed this with Dr Jones, it is likely that Mr Haenga made the decision himself to stop taking it.

This is supported by the fact that on 2 May 2013 Mr Haenga saw Dr Jones. During that consultation, Mr Haenga told Dr Jones that he had stopped taking quetiapine and that it did nothing for him apart from increasing his weight gain. In Mr Haenga's progress notes, Dr Jones wrote on 2 May 2013: "*Stopped taking Seroquel…Seroquel [increased] my [weight], didn't do nothing for me*". Dr Jones explained in both his statement, and during his evidence in the inquest, that whilst he *intended* to stop Mr Haenga's quetiapine prescription he did not *actually* do so.

The effect of this was that on 6 May 2013 Dr Baguley recharted the prescribed dose of quetiapine. Dr Baguley did so because he saw that Mr Haenga had not been taking his quetiapine between 29 April 2013 and 4 May 2013. At the time that he recharted the quetiapine Dr Baguley was not aware of the notation which Dr Jones had made in the progress notes on 2 May 2013 regarding Mr Haenga ceasing to take quetiapine. Dr Baguley explained that he would not put a stop on medication, such as quetiapine, as a matter of prudence without first discussing it with the prescribing physician, Dr Jones.

Dr Jones acknowledged that whilst he had discussed the ceasing of quetiapine with Mr Haenga, he (Dr Jones) never formally ceased the order, or documented it in the progress notes. In evidence Dr Jones was asked why he had not written about his intention to stop quetiapine in Mr Haenga's clinical progress notes. Dr Jones frankly acknowledged that it was an omission on his part which he regretted. Dr Jones explained that as Mr Haenga had told him that he had stopped taking the quetiapine that was, to Dr Jones, as good as if he had not prescribed it. Dr Jones believes that after Mr Haenga told him he had stopped, he (Dr Jones) became relieved and simply thought that it was good that he had done so.

In evidence Dr Baguley was asked a number of questions about the circumstances which led to him recharting the quetiapine on 6 May 2013. Dr Baguley was firstly asked whether he had noticed that Mr Haenga had not taken his quetiapine for 6 days. Dr Baguley said that he had noticed this but that he had also noticed that Mr Haenga had taken quetiapine on 5 May 2013. This led Dr Baguley to assume that Mr Haenga had simply started taking it again. Dr Baguley also said that he relied on there being a stop order on the medication chart to prevent the inadvertent recharting of medication.

Dr Baguley was also asked whether he would have been concerned by the fact that Mr Haenga had suddenly started taking the quetiapine after 6 days. Dr Baguley said that he would not have been concerned and thought it was a good thing that Mr Haenga had started taking the quetiapine again. Dr Baguley went on to explain that if Mr Haenga had continued to not take the quetiapine he (Dr Baguley) would probably have asked to see him in order to find out why.

Finally, Dr Baguley was asked whether it was policy at Junee for a GP to rechart medication which had been prescribed by a psychiatrist. Dr Baguley explained that whilst it was not policy it was a customary practice. Dr Baguley said that in his lunch hour he would rechart up to 50 or 60 medication charts where it was required (that is, where the medication charts were approaching their 6 week limit). As to this last point, there is no evidence to suggest that such a practice was inappropriate. Dr Jones said that he had no issue with it and was aware that Dr Baguley followed such a practice. Dr Ellis also said that he saw no issue with the practice adopted by Dr Baguley and indicated that in his own practice he (Dr Ellis) would often rechart medication prescribed by a GP.

CONCLUSION: I accept that Dr Jones, as part of his attempts to rationalise Mr Haenga's medication regime, intended to stop the prescription of quetiapine. However, this was neither documented on Mr Haenga's medication chart nor in his progress notes at any time. It should have occurred on 2 May 2013 when Mr Haenga told Dr Jones that he had stopped taking the quetiapine. If it had occurred Dr Baguley would not have recharted it. Dr Baguley only did so because the medication chart was approaching its 6 week limit.

Although Dr Baguley was aware that Mr Haenga had resumed taking the quetiapine after a 6 day hiatus, there was nothing to indicate on the information available to Dr Baguley that it should not have been recharted. Dr Baguley was appropriately more concerned about the 6 day hiatus from taking quetiapine rather than the sudden recommencement of taking it; the former situation raised an appreciable risk that Mr Haenga may have decompensated and developed symptoms of psychosis. It was also appropriate for Dr Baguley, as a GP, to follow his usual practice of recharting medication which had been prescribed by the psychiatrist, Dr Jones.

Were any policies or guidelines in place to prevent the inadvertent recharting of the quetiapine?

In order to stop the quetiapine Dr Jones should have complied with ***clauses 7.1.12 and 7.1.3.6*** of the 2012 Medication Guidelines. These clauses provide that if a medical officer wishes to cease a medication order that medical officer must draw a line after the last entry where the medication is recorded as being administered and then sign and date the medication chart. This obviously should have occurred, but did not. There is no reason to doubt Dr Jones' frank concession that it was due to omission on his part. On 2 May 2013 Dr Jones complied with clauses 7.1.12 and 7.1.3.6 when he increased Mr Haenga's dose of pericyazine. That is, Dr Jones crossed out the old prescription of 20mg and recharted the new prescription of 30mg.

No reason was recorded why the quetiapine was not administered by nursing staff. The failure to do this was contrary to the 2012 Medication Guidelines. ***Clause 6.2.10*** of the 2012 Medication Guidelines stipulates that if medication is not, or cannot be, administered, the reason for this must be indicated on the medication chart and in the patient's notes. This means that for each of the 6 days between 29 April 2013 to 4 May 2013 there should have been a note on Mr Haenga's medication chart and in his progress notes as to why he did not take his quetiapine. However, for each of these 6 days no such notes were made.

As quetiapine is an antipsychotic medication, an additional requirement applied. ***Clause 6.6.1*** of the 2012 Medication Guidelines applied to antipsychotic and antidepressant medication and provided that if a patient does not attend to receive such medication then they must be followed up immediately. If the patient refuses to take their antipsychotic medication the patient must be seen by the treating psychiatrist "*at the earliest opportunity*" and there should be daily contact with the patient until the psychiatrist sees them.

A similar provision is contained in the Junee Correctional Centre Operating Manual, Medication Administration Policy dated 29 June 2012 (**the 2012 Junee Medication Policy**). This was in operation in May 2013. Clause 4.7.1 of the 2012 Junee Medication Policy stipulated that when a medication could not be administered details as to why it was not administered should be recorded in the progress notes. In a case where an inmate patient fails to collect his medication then a nurse should contact a medical officer for further advice.

CONCLUSION: There were appropriate Justice Health and GEO polices and guidelines in place in May 2013 to prevent the inadvertent recharting of quetiapine to Mr Haenga. The recharting only occurred due to non-compliance with specific requirements in these polices and guidelines. Dr Jones omitted to cease the prescription in accordance with clauses 7.1.12 and 7.1.3.6 of the 2012 Medication Guidelines. The reason why Mr Haenga did not take his quetiapine between 29 April 2013 to 4 May 2013 was not documented on his medication chart and progress notes by nursing staff in accordance with clause 6.2.10 of the 2012 Medication Guidelines or clause 4.7.1 of the 2012 Junee Medication Policy. After Mr Haenga did not take his quetiapine on 29 April 2013, and the days after, there was no follow up to ensure that he was seen by Dr Jones in accordance with clause 6.6.1 of the 2012 Medication Guidelines.

Changes to policies and guidelines since 2013

The above clauses that I have referred to relate to the 2012 Medication Guidelines which applied at the time of Mr Haenga's death.

Since then, there have been at least 2 revisions to the guidelines, once in December 2016 (**the 2016 Medication Guidelines**) and again in August 2017 (**the 2017 Medication Guidelines**).

Clause 6.2.10 of the 2012 Medication Guidelines is reproduced in identical terms in ***Clause 6.2.9*** of the 2017 Medication Guidelines. Clause 6.2.9 provides:

"*In circumstances where a medication is not, or cannot be administered, the details as to why the medication is not administered* ***must*** *be indicated on the medication chart and in the patient's medical notes* [original emphasis]".

In contrast the Junee Correctional Centre Operating Manual: Medication Administration Policy issued on 21 April 2017 (**the 2017 Junee Medication Policy**) provides at clause 4.7.1: "*In circumstances where a medication cannot be administered, details as to why the medication was not given* ***should*** *be indicated in the progress notes* [emphasis added]*".*

It is obvious from a comparison of the two clauses that the one contained in the 2017 Medication Guidelines is mandatory whilst the one contained in the 2017 Junee Medication Policy is discretionary.

As GEO, pursuant to its management agreement with CSNSW, is obliged to comply with policies established by Justice Health (and the NSW Ministry of Health), including the 2017 Medication Guidelines, this inconsistency is highly undesirable and has the potential to cause confusion amongst clinicians and lead to inconsistent clinical practice.

The inquest identified one further discrepancy in the 2017 Junee Medication Policy in clause 4.14.8. This clause is found within a section which deals with the supplying of medication by telephone orders. Clause 4.14.8 refers to the "*Justice Health and Forensic Mental Health Network medication guidelines* ***2015*** *for further guidance* [emphasis added]". This is clearly a reference to a guideline which is no longer current, and should instead refer to 2017 Medication Guidelines.

CONCLUSION: There are fundamental inconsistencies and discrepancies between the 2017 Medication Guidelines established by Justice Health and the 2017 Junee Medication Policy. These inconsistences and discrepancies have the potential to lead to undesirable, and possibly unsafe, clinical outcomes and should, obviously, be corrected.

RECOMMENDATION: *I recommend that GEO review its current Medication Administration Policy to ensure that it accurately reflects the equivalent provisions contained within the 2017 Justice Health Medication Guidelines including, but not limited to, clauses 4.7.1 and 4.14.8 of the 2017 Junee Medication Administration Policy.*

The 2016 Medication Guidelines replaced clause 6.6.1 of the 2012 Medication Guidelines with a new clause 6.7.2. Essentially clause 6.7.2 was in the same terms except that it applied to *all* supervised medication, and *not only* antipsychotic or antidepressant medication. This same clause is reflected in the 2017 Medication Guidelines. Clause 6.7.2 provides that if supervised medication is not administered the reason why must be documented in the inmate patient's health record. Furthermore, any patient who does not attend for medication must be followed up and this must be communicated at handover. If a patient continues to refuse to take medication once follow up has occurred then this must be discussed with an appropriate clinician within 48 hours.

In evidence during the inquest, Ms Jan Te Maru, the Health Services Manager at Junee, was asked about these two discrepancies. Ms Te Maru said that she only became aware of the 2017 Medication Guidelines in the "*last few days*" prior to giving evidence at the inquest. When taken to the differences between clause 6.6.1 of the 2012 Medication Guidelines and clause 6.7.2 of the 2016 and 2017 Medication Guidelines Ms Te Maru was not aware that there had been any amendment.

Ms Te Maru accepted that so far as the overall circumstances which led to the recharting of the quetiapine to Mr Haenga there had been non-compliance with the 2012 Medication Guidelines in a number of respects. When asked to provide any reason why such non-compliance might not occur today, Ms Te Maru was unable to provide any. However, she agreed that further education of clinical staff at Junee about the need to comply with the 2017 Medication Guidelines would be beneficial.

Having regard to the lack of awareness by Ms Te Maru regarding the change to clause 6.7.2 of the 2016 and 2017 Medication Guidelines, and the inconsistencies between the 2017 Medication Guidelines and the 2017 Junee Medication Policy, it also appears that training of clinical staff to educate them about these changes is required.

During the inquest counsel for Justice Health asked Mr Gary Clark, the Operations Nurse Manager for Justice Health how changes in guidelines are communicated to clinical staff at the operational level.

Mr Clark pointed to two methods: (a) accessing guidelines via the Justice Health intranet; and (b) the deployment of Justice Health nurse education consultants to provide training for clinical staff at different correctional centres. When asked about the second of these methods Ms Te Maru indicated that nurse education consultations are not available at Junee as a matter of course.

It emerged from the evidence at inquest that in order for such education to be provided GEO would have to make a request to CSNSW (pursuant to its management agreement) for the necessary funding to be provided for Justice Health to, in turn, provide it.

In closing submissions Justice Health submitted that procedures are in existence for policies and guidelines to be disseminated and distributed at the operational level. However it became apparent during the inquest that a number of witnesses (Dr Jones, Dr Baguley, Dr Chew, Dr Roberts) had either never seen a guideline such as the 2012 Medication Guidelines, or were not familiar with some of its precise provisions. Of particular importance was the fact that Dr Katerina Lagios, the Clinical Director, Primary Care, for Justice Health, said in evidence that she was not aware of one Justice Health guideline and had not read not read a policy directive that was relevant to the issues considered by the inquest.

CONCLUSION: Clinical staff at Junee should be educated about current medication administration requirements. The available evidence suggests that reliance on existing procedural dissemination of relevant guidelines and policies is not as effective as specific targeted education. The lack of awareness amongst senior executive personnel within both Justice Health and Junee reinforces this ineffectiveness.

RECOMMENDATION: *I recommend that GEO, CSNSW and Justice Health work collaboratively to provide further targeted education and training, through the use of Justice Health nurse education consultants, to GEO clinical staff at Junee in relation to medication administration requirements pursuant to the 2017 Medication Guidelines, in particular in relation to clauses 6.2.9 and 6.7.2.*

Were any other systems in place in 2013 to prevent the inadvertent recharting of the quetiapine?

In answering this question there was focus on two issues during the inquest: clinical handover and multidisciplinary team meetings. It was suggested that either or both of these clinical practices might have been able to detect the fact that quetiapine had continued to be prescribed to Mr Haenga, and that he had not participated in metabolic monitoring (discussed further below). In May 2013 (and since) there were no formal policies or guidelines which governed either practice.

Clinical Handover

The issue of clinical handover arises in the context of Mr Haenga's transfer from Junee to the MSPC on 27 May 2013. When he arrived at the MSPC Mr Haenga was seen by a primary health care nurse as part of an intake screening process. However, because he was being transferred from another correctional centre, and was not a person newly entering custody, Mr Haenga was not seen by a mental health nurse for a mental health assessment. In the period between 27 May 2013 and 7 June 2013 the PAS indicates that Mr Haenga had a number of other appointments with primary health nurses, but none with any mental health nurse. Mr Haenga was also not reviewed by a psychiatrist, nor did he have an appointment on the PAS to see one.

In evidence, Dr Lagios said that she would have expected Mr Haenga to have been placed on waitlist to see a mental health nurse and that his mental health issues would have been identified at that presentation. According to Dr Lagios this process would have occurred within approximately 2 weeks of Mr Haenga's arrival at the MSPC on 27 May 2013.

As Dr Roberts was the VMO psychiatrist at the MSPC at the time of Mr Haenga's transfer he was asked about the handover process in evidence. Dr Roberts said that there is no formal handover process and the majority of transfers initiated by CSNSW occur with little or no notice. Due to security reasons, inmates are often not provided with much notice prior to being transferred between correctional centres. This in turn means that no notice is often provided to an inmate's treating clinicians, as occurred in Mr Haenga's case.

Dr Roberts explained that in an ideal system CSNSW would notify a patient's treating psychiatrist of any prospective transfer and that treating psychiatrist could then contact the receiving psychiatrist at the correctional centre that the inmate is being transferred to so that there can be continuity of the therapeutic process. Dr Robert was asked about the ability to effectively perform a handover after the event, that is, for a current treating clinician to contact a previous one. Dr Roberts explained that this was not practical because it would mean contacting a previous clinician who had not seen a patient for weeks (meaning that the patient's clinical status could have changed significantly during that time) and who did not have access to the patient's file.

Dr Baguley said that in the period from 2011 to 2013 there was no formal handover process when a patient either arrived at, or was transferred away from, Junee. Dr Baguley said that in his experience he might have only received 2 or 3 calls per year from a GP at another correctional centre with respect to a new inmate who had arrived at Junee.

Dr Jones said in evidence that due to inflexibilities within the custodial setting they have the bare minimum of processes in relation to patient handover. He said that a clinician-to-clinician handover was not as common as in other medical care settings due to the difficulty in communicating between clinicians.

Multidisciplinary team meetings

Dr Baguley explained that in the period from 2011 to 2013 there were no team meetings between clinicians because there was neither the time, nor the facility, to hold such meetings. Instead, Dr Baguley described the process as much more informal in the sense that "*everyone did their job*". This meant, according to Dr Baguley, that if a nurse had a concern he or she would approach Dr Baguley and that, similarly, if Dr Baguley had a concern about a mental health issue he would approach Dr Jones. Dr Baguley also referred to the fact that there would often be "*corridor conversations*" regarding a patient. That is, there would be informal discussions in passing between clinicians regarding any issue relating to a patient which may require further action or increased observation.

In evidence Dr Jones said that he thought Dr Baguley had underestimated how communication took place between clinicians regarding patients. Dr Jones said that, in his experience, after reviewing patients he would spend about 20 to 30 minutes discussing the patients (usually those patients who had more significant management needs) with Dr Baguley and the nursing staff.

CONCLUSION: Best practice medicine indicates that there should be multidisciplinary team meetings to discuss the care and management of patients, and a formal clinician-to-clinician handover process when the care of a patient is transferred. However, the limitations of the correctional setting means that such ideal practices can rarely be implemented which in turn means that pragmatic and informal processes are adopted.

Have any changes or improvements been made since 2013?

Dr Huong Van Nguyen, the Director of Medical Programs for Justice Health was invited to indicate whether any systems are in place to detect a situation such as occurred in May 2013 when Dr Jones inadvertently failed to stop the order for quetiapine. In her statement and in evidence Dr Nguyen referred to a number of changes to address this issue.

Firstly she referred to the fact that medication chart reviews are routinely conducted by clinical pharmacists at a number of correctional centres where Justice Health provides health care.

Such reviews were likely to detect omissions in the prescribing and administration of medication, and the reasons for such omissions. She was asked to elaborate about this in evidence and indicated that the sample size for such reviews was 10 medication charts at each correctional centre. As this sample size seemed disproportionately low compared to the number of inmate patients, Dr Nguyen went on to explain that other methods current exist to detect the error in Mr Haenga's medication prescription: 3-monthly checks performed by drug and alcohol services, and the fact that Mr Haenga was on the methadone program and positive for Hepatitis C would have registered a chronic disease notification.

Secondly Dr Nguyen referred to a new Long Stay Medication Chart (**LSMC**) introduced in 2016. The back page of the LSMC contains a section containing a number of codes for nursing staff to enter on the chart to indicate the reason why a medication has not been administered. For some of the codes there is an additional prompt for the nurses to notify the medication prescriber that the medication has not been administered.

Thirdly Dr Nguyen referred to the fact that Justice Health is in the initial stages of moving to an electronic medication management system. According to Dr Nguyen this system will, amongst other things, "*improve accuracy and visibility of medication information being communicated between health care providers*".

Dr Jones was also asked about improvements at Junee since 2013 and explained that there is now a non-compliance register in which a nurse records the names of patients who have not collected their medication for 3 days. Dr Jones also pointed to informal daily handover meetings where if it was identified that a patient had not collected their medication they might be placed on supervised administration.

CONCLUSION: Appropriate changes and improvements have been put in place by Justice Health, and at Junee, since 2013 to reduce the likelihood that the non-compliance with guidelines that led to the inadvertent recharting of quetiapine will be repeated.

Was Mr Haenga provided with adequate health care?

When Mr Haenga first saw Dr Jones in June 2011 he weighed approximately 150 kilograms. At the time of his death Mr Haenga weighed 199 kilograms. It has already been established that because of Mr Haenga's morbid obesity he was at risk of sudden cardiac death.

Further, Dr Ellis explained that because Mr Haenga was on a complex medication regime, his overall management should have included regular physical examinations, regular testing for the QT interval, and regular blood monitoring. The evidence established that these risk factors could have been assessed through the use of metabolic monitoring and ECG testing.

Metabolic monitoring

Metabolic Syndrome refers to a cluster of cardiovascular risk factors including insulin resistance, hypertension, central obesity and dyslipidaemia. These factors result in significantly increased risk of cardiovascular disease and mortality. Persons with mental health issues, particularly those with diagnoses of bipolar disorder, have up to four times greater risk of developing metabolic syndrome than the general population as a result of lifestyle factors and the side effects of medication regimes.

In order to reduce the risk of cardiovascular disease and mortality, persons at risk of metabolic syndrome are monitored under a system known as metabolic monitoring. This monitoring involves regular tests being conducted to measure a person's weight, girth, blood pressure, cholesterol level, calculate their body mass index, and screen them for type 2 diabetes and insulin resistance.

Prior to September 2012, metabolic monitoring at Junee was conducted on an informal basis. In Mr Haenga's case, the monitoring was performed by Ms Janice Workman RN who first met Mr Haenga on 13 September 2010 in her capacity as the mental health nurse at Junee. The metabolic monitoring was initiated by Ms Workman because of Mr Haenga's cardiac risk factors and because he was on the methadone program, as methadone use carried a known risk of QT interval prolongation.

Ms Workman conducted metabolic monitoring which included measurement of Mr Haenga's girth, weight, blood sugar level, blood pressure, pulse and she also made arrangements for ECG testing. Ms Workman explained that she used the metabolic monitoring appointments with Mr Haenga to promote healthy lifestyle choices and spoke to Mr Haenga about weight loss, exercise, developing metabolic syndrome, the potential side effects of antipsychotic and mood-stabilising medication, and the importance of ECG testing.

The clinical progress notes reveal that although Ms Workman made a number of metabolic monitoring appointments for Mr Haenga he, unfortunately, did not attend most of them.

Between October 2010 and July 2012 Mr Haenga did not attend 8 scheduled metabolic monitoring appointments and declined a suggestion from Ms Workman on 10 July 2012 that he attend a 9th appointment. However during this period Mr Haenga did attend 3 metabolic monitoring appointments with Ms Workman on 15 November 2010, 21 June 2011 and 5 April 2012.

In September 2012 Junee received funding from CSNSW to employ a full-time metabolic monitoring nurse. From 15 October 2012 to the time of Mr Haenga's death this was Samantha Byrne RN. However it appears that Ms Byrne never performed any monitoring on Mr Haenga because Mr Haenga declined to attend the only 2 scheduled appointments that Ms Byrne made for him on 30 October 2012 and 4 March 2013.

Apart from metabolic monitoring to address Mr Haenga's weight gain and cardiac risk factors, another measure was available. On 5 April 2012 Dr Baguley referred Mr Haenga to the Junee Health Promotions Officer. At the time this was Matthew Canny RN. Mr Canny's role was to provide health education and healthy eating advice to inmates.

This was incorporated into a 12 week program run by Mr Canny. The program involved the taking of metabolic measurements at the start of the program, an exercise component, a classroom education component which focused on health eating options, a healthy cooking class, and metabolic measurements at the end of the program to monitor any changes.

Mr Canny recalls that Mr Haenga often attended both the classroom education component and the healthy cooking class. It was hoped that the education provided by Mr Canny and Ms Workman would influence the food that Mr Haenga purchased during his "buy ups".

Apart from the metabolic monitoring conducted by Ms Workman and the program run by Mr Canny, the evidence established that Dr Baguley often spoke to Mr Haenga about his weight gain. However, Dr Baguley said that Mr Haenga was resistant to making necessary lifestyle changes, such as improving his diet and exercising, despite being told about the risks to his health.

Although Mr Haenga's failures to attend metabolic monitoring appointments with Ms Workman and Ms Byrne were documented in his progress notes, Dr Baguley was never directly informed of Mr Haenga's non-attendances. Dr Baguley explained that had he been made unaware of these non-attendances he would have attempted to persuade Mr Haenga to attend. It is clear that Dr Baguley, and Ms Workman and Ms Byrne, had limited options available to them to manage Mr Haenga's reluctance to participate. As they could not compel Mr Haenga to participate the only alternative left to them was continual advice and reminders about the benefits of participation, leaving it to Mr Haenga to decide whether he would act upon their advice.

CONCLUSION: Measures were put in place for Mr Haenga to participate in metabolic monitoring both on a formal and informal basis. Unfortunately, Mr Haenga declined to attend 8 out of the 11 metabolic monitoring sessions that were scheduled for him. Although these non-attendances were noted in Mr Haenga's progress notes, it appears that neither Ms Workman nor Ms Byrne advised Dr Baguley when Mr Haenga declined to attend. Even if Dr Baguley had known about Mr Haenga's non-attendance from reading the progress notes there was no means to compel Mr Haenga to attend. The evidence indicates that Mr Haenga was provided with ongoing education by Ms Workman, Mr Canny, Dr Jones and Dr Baguley about the potential health risks involved with metabolic syndrome and how metabolic monitoring could be of benefit to him. It was unfortunate that Mr Haenga declined to act on this advice. I therefore conclude that the general health care provided to Mr Haenga, specifically in relation to the attempts to engage him in metabolic monitoring, was appropriate.

ECG monitoring

Given that Mr Haenga was taking medication known to prolong the QT interval Dr Ellis said that it would have been helpful for ECG testing to have been performed before Mr Haenga was started on new psychotropic medication and whilst he was on it. In evidence Dr Ellis elaborated by explaining that it was important to ensure that Mr Haenga's physical parameters were monitored because Dr Jones was departing from typical prescription practices in circumstances where Mr Haenga had significant comorbidities.

In evidence Dr Samuels expressed some reservations about ECG testing. This was because, he said, it may have been difficult to know what to do with the results. This was because a balancing exercise would be required to determine whether the psychiatric risks outweighed the physical risks, or vice versa. In other words, if the ECG test results showed some degree of QT interval prolongation it may still have resulted in continuation of Mr Haenga's psychotropic medication if his psychiatric needs were greater than any physical medical risk. Dr Ellis agreed that reconciling these two considerations was difficult and said that there was no standard formula to apply. However, Dr Ellis explained that even if the ECG test results did not guide treatment in either direction, the absence of *any* testing results meant that there was effectively only one treatment option.

Four ECG tests were performed on Mr Haenga whilst he was at Junee: 13 September 2010, 15 November 2010, 15 May 2011 and 21 June 2011.

Apart from the test on 15 May 2011 all the tests were performed as part of metabolic monitoring conducted by Ms Workman. It appears that the 15 May 2011 test may have been related to monitoring for pneumonia and septicaemia that Mr Haenga was being managed for at the time.

Dr Jones explained in evidence that he was aware that Mr Haenga was undertaking metabolic monitoring because he was on the methadone program and because of his cardiac risk factors. However the results from the monitoring were not sent to Dr Jones. In hindsight Dr Jones said that, ideally, he would have liked for ECG testing to be performed before and after each change in Mr Haenga's medication, or dose of medication. Dr Jones also said that he wished he had been more assertive in encouraging Mr Haenga to take part in ECG testing and that the test results may have provided clinical guidance.

CONCLUSION: Mr Haenga had been prescribed several antipsychotic drugs and was on the methadone program. These drugs carried the risk of prolongation of the QT interval. ECG testing would have been beneficial in the management of Mr Haenga's care in order to guide his treatment, and inform the question of how best to manage his physical and mental health needs, and their associated risk factors.

The NSW Ministry of Health and Justice Health have produced a guideline, information bulletin and resource with respect to the use of metabolic monitoring and ECG testing. Each of these documents is discussed further below.

In her statement Dr Lagios expressed the view that Mr Haenga should have had ECG testing in accordance with a Justice Health document titled,

"*Metabolic Syndrome, From Monitoring to Management, A Resource for Health Professionals 2011*" (**the 2011 Metabolic Syndrome resource**). The Metabolic Syndrome resource is a 63-page document. The only reference to ECG testing occurs at page 8 in a table within a section titled "Monitoring Schedule". In the table it appears that ECG is referred to as one of a number of investigatory tests (along with full blood count, kidney function test (UEC), liver function test) to be "*completed as a component of annual health assessment*". No mention is made in the table of the rationale for performing an ECG as part of metabolic monitoring.

Sections 1.2 and 1.3 of the 2011 Metabolic Syndrome resource deals with Metabolic Syndrome and mental illness and how it is screened and monitored.

These sections highlight that there is evidence that mental health patients are up to 4 times more likely to develop metabolic syndrome than the general population, that this increased risk is due in part to weight gain associated with using antipsychotic medication, and there is a need to regularly screen patients prescribed psychotropic medication for the presence of metabolic syndrome. However there is no reference within these sections to ECG testing being used for such screening and monitoring purposes.

Counsel Assisting took Dr Lagios to this issue during her evidence. Dr Lagios conceded that she could not locate any reference to ECG testing in the Metabolic Syndrome resource; the reference in the table at page 8 was only identified later in the evidence. Dr Lagios indicated that in such circumstances Justice Health should conduct a review of the 2011 Metabolic Syndrome resource to ensure that ECG testing is specifically referred to.

The Justice Health document titled "*Psychotropic Medications – Guidelines for Prescribing and Monitoring Use Within Custodial and Forensic Mental Health Settings 2017*" (**the 2017 Psychotropic Medications guideline**) repeats the same principles described above in the Metabolic Syndrome resource.

However it goes further to specifically identify the increased risk of QT prolongation with the use of psychotropic medication and specifies that ECG testing should form part of the initial physical examination of a patient before psychotropic medication is initiated. The Psychotropic Medications guideline additionally specifies that ECG testing should, generally be performed every 12 months as part of a patient's ongoing review, and that it should be performed every 6 months if the patient is prescribed quetiapine.

Finally, the NSW Ministry of Health published an information bulletin in July 2012 titled, "*Metabolic Monitoring, New Mental Health Clinical Documentation Module*" (**the 2012 Metabolic Monitoring module**). It provides a structured format for the way in which metabolic monitoring is conducted.

In evidence Dr Jones said that, currently, when prescribing antipsychotic medication, the use of metabolic monitoring has become more prominent in his clinical thinking, and more a part of his regular day-to-day practice. When asked whether he was aware if ECG testing was required as part of any policy Dr Jones said that he believed it was part of the metabolic monitoring protocol. As the 2017 Psychotropic Medication Guidelines were only published in August 2017, and had not been produced for the inquest by Justice Health at the time that Dr Jones gave his evidence, I infer that by referring to a protocol Dr Jones meant the 2011 Metabolic Syndrome Resource.

In evidence both Dr Lagios and Mr Clark agreed that, from the perspective of Justice Health, the core documents which guide clinical staff in carrying out metabolic monitoring are the 2011 Metabolic Syndrome Resource and the 2017 Psychotropic Medication Guidelines. However, in her evidence Ms Te Maru said that only the 2011 Metabolic Syndrome Resource was used as part of Junee's metabolic monitoring policy.

It is evident from the above that there are currently 3 separate documents produced by the Ministry of Health and Justice Health which govern the metabolic monitoring performed by clinical staff in the correctional setting. It is also evident that the 2017 Psychotropic Medication Guidelines specifically highlights the importance of using physical monitoring (including ECG testing) to manage adverse effects in patients prescribed psychotropic medications. It also provides timeframes for the baseline and ongoing frequency of such testing, both in general, and in relation to specific types of psychotropic medication.

Whilst the 2011 Metabolic Syndrome Resource contains a table of the medications (which include amisulpride, pericyazine, and quetiapine) which are targeted by metabolic monitoring, there is no specific reference to the use of ECG testing, the reason why ECG testing is of benefit in monitoring the QT interval, nor any information regarding when, and how often, ECG testing should be performed.

CONCLUSION: There are 3 separate documents produced by the Ministry of Health and Justice Health which govern the metabolic monitoring performed by clinical staff in the correctional setting. Whilst they are intended to be read in conjunction with one another, it appears that Junee has only adopted 2011 Metabolic Syndrome Resource as part of its metabolic monitoring policy. There are clear clinical benefits in all 3 documents being adopted particularly because the 2017 Psychotropic Medication Guidelines specifically address the importance of monitoring (including ECG testing) with respect to patients prescribed psychotropic medication that carry the risk of QT interval prolongation.

RECOMMENDATION: *I recommend that Junee, as part of its metabolic monitoring, adopt the Justice Health 2017 Psychotropic Medication Guidelines and the associated NSW Ministry of health 2012 Metabolic Monitoring module.*

The 2017 Psychotropic Medication Guidelines refers to both the 2011 Metabolic Syndrome Resource and the 2012 Metabolic Monitoring module in relation to the requirements for metabolic monitoring.

There is no similar cross-reference to the 2017 Psychotropic Medication Guidelines in the 2011 Metabolic Syndrome Resource. Moreover, due to the single reference to ECG testing in the 2011 Metabolic Syndrome Resource, no information is provided regarding the relevance of its use, and how it should be used, as part of metabolic monitoring.

For example, although a number of psychotropic medications are identified as being targeted medications as part of metabolic monitoring, no correlation is drawn between the medications and ECG testing, nor is any guidance provided regarding when and how regularly ECG testing should be performed. It seems to me that there are obvious practical clinical benefits in ensuring that there is cross-referencing between the 2017 Psychotropic Medication Guidelines in the 2011 Metabolic Syndrome Resource, and ensuring that the use of ECG testing, and its relevance, is specifically addressed in the 2011 Metabolic Syndrome Resource.

At the conclusion of the evidence in the inquest a draft set of recommendations was circulated to counsel for the various interested parties. The draft included a recommendation in terms of what is set out in the immediate paragraph above. Counsel for Justice Health submitted that more recommendations to Justice Health were not required and that producing an excessive number of policies would only serve to "*paralyse*" the system. Instead, counsel for Justice Health submitted that an observation should simply be made that the best practice for all clinicians is to simply read the resources that have been provided to them and to exercise their own professional judgment.

During the inquest, counsel for Justice Health explored this issue with Dr Jones, Dr Lagios and Mr Clark. The questions posed to these witnesses seemed to suggest that a clinician's understanding, based on their training and need to comply with ongoing registration requirements (with the Australian Health Practitioner Regulation Agency), of what constituted best medical practice would be sufficient to ensure that deficiencies in care did not arise.

I think that there are some difficulties with submissions made by counsel for Justice Health Firstly, Justice Health is under an obligation to follow any policy directive disseminated by the NSW Ministry of Health and to use its own discretion as to how to implement such directives within its own network.

Resistance to the use of further policies and guidelines does not seem to sit comfortably with this obligation nor with the submission made by counsel for Justice Health, which I agree with, that the primary objective of Justice Health is to provide adequate and clinically sound health care. Secondly, placing reliance on individual clinicians to use their own training and understanding of best medical practice, without relevant policies and guidelines for unique settings such as the correctional setting, has the potential for variable and inconsistent outcomes.

Such reliance would not create public confidence that there is a primary system in place to protect against individual shortcomings.

Thirdly it is often the case that policies, and amendments to them, arise because individual shortcomings are identified. Without a primary, overarching system, other clinicians within the system would be deprived of opportunity to learn from such shortcomings. Finally, the need for there to be a review of the 2011 Metabolic Syndrome resource was conceded by Dr Lagios in evidence during the inquest.

RECOMMENDATION: *I recommend that Justice Health revise the 2011 Metabolic Syndrome Resource to include: (a) the provision of sufficient information and guidance to clinical staff regarding the use, and relevance of, baseline and ongoing ECG testing as part of metabolic monitoring; and (b) to cross-refer to the recommended clinical timeframes for ongoing ECG testing as set out in the 2017 Psychotropic Medication Guidelines, in particular in relation to additional monitoring recommended for specific antipsychotic medication.*

Findings

Before turning to the findings that I am required to make, I would like to acknowledge and thank Mr Peter Aitken, Counsel Assisting and Ms Carolyn Berry, instructing solicitor from the NSW Crown Solicitor's Office. I am extremely grateful for their valuable assistance and their significant contributions during the inquest and in the many months spent preparing for it. I would also like to thank and express my appreciation for the efforts of the police officer-in-charge of the investigation, Detective Senior Constable Melissa Martens.

Formal Finding:

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

Identity

The person who died was Mr Edward Haenga

Date of death

Mr Haenga died sometime between 10:00pm on 8 June 2013 and 7:15 am on 9 June 2013.

Place of death

Mr Haenga died at the Metropolitan Special Programs Centre at Long Bay where he was in lawful custody serving a custodial sentence.

Cause of death

The cause of Mr Haenga's death was cardiac arrhythmia.

Manner of death

Mr Haenga died from natural causes in circumstances where complications from his morbid obesity and his use of multiple, concurrent psychotropic medications which carried the risk of QT interval prolongation, probably contributed to Mr Haenga suffering a fatal cardiac arrhythmia.

Epilogue

During the words spoken by Mr Haenga's father at the end of the evidence in the inquest it was obvious that Mr Haenga's death has had a profound and devastating effect on Mr Haenga's family. Rather than seeking to assign blame, Mr Haenga's father expressed his appreciation for the inquest process and graciously thanked all counsel, solicitors and court staff involved in the inquest. The dignity shown by Mr Haenga's father should be warmly acknowledged.

On behalf of the coronial team and the Coroner's Court I would like to offer my sincere and respectful condolences to Mr Pepe Haenga, Mr Haenga's children, Ms Aparacio, and their extended families.

5. 173338 of 2014

Inquest into the death of Benjamin Gilligan. Finding handed down by Deputy State Coroner Grahame at Glebe on the 7th July 2017.

Introduction

This is an inquest into the death of Benjamin Gilligan. Ben was 22 years of age at the time of his tragic death on a roadside near Coonabarabran. In the months prior to his death Ben had been increasingly unwell. He had recently been receiving mental health treatment at Dubbo Base Hospital and medical staff had come to believe that it was most likely that he had been suffering from a drug induced psychosis. Ben absconded from Dubbo Base Hospital on 22 May 2014, whilst on gate leave. He remained in the community until his parents again sought urgent assistance on 5 June 2014. That evening Ben was brought to Dubbo Base Hospital under police escort. Shortly afterwards he made a violent escape from the Emergency Department. Ben took his father's car, telling him that he was on his way to Queensland. Police were contacted and the vehicle was later seen on the Newell Highway. There was a short pursuit, which was terminated after police lost sight of the vehicle. Shortly afterwards, it appears that Ben lost control of the car and smashed into a tree on the Oxley Highway, about 30 kilometres from Coonabarabran. Emergency Services were called, but Ben could not be revived.

Ben's parents Wayne and Astrid Gilligan attended each day of the inquest and their love for their son was evident. They felt let down by the mental health system and unsupported in their efforts to help the child they loved so dearly. Ben's death has been a devastating loss for the Gilligan family.

The Role of the Coroner and the scope of the inquest

The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.

In this case there is no dispute in relation to the identity of Ben Gilligan, or to the date and place or medical cause of his death. For this reason the inquest focused on the circumstances surrounding Ben's death, in particular his treatment prior to leaving the Dubbo Base Hospital.

It should however be noted that this is a mandatory inquest because Ben's death occurred "during the course of a police operation". Parliament requires that inquests of this kind are conducted by a senior coroner. This statutory position reflects the importance of independence and transparency when it comes to investigating deaths in this category. The circumstances surrounding these deaths should be carefully scrutinised and care must be taken to ensure that all relevant police policies and practices are most carefully reviewed. For this reason Ben's death was investigated pursuant to the NSW Police critical incident guidelines. However, as will become apparent, the issues requiring most attention during the inquest related to Ben's medical care, rather than the conduct of the police search for Ben after he had absconded from hospital. This focus was one which was supported by the Gilligan family.

A draft list of issues was circulated prior to the commencement of the inquest. Aside from the formal findings pursuant to the Act, the following issues were identified

1) Was the management of Mr Gilligan by Dubbo Hospital following the determination by the Mental Health Review Tribunal on 21 May 2014 appropriate, particularly in so far as the decision to grant Mr Gilligan "gate leave" on 22 May 2014 and to subsequently discharge him on 23 May were concerned ?
2) Having regard to the circumstances in which Mr Gilligan was discharged from the Hospital on 23 May 2014, was there adequate follow up from the Western NSW Local Health District?
3) What were the circumstances in which Mr Gilligan was able to abscond from the Hospital? In particular:
    - Were the procedures, facilities and arrangements for his placement in the "purple room" appropriate to secure him and prevent him from escaping?
    - Were there any alternative facilities available that would have better ensured he was secured and prevented from escaping?
4) Are there any recommendations that are necessary or desirable to make in relation to any matter connected with the death?

The Court heard evidence over eight hearing days and received extensive documentary material including written statements, photographs, expert reports and various recordings. Much of the material was summarised by counsel assisting the court in his detailed opening. I intend to largely adopt the factual summary distilled by counsel as the basis of my chronology.

A short chronology of events

Social history:

Ben Gilligan was born in Sydney in 1991. He had one older sister and was close to his parents Wayne and Astrid. The family moved to Dubbo when Ben was in his last year of primary school. He loved sports and had a large group of friends. His family described his warm smile and sense of humour.

Ben's parents reported that he had been a happy and healthy child.

At about the age of ten Ben was diagnosed with Tourette's syndrome after developing facial and body ticks. He did not have verbal symptoms and the physical symptoms seemed to cease after puberty. However, Ben is reported to have developed mild symptoms of obsessive-compulsive disorder and some anger management issues around this time.

Ben left school in year 10 and commenced, but did not complete, a chef's apprenticeship. Later he worked in the food industry as a cook.

In 2010 Ben and his then partner, Sinead had a child, Maddie. Ben was apparently overjoyed to be a father. Unfortunately, the relationship with Sinead did not last and Sinead and Maddie moved to Queensland.

At the end of 2012 or the beginning of 2013 Ben moved to Queensland to be closer to Maddie. He began working in a coffee shop and later commenced a personal trainer's course. However, he injured his right thumb and required surgery to repair it. Ben could not work during the recovery period and this led to financial difficulties. Ben returned to Dubbo in about July 2013 and his father noticed that he appeared depressed and demonstrated some anger management issues.

In around November 2013, Ben began working as a casual labourer through an employment agency and developed "an obsession with the gym", attending up to three times a day. There is some evidence that he had experimented with the use of steroids around this time.

In around January 2014, Ben began to turn down work with the employment agency. His depression persisted and his behaviour deteriorated. He became rude and uncharacteristically aggressive towards his mother. He was secretive, irrational and made threats of suicide and violence against others. Ben's parents were worried and tried to persuade him to seek help. Ben refused to see a doctor or counsellor despite his father's encouragement and efforts.

Unfortunately, Ben's behaviour became increasingly irrational with talk of suicide and threats of violence towards anyone he thought might be persecuting him. Around this time, his mother, Astrid became increasingly frightened of Ben and his behaviour.

Dubbo Base Hospital Attendance – 5 April 2014

On 5 April 2014 Ben had contact with the psychiatric liaison service in Dubbo after he was brought into the Emergency Department of the Dubbo Base Hospital by the police. These events coincided with Ben breaking up with his girlfriend of the time. He apparently made suicidal threats and told his family that he would never see them again. Ben was diagnosed with "anxious impulsive personality" and immediately discharged home with plans for follow-up by a general practitioner with input from a psychologist.

Dubbo Base Hospital Attendance – 17 April 2014

During April 2014, Ben began a brief relationship with Christina Dowling, which lasted about three or four weeks. His parents remained concerned about his mental state. On 17 April 2014 Ben's father contacted police to report that Ben was agitated and exhibiting paranoid behaviour and threatening self-harm. This followed a serious dispute between Ben and Christina at her home in Dubbo after they had apparently broken up. Police attended and described Ben as appearing to be "very ignorant, [sic] despondent and agitated." Police apprehended Ben and took him to the Emergency Department of Dubbo Base Hospital under section 22 of the *Mental Health Act* 2009. Ben was assessed as not being "mentally ill" and was discharged from hospital into the care of his parents. They felt helpless in their efforts to assist their son.

Dubbo Base Hospital Attendance – 14 May 2014

In May 2014, Ben began a relationship with Priscilla Smith, who for a time lived with Ben and his parents at their Dubbo home.

On 14 May 2014, Ben and Priscilla attended an appointment at the Dubbo office of Centrelink. On this occasion, it seemed that Ben suffered a severe psychotic episode. Ben was having paranoid delusions about Priscilla. He believed that she was involved with people who were bugging his phone and placing special Bluetooth devices in her earrings and jewellery that were capable of tracking him.

Once again Wayne Gilligan contacted the police to report Ben's paranoid and psychotic behaviour, which included shredding Priscilla's handbag with a Stanley knife and attempting to destroy her telephone. Police apprehended Ben under section 22 of the *Mental Health Act* 2009.

An ambulance arrived at the family home and took Ben to Dubbo Base Hospital, where he was admitted and came under the care of consultant psychiatrist, Dr John Bardon and psychiatric registrar, Dr Anizar Ghazalli. It appears that on initial presentation to hospital, Ben strenuously denied any drug use. At this stage his family were also unaware that Ben had apparently been using amphetamines. In the circumstances, a plan was developed involving Ben staying in the hospital as an involuntary patient for 4 weeks. This was on the basis that there was no clear evidence of the cause of Ben's psychosis, Ben demonstrated a lack of insight into his condition and was resistant to treatment.

Mental Health Review Tribunal – Involuntary Treatment Order – 21 May 2014

On 21 May 2014, the Mental Health Review Tribunal made an order that Ben was "a mentally ill person, and must be detained in or admitted and detained in Dubbo Base Hospital for further observation or treatment, or both, as an involuntary patient until a date no later than 18 June 2014".

The reasons recorded by the Mental Health Review Tribunal refer to the fact that Ben had a "strongly supportive family" who "want him home when well". It is also recorded that Ben "had been brought in by police after family registered their concerns about Ben. He had been very paranoid and irrational - still guarded and unwilling to engage. First presentation psychosis – CT scan scheduled. Says medication is making him drowsy. No memory of allegations about mobile in water, shredding handbag. Prior misadventure, family concerned about his safety. Concerns regarding compliance [indistinct] medication and relapse. No insight at all."

In her report to the Tribunal, dated 19 May 2014, in support of the application for involuntary detention and treatment, Dr Ghazalli noted that Ben's "resistance, guardedness and lack of insight into his condition makes it unlikely that he will be able to be managed outside a secure hospital setting.

His family have also requested for him to be treated in hospital and not prematurely discharged as they have grave concerns for his safety and have not been able to care for him at home". Ben opposed the inpatient order. However, when it was granted his parents were somewhat relieved and sincerely hoped that Ben may finally get the assistance he needed.

Ben's admission to using "ice" and the diagnosis of drug induced psychosis

After the Tribunal hearing, Ben asked to speak with Dr Ghazalli. He admitted to Dr Ghazalli that he had been "shooting ice" daily for the past few months. Dr Ghazalli apparently discussed with Ben the possibility of engaging with drug and alcohol services. Ben apparently indicated that he was willing to try.

Dr Bardon and Dr Ghazalli reviewed Ben's treatment on the following morning. There appears to have been a further interview with Ben, during the course of which he again made reference to shooting ice over the previous few months.

Dr Ghazalli recorded that at the time of the review, "Ben made good eye contact and displayed no psychomotor abnormalities. He was not sedated and engaged openly. He described his mood as "okay" and his affect was reactive and congruent. His speech was normal as far as rate, rhythm and tone. He displayed no further thought disorder and appeared to be thinking in a logical manner. He denied any thoughts of self–harm, suicide or homicide. There were no perceptual abnormalities and he appeared to have fair insight and rapport. Despite expressing a desire to stop using ice, Ben was still opposed to his parents being informed of his drug use".

As a result of that review, it is apparent that both Dr Bardon and Dr Ghazalli arrived at a working diagnosis of drug induced psychosis and formed a treatment plan that would involve input from local drug and alcohol services, cancelling the brain CT scan, encouraging Ben to inform his parents about his drug use and then liaising with Ben's parents once Ben had told them of his drug use.

Gate leave and discharge – 22 May 2014

At 11.55 am on 22 May 2014, Dr Ghazalli had a further discussion with Ben and stressed to him the importance of telling his parents about his ice use. This needed to happen before he could be discharged. From the notes made by Dr Ghazalli it appears that Ben was too embarrassed to tell his parents himself, but finally agreed to Dr Ghazalli telling them.

Dr Ghazalli then spoke to Ben's father, Wayne and updated him on Ben's progress. This included telling Wayne about Ben's confession to ice use. Dr Ghazalli also advised Wayne that Ben could have two hours gate leave with his parents that night, with a view to Ben being discharged the following day.

Although Dr Ghazalli recorded in the notes that Mr Gilligan was agreeable and supportive of the plan to grant Ben leave with a view to discharge, Mr Gilligan says that he always questioned the decision and felt it was too soon to be talking about both gate leave and discharge. In evidence he said “I vehemently deny that I was in favour of it, and I spent half an hour on the phone with the doctor arguing against gate leave and asking her questions like what are your criteria for saying that he’s all of a sudden better?”

On the other hand, Dr Ghazalli made contemporaneous notes and stated that had Mr Gilligan expressed opposition or objection, it would have been documented and it was not. She said no concerns were raised and in fact Mr Gilligan was agreeable and supportive of the plan.

While I accept that Dr Ghazalli is relying on her careful review of the clinical notes, I think she must be mistaken in her memory of the entire interaction. Mr Gilligan may not have expressed his concerns as forcefully as he now remembers, but I find it very difficult to believe that he expressed no concern whatsoever. By this time the Gilligan’s were desperate to find appropriate help for their son. It is documented that after the MHRT hearing, they were relieved and felt that finally he might “get the help he needs”.

It seems inconceivable that they would do such an abrupt about turn and whole heartedly support gate leave and imminent release. I understand that the Gilligan’s would have done anything to assist their son and it may be that this steadfast position was misinterpreted as support for the therapeutic plan the psychiatrists intended. It strikes me that had a written document been prepared for leave planning, such a miscommunication may not have occurred.

In any event, that afternoon Wayne Gilligan picked up Ben from Dubbo Hospital and took him home. Later that day, Wayne left Ben at the house, in the company of Priscilla, and went to collect Ben’s mother, Astrid, from work. Ben took this opportunity to leave the house prior to his parents’ return.

Wayne returned to Dubbo Base Hospital and was advised to report the matter to the police. Police were also called by the Hospital. Hospital staff advised Wayne that the plan was that Ben was likely to be discharged the following day.

On 23 May 2014 the Hospital formally discharged Ben.

It was Dr Ghazalli's evidence that the decision to discharge was based on the fact that staff believed Ben had gone to Queensland and also that following her conversation with Wayne Gilligan she understood Wayne to "be agreeable to discharge" and to "have no acute concerns". Wayne Gilligan denies he was agreeable or that he had no concerns.

Post discharge involvement by the Local Health District

It appears clear that there was no direct contact between the Hospital or any associated mental health service and Ben following his discharge on 23 May 2014.

Following Ben's formal discharge on 23 May 2014, responsibility for his care was initially handed over to the Consultation Liaison Team for an initial 7 day period and thereafter to the Community Mental Health Team.

No introduction or contact between Ben and those who would ultimately be responsible for his care in the community had been established prior to his being granted leave or his subsequent discharge.

It appears that there was an initial attempt to contact Ben made by a registered nurse, Elizabeth Luffman, who had tried to telephone Ben at the family home and who then spoke with Wayne Gilligan. Wayne apparently told RN Luffman that he had spoken with Ben and that Ben was safe. Wayne was unable to provide a mobile telephone number for Ben at that time.

RN Colleen Weaven also attempted to contact Ben at the family home on 24 May 2016. At that time she also spoke with Ben's father, Wayne. Wayne informed the nurse that Ben had gone to Queensland to visit his daughter. Wayne was unable to provide a telephone contact number for Ben at that time. On 26 May 2014 a case review was conducted by the Community Liaison Team, at which it was determined to discharge Ben from the Community Liaison Team and refer his case to the Community Mental Health Team for follow-up, in the event that he re-presented or returned to Dubbo.

That same day RN Weaven again spoke to Wayne Gilligan and she says that she provided him with contact numbers for the after-hours Mental Health Emergency Care Rural Access Program and the Community Mental Health Team contacts in case he required assistance at a later stage. Wayne apparently told RN Weaven that he believed Ben was in Queensland and was not currently contactable. RN Weaven also placed Ben's progress notes in a tray to be picked up by the Community Mental Health Team.

RN Weaven states that on 27 May 2014, she made contact with a nurse at the Community Mental Health Team, registered nurse Tuapikepike Hickey also known as RN Tu-tu. The precise details of that contact cannot be confirmed and we now know RN Hickey was due to leave her employment with the Dubbo Community Mental Health Team on 30 May 2014 and was not taking on new patients at that time.

In any event, following the telephone conversation between RN Weaven and Wayne Gilligan on 26 May 2014, there was no further contact with Ben or his family from any representative of the Community Mental Health Team or any other health service associated with the Local Health District until the events of 5 June 2014.

Wayne Gilligan has stated that after he spoke with Dr Ghazalli on 23 May 2014, he telephoned Ben's mobile and told Ben that he had been discharged from Hospital. According to Wayne, Ben returned soon afterwards. The exact time of his return remains somewhat unclear.

What is certain is that once Ben returned to the family home in the days after his discharge he continued to behave in a troubling manner. I accept that Wayne and Astrid Gilligan continued to have significant concerns for their son's welfare and that these continued well after Ben's formal discharge. After his return Ben's mental health continued to slowly deteriorate. It appears that the Gilligan's, like many families whose adult loved ones are struggling with mental health issues, felt powerless and somewhat unsupported. Ben was not interested in treatment and his family felt they could do nothing until an acute situation arose again.

Dubbo Base Hospital – 5 June 2014

At about 11 am on 5 June 2014, Ben telephoned Wayne. He was talking rapidly and not making much sense. He said to his father, "Come and get me now Dad, I'm in trouble. There are all these people in white cars with "B" on the number-plate chasing me".

Wayne Gilligan told Ben that he did not have the car but he would catch a cab to get him. Ben then screamed into the phone, "I'm fucking dead then! By the time you get here they will have killed me! You gotta steal a car Dad, take one of the neighbour's cars and bring a gun… I don't know what I'm gunna do, I've gotta get out of Dubbo before they kill me. They're all in on it, the police, the hospital and I've found out even the government want me dead. Dubbo's not safe for us anymore. If they kill me, at least get Mum, get in the car and just leave everything and get out of Dubbo." Ben then hung up.

Wayne Gilligan was extremely concerned. He telephoned the police and explained the situation. About 15 minutes later, Wayne saw Ben walking towards the house. He called the police again.

Shortly afterwards Sergeant Bradley Edwards, Senior Constable Todd Williams and Senior Constable David Sendt attended the Gilligan home. According to Senior Constable Williams, Ben was expressing obviously paranoid thoughts about being followed by bikies and needing to get his family out of town.

While Sergeant Edwards and Senior Constable Williams attempted to speak with Ben, Senior Constable Sendt had a telephone conversation with Dr Ghazalli about the previous admission. During this conversation, Dr Ghazalli informed Senior Constable Sendt that Ben had failed to return from leave a week prior and had been discharged in his absence.

Dr Ghazalli also advised Senior Constable Sendt that Ben had been suffering from paranoid delusions, which appeared to have been in response to heavy amphetamine usage shortly prior to his earlier admission.

Ben was subsequently detained under section 22 of the *Mental Health Act* 2009, handcuffed and transported by ambulance to Dubbo Base Hospital. Senior Constable Sendt accompanied Ben in the ambulance. The Gilligan family had no complaints about the way police handled this difficult situation.

At about 11.50 am on 5 June 2014, Ben was admitted to Dubbo Base Hospital. Senior Constable Sendt provided Ben's details to the triage nurse, Cindy Graham. At that time Ben was non-compliant, manipulative and tried to leave. Police placed him directly in a "secure" room at the hospital known as the "Purple Room".

The "Purple Room"

The Purple Room is located in the Emergency Department about 6 metres from the ambulance entrance and adjacent to the ambulance holding area. It has a corridor on either side with 2 doors. Both doors have viewing panels measuring 200 mm x 550 mm. The entry door, accessible from the ambulance corridor is lockable from the outside and the other door is a "fob" exit only that leads to what is referred to as the RAFT corridor. Entry can also be gained from the RAFT corridor via that door using an external handle. The room itself is approximately 3.1 x 2.4 metres and contains a vinyl covered foam mattress on the floor. There are two CCTV cameras inside the room and another camera in the ambulance corridor.

The room is not acoustically soundproof and does not allow for total privacy for the client. Patients in the room, who may be verbally loud and abusive, can be heard throughout the Dubbo Base Hospital Emergency Department.

In addition the Purple Room is not plumbed. As a result of the mental health client needs to be toileted, a security officer or clinician is required to walk the client to the toilet opposite the room. That bathroom contains fittings and fixtures that increase the risk of self-harm or injury to others and are not within the mental health facility guidelines. As at 5 June 2014, the Purple Room was used, when necessary, to assess patients that were designated as unsafe to be placed in the Emergency Department waiting room, or who were required to be separated due to concerns for the safety of staff, other patients or hospital visitors. The room was also used from time to time to assess inmates from Wellington Correctional Centre and local juvenile justice facilities.

The Purple Room was, at the time of these events and indeed remains, the only room available at Dubbo Base Hospital that is capable of being used to control patients in the Emergency Department until they can be moved to a treatment cubicle or resuscitation bay.

Escape from the Purple Room

It appears that Sergeant Edwards and Senior Constable Williams remained immediately outside the secure door to the Purple Room while Senior Constable Sendt completed the section 22 form. It was not until Dubbo Base Hospital health and safety security assistants, Luke Sullivan and Ben Costa arrived at the location that police were able to leave. During that time Ben displayed various "flight risk" behaviours. At one point he pleaded to use a toilet and attempted to push past the police officers when they allowed him out of the Purple Room to access a nearby toilet cubicle.

Ben was triaged by the Nurse Unit Manager, Cindy Graham. RN Graham allocated Ben a triage category of four. Nurse Graham also left a message for the Mental Health Community Liaison Team.

About 12.30 pm Dr Ghazalli attended the Emergency Department to see Ben. It appears that Dr Ghazalli was concerned about the security implications of dealing with Ben alone. She briefly discussed the issue with another registrar, Dr Alexander Matthews.

Dr Ghazalli spoke to Ben through the Purple Room door. At that time she was unable to get a coherent history from him as he was agitated and uncooperative. Dr Ghazalli also said that Ben was "diaphoretic" holding his stomach and saying that it needed to be pumped. Ben's agitated presentation prevented any full assessment by Dr Ghazalli.

Dr Ghazalli determined that Ben required sedation by Acuphase injection and physical restraint. She consulted Dr Barden and discussed her proposed management plan. It was decided that the use of Zuclopenthixol Acetate (Acuphase) was appropriate and that Ben should be admitted into the Mental Health Unit. While Dr Ghazalli was away from the Emergency Department, Ben continued to complain of being unwell, having chest pains and claiming that he had heroin in his stomach. He asked for and was given water.

When Ben asked for more water, Mr Sullivan opened the door to take the empty cup from him. At this point Ben grabbed the door and pulled it out of his grasp. Ben ran out of the door pushing at Mr Sullivan and Mr Costa and throwing punches. He ran towards the X-ray department with Mr Sullivan and Mr Costa behind him.

The CCTV footage shows that Ben was very agitated. He was a strong man and was apparently threatening violence verbally. Nearby was an exit door to the Hospital which could be activated by pushing a green button. Mr Costa said to Ben “push the green button”. Ben pushed and when the door released he ran immediately towards the exit. The security officers followed, but Ben escaped by jumping a fence and running towards a nearby TAFE campus.

About 6 pm on 5 June 2014, Ben telephoned his father. He was apparently in the company of another unidentified man at the time. Ben demanded that Wayne provide the family car to him. The unidentified man also spoke to Mr Gilligan and suggested that Ben was in trouble and needed to get away to “sort himself out”. Ben got back on the telephone line and threatened to shoot anyone who got in his way of taking the car. A short time later, Ben called again saying that he was going to take the car. Mr Gilligan decided that the threat of violence from Ben or his friend was real and decided to give him the keys to the car.

Ben arrived at the family home with an unidentified male and his father gave Ben a plastic bag containing his jacket, his telephone and the car keys. About 30 minutes later, Mr Gilligan telephoned the police. Later, Ben telephoned Wayne from the car and told Wayne that he was on his way to Queensland.

The pursuit in Coonabarabran

At 7.55 pm, police officers in two separate vehicles attached to the Coonabarabran Police Station heard a “keep a lookout for” radio broadcast in relation to a silver Ford XR6 registration AD 24 AM, being the vehicle in which Ben was driving.

Detective Senior Constable David Aitken and Detective Senior Constable Scott Bennett were patrolling Coonabarabran in police vehicle CNB 105. Senior Constable David Yeo and Sergeant Cheyne Gasson were using police vehicle CNB 16 which was a marked caged vehicle.

The radio broadcast requested that officers be on the look out for Ben Gilligan, who had mental health issues and who had absconded from Dubbo Base Hospital earlier that day. Shortly after 9.17 pm Officers Yeo and Gasson in CNB 16 saw the relevant vehicle travelling fast in a southerly direction along the Newell Highway. They followed the vehicle back towards Coonabarabran with a view to catching up with it.

Shortly after Ben's vehicle reached Coonabarabran and with CNB 16 behind it, Officers Aitken and Bennett in CNB 105 followed behind CNB 16. At that point CNB 16 advised that Ben's vehicle was failing to stop and they were in pursuit. The time was then 9.20 pm.

As the three vehicles proceeded south along the Newell Highway through the township of Coonabarabran their speed was approximately 40 km/h. Shortly after the pursuit was called in, Ben's vehicle appeared to stop outside Coonabarabran High School with police vehicle CNB 16 nearby and CNB 105 to the rear. However, the vehicle did a quick U-turn evading both police vehicles and sped away. Police vehicle CNB 105 followed. Some of this action was apparently recorded on CCTV footage later obtained by police. It is however most unfortunate that the footage was lost during the investigative process.

At 9.22 pm, Officer Gasson transferred to a marked police vehicle CNB 36. Officer Yeo continued in pursuit in CNB 16 with police vehicle CNB 105 in front. They soon lost sight of the vehicle.

At 9.23 pm, police radio advised officers to terminate the pursuit. Police radio further required that permission be sought before re-engaging the pursuit.

Shortly after 9.30 pm, a witness, Glynne Stone was driving along the Oxley Highway about 20 km out of Coonabarabran and towards her home. She noticed a vehicle fast approaching from her rear. Without slowing, the vehicle, which she observed to be a silver sedan, overtook her vehicle on a blind bend and over double unbroken lines, only narrowly avoiding a head-on collision with a large truck. Ms Stone estimated that the silver vehicle was travelling at about 180 km/h. Shortly afterwards Ms Stone came round a sweeping right-hand bend and saw a huge dust cloud on the right-hand side of the road and ultimately Ben's vehicle completely wrecked and wedged part way up a tree. Ms Stone tried to call 000 at about 9.34 pm but she could not get a mobile phone signal. She was able to make contact at 9.39 pm and reported the accident to police. At 9.42 pm police radio broadcast information concerning the accident.

Officer Gasson was the first to arrive on the scene at about 9.55 pm, shortly followed by Officer Yeo. Officers Aitken and Bennett arrived in CNB 105 at about 10 pm. Ben was apparently already deceased.

Investigation of the crash

Senior Constable Steve Redden of the Dubbo Crime Scene Section investigated the crash site. After a thorough examination of the scene and consideration of all the information provided to him, Constable Redden concluded that Ben had been driving along the Oxley Highway in a generally easterly direction at a speed in excess of 100 km/h.

Shortly after negotiating a right-hand bend in the road his vehicle left the bitumen surface and commenced a yaw on the gravel or dirt shoulder for a distance of 33.2m. The vehicle became slightly airborne and commenced a rolling movement which resulted in the vehicle impacting heavily with a tree on the left side and roof area of the vehicle.

As a result of impacting with the tree the roof of the vehicle compressed and came into contact with Ben. He sustained fatal injuries as a result. There was no evidence to indicate the involvement of an animal strike or any other vehicle in the accident and there was no roadway evidence to suggest that Ben had attempted to brake prior to the collision.

The extent of the collision damage was such that a subsequent examination of the vehicle was unable to identify any defects or component failures that may have contributed to the collision occurring. All four tyres were still inflated, however they were observed to be in a poor condition with significant wear and tear. I am satisfied that the collision occurred at a time when Ben was not being pursued and that no other vehicle was involved.

Post mortem examination and medical evidence

An autopsy was conducted by forensic pathology registrar Dr Leah Clifton under the supervision of Dr Brian Beer, Senior Staff Specialist in Forensic Pathology at the Newcastle Department of Forensic Medicine on the afternoon of 12 June 2014. The cause of death was noted to be the result of multiple injuries. The multiple injuries identified in the course of the post-mortem examination were consistent with blunt force trauma sustained in a high-speed motor vehicle collision. It is considered likely that the injuries were so significant that they would have caused instantaneous death.

Toxicological testing showed that Ben's post-mortem femoral blood had 0.10 mg of amphetamine per litre and 0.60 mg of methylamphetamine per litre, as well as low levels of alprazolam (less than 0.005 mg/l) and nordiazepam (less than 0.005 g/l) .

These results were later analysed by a forensic pharmacologist Dr Judith Perl, Dr Perl concluded that because the blood taken from Ben was femoral blood, the concentrations are likely to have closely resembled the concentrations at the time of his death. In her opinion the blood concentration of methylamphetamine was within the toxic and potentially fatal range.

She told the Court that the blood level of methylamphetamine found is indicative of a very high dose of methylamphetamine having been used, but that the high level of amphetamine (expected to have resulted from the metabolism of methylamphetamine) also suggested repeated dosing (ie doses only a matter of hours apart) and possibly some residual level due to use within the previous few days.

Significantly the blood level of methylamphetamine was such that there would have been very significant psychomotor impairment and impairment of driving ability. A psychotic episode due to methylamphetamine toxicity was certainly possible. It was her view that the impairing effects of methylamphetamine would have been a significant factor contributing to Ben's manner of driving. The low levels of alprazolam and nordiazepam where not suggestive of recent use and are unlikely to have impaired Ben's driving ability.

The conclave of experts

As has been stated, the real issue as it emerged during the inquest was not the police pursuit, which had been terminated by the time of Ben's death. But the need for close examination of Ben's mental health care in the context of his flight from Dubbo Base Hospital and the circumstances of his tragic death.

In this regard the court was assisted by the expert evidence of four psychiatrists, Dr Danny Sullivan, Professor Matthew Large, Dr Peter Klug and Dr Michael Giuffrida. Each of the doctors was highly qualified and eminent in their field. Each of the doctors provided reports and they gave evidence over two days during an expert conclave. The conclave process was extremely useful in distilling the important issues and in identifying the significant areas of agreement that existed between them. I do not intend to review their evidence in great detail, as it will be sufficient to examine it in relation to the limited number of relevant topics that emerged.

The diagnosis and treatment

On reflection, during the conclave all experts agreed that after Ben Gilligan admitted his ice use, the most likely diagnosis was drug induced psychosis. Dr Sullivan, speaking for them all, said “at the time at which Mr Gilligan professed to substance use and given that there had already been collateral information from others about likely substance abuse we agreed that it became at that time much more likely than not that a drug induced psychosis was the likely diagnosis”.

There was also general agreement that at some later time, had Ben’s symptoms kept recurring, even after a period of abstinence that some other diagnosis would be considered.

However, Dr Sullivan explained that given Ben’s presentation and the absence of “negative symptoms”, the reduction of his symptoms after minimal medication and the admission to heavy ice use, it would be a “very long bow “to diagnose schizophrenia during the May 2014 admission and that “not very many psychiatrists” would do it.

Even Dr Giuffrida, who said he had a “slightly different view” and was suspicious that there may be an underlying psychotic illness such as schizophrenia appeared to accept that at this point in Ben’s presentation it would be too early to make a definitive diagnosis of schizophrenia.

It follows and I accept that the diagnosis made by Dr Ghazalli and Dr Bardon was open to them and based on sound clinical judgement.

Gate leave

Each of the experts was asked about the appropriateness of granting “gate leave” to Ben Gilligan on 23 May 2014, particularly in the context of his very recent admission to drug use. In summary each of the experienced psychiatrists was of the view that leave is a useful part of inpatient psychiatric practice and can be used as respite from the ward, as a testing mechanism, as a chance to get some fresh air and sunlight or as an opportunity to undertake small jobs outside the hospital. Each seemed to accept that it always involves the risk that a patient could abscond and that assessing the likelihood of that risk is sometimes difficult.

Dr Giuffrida was of the view that a more graduated leave program may have been appropriate, such as allowing leave on the hospital grounds with a staff member. Each of the other doctors thought any lesser leave than a couple of hours may have been impractical and in reality it would test very little. Dr Klug described staff escorted leave as something from a “bygone era”.

Counsel for the Gilligan family submitted that the leave planning which took place was "cursory and rushed". It was "intimately linked with discharge" and based on an inadequate assessment of any behavioural changes in Ben, which were tenuous, time-limited and potentially explained by medication.

However, aside from Dr Giuffrida's reservation about the type of leave allowed, none of the other doctors were critical of the decision to grant leave, in itself. I accept that while the decision to grant leave involved risk, it was not inappropriate in the circumstances of this case. Counsel for the family suggested that Benjamin Gilligan was sent through a 'revolving door'. I do not accept the implication inherent in this phrase that there was little or no care given to the decision.

Even gate leave in the Hospital grounds would have provided Ben with an opportunity for flight, if he was determined to go. I accept the opinion of the treating psychiatrists that Ben appeared well enough to be tested and I accept that finding the balance between safety concerns and the principle of "least restrictive care" presents a real and ongoing difficulty for clinicians.

One area of possible improvement was, however, identified. Professor Large suggested that the granting of leave in NSW Hospitals could perhaps be better documented. He said "it is my belief that we should formalise the conditions under which we grant patients leave in New South Wales a little bit more than we have done so… I think we should get better at articulating what we mean by conditions of leave" It is certainly easy to see that it would have been preferable had the conditions of leave been plainly articulated in a signed document for the Gilligan's in this case. As I have already stated, there are conflicting accounts about the family's attitude towards Ben being granted leave. Formalising this process may provide a clearer process for families to express their fears and concerns.

Treatment prior to discharge

The experts appeared to accept that different psychiatrists may hold differing views about whether medication should be reduced or ceased prior to discharge in the circumstances of Ben's case. However, they appeared comfortable with the range of clinical opinions that may exist here.

In relation to establishing drug and alcohol treatment prior to discharge, Dr Klug suggested that "in an ideal world that would be a very good thing to do", but that it is not always possible. Professor Large cautioned against "too much magical thinking in relation to what a drug and alcohol counsellor might do".

He noted that psychiatric registrars should have skills to deal with this issue and stressed that one cannot detain someone purely for the purpose of arranging drug and alcohol counselling. He said that if a person wants to stop using drugs, arrangements can be made for outpatient services and it is not essential for counselling to commence on the ward.

It is clear that the treating doctors in this case had noted on the written plan for Ben, that Drug and Alcohol Services would be contacted. Of course we now know that he absconded prior to that happening. However, none of the doctors including Dr Giuffrida appeared to suggest that commencement of Drug and Alcohol counselling on the ward was a necessary pre-requisite to the granting of limited gate leave.

Decision to discharge

There was considerable discussion about the decision to discharge Ben after his failure to return from leave on the evening of 22 May 2017. The possibility of holding a bed open for Ben was discussed, but given that the Hospital had been informed that Ben had gone to Queensland, this appeared impractical when one took into account the very real pressure for beds in public hospitals and the unlikelihood of his early return.

Each of the doctors agreed that while there is legislation which allows for an interstate apprehension order, it is used very rarely. The doctors seemed to agree that it was only likely to be considered in relation to forensic patients or where extreme risk could be established. None of the doctors would have considered going down this path. There was also some acknowledgement that it also would involve risk for Ben if the police had to pursue him over state borders.

I have considered whether the attitude of Ben's family would have realistically affected the decision to discharge at this point. As I have stated, Wayne Gilligan denies that he told Dr Ghazalli that he agreed with the plan to discharge. On reflection it appears to me that whatever was said during the conversation between Dr Ghazalli and Mr Gilligan, it appears likely that the Hospital would have gone ahead with discharge at that point. It was almost inevitable in the circumstances of Ben's short mental health history and his flight from Dubbo Hospital. It is certainly significant that at that time clinicians believed Ben had travelled to Queensland. I note that it was Dr Bardon's unchallenged evidence that had he been told that Ben had returned to his parents' home in Dubbo, after his flight from the Emergency Department, he would have "asked the police to go around and bring him back to the hospital".

In the end there was some agreement that the decision to discharge was, at least in part, as Professor Large described it, “pragmatic”. Once Ben removed himself from the Hospital, there was no treatment that they could offer and the bed was needed for other patients. In the circumstances of the case, I am not critical of that decision.

Adequacy of follow up after discharge and the need for discharge planning

Dr Sullivan stated that in general terms there was agreement between the experts that the follow-up after discharge was adequate. While he had initially thought the two stage process involving the Community Liaison team and the Community Mental Health team was unnecessarily complicated, he now understood that it was based on a desire to make sure that patients were contacted in the first seven days after discharge. He accepted that there were efforts to contact Ben and his family and that given that the Hospital had been informed that Ben had absconded and gone to Queensland the efforts appeared reasonable, under all of the circumstances.

Dr Giuffrida had a slightly different view. While he agreed that in the circumstances they did what they could, once Ben had been discharged, he felt that the lack of early discharge planning became an issue. I take this to mean that Ben left without contacts for help in the community.

Dr Sullivan, Dr Klug and Professor Large believed that discharge planning had “commenced” and would have been completed had Ben returned after his gate leave. Dr Giuffrida conceded that “some effort” had been made. There was certainly a documented plan which included the provision of Drug and Alcohol services, but contact had not yet been made prior to gate leave being granted. There was some difference of opinion expressed by the experts about whether drug and alcohol counselling was best commenced in the community or prior to discharge. It was also acknowledged that as Ben had denied drug use on his arrival, a referral could not have been made at an early stage.

The Gilligan family submitted that a care co-ordinator should have been appointed at the beginning of the admission. This was in breach of standards set by NSW Health. Dr Sullivan agreed that this would be “ideal” while Professor Large and Dr Klug were concerned that this was a standard that could not be met across the state. It is certainly troubling if health standards which have been identified as best practice cannot be reached consistently throughout NSW.

Ben’s management at Dubbo Base Hospital on 5 June 2014

Counsel for the family submitted that Ben was incorrectly triaged on his arrival at Dubbo Base Hospital and this is likely to be correct.

However, when the experts were asked about the allocation of the triage category given to Ben on his arrival at Dubbo Hospital on 5 June 2017, there appeared to be general agreement that even if a lower triage category was appropriate, Ben was dealt with as a matter of urgency and seen as quickly as was possible. It was Dr Giuffrida's view that he should have been a category 1 or 2, not a category 4 but he agreed that little turns on it as he was dealt with as a 1 or 2 in any event. Each of the doctors was in agreement that notwithstanding any relevant definitions found in NSW Health Policies, they regarded placing Ben in the Purple Room as a form of seclusion. Mr Grose from the Local Health District described the Purple Room as a "safe assessment room" rather than a "seclusion room", but there was no real dispute about what it was used for.

There were differing views about the adequacy of the facility and whether plumbing and other facilities needed to be provided. It appears that standards differ greatly across the regions and across the country.

Each of the doctors spoke of the difficulties faced by staff in situations such as the one that presented at Dubbo Base Hospital Emergency Department on 5 June 2014.

The doctors seemed to agree that the particular problem faced by staff where drug affected psychotic patients demonstrate significant violence is increasing. There are a variety of ways to deal with the situation depending on the size of the unit, the number of staff present and the resources available. There were differing opinions on the best approach. Clearly not all facilities will have the capacity to restrain and medicate a patient on a trolley in a resuscitation bay. Not all facilities will have the staff capacity to quickly organise a controlled restraint.

As Dr Large explained medical staff are faced with "a range of unsatisfactory alternatives with no strong sort of, no consensus actually within accident and emergency specialists and within psychiatrists working in this area as to what is precisely the best thing to do, and that would also be influenced by factors such as …the nature of the room involved, the staff and their training…

This is a contemporaneous decision that takes place. So I'm not critical of them placing him in a seclusion room. I don't think they could have foreseen that he would escape from the Purple Room/seclusion room." There is great force to his evidence.

I am certainly satisfied that Dr Ghazalli, a first year trainee registrar, was faced with an extremely difficult situation when she was called upon to treat Ben Gilligan on 5 June 2014. I am satisfied that it was appropriate for her to consult Dr Bardon in relation to the prescription of sedatives. Having reviewed all the expert evidence.

I am satisfied that the decision to place Ben in the Purple Room was appropriate, given the options available, at least until arrangements could be made for further treatment. I am satisfied that those arrangements were being made in a timely manner when Ben escaped. Dr Ghazalli was an impressive witness who appeared both thorough and caring in her approach. I am satisfied she acted appropriately on this day.

Changes made since Ben's death

The Inquest received material from the Local Health District which outlined a number of changes that have been made or are planned since Ben's tragic death. Some of those changes relate to streamlining the process of transferring patients to the Community Mental Health Team and were described in the evidence of Ms Rebecca Leman and elsewhere.

There was also evidence that as a result of Ben's death, there had been training for clinical and security staff in relation to the Purple Room and in relation to the management of aggressive patients. The way patients are monitored has changed and there is a register in use. Other evidence provided by Mr Clinton Grose, Mr Jason Crisp and Ms Debra Bickerton related to changes foreshadowed with the renovations currently in planning for the Hospital. The new Emergency Department will have a purpose built seclusion room(s). The redevelopment is currently scheduled for completion in 2019.

The need for Recommendations

One of the issues that emerged from the expert conclave was the real difficulty presented by the growing problem of acute behavioural disturbance in emergency departments across the state. This appears to have been exacerbated by increasing amphetamine use in the community. The problem may be more extreme in smaller hospitals with fewer resources and lower staffing levels. Dr Giuffrida described the level of violence as alarming. Dr Klug spoke of the difficulties faced by registrars and others working in this environment. Professor Large spoke of the rising number of psychiatric presentations in emergency departments generally.

What emerged is that there is no easy answer about how best to deal with these kind of presentations in emergency departments. Professor Large noted that each unit does things a little differently and that leaves practitioners exposed when something goes wrong. While he accepted that it would be a complicated process to get anaesthetists, emergency doctors and psychiatrists all on the same page, he suggested that it would be a worthwhile process to encourage all those involved to consider a joint approach to acute behavioural disturbance in this context.

He asked the questions, when is it appropriate to use heavy sedation? When is it appropriate to seclude a patient? When is it appropriate to physically restrain and how should it best be done? A further issue raised by the circumstances of this case may be the role of security staff and their training to deal with these issues.

The answers to these complex questions are beyond the scope of this inquest. However, violence and behavioural disturbance in emergency departments and how to deal with it is a critical current issue and I intend to urge the Minister for Health to consider having his Department convene a forum for open discussion of the issues raised by Professor Large. A copy of the transcript of the expert evidence in this matter should be forwarded to the Minister to facilitate this process.

More specifically, the evidence raises matters for the consideration of the Local Health District. I thank the Local Health District for their co-operation and willingness to openly discuss the issues involved. Some significant changes to the relevant policy and procedures have already been made.

However, I intend to recommend that the Local Health District review the formal requirements of their gate leave policy and that it reconsider its policy in relation to the Purple Room. I note that as a result of the expert evidence, Debra Bickerton, General Manager of Dubbo Health Service has already expressed a commitment to review the local policy and to take into account the reality that the Purple Room acts as a seclusion room.

Conclusion

It is important to remember that the right to refuse medical treatment is a basic common law right and should not be interfered with lightly. The *Mental Health Act* seeks to strike a balance between this important right and the need to protect people who may be incapable of making rational decisions or of displaying insight into the dangers their illness presents to themselves or others. Decisions made in relation to a person's care pursuant to the *Mental Health Act* 2007 are often difficult and very finely balanced. When assessing "mental illness" practitioners must take into account a person's "continuing condition" and treatment decisions need to take into account any likely deterioration. At the same time there is an emphasis on the "least restrictive care" that is safe and effective. Decisions to allow gate leave and discharge involve inherent risk and must be carefully considered. I am satisfied that the clinicians involved in Ben's care used sound professional judgement in the decisions they made.

Finally, I again offer my sincere condolences to the Gilligan family and I thank them for their participation in this inquest. I am confident that they will continue to remind Ben's daughter, Maddie of all his positive attributes, good humour and love for her. Wayne and Astrid Gilligan's attendance at this inquest is a testament to the love they have always expressed for their son. I would like to reassure them that many people will continue to reflect upon the difficult issues which surround involuntary mental health care in the hope those improvements to our system can be made.

Formal Finding:

The identity of the deceased

The deceased person was Benjamin Gilligan.

Date of death

Mr Gilligan died on 5 June 2014.

Place of death

He died on the side of the Oxley Highway, about 30 kilometres north east of Coonabarabran, NSW.

Cause of death

He died as a result of multiple injuries caused when the vehicle he was driving collided with a tree.

Manner of death

Ben was affected by methylamphetamine at the time of his death and in need of psychiatric care.

Recommendations pursuant to s 82

To the Minister for Health

I recommend,

That the Minister give consideration to having his Department convene a state wide forum to discuss best practice management procedures for patients with acute behavioural disturbances presenting to NSW Emergency Departments.

To the Western NSW Local Health District

I recommend,

That the Western NSW LHD give effect to the requirements of the existing leave policy by developing a written document to be provided to patients exercising gate leave and any family or carers who may be responsible for the patient while they are on such leave. The document should set out information concerning leave, including the purpose of leave, the time at which the leave commences and when the patient is due back and any particular requirements or restrictions such as ensuring the patient remains in the carer's company at all times or does not attend certain locations etc.

That, pending the redevelopment of the Emergency Department at Dubbo Base Hospital, the Western NSW LHD develop and implement a site-specific policy relating to the use of the "Purple Room" to give effect to the intent and aims of the existing NSW Health Policy concerning aggression, seclusion and restraint in mental health facilities in NSW.

6. 59894 of 2014

Inquest into the death of PM. Finding handed down by Deputy State Coroner Grahame at Glebe on the 10th November 2017.

Pursuant to section 75, I order that there be no publication of the name or identifying information of the deceased or his partner. Initials may be used as pseudonyms.

Pursuant to section 75(5) I permit publication of the information contained in these findings in accordance with the above restrictions.

Introduction

PM was 42 years of age at the time of his death. He was serving a term of imprisonment at Parklea Correctional Centre. That gaol is privately operated by the GEO group Australia Pty Ltd (GEO), through a contractual agreement with the Commissioner of Corrective Services. Parklea Gaol is in metropolitan Sydney.

On 14 February 2014, PM appeared at Newcastle Local Court in relation to a number of property offences. He was granted bail. One of the conditions included that an acceptable person must deposit and agree to forfeit $2000 in cash. This condition was not met and PM remained in custody. He was kept briefly at Penrith Court cells. On 16 February 2014 PM was moved to Amber Laurel Correctional Centre.

On 18 February 2014, PM was assessed by a registered nurse at Amber Laurel. At that time PM indicated that he had no history of mental health problems and no history of self-harm or suicide attempts. It was recorded that he had a recent history of intermittent chest pain and that he should be observed for faintness, pain to the left side of his chest, or skin that may appear clammy, cold or pale. He was taken to Nepean Hospital and assessed. No physical abnormality was found.

On 20 February 2014, PM was transferred to Parklea Correctional Centre. He was seen there by a registered nurse and again indicated that he had no history of mental health problems and no history of self-harm or suicide attempts. He was considered suitable for “normal cell placement”. PM was then housed in the ground floor area 3C, which was an area primarily reserved for fresh inmates.

On 25 February 2014, PM was released into the common area of 3C around 12:10 PM with other mostly new inmates.

He made a telephone call from the offender telephone system in the common area to his partner LB at 12:40 PM. During the phone call LB indicated that she did not want PM to live with her when he was released, and that she wanted to end their relationship. PM stated that he would “neck himself”, and that he “couldn’t deal with it”.

The phone call finished around 12:44 PM. PM returned to his cell about 12:51 PM after a brief period in the common area. Correctional officers conducted a “lock in” of the cells between 1:10 and 1:15 PM. At about 2:06 PM, CCTV showed an inmate stand outside PM’s cell. This inmate was Philip Robinson who was performing the role of “sweeper” in the area. This role included handing out laundry bags on Tuesdays and Fridays. He recalled banging on the cell door, but receiving no response. He heard a small movement which he thought may have been someone getting off the bed, but the door was not opened. The window on the cell door was almost entirely covered. Through a small gap he could see that it was completely dark in the cell. Philip Robinson waited at the door for about 30 seconds before continuing on his rounds.

CCTV surveillance shows that PM’s cell remained closed until correctional officers were conducting a routine muster of the pod at about 3:15 PM. At that time officers opened the cell and observed that PM appeared to have hanged himself, using a torn bed sheet secured to a part of the window. Officers cut the material wrapped around PM’s neck and began first aid. At 3:22 PM nursing staff attended the scene and continued the resuscitation attempts. Paramedics arrived at 3:47 PM to assist, however PM could not be revived and he was pronounced dead at 4:12 PM.

A post-mortem examination was conducted on 26 February 2014. The forensic pathologist conducting the examination confirmed that PM’s death was caused by hanging. He was later formally identified by fingerprint analysis.

A finding that a death is self-inflicted should not be made lightly. The evidence should be extremely clear and cogent in relation to intention. There is sufficient evidence to establish that PM consciously intended to die on 25 February 2014 and that he undertook the necessary steps to kill himself. His proximate conversation with Ms B signalled his intention and the deliberate conduct he undertook to make a noose is relied upon.

I note that toxicological testing revealed that he was not affected by drugs or alcohol at the time of his death.

The role of the Coroner

The role of the Coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death.

The Coroner is also to address issues concerning the manner and cause of the person's death. In addition, the Coroner may make recommendations in relation to matters that may have the capacity to improve public health and safety in the future.

In this case there is no dispute in relation to the identity of PM, or to the date and place of his death. For this reason the inquest focused on the manner and cause of his death. It was also necessary to consider whether or not his death was in any way avoidable and if so what mechanisms, if any, could be put in place to help prevent such a situation recurring.

Where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a Senior Coroner. When a person is detained in custody the state is responsible for his or her safety and medical treatment. For this reason it is especially important to examine the circumstances of each death in custody and to understand how it occurred. Over the years there have been many hanging deaths in NSW correctional centres. There is a public interest in looking towards finding further ways to reduce this tragic statistic.

Section 81 (1) of the *Coroners Act* 2009 NSW requires that when an inquest is held, the Coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of PM.

Scope of the inquest

A number of issues relevant to PM's death were identified prior to the inquest commencing. These issues included:

- Should PM have been considered a suicide risk on reception?
- Should officers have been aware of his recent threat to "neck himself"?
- What steps are still necessary to remove or reduce the risk of inmates hanging themselves?

The inquest took place on 23 October 2017. A large number of statements were tendered, along with recordings, gaol and medical records. Detective Senior Constable Melissa Martens gave short oral evidence.

Background

PM was born on 8 March 1971. He grew up in Toronto on Lake Macquarie with his parents and siblings. It is reported that he had a fairly happy childhood and had extended family living in the local area.

P's criminal record commenced in his teenage years and reflects the kind of offences associated with drug use. It is reported that he developed a drug problem from a young age using cannabis and later heroin and amphetamines. There was some family discord in relation to money and over the years P lost touch with most of his family.

P had two sons from an earlier relationship and at the time of his death was involved with LB. They lived together, along with her children from an earlier relationship. LB reports that P had a serious gambling problem and that this caused major tension in their relationship.

Prior to P's arrest in February 2014, LB had been increasingly concerned about P's mental health. He was behaving strangely and had threatened self-harm. Nevertheless, L was apparently used to P making these types of threats and did not think that he would actually harm himself.

Should PM have been considered a suicide risk on reception?

Despite his denial of suicide ideation or self-harm risk on reception into custody in February 2014, when one carefully reviews the complete Justice Health file for PM there is some evidence of a prior suicide attempt back in 2001. A number of entries relating to PM from March 2001 also indicate that he had a history of depression for which he had been medicated. It was recorded that he had taken an overdose of Doxepin six months previously "when it all got too much for him".

A Mental Health Assessment questionnaire completed on 15 March 2001 records a history of depression and a prior suicide attempt. It appears that this attempt took place in the community.

There does not appear to be any further recognition of this event in the file and later documents make no reference to it. On the contrary, it appears that all later assessments do not record a prior suicide attempt. Each of these documents appears to have been completed during a face-to-face interview with PM and relied on information he provided. PM also makes no reference to feeling suicidal when questioned on his most recent reception. There are five forms filled out between his transfer from Amber Laurel and his reception at Parklea on 20 February 2014. Each indicates that he has no history of self-harm or suicde.

It may be that P did not feel the attempt back in 2001 was relevant to disclose. It may only be that it was not until he spoke with his partner on 25 February 2014 and found out that their relationship was apparently over, that his suicidal feelings emerged.

From the information before the court, there is no recorded reference to self-harm for 13 years. It appears that PM had no documented attempt of self-harm whilst in custody and one would not have expected to have seen an alert on his file in this regard. Equally, on the information he provided to Justice Health and the GEO group, there was nothing at February 2014 which would have suggested that his file should have had a new "Self-harm – risk" alert placed on it.

As far as prison authorities were aware there was nothing to suggest that PM needed to be placed with another inmate or in an observation cell. In fact P was placed with another inmate on 21 February 2014, but that inmate was released on bail the same day. While it can be a useful protective mechanism, there was nothing on file to suggest that P needed to be placed "two out".

Should officers have been aware of his recent threat to "neck himself"?

While there is no evidence that P disclosed to anyone but LB that he would "neck himself", protocols in place within Parklea Correctional Centre give prison officers the power to monitor telephone calls. The court has been provided with a recording of PM's call to LB.

He is heard to say "I'll neck myself…I can't deal with it hey…I can't deal with it".

However there is nothing to suggest that anyone in the prison environment heard the call until well after PM's death. It is not suggested or reasonable that the prison should institute real time surveillance of all calls in case a prisoner should express self-harm. It is also evident that LB did not alert prison authorities of the content of the call prior to P's death. It appears that in the context of their relationship, she had no reason to believe it was a serious or imminent threat.

The court had the opportunity to review the call. While the call took place in a common area, it was made away from other inmates and staff. PM only raises his voice slightly when he says he will "neck himself" and quickly returns to a fairly level tone before he ends the call. A staff member would have had to be listening extremely carefully to realize that PM was distressed. Prison staff would have been attending to a number of other tasks when PM made the call and P, like most prisoners would have wanted privacy.

In my view, given that it appears P killed himself within hours of having threatened self-harm in a private telephone conversation to his partner, officers cannot be criticised for having no knowledge of the imminent risk.

What steps are necessary to remove or reduce the risk of inmates hanging themselves?

One of the tragedies of PM's death is that it is not an isolated incident. Hanging points are a longstanding and well recognised problem in the custodial environment. As a result of Coronial recommendations back in 2010, Corrective Services NSW conducted a state-wide survey and audit of the Corrective Services estate for obvious hanging points and "high risk" furniture installations. This has resulted in some positive change in relation to "step down cells" in a variety of NSW Gaols, not including Parklea. More recently there have also been some attempts to address suicide mitigation strategies at Parklea Correctional Centre.

GEO was informed of this inquest, but was not represented. However, the court was supplied with a document entitled "Action Plan – Vulnerable Inmate Management & Suicide Prevention Strategies" (dated 1 September 2017) prepared by GEO operational staff to address suicide mitigation strategies. Although GEO stated that the plan had not been created for or in contemplation of this inquest, it deals with a relevant issue. GEO is clearly aware of the risk of suicide in prisoners who have not previously been identified as "at risk".

It appears that GEO is confident that it has some useful strategies in place for inmates known to be exhibiting self-harm behaviours, but is aware that it needs to develop strategies to address possible self-harm in inmates who may not have been displaying "at risk" behaviours. Thus it is recognised that inmates, such as PM, in a "normal" cell placement, who have not identified themselves as being at risk and are not identified by Justice Health or correctional officers as being at risk, may also develop a suicidal plan. Their actions may be sudden, impulsive and unexpected.

Many of the changes that can still be made are simple. Removal of shower rods and window louvres can make a difference. Changes to lighting and shelving can also remove obvious hanging points.

One of the purposes of the Action Plan is "to review the physical nature of the cells to identify the physical factors that may contribute to the suicide ideation of inmates and further mitigation and remove as many of these risks from all cells within the centre". Given that GEO is the operator, not the owner of the physical assets, approval of the mitigation strategies requires the financial backing of Corrective Services NSW.

An addendum to the Action Plan was supplied to the court and it is clear that some strategies identified have yet to be costed and fully implemented. Guaranteed funding for these works appears to be a matter of urgency. This issue has been well understood for many years and it is shameful that these changes have not already been made.

The need for recommendations

It appears that GEO has now identified a number of further strategies in relation to suicide mitigation for inmates in “normal cells” as well as those in special cells for “at risk” inmates. This is especially important when one considers the experience of PM. He was not known to have been “at risk” and his death may have been hastily planned and impulsive. His method of death was made possible by the physical environment he was in. Obvious hanging points must be eliminated wherever possible.

The physical assets are not owned by GEO and it requires funding to be allocated by Correctives Services to complete the work identified. For this reason the recommendation I make under section 82 of the Act is directed to the NSW Commissioner for Corrective Services, not GEO.

Conclusion

PM’s death was unforeseen by those entrusted with his care. I accept that his decision to take his own life was sudden and unexpected. Sitting alone in his cell, ruminating on the breakdown of his relationship appears to have caused him profound despair. Had he not been able to attach his torn bed sheet to the window so easily, he may have survived until he was released back into the common area later that day. PM is not the only prisoner to have died in these circumstances. Urgent action must be taken to improve conditions at Parklea and elsewhere.

Finally I offer my sincere condolences to PM’s family and friends. His despair in custody is a tragedy and I acknowledge their grief and loss. I strongly urge that any published report of this death include reference to suicide prevention contact points.

Formal Finding:

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

Identity

The person who died was PM.

Date of death

PM died on 25 February 2014.

Place of death

PM died at Parklea Correctional Centre, Parklea, NSW.

Cause of death

PM died from hanging.

Manner of death

PM's death was intentionally self-inflicted.

Recommendations

I make the following recommendation pursuant to section 82 of the Act,

To Commissioner of Corrective Services

I recommend that urgent funding be provided to facilitate the removal of hanging points in prisoner cells in Parklea Correctional Centre in accordance with the by Action Plan prepared by the GEO Group Australia Pty Ltd, dated 1 September 2017.

7. 261690 of 2014

Inquest into the death of David Lobejko. Finding handed down by State Coroner Barnes at Glebe on the 12th October 2017.

The Coroners Act in s. 81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of David Zbigniew Lobejko

Introduction

On the evening of 4 September 2014, Mr Lobejko was driving home from a yoga class when he was directed by police to stop at a stationary random breath testing site in Pennant Hills. He was unlicensed and his car was unregistered. An argument between Mr Lobejko and the police escalated into a violent struggle that resulted in him falling or being thrown to the ground and being handcuffed. Mr Lobejko lost consciousness. After receiving first aid from a couple of passing doctors he was taken from the scene by ambulance to the Ryde Hospital where he was declared dead soon after arrival.

The inquest

Section 81 of the *Coroners Act 2009* requires a coroner presiding over an inquest to confirm that the death occurred and to make findings as to the identity of the deceased and the date, place, manner and medical cause of the death. Under s. 82 of the Act a coroner may make such recommendations considered necessary or desirable in relation to any matter connected with the death, including in relation to public health and safety.

In this case, there is no doubt that Mr Lobejko died shortly before he arrived at the Ryde Hospital on 4 September 2014 and an autopsy established that he died due to heart disease after engaging in a violent struggle with police. The issues in contention were whether police acted appropriately before and during the arrest of Mr Lobejko and whether they responded adequately to his condition when he lapsed into unconsciousness.

Social history

David Lobejko was born in Warsaw, Poland on 27 February 1960. He was a gifted student and excelled in languages. He also achieved international recognition in Greco Roman Wrestling as part of the Polish National Wrestling Team. He was selected for the 1980 Moscow Olympics but was unable to compete because of injury. In 1982 Mr Lobejko migrated to Australia.

He became an Australian citizen in 1985. He met his future wife Teresa in 1983 and they married in 1988. They had three children.

Soon after arriving in Australia, Mr Lobejko completed a course in electrical engineering and gained employment as technical and sales manager in a computer company. Subsequently he held a senior position with Fuji Xerox as a sales and service manager. In 1997, Mr Lobejko completed a bachelor of business, majoring in computing and marketing. From 2005 to 2011 Mr Lobejko worked as a national systems sales engineer for a large medical technology company. Mr Lobejko remained committed to physical fitness and personal health throughout his life. In 2013 he became involved in practising Bikram Yoga. He is undoubtedly sorely missed by his wife and three children. They formed a very close and supportive family. I offer the family my sincere condolences.

Criminal justice and traffic history

Mr Lobejko was never convicted of any criminal offences. However he had an unenviable traffic history. He was never convicted of any particularly serious traffic infringements but from 1982 when he first gained his licence up until 2013 he was regularly issued with infringement notices for various offences such as speeding, disobey traffic lights, disobey road signals and driving with a hand held mobile phone He was issued 18 infringement notices in the period 1982 to 2013. These infringements resulted in fines being imposed and his licence being suspended for the accumulation of demerit points. In 2013 Mr Lobejko's license expired and because he had unpaid fines outstanding he was not able to renew it until those fines were paid in full. From that period until his death he had ongoing disputation with Roads and Maritime Services.

They sent letters of demand to him that he either ignored or he entered into arrangements to pay fines which were not adhered to and this resulted in the registration of any motor vehicle registered in his name being cancelled. Once this occurred Mr Lobejko would again pay some of the amounts outstanding and the vehicle registration was restored.

At the time of his death the registration had again been cancelled for non payment of fines and he had not sought to renew his driver's license. He was therefore at the time of his interception driving unlicensed and driving an unregistered vehicle.

Medical history

Generally speaking Mr Lobejko was very health conscious. He engaged in active exercise throughout his life and was interested in maintaining a healthy diet.

For the last few years of his life he regularly practiced yoga. He had no diagnosed diseases other than some history of cardiac disease. In 1996 he had an ECG performed. The results of that are unknown. However in 1998 following a bout of chest pain while at the gym he was referred to a cardiologist. He was diagnosed with “thickening of the arteries and double vessel coronary disease”. He was prescribed cholesterol lowering drugs which he took for some time and then discontinued.

An independent cardiologist who examined Mr Lobejko’s medical records on behalf of the court concluded that he had suffered a heart attack in 1998. He did not accept advice to take medication in relation to his heart disease and did not have the condition monitored. He had limited contact with medical professionals in the last decade of his life. Evidence of cardiovascular disease was confirmed at autopsy. He had an enlarged heart and all the major coronary arteries were heavily calcified and rigid. The arteries variously showed up to 80-90% narrowing of the lumen.

The events surrounding the death

Shortly after 7.30 pm on 4 September 2014 Senior Constable David Potter and Senior Constable James Anderson set up a stationary random breath testing site at an approved location on the southbound lanes of Beecroft Rd Pennant Hills just south of its intersection with Pennant Hills Rd. The in car video system (ICV) was activated at 7.38 pm, resulting in everything that occurred after that time, in the near vicinity in front of the car, being visually recorded.

In the next 13 minutes, twenty cars were pulled over and the drivers tested without incident.
The ICV recording captured Mr Lobejko’s car being waived into the testing site at 7.56 pm. Senior Constable Potter immediately approached the car and spoke to Mr Lobejko.

Because he did not take with him the microphone that was in the battery charger in the centre console of the police car, the first three and a half minutes of the interaction between the officer and Mr Lobejko were not audio recorded. That was remedied when Senior Constable Anderson approached the car bringing with him a microphone.

In addition, evidence of what occurred was provided by another motorist who had been pulled over just before Mr Lobejko and who stayed at the scene for about five minutes after Mr Lobejko arrived; a nurse and her brother who lived adjacent to the RBT site and who came home at about 8.07 pm and two medical doctors who drove past after Mr Lobejko collapsed and stopped to render assistance at about 8.13 pm. Senior counsel assisting distilled from the video and audio recordings and the evidence of the eye witnesses a chronology of events.

It was reviewed and improved upon by those granted leave to appear. It was been broadly accepted as a reasonably accurate account of the events that could be seen and when they occurred.

The audio and visual recording of events is in evidence. Because of the detail those records contain, I do not propose to recount a narrative version of the facts. Rather, I will list only the key occurrences required to appreciate the analysis of the issues described in the following section of this report.

Outline of interaction between deceased and police

The first part of the interaction between Mr Lobejko and police involved only Senior Constable Potter and was not audio recorded because the officer failed to take a microphone from the police car when he approached Mr Lobejko's vehicle. Senior Constable Potter approaches the car and speaks to Mr Lobejko. It seems clear that he directed Mr Lobejko to state his name and address and to produce his license and that Mr Lobejko failed to do so. It is likely that he told the officer that his first name was David. Speculation that Mr Lobejko also told the officer his last name is inconsistent with Mr Lobejko's failure to do so when their conversation is recorded. I conclude he did not do so.

On a number of occasions Senior Constable Potter reaches into the car in an attempt to grab the car keys from the ignition switch. He is unsuccessful despite some fairly violent struggles through the window.

After making repeated attempts to attract the attention of Senior Constable Anderson who is in the police car writing up an infringement notice for another motorist, Senior Constable Potter is joined at the side of Mr Lobejko's car by the other officer approximately 3 minutes and 30 seconds after he had first spoken to Mr Lobejko. The conversation from this point on is audio recorded, although the recording does not allow everything that is said to be heard and understood.

Senior Constable Potter again demands that Mr Lobejko produce his license and state his name and address. Mr Lobejko advises that he does not have a license. They argue about what Mr Lobejko is legally obliged to do. Mr Lobejko is repeatedly asked to state his name and address and warned that he will be arrested if he fails to do so. Mr Lobejko does not comply.

Senior Constable Potter tells Mr Lobejko that he is under arrest and opens the door of his car. Mr Lobejko gets out of his car.

This occurs approximately 7 minutes after the car is stopped. From very soon after Mr Lobejko alights from his vehicle, he is grabbed by the two officers and a struggle ensues. Initially Mr Lobejko is facing away from his car, with Senior Constable Potter in front of him near the distal end of the open front car door and Senior Constable Anderson is to Mr Lobejko's right standing adjacent to the centre pillar of the car.

Mr Lobejko is told to take his hands out of his pockets before he turns around and leans back into the car. Senior Constable Anderson grabs Mr Lobejko by his left arm and Mr Lobejko braces himself against the car. Senior Constable Potter joins in trying to get Mr Lobejko away from the car while he repeatedly expresses his wish to "close the car". He resists the officers' efforts to move him away from the vehicle by holding onto the door opening and the door frame. Senior Constable Potter, who by this stage has come around to be next to his partner on Mr Lobejko's left hand side, can be seen to knee Mr Lobejko twice in the upper thigh or lower abdomen.

The officers' efforts either succeed in causing Mr Lobejko to release his grip on the car, or he lost the capacity or intention to continue resisting them. The sudden cessation of his resistance appears to have caused Mr Lobejko and Senior Constable Potter to lose balance and both fall to the roadway. Each officer has hold of one of Mr Lobejko's arms and so he lands forcefully on his chest and face without an opportunity to use his hands to break his fall.

When he crashes down Senior Constable Potter is on Mr Lobejko's back and lunges forward towards his head to gain control of his arms behind his back. When doing so his forearm appears to come into contact with the back of Mr Lobejko's head. Both of his arms are handcuffed behind his back. This occurs at approximately 8.04.30 pm or 8 and half minutes after Mr Lobejko is first stopped by police.

Mr Lobejko does not say anything intelligible after this point and apart from some flailing of his legs he cannot be seen to make any purposive movements. The officers initially try to get Mr Lobejko to his feet but he is unable or unwilling to comply with their demands to stand up. Although Senior Constable Potter was later to claim that he assumed Mr Lobejko was continuing to be deliberately uncooperative, he can be heard to say on the audio recording, *"There's something seriously wrong with this guy."* About 1 minute after Mr Lobejko is handcuffed, Senior Constable Anderson radios for a caged vehicle to come to the scene, presumably to transport Mr Lobejko to the police station for further questioning and charging.

At 8.07 pm, a car driven by an off duty nurse who lives in a residence adjacent to where the incident is unfolding, arrives home and parks her car parallel to the curb facing in the same direction as the police car and Mr Lobejko's car, beside the police car.

She saw Mr Lobejko lying on his side with an officer we know to be Senior Constable Potter with a hand on Mr Lobejkos chest, apparently to stop him rolling forward onto his front. She said Mr Lobejko appeared unconscious. She was concerned that he would not be able to maintain a patent airway in the position he was in with his head flopping forward.

She told the other officer she was a nurse and offered to assist. She was told by Senior Constable Anderson that wasn't needed because, "*He's alright."* At 8.07 pm Senior Constable Potter can be heard saying over the radio to VKG, "*Can we change that to an ambulance as well thanks."* When asked by the VKG operator for the reason he describes Mr Lobejko as going nuts and says "*We've had a wrestle and now he's pretending to be unconscious*."

By 8.11 pm, Senior Constable Potter's suspicion that Mr Lobejko was feigning injury seems to have resolved as he advises VKG that "*He has gone unconscious. He is breathing. Still has a pulse."* Senior Constable Anderson makes checks on police data bases via an in car device and confirms Mr Lobejko's name and address from the car registration number and notes that his license is cancelled.

At 8.13 pm two off-duty medical doctors arrive on scene, examine Mr Lobejko and commence doing CPR on him. They say he was not breathing; he was taking irregular gasps; and had his eyes open with equal and fixed pupils. The first ambulance arrived on scene at 8.16 pm. Mr Lobejko was still handcuffed with his hands behind his back as the two off duty doctors attempted to perform CPR.

The paramedics confirmed that he had no pulse, no recordable blood pressure, and he was not breathing. With a defibrillator it was established that Mr Lobejko was in cardiac arrest – his heart was in ventricular fibrillation meaning blood was not being pumped to his brain or other organs. They administered shocks via the defibrillator and continued CPR with a bag and mask and an airway tube.

When another ambulance arrived, the handcuffs were removed and Mr Lobejko was loaded into the ambulance where he was administered adrenalin in an attempt to restart his heart and he was intubated. By this stage the defibrillator was showing his heart to be in asystole – that is without electrical rhythm.

The ambulance departed the scene at 8.34 pm and arrived at the Ryde Hospital at 8.57 pm. Resuscitation attempts continued but neither spontaneous circulation nor respiration were established and Mr Lobejko was declared dead at 9.12 pm.

Expert evidence

Autopsy

On 5 September 2014 an external examination and three cavity autopsy was undertaken on Mr Lobejko's body by Dr Istvan Szentmariay, an experienced forensic pathologist.

The external examination revealed the following injuries to the head and neck:

- A 4 x 3 cm area of abrasion present over the mid portion of the forehead
- A 6 x 6.2 cm area of abrasion and contusion in the area above the left eyebrow
- The left eyelid was swollen and showed dark discoloration
- A 2 x 1 cm abrasion and a .5 cm laceration on the left eyelid
- Adjacent to and below the left eye there was a 3.5 x 1.5 cm abrasion
- A 4.2 x 2.6 cm abrasion was present on the left side of the face between the nostril and the lips
- A 6 x4 cm oval shaped abrasion was noted over the chin
- A 1 cm roughly round abrasion was noted over the bridge of the nose
- A 2.3 x 1 cm area of abrasion was noted below the right eye

Internal examination showed no intracranial haemorrhages and no skull fracture, no bleeding in or around the brain and no macroscopic traumatic changes to the brain. The torso showed numerous injuries consistent with the effects of CPR being undertaken while the deceased was lying on the roadway. There were numerous small contusions and underlying subcutaneous haemorrhages on the left upper arm. The right arm showed a 4.5 x 4.5 cm area of blue contusion on the dorsal aspect of the upper arm. Subcutaneous dissection showed a 6.4 cm area of haemorrhage. There were numerous small abrasion and bruises on the lower legs.

Internal examination confirmed that there were no skull fractures and there were no extradural, subdural or subarachnoid haemorrhages. The soft tissues of the neck showed no evidence of injury. The heart was enlarged. All major coronary arteries were heavily calcified and rigid. The coronary arteries variously showed 80-90% narrowing. There was extensive fatty streak deposition of the ascending thoracic aorta. Numerous plaques of the thoracic and superior abdominal aorta.

Dr Szentmariay came to the conclusion that the cause of death was ischaemic heart disease due to coronary artery atherosclerosis.

Cause of death

Associate Professor Mark Adams is the Head, Department of Cardiology at the Royal Prince Alfred Hospital. He reviewed Mr Lobejko's medical records, the statements of various witnesses, the autopsy report and the ICV sound and vision. In his opinion, Mr Lobejko suffered a sudden cardiac death as a result of atherosclerotic cardiovascular disease. Associate Professor Adams concluded:

I think it most likely that increased cardiac output due to anxiety and exertion led to increased need for coronary artery blood flow; this led to myocardial tissue becoming ischaemic and this led to a fatal arrhythmia.

While not expert in CPR, Associate Professor Adams expressed the view that he didn't think CPR was necessary before 8:06:52 pm and that it was difficult to say when after that it became necessary.

First aid

The inquest received two reports from Clinical Associate Professor Paul Middleton an expert in emergency medicine and the Chair of the Australian Resuscitation Council, NSW Branch. He also gave oral evidence. Associate Professor Middleton reviewed the witness statements of the off duty doctors who attended the scene of Mr Lobejko's arrest, the autopsy report and some medical records of Mr Lobejko. He also reviewed the ICV audio and visual recording. Dr Middleton made the following observations:

DL fell to the road at approximately 20:05, landing prone with his chest hitting the ground with an officer falling on his back. DL appeared to make no discernible voluntary movement following this and when the officers attempted to get him to stand, his head can be seen to be hanging down, his legs dragging on the ground and he makes no attempt to move.

Shortly after 20:05 one officer states that "something is seriously wrong with this guy" following which DL starts moaning unintelligibly and rolling around on the ground kicking out with his legs; this movement ceased at 20:05:39 although he continued to moan.

At 20:05:53 it was suggested they put him on his side, after which there were no sounds audible from DL. There appeared to be some head movements until approximately 20:06:45 although it is unclear whether this is voluntary or whether it is a result of the officer securing DL's hands.

…when DL was moaning unintelligibly and rolling around he must have been by definition still breathing. Moaning, kicking his legs, and rolling around suggests he had some sort of decrease in his level of consciousness ; although it could certainly be true that in this particular situation he could also be mimicking illness or injury, the appropriate course would still be to presume that there is a real problem.

… specifically, therefore it seems appropriate that DL was turned into the recovery position when seemingly unconscious and moaning, however once the moaning had stopped the situation becomes less clear. Although victims of cardiac arrest occasionally appear to maintain some movement for a few seconds after the heart has stopped beating, due to the residual oxygen in the blood still reaching the brain, this ceases very soon afterwards so continuing moaning heard from DL on the video would therefore imply that at this point he was not in cardiac arrest.

At 20:05:53 there is no more moaning heard and DL appears to be still apart from some minimal head movement. At the same time it appears that the officer crouching down next to DL is securing his hands or at least performing some action involving the hands, which may have moved DL's head. If we assume that if this was in fact spontaneous movement, if definitely ceases at 20:06:45. This may have been the time of cardiac arrest or it may have conceivably have been at the earlier point of 20:05:53, some 68 seconds earlier (sic).

Even if we cannot time the cardiac arrest exactly to either of these time points, what we can say is that from 20:06:45 he was showing no signs of life that are apparent on the video."

Associate Professor Middleton quoted the Australian Resuscitation Guidelines that discourage the checking of the carotid pulse to determine the presence or absence of circulation because of its lack of accuracy in other than expert hands.

Those guidelines as current at the time of Mr Lobejko's death stated:

"Start CPR if the victim is unconscious (unresponsive) not moving and not breathing. Even if the victim takes occasional gasps rescuers should suspect that cardiac arrest has occurred and should start CPR."

Associate Professor Middleton points out that cardiac arrest is recognised by the absence of normal breathing, coughing or movement. However, he goes on to acknowledge that recognising normal breathing is not easy for people who have not received appropriate training. The slow intermittent "agonal" respiration that may be seen in cardiac arrest victims is not normal and represents a situation where CPR should be commenced.

Agonal breathing has been described as irregular gasping, sporadic breaths that occur at a rate much less than normal breathing. Having regard to these principles and his review of the recorded vision and audio, Dr Middleton said that the first aid response was "*unsatisfactory, if they had in fact been trained in first aid and emergency responses based on ARC guidelines from 2000 onwards and definitely if 2010 guidelines had been used in their training."*

After movement stopped at approximately 20:06:45 the officers should have immediately checked David's responses and commenced CPR.

Associate Professor Middleton goes on to quote well known statistics that after cardiac arrest, mortality increases at approximately 10% each minute until defibrillation takes place and that poor outcome is only altered by effective CPR that reduces this figure to 3-4% for each minute. In conclusion he says "*DL showed no signs of life from 20:06:45 .*

At this point the appropriate intervention would have been to roll him on his back, open his airway and check for normal breathing."

If he remained unresponsive and was not breathing normally after ten seconds immediate CPR should have been commenced. Ambulance response should have been requested as an emergency when he was found to be unresponsive. In Associate Professor Middleton's opinion, a defibrillator should have been available to check the patient's cardiac rhythm and to treat it.

Analysis and conclusions regarding issues of concern

Audio recording traffic stops

The *Law Enforcement (Powers and Procedures) Act 2002* in sections108A - 108C mandates that all conversation between a police officer and the driver of a vehicle stopped by police must be visually and audio recorded if the police vehicle is equipped with ICV equipment. This is reinforced by the NSWPF Standard Operating Procedures. Senior Constable Potter did not do this when he first spoke to Mr Lobejko. Later, when asked by Mr Lobejko whether he knew the law, the officer asserted "*Of course I do, it's my job."* It seems he was overconfident. It also seems that he has now familiarised himself with the requirements of the sections quoted above. Absent any evidence that ignorance of the provisions is more widespread, and having regard to the Police Driver Training Unit having been made aware of the failure to comply with the provisions, I don't consider any further comment or recommendation in relation to this error is necessary.

Attempt to seize keys

At the material time, the *Law Enforcement (Powers and Procedures) Act 2002* in section 189 authorised a police officer who has stopped a motorist for a random breath test to "*take such steps as in the opinion of the police officer, are necessary in order to immobilise the motor vehicle if the police officer reasonably suspects that the person is likely to abscond before undergoing the breath test."* The officer must first "*require the person to immediately hand over all ignition keys."*

Senior Constable Potter said he tried to grab the keys from the ignition of Mr Lobejko's car because he was concerned he might drive off. He doesn't suggest he asked Mr Lobejko for the keys before he grabbed at them the first time and he acknowledges that Mr Lobejko offered to take a breath test on a number of occasions.

However, an officer is also entitled to demand that a driver produce his or her license and state his or her name and address: see the *Road Transport Act 2013* section 175. Senior Constable Potter made repeated requests of Mr Lobejko in this regard.

Mr Lobejko admitted he did not have a license but he deliberately refused to engage with questions about his name and address. No doubt he refused to provide this information because he knew he was unlicensed and the car he was driving was unregistered. He was lawfully arrested for this failure.

Conclusion

Senior Constable Potter did not have authority to grab the keys from the ignition of Mr Lobejko's car when he had not made a request for them to be provided to him and when he had no basis to assume Mr Lobejko would abscond before a breath test could be administered. I don't consider the evidence indicates the officer wilfully ignored the relevant provisions or the policies that caution against reaching into an intercepted vehicle. I expect these proceedings have made clear to the officer the limits of his powers. Absent evidence that ignorance of these matters is more widespread I do not consider a remedial recommendation in relation to them is necessary.

Use of force

Mr Lobejko exited the car when instructed to do so after he was told he was under arrest. The interaction became violent when he then turned back towards his vehicle and leant inside it. He said repeatedly – "*I want to close the car."*

From this distance, it is now easy to accept that all Mr Lobejko was seeking to do was to retrieve the keys so that he could put up the window and lock the car. However the officers did not know that he was generally a law abiding citizen whose only previous infringements resulted in traffic fines. For example, they did not know that he was not seeking to retrieve a weapon or seeking to re-enter the vehicle with a view to escaping.

I do not accept the submissions made on behalf of the family that it was reasonably practicable for the officers to identify Mr Lobejko with sufficient certainty so that they could have proceeded against him by way of a Court Attendance Notice rather than by way of arrest.

Having arrested him, the officers had lawful authority to use such force as was reasonable to take him into custody - *Law Enforcement (Powers and Procedures) Act 2002* sections 230 and 231. There is no doubt that Mr Lobejko resisted the efforts of the officers to get him away from the car.

The use of knee strikes may seem severe, but it is a legitimate use of force tactic taught to police officers. The target area of that tactic is the upper thigh. It seems that at least one of those blows missed that area and struck Mr Lobejko in the abdomen. That involves greater risk of injury and is regrettable but there is no evidence that it was intentional and it is easy to accept that it could happen by accident.

In my view Mr Lobejko was not thrown to the road as his family's lawyers submit. Rather, without warning, his grip on the motor vehicle was broken and momentum caused him and Senior Constable Potter to fall to the ground. Because an officer had hold of each arm, Mr Lobejko was not able to break his fall and he fell heavily, face first. Senior Constable Potter scrambled to regain control of him and to hold him down. It appears that in doing so he struck the back of Mr Lobejko's head or neck with his forearm before the officers were able to secure both arms behind his back.

I'm sure the recording of what occurred would have been very distressing for Mr Lobejko's family to see and hear. It was a violent struggle that ended in Mr Lobejko's death. However, he was a large and powerful man with experience in martial arts who strongly resisted the officers' attempts to move him away from the car. They needed to gain control of the situation quickly. While his repeated requests to "close the car" seem quite reasonable now, I accept that the officers had justifiable concerns about what could occur if he were allowed access to the inside of the car.

The autopsy report revealed numerous injuries to Mr Lobejko's face but none was serious and all were consistent with his falling onto the roadway.

There was no evidence that the knee strike which appeared to hit his abdomen caused any injury but that part of the body suffered bruising and broken ribs as a result of the CPR efforts and so any injury the knee strike may have caused could well have been masked. There were no injuries to the back of the head or neck that may have been caused by the forearm blow seen in the ICV vision.

Conclusion

It was a volatile, awkward and violent interaction but I do not consider the violence was gratuitous or that the force used was unreasonable or disproportionate to the resistance Mr Lobejko offered. I consider the force used was lawful but that doesn't mean that the situation could not have been handled better.

Escalation of confrontation

It is doubtful whether Senior Constable Potter had the power to seize the car keys from Mr Lobejko's car when he was offering to undergo a breath test – the purpose for which he had been stopped and no demand had been made for the keys. However, there is no doubt that the officer was authorised to require the driver to state his name and address and the failure of Mr Lobjeko to do so rendered him liable to arrest.

That requirement to provide his name and address was not unreasonable having regard to the strange manner in which Mr Lobejko was allegedly behaving when first approached and which was largely confirmed by his manner evident from when the conversation began to be recorded.

Mr Lobejko was variously oppositional and irrational in his interaction with Senior Constable Potter. He was very difficult to deal with. He would have posed a challenge for an effective negotiator and Senior Constable Potter was clearly not that. He allowed himself to become annoyed and angered by Mr Lobejko's intransigence. He in effect ceded power to the motorist by over-reacting to Mr Lobejko's provocation.

To some extent Senior Constable Potter was also a victim of his own mistake. Had he taken a voice recorder with him as required by law and NSWPF SOPs he would have been able to attract his partner's attention earlier which may have reduced his evident frustration.

Having said that, even when Senior Constable Anderson became involved he did nothing constructive to de-escalate the dispute between Senior Constable Potter and Mr Lobejko. The officers did not act as a team other than when they resorted to the application of physical force.

Conclusion

It is an unavoidable reality of policing that a significant proportion of the members of the public that an officer interacts with will be less than fully cooperative, for a variety of reasons. An officer who responds by simply enforcing the law to its full extent does not act in the public interest or bring credit upon himself or his or her police force.

It is the role of officers to protect the public, but enforcing the law is only one mechanism by which that can be pursued. Constructive problem solving requires officers to seek to de-escalate tension and to avoid conflict whenever that it is possible without negative consequences. There are circumstances where decisive resort to physical force is essential. In many other cases a more nuanced negotiated response is desirable. Experienced and effective officers learn to distinguish which approach is needed in a given case.

There is no doubt that Mr Lobejko was oppositional and obstructionist. He would have been very difficult to deal with but he was not violent or dangerous. There was no emergency that mandated an urgent response. The officers involved gave insufficient attention to trying to resolve the problem he presented without resort to the use of force, in my view.

That doesn't make them responsible for his death. Mr Lobejko had a serious underlying medical condition. He chose to drive an unregistered car while unlicensed. When intercepted he tried to avoid detection of that action by refusing to comply with the lawful directions of the officers with unintended and unforeseen fatal consequences.

First aid

At 8:04:30 pm Mr Lobejko suddenly released his grip on the vehicle and the momentum generated by the sudden absence of resistance to the officers' continuing efforts to pull him away from it caused Mr Lobejko and Senior Constable Potter to crash to the ground.

It is impossible to say whether Mr Lobejko chose at that point to cease resisting; the officers' efforts overcame his resistance; or a medical emergency robbed him of the capacity to continue to resist.

However, from that point on Mr Lobejko neither said an intelligible word nor made a purposive action. Senior Constable Potter is almost certainly right when he says at 8:05:09, "*There is something seriously wrong with this guy."*

However, apart from putting Mr Lobejko into something resembling a recovery position, neither officer took any steps to provide first aid and declined the offer of an off duty nurse to assist.

That offer was made at a stage in the events after which Associate Professor Middleton, an expert in resuscitation, says that CPR should have been commenced because Mr Lobejko was undergoing a cardiac arrest that led to his death.

It is impossible to say that had CPR been commenced when the nurse offered to provide assistance, the outcome would necessarily have been different. However, it clearly would have increased Mr Lobejko's chances of survival.

Similarly, if Senior Constable Anderson had been attending to the needs of Mr Lobejko when the ambulance passed the scene on the first occasion, instead of completing a traffic infringement notice for another motorist, he or the other officer could have flagged down the ambulance.

Mr Lobejko is likely to have obtained the benefit of high quality CPR including that provided by a defibrillator significantly sooner than he did.

Senior Constable Potter claimed that he thought that Mr Lobejko was pretending to be unconscious and continuing his earlier resistance by refusing to stand or respond to police commands. The officer had no reasonable basis to make these assumptions and it was dangerous to do so in light of the consequences of their being wrong.

Senior Constable Potter also claimed that he could detect a pulse and noted that Mr Lobjheko "*every now and then he takes a gasp."* These factors lead him to consider no intervention was necessary.

Associate Professor Middleton pointed out that so unreliable is a lay person's claim to palpate a pulse that it has been abandoned as a criterion for determining whether to commence CPR in international guidelines adopted by the resuscitation councils in all Australian states. Similarly, agonal gasps are irrelevant to the need for CPR which should commence whenever normal breathing is absent. Agonal gasps are more a sign of death than life.

Conclusion

Because the officers failed to adequately monitor Mr Lobejko's condition while he was lying handcuffed and unconscious on the roadway in their custody, they did not notice that he had suffered a cardiac arrest and was near death. When first aid was finally provided by two off-duty medical doctors who happened along and the ambulance officers who arrived soon after, his decline was irreversible.

Not only did the officers fail to adequately monitor his condition themselves, they declined an offer of assistance from a trained and CPR experienced nurse who could have provided life support in a more timely fashion. They also failed to summon an ambulance with sufficient urgency.

It is impossible to conclude that Mr Lobejko would have survived had the officers summoned an ambulance with the highest priority and delivered high quality CPR expeditiously. He had serious advanced cardiac disease that could have caused his death at any time. Recovery from an out of hospital cardiac arrest, even with the best responses, occurs in a minority of cases. However, a better response from the officers would have increased his chances.

If callous disregard is eschewed as the reason for the officers' failure to adequately respond to Mr Lobejko's medical emergency – and I do reject that explanation - attention must focus on the first aid training provided to police officers. Both of the officers involved in this incident gave evidence that they had some years before completed a first aid course provided by private first aid training organisations. However, all such providers stipulate that first aid training must be regularly revised for recipients to remain competent. If the officers' description of first aid training they have since received from the NSWPF as part of their on-going professional development is accurate, it is completely inadequate.

All officers receive annual weapons training and training in other operational skills and tactics. At the same time they receive some first aid training but these officers described that aspect as merely watching a PowerPoint presentation with or without the presence of a trainer who may ask the group questions as the slides scroll through.

Recommendation 1 – First aid training for police officers

The response of the officers to the medical emergency that culminated in the death investigated by this inquest was inadequate. If their description of the regular first aid training provided to them by the NSWPF is accurate that training is also inadequate. To be effective first aid training must involve participation in accredited courses with proficiency reassessed at fixed intervals.

Accordingly, I recommend that the NSWPF review the provision of first aid to all operational officers to ensure it meets the requirements of the following Commonwealth government accredited courses: HLTAID001 – Provide CPR; HLTAID002 Provide basis emergency life support; and HLTAID003 Provide first aid. All officers should undergo annual refresher or proficiency assessment in the material covered by such courses.

Formal Finding:

The identity of the deceased
The deceased person was David Zbigniew Lobejko.

Date of death
Mr Lobejeko died on 4 September 2014.

Place of death
He died on the way to the Ryde Hospital

Cause of death
The cause of his death was ischaemic heart disease.

Manner of death
David died following a violent struggle with police after he resisted arrest during a routine traffic stop.

8. 286081 of 2014

Inquest into the death of John Inman Bale. Finding handed down by Deputy State Coroner Grahame at Glebe on the 30th March 2017.

This inquest concerns the death of John Inman Bale.

Introduction

John Bale was 60 years of age at the time of his death. He was the much loved father of James, Amy and Charlie Bale. He was reported to be a gentle man who loved his children. He attended church regularly.

Mr Bale had recently faced some personal difficulties. He had coronary by-pass surgery in 2010 and was known to suffer from depression and bipolar disorder. He was retrenched from his position at the Shell refinery in 2012 and found coping with retirement challenging.

Throughout 2014 he continued to suffer from mental health difficulties and undertook electroconvulsive therapy. He apparently struggled with suicidal thoughts and was hospitalised from time to time. Matters became more unbearable when his mother died in August 2014. This was devastating for Mr Bale and he suffered greatly with ongoing grief.

Throughout this period he remained in contact with his children and his psychiatrist. Mr Bale was booked to attend the Northside Clinic for a voluntary admission to commence on Monday 29 September, 2014. However, at 7.15am on that day he rang Premier cabs to cancel a booking to take him hospital. Shortly afterwards he rang “000”. He was transferred to a Police link customer service representative or telephonist called Mr Jacob Tant. Mr Bale explained that he had a rifle and that he was going to shoot himself. He was polite and calm. Police were notified and they made their way to the vicinity of Mr Bale’s house. The conversation with Mr Tant continued for 17 minutes.

The call was terminated at 7.39am at the direction of Sergeant Adam Steele. Unfortunately communication was never re-established and Mr Bale was eventually found dead on his bed shortly before 11am. It was immediately clear that he had died of a gunshot wound.

The role of the coroner and the scope of the inquest

The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death.

The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.

In this case there is no dispute in relation to the identity of Mr Bale, or to the date and place or medical cause of his death. For this reason the inquest focussed on the manner of Mr Bale's death, in particular the response of the NSW Police Force to the "000" call that he made on the morning of 29 September 2014.

This is a mandatory inquest, because Mr Bale's death occurred "during the course of a police operation". Parliament requires that inquests of this kind are conducted by a senior coroner. This statutory position reflects the importance of independence and transparency when it comes to investigating deaths in this category. The circumstances surrounding these deaths should be carefully scrutinised and care must be taken to ensure that all relevant police policies and practices are most carefully reviewed. Any opportunities for improvement should be identified and explored, particularly if they have the capacity to save lives in the future. At the same time it is important to remember that operational policing can be highly unpredictable and stressful. One must always be careful when reviewing decisions made in the field from the relative comfort of the courtroom. The purpose of this inquest is not to lay blame on any individual, but rather to see if it is possible to identify opportunities to reduce the risk of tragedy in situations of this nature.

With this firmly in mind the inquest explored NSW Police policies and procedures in relation to the following matters,

Whether the applicable NSW Police Force policies and procedures were followed regarding the police response to the '000' call made by John Bale, including with respect to:

- the direction by Sergeant Adam Steel to terminate the '000' call;
- the risk assessment undertaken by Sergeant Steel, in particular the basis for the view that Mr Bale was going to kill police and then himself; and
- the critical incident investigation.

Section 81 (1) of the *Coroner's Act* (2009) NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of John Bale.

The Evidence

The Court heard oral evidence over three days and received extensive documentary material including witness statements, expert reports, photographs and recordings.

At the end of proceedings that material was carefully summarised by counsel assisting the court. Each of the parties present accepted the accuracy of her detailed written account, confirming it as a fair statement of what occurred. I thank those assisting me for completing the hard work of distilling a large volume of evidence and I intend to adopt that factual summary in setting out the background to my formal findings.

In summary, the evidence established that the central and uncontested events were essentially as follows:

> At 7.22 am Mr Bale telephoned '000' and spoke with Mr Tant, the PoliceLink telephonist, stating that he had taken an overdose, was going to end his life, had a rifle and was going put it in his mouth to kill himself; shortly thereafter, Mr Tant sent a CAD message (which classified the incident as a 'self harm' job) stating:

"INFT HAS SAID THAT HE IS GOING TO COMMIT SUICIDE. PREVIOUS HISTORY INCLUDES HIS MUMS DEATH AND LOSING HIS JOB. INFT HAS TAKEN AN OVERDOSE OF MOOD STABILISERS ZIPREXA. INFT HAS BIPOLAR DISORDER. INFTS FRONT DOOR UNLOCKED" (and seconds later) "INFT HAS RIFLE AND IS GOING TO KILL HIMSELF";

At around 7.25 am VKG (police radio) (V1) then broadcast the following message:

> *"Available Hills vehicle. Any car in the vicinity of 36 Arndill Avenue at Baulkham Hills cross of Hambledon Avenue. Informant has rang Triple 0 saying that he's going to commit suicide. Reckons he's taken an overdose of some sort of tranquiliser. Has bipolar disorder and has armed himself with a rifle. Also claims to have a shotgun."*

Sometime around 7.27 am - 7.28 am, there was a further exchange on VKG as follows:

> "HILLS 35: *Yeah Hills 35 um, did you say something about a shotgun?*
>
> VKG (V1): *I said something about a rifle and a shotgun. Informant has told the Triple 000 operator that he's armed with a rifle and a shotgun which he intends to shoot himself with."*

At 7.27 am, Sgt. Steel (the general duties mobile supervisor) acknowledged the job; he called off on scene at 7.37 am;

At 7.38 am (whilst on scene), Sgt. Steel broadcasted a request (via VKG) for the '000' caller to terminate the call with Mr Bale;

Around 7.39 am, Mr Tant terminated the '000' call with Mr Bale;

Around 7.53 am, Acting Superintendent Dean arrived on scene and assumed control as the forward commander, sometime shortly after A/Supt. Dean had a conversation with Sgt. Steel who advised that since the '000' call had been terminated, police had been unable to make contact with the male. He also said that "Bale had told the operator that he had a gun between his legs and would shoot anyone including himself if they came in"; and

Around 8.00 am, A/Supt. Dean briefed Mr X (the commander of the Police Negotiation Unit) and Inspector Brett Smith of the Tactical Operations Unit);

Contact with Mr Bale was never re-established and he completed the foreshadowed suicide (his body being discovered around 10.47 am).

It is acknowledged at the outset that the overall police operation involved a multitude of tasks including establishing a perimeter, organizing telephone triangulation, contacting Mr Bale's psychiatrist to name only a few. The Court acknowledges that these complex and diverse tasks were carried out in a timely and appropriate manner and in accordance with the relevant Police policies. For this reason there is no need to review them in detail. I will focus on the "000" call, Sergeant Steele's decision to terminate the call, the effect this had on the first responders work at the scene and on matters related to the investigation of the critical incident.

A High Risk situation

A concept relevant to much of the evidence received at the inquest was that of a "high-risk situation". It is relevantly defined in the NSW Police Force Training Manual "Responding to High Risk Situations" as follows:

"The circumstances and types of situations which may be defined as high risk vary widely.

The essential judgment that needs to be exercised is whether the real or impending violence or threat to be countered is such that the degree of force that could be applied by the Police is fully justified. In this context, one or more of the following criteria may be used to define High Risk for the purpose of this document:

- Seriousness of the offence committed by the person;

- Expressed intention by the person(s) to use lethal force;
- Reasonable grounds to believe that the person:
- May use lethal force
- Has or may cause injury/death
- Has issued threats to kill or injure any person…".

The role of first responders in high risk situations

The NSW Police Force strategy in response to high risk situations is primarily one of 'containment and negotiation', with force to be used as a last resort. The TOU and Negotiation Unit must be contacted in an emergency high risk situation by contacting the Duty Operations Inspector ("DOI").

In terms of the first responder's role, the key considerations include officer survival, taking command, establishing inner and outer perimeters to contain the situation, keeping media and the public away, considering evacuating members of the public to a safe place and gathering intelligence (ie stronghold, POI, hostages, weapons, landline). Further responsibilities include establishing a command post, commencing and maintaining an operations log and maintaining communications with VKG.

The procedure in relation to 000 calls

PoliceLink Command is a division within the NSW Police Force whose mandate includes the training and operation of '000' telephonists. The main role of the '000' caller is to triage the incoming call and when required, create a CAD message for police attendance at the particular location. Once all relevant information is ascertained, the telephonist generally terminates the call; dispatch procedures then begin.

In this regard, Senior Sergeant Alexandra Cooney, manager of the Education and Development Unit within PoliceLink Command (which includes training for '000' telephonists), noted that there are some circumstances where a telephonist will remain on the telephone until police arrive at a location - whether that occurs is determined by the value of the information the caller has for attending police or other emergency services, and "a call from a person advising they are going to, or have, committed self-harm is likely to fall into this category". In oral evidence, S/Sgt. Cooney explained that around 400 self-harm calls were received per month – it would depend on the triage process, but mostly, police would remain on the phone with a suicidal caller.

Mr Tant's receipt *o*f the '000' call

As at 29 September 2014, Mr Tant had been with PoliceLink since 30 June 2014. He thus had around three months experience at the time of the call from Mr Bale and was not yet fully trained. Mr Tant understood his role at PoliceLink to be receiving emergency calls from the public and noting important information while questioning the caller. This information was then forwarded to police radio dispatch officers who could organise a NSW Police Force response. Mr Tant described his training at PoliceLink as "extensive", noted that calls were "regularly audited", and also referred to specific training in relation to dealing with persons with mental health issues referring to committing self-harm.

The Court had the benefit of a complete transcript of the 17-minute '000' call between Mr Bale and Mr Tant, who was then situated at the Lithgow PoliceLink Centre. The call itself was also played in court and I was impressed by the warm tone conveyed by Mr Tant. It was impossible to listen to the call from the relative calm and comfort of the courtroom and not wish that Mr Tant could just continue talking.

The interaction commences with Mr Bale stating: "Yeah, Jacob, mate, I'm in a bad situation, I've just taken an overdose of tablets … I'm gunna, I'm gunna end my life"; Mr Bale states he has taken an overdose of mood stabilisers (Zyprexa) and that: "I've got a rifle, I'm going to shoot myself". Mr Tant elicits various information from Mr Bale, including his location, and talks to him about a range of subjects, including his son (a police officer), his rural property, medical history and livestock breeding (amongst other matters). The conversation finally concludes after Mr Tant receives the direction via CAD (as given by Sgt. Steel through VKG) to terminate the call around 7.39 am as follows:

"Jacob: ---John, I'm sorry, have to let you go, do you mind if I, just wait a 'sec, OK and I might call you back soon, OK.

John Bale: Yeah, all right.

Jacob: But yeah, I'll talk to you later though, OK.

John Bale: Yeah, all right.

Jacob: Righto, so maybe consider that medical stuff, OK maybe put the rifle away or something, all right.

John Bale: Yeah, all right.

Jacob: OK. I'll talk to you later, anyway, all right John.

John Bale: Rightio.

Jacob: OK. Bye.

John Bale: Bye."

In his statement, Mr Tant says the following of his approach to the conversation:

"I was trying to achieve two things by talking to John about different things. Firstly, I was trying to stall him long enough that the local Police could work out an initiate a plan of action. Secondly, I was trying to outright change his mind about committing suicide. I was hopeful that by talking to him about the positive aspects of his life that he would put away the gun and safely seek help from the Police who were mobilising outside his house."

During the call, Mr Tant continued to send messages to police responders via the CAD system (which messages were then available for broadcast over police radio by dispatch officers). Whilst Mr Tant was the primary call-taker, he noted that his supervisor, Mr Geoffrey Waters, was present at the time and regularly checked on his progress throughout the call.

There is no doubt that Mr Tant should be commended for the compassionate and caring way he handled the call with Mr Bale. He made an impressive and skilled attempt to dissuade Mr Bale from taking his life, particularly given his relative inexperience in the role as a PoliceLink telephonist.

In his expert report, Dr Diamond described Mr Tant's attempts to engage with Mr Bale and encourage him into a dialogue and interrupt the intense suicidal intent he was expressing as "… sensitive, measured and effective"; further, Mr Tant's efforts to "pick up on any possible topic for further dialogue [was] impressive", and his interaction was "appropriate and sensible". I accept that assessment of what occurred.

During the call, Mr Tant effectively established rapport with Mr Bale, distracting him with subjects as diverse as the family property, sheep shearing, and cow breeding – in fact, "elongating the process", in the manner Dr Diamond described. It took significant skill and indeed fast talking from Mr Tant to keep Mr Bale on the line – on a number of occasions, Mr Bale said things such as: "Mate, I appreciate you keeping me talking, while somebody's to see me, but I, I just wanna hang up now and just go and do it", and "Mate, can I go now?" and "Yeah dude, … I don't wanna talk anymore, I've had enough".

A poignant reflection of Mr Tant's performance is the statement of James Bale (Mr Bale's eldest son), that: "The operator did an exceptional job on the phone with Dad and my family and I will be forever grateful that his last 10 minutes or so of life were spent with someone who cared, someone skilled to do the job".

Involvement of Mr Geoffrey Waters – supervisor and site floor manager

For his part, site floor manager Mr Geoffrey Waters states that he was seated near Mr Tant at the time of the call. He "monitored the situation", and was able to both see and hear Mr Tant from where he was seated. Mr Waters stated that as Mr Tant had determined the caller's location and was "effectively managing the call by keeping the conversation going with the caller there was no need for further supervisory involvement during the call."

Mr Waters also stated:

"I didn't offer any advice or prompting as Jacob had built a rapport with the caller and from my point of view was doing a great job talking with him and taking his mind away from what he was considering.

I listened to the call for a very short period of time, about 30 seconds, to "get a feel" for the caller, in the event that I would be required to become further involved with the job. I monitored the situation whilst Jacob was still on the call waiting for Police to arrive until the call was terminated at the instruction of attending police, given via PoliceCAD Dispatcher Message."

As to the site floor manager's role where a person is threatening self-harm, Mr Waters states that it can involve advice to the telephonist to assist in determining the location of the caller, COPS searches, requests to telecommunications providers for mobile location information and support, advice and "talking points" to keep the caller on the line pending the arrival of police.

At 8.10am, Mr Waters sent a 'serious, unusual or newsworthy' (SUN) notification email about the incident to relevant staff within PoliceLink Command. Mr Waters acted professionally throughout his involvement with the call.

The VKG Broadcast

Around or shortly after 7.25 am VKG (police radio) (V1) broadcast the job in the following terms:

"Available Hills vehicle. Any car in the vicinity of 36 Arndill Avenue at Baulkham Hills cross of Hambledon Avenue. Informant has rang Triple 0 saying that he's going to commit suicide. Reckons he's taken an overdose of some sort of tranquiliser. Has bipolar disorder and has armed himself with a rifle. Also claims to have a shotgun."

Subsequently, around 7.27 - 7.28 am, there was a further exchange on VKG as follows:

"HILLS 35: Yeah Hills 35 um, did you say something about a shotgun?

VKG (V1): I said something about a rifle and a shotgun. Informant has told the Triple 000 operator that he's armed with a rifle and a shotgun which he intends to shoot himself with."

A number of police crews acknowledged and responded to the job.

Evidence of Sergeant Steel

Sgt. Steel's account of events was central to the matters explored during the inquest. It is appropriate and necessary to set out his evidence in some detail. The Court has the benefit of Sgt. Steel's contemporaneous notes in his police notebook, his directed interview on the afternoon of 29 September 2014 and his oral evidence at the inquest. Sgt Steel's oral evidence demonstrated how deeply the events had affected him. I accept that he felt greatly saddened about what had happened and attended the inquest to assist as best he could.

Importantly, for around 16 minutes from 7.37am until 7.53am until he was relieved by A/Superintendent Helen Dean, Sgt. Steel was the most senior officer and thus the forward commander in control of the scene during that time. The responsibility clearly weighed heavily upon him.

Background and experience

Sgt. Steel has been an officer of the NSW Police Force for 15 years, and had initially worked at Castle Hill Local Area Command for seven or eight years, later returning there. He told the Court that he had completed the mandatory training package on responding to high risk situations in 2011/2012, and had also learnt on the job, having been involved in around 10 high risk situations, three or four of which he was the forward commander on the ground.

Initial response to the job and police radio broadcast

Sgt. Steel commenced the morning shift as the mobile supervisor at Castle Hill Police Station – this involved him monitoring jobs and determining which to attend. He was working as an alpha unit. Sgt. Steel heard the job on police radio about 36 Arndill Avenue, Baulkham Hills and decided to attend immediately. In this regard, in his directed interview, he stated

"On the way to the job, I heard that there was, he had a rifle and that he was gunna kill himself, that he had taken tablets and that he was gunna kill police and then himself, and that he also suffers from bipolar."

In oral evidence, Sgt. Steel told the Court that en-route to the job, he was "starting to formulate a plan" in his head as to how to deal with the situation, including the establishment of a command post, as well as considering his options in relation to whether or not to "cancel the triple-000 phone call".

Sgt. Steel said that whilst en-route, he believed he heard the VKG operator refer to the POI as being armed with a rifle and shotgun.

However, instead of the words “and he intends to shoot *himself now*”, Sgt. Steel said he “definitely” did not hear those two final words, but was certain he heard the word “police”, such that he “honestly heard” a VKG broadcast that the POI intended to shoot police. Sgt. Steel said that on receiving the brief a year later, he read the VKG recording and went “Wow”; he did not dispute the VKG recording, and was not sure how the error had come about, whether due to the “mumbling” of the triple-0 operator (who Sgt. Steel said “tripped over some words”), radio break-up/drop-out or cross-over or interference from the siren.

Sgt. Steel also explained that because the two words had occurred at the end of the message and he thought he had heard “shoot police”, he did not think to question the message (it would have been otherwise, however, had the message been “cut out” in the middle).

More generally, Sgt. Steel’s evidence was that this was not a standard job – it struck him as being potentially very high risk because of the job description given on VKG, and the direct threat to shoot police. Under examination by his own counsel, Sgt. Steel also stated that hearing over police radio that the POI was “armed with a rifle and shotgun”, made it “sound worse that … just a suicide attempt at that stage”.

Sgt. Steel’s decision to terminate the call

Sgt. Steel gave detailed evidence as to the reasons why he formed the view that, weighing up the pros and cons, he should direct that the ‘000’ call with Mr Bale be terminated. He told the Court that it was an “extremely difficult” decision to make and appeared emotional when explaining his reasoning. In oral evidence, Sgt. Steel amplified the matters raised in his directed interview with respect to his decision to terminate the ‘000’ call. He explained that there were numerous reasons he had terminated the ‘000’ call, having weighed up the pros and cons during the ten minutes whilst travelling to the job. He emphasised that it was not a “split-second decision”.

Sgt. Steel gave the following reasons for his decision to terminate the ‘000’ call:

Sgt. Steel considered the “high likelihood” police would be able to get through to Mr Bale because his phone call had been voluntary.

He was considering, as forward commander, the worst case scenarios (including that the POI might come out shooting).

He stated that he took into account logistical issues, including the timeframe and lag in conveying information through police radio (given it was “probably one of the most dangerous jobs a police officer could possibly attend to”).

He was concerned by the possibility of “Chinese whispers or misinformation” with the information going through many sets of hands, and potentially making “life threatening decisions on misinformation that is now five minutes old”, all of which could be alleviated by a “real time telephone call” with the POI at the scene.

He said he considered the “syphoning of information”, in that information thought to be important by the triple ‘000’ telephonist and information important to a forward commander leading a siege were “two drastically different things”.

He stated that he took into consideration “policy and procedure”.

Although there was no policy which specifically applied to first responders dealing with a situation where contact with the triple ‘000’ operator is established, the ‘New South Wales Police Operations Manual’ outlined the responsibilities of police at the scene in high risk situations, which included getting in contact with the person and developing rapport.

Sgt. Steel stated he needed to get in contact with the POI to establish certain information. Sgt. Steel also recalled an ‘educational package’, with one slide that “popped up” into his head that it was “essential that first responding police attempt to make contact with the person”.

He applied his previous experience running a siege involving a male with a mental illness in possession of a firearm in which the importance of establishing contact with the POI was emphasized. He also recalled discussions with TOU commanders and negotiators after incidents.

He also told the Court there were numerous checking mechanisms in place - namely A/Supt. Dean, the Duty Operations Inspector (“DOI”) and the triple ‘000’ supervisor - who could “step in” had his decision been incorrect.

He stated that he did not view the CAD before making the decision to terminate the call. If aware of the CAD message from Mr Tant (the telephonist) which stated: “Attempting to hold off the informant from shooting himself now”, Sgt. Steel said he would have “needed to be in the moment ...”, but any new information would have been taken into consideration; he agreed, however, that that information suggested it was a “pretty tenuous conversation”; he also said he “may have held off at that time … let it extend a little bit longer” to work out what that actually meant, if aware of it. Sgt. Steel believed that any important updates coming through CAD would be broadcast to officers at the scene. Had that information (as to holding off the informant from shooting himself) been broadcast by VKG, Sgt. Steel said he would “definitely have delayed the decision” and made inquiries to get in contact with someone to try and work out further information.

I accept Sgt. Steel’s evidence. I accept that he was a conscientious officer who tried to do his best that day. With the benefit of hindsight, it is clear that the direction to terminate the call with Mr Bale was extremely unfortunate.

In the circumstances of trust that had been established it had the effect of abruptly ending an important conversation in which Mr Tant was "attempting to hold off" Mr Bale shooting himself.

It is acknowledged that Sgt. Steel's direction for the '000' caller to terminate the call was given pursuant to his understanding of the 'contain and negotiate' approach to high risk situations. In fact it was the evidence of Mr X that everything Sgt. Steel did was in accordance with policy. It is difficult to be critical of Sgt. Steel in relation to the decision he made, notwithstanding that it is clear that a different approach ought to be considered should similar circumstances present in the future.

In this respect, it is important to stress that it is impossible to say whether or not Mr Tant might have successfully talked Mr Bale out of taking his own life had the conversation continued. However, it was the evidence of Dr Diamond that suicidal intent peaks and wanes; even though people may at one moment be intensely suicidal, the state of ambivalence (which can be detected at some points in the discussion with Mr Tant –

for example, where reference is made to whether he might be charged with firearms offences if he survived) is the key to successful suicide intervention. Whilst there may ultimately have been only a slim prospect of dissuading Mr Bale from completing the suicide, "there was just that tiny little bit of ambivalence, that little bit of responding to the humanity of the dialogue."

The Court was heartened by the NSW Police Force's proactive and open examination of the issues raised by the termination of the "000" call in these circumstances.

Basis for Sgt. Steel's understanding that Mr Bale would shoot and kill police

It is important to say something further about Sgt Steele's understanding that Mr Bale would shoot and kill police, given the pain that the reporting of this information gave members of Mr Bale's family. It should be stressed that it is patently clear that Mr Bale never made any threat to kill anyone other than himself – so much is irrefutable from the '000' transcript. Nothing said by Mr Bale to Mr Tant could even be thought ambiguous in this regard.

It was Sgt. Steel's account that the error (which he readily accepted as such given the content of the transcript) may have occurred because of the mumbling of the broadcaster, radio-drop out or break-up or interference from his police siren. That may well be the case, however, it is odd that at no time whilst he was the forward commander did he make any reference to the threat, as he understood it, to shoot and kill police, in any of the numerous VKG broadcasts he made.

He told the Court that initially he was too busy establishing the command post and perimeter to make reference to the threat over VKG, and upon A/Supt. Dean assuming command, he did not broadcast reference to the threat as to do so would be "stepping on her toes".

Further, Sgt. Steel's evidence, that upon arrival at the command post he referred to the threat to shoot police in briefing the junior crews, was contradicted by the evidence of at least Constables Marks, Haller and Constable Klinar (noting also the evidence of S/Cst. Desira). In this regard, it was Constable Klinar's evidence that once Sgt. Steel attended the scene, "there was no discussion of threats to kill police or anyone who attempted entry", although he did comment upon the POI "having a long arm" (referring to his firearm and consequent firepower).

Whatever the source of the confusion and the reason for its continuing, it is extremely unfortunate that Mr Bale's family were not informed more quickly of this mistake once it became apparent.

Briefing with crews on scene at Rowe Place

After arriving on scene at Rowe Place, Sgt. Steel had a "fairly quick briefing" with the two crews present (Hills 20 and Hills 35) and told them to put on their ballistic vests due to the radio report that the POI "had a firearm and that he was willing to use it against police".

Sgt. Steel determined that the best way to proceed would be to "contain and negotiate" the situation. He told the Court that during this briefing, (then) Constable Christie Desira (an officer in Hills 35) approached him and said something along the lines of: "Did you hear the threat to shoot". Sgt. Steel said this validated what he believed he had heard on the way there (that is, that there was a threat to shoot police). He also gave evidence that at this briefing (and notwithstanding Constable Troy Klinar's evidence to the contrary), he believed that he had referred to the threat to shoot police, considering it important to do so.

According to Sgt. Steel, the plan was that Constable Troy Klinar (of Hills 20) would use Sgt. Steel's mobile phone to try and establish contact with Mr Bale, and immediately let him know if this occurred. Sgt. Steel did not want to take over negotiations, however. That evidence was at odds with Constable Klinar's evidence, which was to the effect that if contact was established, Sgt. Steel would then undertake negotiations. Sgt. Steel ultimately agreed with the proposition that it was *undesirable* that there be a misunderstanding as to whom was to conduct the negotiations. Sgt. Steel told the Court he had instructed Constable Klinar to keep trying to call Mr Bale until he was in contact, having provided both mobile and land-line numbers for him.

Sgt. Steel also explained that he had sent Constable Klinar, who had some military training, to "get eyes on the premises", trusting his ability to find a "good safe place".

Briefing to A/Superintendent Dean

Following A/Supt. Dean's arrival on-scene around 7.53 am, Sgt. Steel gave her a briefing at the command post, as she was taking over as the forward commander (given her rank as the local area commander and pursuant to policy).

During the briefing, Sgt. Steel spoke about the "points people were on", the fact he had cancelled the triple '000' call, and "the primary police strategy of contain and negotiate" in play. Sgt. Steel accepted that he may have told Superintendent Dean that "Mr Bale had told the operator that he had a gun between his legs and would shoot anyone, including himself, if they came in". He did not accept that there was a relevant difference between that formulation, however, and a threat by Mr Bale to shoot police and then himself, stating:

"They're just the words that I used at the time but I would have said there's a threat to shoot police. That's about as dangerous as it gets and it can be interpreted any way you like. I don't see a massive difference, whether we go in or he comes out. I may have said if we go in and I may have used those words to her. I can't remember …"

Other steps taken by Sgt. Steel (including establishing a perimeter)

In relation to the subject premises, Sgt. Steel referred to the difficulties of the location with seven different entry points, and stated that it took a bit of time to work out which cars were coming and where they were going to be sent to.

He was made aware that the sirens were upsetting the POI and accordingly advised all cars to "kill their sirens on attendance so we could try and keep him not getting too upset".

During his evidence, Sgt. Steel was shown various extracts of his police radio broadcasts throughout the operation, including transmissions which related to ensuring all police were vested up; however, Sgt. Steel told the Court that following A/Supt. Dean's arrival, he did not think that he made any further radio transmissions without her input or permission. As to the absence of a broadcast over police radio regarding the threat to shoot police, Sgt. Steel explained that given the position of the various crews (a couple of hundred metres away from the subject premises), he did not consider them to be in any immediate danger; he also said that as further police arrived he told them about the danger because they were in close proximity to the house. Sgt. Steel subsequently referred to the "extenuating circumstances" of being busy setting up a perimeter with four police, and that after handing over to A/Supt. Dean, she was advised of the threat and it was up to her to broadcast further information if she saw fit.

Sgt. Steel said he did not tell Constables Desira and Marks (who were headed to 8 Hambledon Avenue located behind the subject premises) to evacuate the residence. This was because he did not want residents walking around the premises; he said he told the officers "to be safe". He could not remember whether he referred to the threat to shoot police.

Sgt. Steel took other steps with respect to the operation, including organising a triangulation of the POI's mobile phone to confirm the location, coordinating Hills 35 to contact persons in the neighbouring property (who advised that the POI suffered bi-polar), monitoring the entrance and egress of the property and also the radio, as well as generally assisting A/Supt. Dean.

After the operation concluded (Mr Bale having been found deceased around 10.47 am), Sgt. Steel returned to the station and, appreciating that he would be interviewed, prepared notes in his notebook to try to jog his notebook memory and "give the best account" of himself in the interview that he could.

Evidence of Senior Constable Christie Desira

Senior Constable Desira provided two statements regarding her involvement in the matter and was called to give oral evidence. She has been an officer of the NSW Police Force for just over six years, and is currently attached to the Hills LAC.

On 29 September 2016, she (then a Constable) was undertaking general duties in Hills 35 (a marked police car), working with Constable Luke Marks.

S/Cst. Desira recalled the briefing with Sgt. Steele upon his arrival at the scene; she explained they were outside their vehicles and parked on the left hand side of the cul de sac (in Rowe Place, the command post).

In terms of her understanding of any threat to shoot and kill police, she stated: "I believe I heard that via the police radio on the way to the job. However, it may have been said while we were briefing". S/Cst. Desira could not see reference to that information in the transcript from police radio, but still believed that was when she heard it, although accepted the possibility it came from other sources. However she received the information, S/Cst. Desira agreed she had a clear recollection that she thought the POI would shoot anyone that came near.

When questioned by counsel for Sgt. Steel, S/Cst. Desira stated that she did not remember saying to Sgt. Steel during the briefing: "Did you hear the call about shooting".

S/Cst. Desira otherwise confirmed that the Hills district has both black spots and radio black-out.

Evidence of Senior Constable Brigitte Monro

Senior Constable Brigitte Monro provided two statements regarding her involvement, and gave evidence at the hearing. She has been an officer of the NSW Police Force for almost eight years, and is currently attached to Castle Hill Police Station.

It was S/Cst. Monro's evidence that shortly before 7.30 am, she partially heard a self-harm job broadcast at Baulkham Hills; five or ten minutes later, she became aware from another officer,

Detective Sergeant Andrew Hamill that the situation had turned into a siege, and they (the detectives) were required to attend. Together with D/Sgt. Hamill and Detective Jedda Thompson, S/Cst. Monro travelled to the command post at Rowe Place in vehicle Hills 102. At this time, she believed they were in phone contact (via personal mobile phones) with another car in which Detectives Davies and Bruce were travelling. No one was in contact with the command post, however, whilst they were en-route.

S/Cst. Monro's understanding that the situation had become a siege was a "different level of threat" – this was why the detectives had to attend (as compared with the initial broadcast as a self-harm, when they were not required).

In relation to her statement that: "I believe I heard via the police radio that the male would shoot anyone who came in and shoot himself", S/Cst. Monro said: "… I believed that that's where I heard that information … I believe I heard it via the police radio but the transcript doesn't reflect it". She was "absolutely 100 [percent]" convinced that by the time she was in the car, she understood there was a threat to shoot other people. As to the source of the information, S/Cst. Monro stated – "I've tried to find it and honestly I wasn't able to find where that information came from".

S/Cst. Monro said that upon arriving at the command post, she had a brief conversation with Sgt. Steel about which officers were in cars Hills 20 and Hills 35. During this conversation Sgt. Steel did not say that Mr Bale had threatened to shoot police.

Evidence of Chief Inspector Helen Dean

Chief Inspector Helen Dean provided two statements, and also gave oral evidence at the hearing. She has been an officer of the NSW Police Force for 22 years.

During this time, C/Insp. Dean said she had been involved in numerous high risk incidents and particularly those involving firearms (having worked in South West Sydney for 15 years).

In terms of her relevant involvement in events on 29 September 2014, C/Insp. Dean told the Court that whilst in the duty officer's room, she first heard Sgt. Steele request that the '000' phone call be terminated so he could initiate contact with Mr Bale; at this time, she had just walked into the building up the stairs and into the office.

Having arrived on scene at Rowe Place at 7.53 am (after travelling alone, using the call sign 'Hills 10'), C/Insp. Dean (who was then acting as Superintendent or commander of the LAC) assumed control of the scene as forward commander. C/Insp. Dean said that Sgt. Steel gave her a briefing which went for a couple of minutes. He told her what staff were on the ground, who had what point and that Constable Klinar had his mobile to try and initiate contact with the POI who was inside with firearms. She agreed that Sgt. Steel had told her that: "Bale had told the operator he had a gun between his legs and would shoot anyone including himself if they came in".

She accepted the accuracy of the information conveyed by Sgt. Steel. C/Insp. Dean had no recollection that Sgt. Steele had told her the POI was going to kill police and then himself.

As to whether it was a significant piece of information that the POI had a gun between his legs and would shoot anyone including himself if they came in, C/Insp. Dean stated:

“Not with how I would have run the job, the fact that he was inside with firearms made no difference as to how I would've run that job. It's a person armed with firearms and multiple firearms. How I managed the job and the decisions I made had nothing to do with whether he was only going to shoot himself or whether he was going to shoot anyone else.”

C/Insp. Dean saw no distinction between a direct threat to kill police and one’s self, relative to a threat being contingent upon someone entering the property. She stated: “One life is important to the other – one life is no more valued than another, whether its police officer’s life or a next door neighbour’s, or anyone that could have – yeah, it makes no difference”. C/Insp. Dean explained that her priority was to make sure the perimeter was shut down and get on to experts such as the negotiators.

Notwithstanding, C/Insp. Dean agreed that once negotiators became involved, real accuracy regarding the nature the threat was important. She also agreed that it was important for first responders to appreciate the nature of the (relevant) threat.

In this instance then, it was important for first responding crew (such as Hills 35 and Hills 20) to understand if there was a direct threat to shoot and kill police. C/Insp. Dean pointed out that with anyone bearing a firearm, however, “you deal with it with the assumption that at any time it could be turned on you”.

She agreed though, that there was a degree of escalation where there was an offensive threat to shoot and kill police, and that it was important that all first police responders understood that. Avenues for advising first responders of such information included VKG and briefings.

C/Insp. Dean agreed that each high risk situation may involve different levels of threat to police, and that an important role for first responders on scene is to gather as much intelligence about a situation as possible (including as to who the offender is, what he wants, whether he is suicidal and armed, and how the episode began). In this regard, she agreed that with the benefit of hindsight, it would have been possible to have made contact with the ‘000’ telephonist (via VKG).

C/Insp. Dean said she did not discuss with Sgt. Steel his decision to terminate contact with Mr Bale at the scene. As to whether it had been a good call, she stated:

“It's difficult to negotiate with somebody especially with a mental health issue through a third party, and also the triple-0 operator isn't always aware of the information we need, such as the questions that were raised. They might ask other things to keep the person calm and keep them on the phone but knowing about whether he grazed cows or sheep doesn't help me at the scene, so by talking to the person myself or having a member of my staff speak to them, there's certain information that the police - that would assist us.”

In relation to a briefing with Mr ‘X’ (Commander of the Police Negotiation Unit within the State Protection Group) and Inspector Brett Smith (a tactical commander within the Tactical Operations Unit) around 8 am that morning, C/Insp. Dean said she recalled the briefing but not what was said. Noting discrepancies between the account of Mr ‘X’ and Inspector Smith, C/Insp. Dean said she had no reason to question the accuracy of the latter’s account. She agreed that the information about Mr Bale lying on his bed with a shotgun between his legs and that he would shoot anyone who came in was an important piece of information; it was something the negotiators needed to know, and thus she thought it “likely” she would have conveyed that; however, C/Insp. Dean could not recall which account was likely to be more accurate, and told the Court there may have been a number of conversations (with Mr ‘X’ and Inspector Smith).

Evidence of Mr ‘X’

Mr X is a Detective Inspector of Police, and the commander of the NSW Police Negotiation Unit, State Protection Group. He prepared a statement dated 21 March 2016, and also gave evidence at the inquest.

Mr X was involved in preparing the mandatory continuing police education program regarding responding to high risk situations in 1998; he had had an ongoing role since. That mandatory package was delivered to all NSW police in the year 2000 and 2011/12.

Mr X provided the Court with general information regarding responses to high risk situations. He agreed with the proposition that high risk situations vary significantly from one incident to the next – “no two situations are ever exactly the same …”. In high risk situations, intelligence is always important, and “every piece of information and intelligence especially to police negotiators is extremely important”. Adequate intelligence helps with proper decision making, and would include who the offender is, what he wants, whether he is suicidal, how he is armed, what is known about his weapon capability and background, how the incident began, what the person says they want, what they have said and what they are threatening. Information of that nature is important to assess the intent and capability of the offender. Mr X also gave evidence that if negotiators could obtain intelligence as to the stated intention of the person, they should do so.

Thus, information that a person was fixated or wanted to kill police would be important information; equally, Mr X agreed it would be important information for negotiators to be told if a person was threatening to shoot anyone if they came into the house and interrupted the act of suicide.

Briefing by A/Supt. Dean and Mr X's understanding as to the nature of the threat

Mr X confirmed that it was his practice to take contemporaneous notes of all high risk situations or negotiation jobs "every single time". It was necessary for him to satisfy himself as to the involvement and deployment of police negotiators.

In this particular case, Mr X's notes recorded an initial call from the DOI (Inspector McCormack) around 8 am; he advised that there was a high risk situation at the Baulkham Hills address involving a male armed with a shotgun and threatening suicide. There was a request for activation of police negotiators. A/Supt. Dean's mobile was provided. From his office at the Sydney Police Centre, Mr X then rang A/Supt. Dean together with Inspector Brett Smith around 8.14 am and there was a conversation on speaker phone. During the phone call, Mr X agreed that A/Supt. Dean had advised him that the male involved was believed to be John Bale, aged 60, who lived at the address and suffered bipolar disorder. He was also told that the POI had rung '000' and said he had a shotgun between his legs and would commit suicide. Mr X stated that he did not have an independent recollection of the conversation.

Mr X said he had no recollection of A/Supt. Dean telling him that John Bale had said he would shoot police – Mr X stating that if that had been said, "I have no doubt in my mind through my … set procedures I would've written that down…".

Mr X also stated that had he been told that Mr Bale would shoot anyone including himself if they came in, he would have recorded that in his notes, that being important information. If told that information, Mr X said he would have told his negotiation team that detail.

Mr X agreed that it was the role of the negotiation team to seek to obtain intelligence through witnesses; in this regard, he agreed that someone should have made contact with the '000' telephonist.

Under examination by counsel for Sgt. Steel, Mr X opined that Sgt. Steel had done everything in accordance with policy.

Evidence of Inspector Brett Smith (Tactical Operations Unit)

Inspector Smith provided two statements for the inquest, dated 1 October 2014 and 12 October 2016 respectively, and also gave oral evidence.

Inspector Smith has been a police officer for 26 years, including over 20 years in association with the Tactical Operations Unit ("TOU"). Since 2005, Inspector Smith has been a tactical commander attached to the TOU, which involves the coordination of TOU responses to high risk incidents, liaising with commanders as well as the planning associated with high risk operations.

In terms of Inspector Smith's recollection of the briefing with Mr X and A/Supt. Dean on the morning of 29 September 2014, he did not take notes regarding that specific conversation, but subsequently made some notes in his personal diary about the incident generally. Inspector Smith had no independent recollection of the conversation with A/Supt. Dean; he recalled Mr X taking notes however.

As to the apparent discrepancy between Inspector Smith's first statement (which relevantly referred to Mr Bale calling '000' threatening self-harm, stating he was lying on his bed with a shotgun between his legs and that he would shoot police and himself), and that of A/Supt Dean (to the effect that Mr Bale had said he had a gun between his legs and would shoot anyone, including himself, if they came in).

Mr X's account (of the man having a shotgun between his legs and stating that he would commit suicide), Inspector Smith could not recall whether he had used the precise wording of what was said on the call, or whether he had "extrapolated the information as it came in" and added it in preparing his statement.

Inspector Smith agreed with the evidence of Mr X that information to the effect that the person was lying on his bed with the shotgun between his legs and would shoot police and himself was important information, and that it would inform matters relating to the operation. He also agreed there was a difference between someone threatening self-harm compared with an offensive threat against police, but explained that it was not uncommon for people in distressed situations to make aggressive statements towards police.

The role of TOU once on the ground was to evaluate that risk and the strategies and tactics to put into place. Inspector Smith agreed it was important that first responders understood the nature of an incident, and that an important means for doing so would be VKG (police radio); it would also be important for the forward commander of the first response police to advise junior crews about a threat to kill police. That information was also relevant to matters such as setting the perimeter, taking cover and giving instructions about evacuating or locking down premises.

Inspector Smith agreed that this matter was always a high risk situation, although explained that prior to deploying TOU, it was necessary for first responders to verify certain information; there was also a process requiring that permission to deploy TOU from the superintendent in charge be sought (who would then seek permission from the assistant commissioner to use special weapons and tactics).

The first responder verification process was to avoid wasting resources; it would be undesirable to roll out TOU personnel and surround an empty house if the person was actually at another location. Inspector Smith also gave evidence that Sgt. Steel had taken the appropriate approach in only activating negotiators after the first responders could not make contact, given that the initial contact might have resolved the situation (for example, the person might have come out and surrendered etc). In terms of the verification steps first responders might take, Inspector Smith stated that they could "make reasonable attempts", including containing the location, making observations and attempting to speak to the person of interest (although it might not ultimately be possible to provide verification).

In relation to any distinction between a male believed to be in a house threatening to shoot himself compared to a person also threatening to shoot police,

Inspector Smith initially said there would be no difference in the response of attending police – the main concern would be the welfare for officers attending, and resolving the situation in line with the policy of containing and negotiating. However, I understood him to later suggest that there may be a difference in how risks in each situation were weighed up when police were called upon to approach.

The evidence of other police regarding "threats" made by Mr Bale

The evidence of other officers who responded to the job was that they variously understood the threat posed or stated by the "POI" as follows:

Constable Luke Marks was in Hills 35 (with S/Cst. Desira) and heard the VKG job to be the informant threatening to commit suicide;

Constables Melissa Haller and Troy Klinar in Hills 20 referred to the job as a broadcast for self-harm (prior to arriving at the location, radio had advised them that the informant had a rifle on his person);

Around 8.10am, A/Inspector Andrew Hamill ("A/Insp. Hamill") referred to attending the command post (together with S/Cst. Monro and Detective Senior Constable Jedda Thompson ("D/S/Cst. Thompson") in an unmarked police car in response to a male threatening self-harm whilst in possession of a firearm; upon attending he observed Sgt. Steel and A/Supt. Dean and commenced a communications log; that document notes the attendance of himself and the others officers regarding a "suicide intervention", and the information that:

"POI contacted '000' speaking with an Ambulance operator <u>not</u> police radio operator. During conversation POI stated he was in possession of a shotgun which was between his legs and would shoot anyone including himself";

D/S/Cst. Thompson states that she received a call from A/Inspector Hamill during which he advised of a serious incident "being a concern for welfare and a possible siege situation at 36 Arndill Avenue, Baulkham Hills"; together with A/Insp. Hamill and S/Cst. Monro, they drove an unmarked vehicle to Rowe Place; once there, Sgt. Steel stated:

"Around 7.22am this morning there was a 000 call from the resident John Bale, who lives by himself at 36 Arndill Avenue, Baulkham Hills. The caller, Mr Bale said to the telephone operator words to the effect of, "I am lying on my bed with a gun between my legs, if anyone comes to try and stop me, I will shoot them and shoot myself";

From the TOU officers:

Acting Sergeant Dayne Brown ("A/Sgt. Brown") was told by A/Supt. Dean that Mr Bale had told the '000' operator that "he was he was lying on his bed with a shot gun between his legs and would shoot at police or anyone who came near his house";

Leading Senior Constable Steven Davies was advised by A/Sgt. Brown that Mr Bale had contacted '000' threatening self-harm with a firearm;

Sergeant Paul Whitehead referred to attending a "possible suicide intervention" at Baulkham Hills where the person had rung '000' threatening to kill himself with a firearm;

From the Negotiation Unit officers:

Detective Sergeant Mathieu Russell ("D/Sgt. Russell") (the negotiation team leader), spoke with A/Supt. Dean, who advised him and Inspector Smith (amongst others) that Mr Bale "had earlier contacted '000' and threatened suicide with a firearm";

Detective Sergeant Michael Egan received a call from Mr X around 8.00 am notifying him of an incident involving a man possibly armed with a firearm threatening self-harm; upon attending the premises with the team, he and team members A/Sergeant Thomas and Detective Senior Constable Sasha Pinazza ("D/S/Cst. Pinazza") were briefed by D/Sgt. Russell as follows:

"I was advised that the occupant of 36 Arndill Avenue, Mr John Bale, had made a phone call earlier in the morning during which he had made a threat to take his life with a firearm";

D/S/Cst. Pinazza arrived at the command post at 9.10am, and was briefed by A/Sergeant Thomas that the occupant Mr Bale had earlier contacted '000' stating he intended on committing suicide with a firearm.

Confusion in relation to officers' understanding of the 'threat' posed by Mr Bale

As noted above, during his discussion with Mr Tant, Mr Bale only ever threatened self-harm. So much is beyond doubt. Nevertheless, it is clear from the evidence that there were quite discordant understandings as to the exact threat posed that morning among various officers involved in the operation.

Leaving aside the fact that some of these understandings were plainly incorrect, the very fact that they existed simultaneously is cause for concern.

As to the significance of such discrepancies in the threat assessment, there was some evidence from officers such as C/Insp. Dean to the effect that there was no relevant distinction in relation to a job that involved a person threatening self-harm with a firearm, relative to one where the person was actively threatening to shoot and kill police (or others), and then himself. I find that approach hard to understand or accept.

There was also clear evidence to the effect that it was important for first responders to appreciate the nature of any relevant threat, and that accuracy regarding the nature of the threat once negotiators became involved was important. Additionally, adequate intelligence, including as to the offender's threats, assists with proper decision making and every piece of intelligence available to police negotiators is "extremely important". Inspector Smith also gave evidence that it was important that first responders understood the nature of an incident, and agreed there was a difference between someone threatening self-harm as compared with an offensive threat against police.

Of particular concern is that it does not appear that any of the police negotiators understood that Mr Bale was "threatening to shoot and kill police" or anyone who attempted entry to the house. Further, the statements of two of the TOU operatives suggest that they also understood the job was in relation to a "self-harm" involving a firearm.

The existence of these various discrepant understandings even between officers from within the same unit or the fact that some had no knowledge of such an apparently active threat would seem wholly undesirable and potentially a significant risk factor in high risk situations. It may be that the NSW Police Force will continue to reflect on how best to ensure that information concerning a specific threat/risk is known to all officers responding to a high risk situation in future.

The Critical Incident Investigation and Inspector Seddon's involvement

A critical incident is essentially one involving a member of the NSW Police Force which results in the death of a person arising from a police operation. The defining feature of a critical incident investigation is that it is constituted by an independent specialist investigative team, whose investigation is in turn reviewed by an independent review officer.

A critical incident investigation is essentially governed by the Critical Incident Guidelines which were developed to assist officers to manage, investigate and review critical incidents.

The preamble to the Guidelines states the NSW Police Force's commitment to investigating all critical incidents in an "effective, accountable and transparent manner" and notes that if "public credibility is to be maintained, such investigations are most appropriately conducted independently". The Guidelines are said to be a statement that the community can have full confidence that the facts and circumstances of a critical incident will be thoroughly examined and reviewed by the NSW Police Force.

In conducting a critical incident investigation, the Guidelines state that the critical incident team are to conduct a full investigation of the incident, including relevant events and activities leading up to it, as well as the lawfulness of police action and the extent of police compliance with relevant guidelines, legislation, internal policy and procedures. The investigation report from the critical incident investigation should comment on these matters and include reference to any problems that have been identified.

The primary role of the senior critical incident investigator ("SCII"), who is the leader of the critical incident investigation, is to "ensure critical incidents are rigorously and thoroughly investigated". Inspector Nicholas Seddon, from Ku-ring-gai LAC, who was an Acting Inspector on 29 September 2014, was appointed as the Senior Critical Incident investigator on Strike Force Parabel – the investigation into John Bale's death. He provided four statements; he also gave oral evidence at the inquest. An officer of the NSW Police Force since 2000 (with 16 years of experience), he became an Inspector in November 2015 and is currently attached to Griffith LAC.

In terms of his previous experience and involvement in high risk situations, Inspector Seddon stated that he did not have a lot of experience responding to such situations, (he approximated that he had been involved in around five to ten such situations). Inspector Seddon stated that he had completed the mandatory training for high risk situations.

Inspector Seddon agreed that in relation to a high risk situation it would be important to assess a situation on its merits with particular regard to the specific threats. If he heard a threat "that the POI was going to shoot and kill police" and then himself, Inspector Seddon agreed he would definitely tell attending police either during a briefing, or via police radio so that people were "aware of what they are possibly coming into as they arrive at the situation". If acting as supervisor, Inspector Seddon said he would broadcast the threat on VKG himself, "to ensure that people are aware of what's going on and also to make sure they're obviously wearing their ballistic vests and taking appropriate measures in relation to their safety".

In terms of Inspector Seddon's training in investigating critical incidents, he stated that as at September 2014, he had "no direct experience in critical incident investigations," other than his general experience in policing and investigations". He also said he had not received any training in relation to conducting critical incident investigations, and was aware of the existence of the Guidelines, but "… not totally conversant with them at the time of the incident". Inspector Seddon subsequently explained that by this, he meant that while he had read the Guidelines, he "could not state categorically every duty and requirement that was expected of the senior investigator or the other people involved in an investigation of this type".

In a statement dated 5 October 2016, Inspector Seddon noted that he had become aware that the NSW Police Force conducts a two day 'senior critical incident investigators workshop'. Inspector Seddon had not completed the course at the time of conducting the investigation into Mr Bale's death.

However, he stated that undertaking critical incident investigation training would have assisted him, and provided further skills, knowledge and understanding of the processes relating to such investigations (although he is no longer in a role where he would undertake such investigations). Looking back on the matter, Inspector Seddon reflected on a number of things that he would have done differently (including re-interviewing Sgt. Steel as to the origin of his belief regarding Mr Bale's threat to harm others and also informing the family of the error surrounding such information in a timelier manner).

A statement of Detective Inspector Glen Browne (currently attached to the Professional Standards Command) was tendered into evidence during the hearing. That statement outlines the training provided regarding critical incident investigations, including the two day 'Senior Critical Incident Investigators' workshop (which was piloted in December 2014), and which has since been conducted on ten separate occasions at various locations around the state.

Inspector Seddon's reflection as to matters that he would approach differently if he were to undertake another critical incident investigation shows insight and integrity. Further, Inspector Seddon's concession that he ought to have explored the discrepancy relating to the evidence and Sgt. Steel's account of the threat apparently stated by Mr Bale, further attests to these qualities.

Inspector Seddon's communications with the Bale family

Mr James Bale, an officer of the NSW Police Force, described working at Newtown Police Station when on the morning of 29 September 2014 when he was taken into an office by two senior officers and advised that his dad had made a call to '000' stating that he was armed with a gun and "that he was going to shoot himself and/or anyone that attempted to enter his house."

James described this information as the “most shocking and unimaginable information to receive”, as he knew his father well. He could not understand the reported behaviour, given his father had never been violent to others nor had he been known to threaten others.

Some time around 10 am it appears James Bale was conveyed to the command post set-up at Rowe Place. Around 11.10 am, James was advised that his father was deceased.

Subsequently, longstanding neighbours came to understand that there had been a “siege” and that Mr Bale had said he was going to shoot himself and then others.

James Bale noted that it was not until 13 November 2015 (in a meeting with officers assisting the Coroner), that there was an indication given that there was no evidence that Mr Bale had threatened to shoot or harm anyone other than himself.

James stated that believing his father had threatened to shoot and kill others on 29 September 2014 had compounded the family’s grief and loss, and caused great anguish and distress, as well as “almost irretrievably and wrongly” tarnishing his father’s reputation.

Amy Bale, Mr Bale’s daughter, recalled being told by James on that terrible day in September that the family were lucky Mr Bale “didn’t hurt anyone”. Amy stated that she was unsure when police became aware of the “true facts” regarding her father’s death, but stated that other than in conversation with the family’s barrister, she had never been spoken to by police to explain that “there was never any threat by my father to hurt anyone other than himself”.

She stated that the misinformation had affected her father’s reputation but also “impacted terribly” upon the grief she had struggled with since.

Inspector Nicholas Seddon interviewed Sgt. Steel on the afternoon of 29 September 2014. At this time, he became aware of the perception of at least that officer that Mr Bale had threatened to shoot and kill police.

He subsequently received, reviewed and uploaded onto the Eaglei system contemporaneous information concerning the circumstances leading up to Mr Bale’s death relevantly (namely, a CAD incident (2 October 2014), VKG transcripts (17 October 2014) and the ‘000’ call transcript (6 November 2014)). Inspector Seddon stated that after reviewing this information and given his knowledge of matters, it was obvious that Mr Bale never said he intended to harm other persons or police.

By statement dated 5 October 2016, Inspector Seddon acknowledged his mistake and oversight in failing to release information as to the true circumstances of Mr Bale’s death to the family.

He explained that he had misconstrued a part of the NSW Police Handbook concerning the release of information to persons without the Coroner's consent (but noted that in any case he could have sought the Coroner's consent to seek the release of the information). Inspector Seddon apologised to the family for this error of judgment on his part.

It is extremely regrettable that the Bale family were inadvertently misled as to the circumstances of their father's death for over a year. The significant human impact of that misinformation, compounding the family's grief and in their view, irreparably affecting their father's reputation, is clear.

To his significant credit, Inspector Seddon accepted responsibility for the break-down in communications with the Bale family and unreservedly apologised to them, and in doing so, has shown himself to be an officer of integrity.

Evidence of Dr Michael Diamond, forensic psychiatrist

The Court obtained two reports from forensic psychiatrist Dr Michael Diamond, and also had the benefit of his oral evidence. He gave compelling evidence based on his extensive knowledge and experience

Dr Diamond is a specialist psychiatrist. He has been a Fellow of the Royal Australian and New Zealand College of Psychiatrists since 1984 and has been practising as a psychiatrist for 32 years. Dr Diamond also has longstanding experience and ongoing involvement as a consultant to the Negotiation Unit of the NSW Police Force.

In his reports, Dr Diamond noted that an adequate threat assessment could not have been made by Sgt. Steel because he was unaware of critical information about the call between Mr Bale and Mr Tant. Specifically - Sgt. Steel was unaware of the severity of Mr Bale's suicidal intent, and did not appreciate that Mr Tant was engaged in a tenuous dialogue with Mr Bale that was effectively disrupting Mr Bale's plan to take his own life.

In oral evidence, Dr Diamond explained that "what was tenuous was Mr Bale's connection with ongoing life. This was a man very close to completing a suicide"; it was not a suicidal threat or distressed person making suicidal hints, but a "suicide in progress".

Additionally, Dr Diamond told the Court that the conversation Mr Tant had developed with Mr Bale was "intensely valuable" and should not have been interrupted, (Dr Diamond noting that Mr Tant had a "wealth of information" and was engaged in a "process that was so precious, so important").

He explained that when involved in a dialogue of that nature, "one doesn't bring anything to completion", because (in effect), it leads to completion of the act of suicide; ending a phone call is an example of a completion process.

Dr Diamond's evidence was that Sgt. Steel's decision to terminate the call between Mr Bale and Mr Tant was not consistent with the practice preferred by police negotiators. The first person to respond to a high risk situation often becomes the "*de facto primary negotiator*" due to the rapport they build with the subject during their communication. In his (second) report, Dr Diamond explained:

"The standard police negotiator procedure is not to interrupt the communication between first responder and subject and to, if necessary, support the de facto primary negotiator with the skills of the assembled negotiation team and to work towards removing the untrained de facto negotiator in due course when the Subject is able to indicate that they accept a transfer of the negotiation to a trained negotiator."

In oral evidence, Dr Diamond reiterated that police negotiators are "trained to work in that ambivalent space where the will to live and the will to die is equally balanced"; he explained that suicidal intent peaks and wanes, and that although someone might be intensely suicidal at one given moment, by "elongating" the process "the chances of success are much greater". He went on to state: "So one works with that ambivalence and the whole key to it is about meaningful communication, slowing down the intensity, allowing a process of extinguishment of the suicidal drive to come into play and creating safety."

What if any are the lessons that can be learnt from these tragic circumstances?

The recommendatory power outlined in s. 82 of the *Coroners Act* is the distillation of the coroner's death prevention role, "speaking for the dead to protect the living". Lessons can often be learnt from the close examination of a single death, and while it is prudent to acknowledge the limited scope of the inquiry, it is equally important to identify areas of possible improvement as they emerge.

In this regard, the inquest proceeded against the background of the NSW Police Force's insight and proactivity in relation to the circumstances surrounding Mr Bale's death.

There were three areas that emerged for consideration. Firstly, the need for increased training of Radio Operations Group and Police Link Command staff regarding the "mental state" of a caller, secondly, the possible amendment of the Standard Operating Procedures that deal with the management and transfer of suicidal callers and finally the need for additional training for Police first responders dealing with suicidal people. I will deal with each in turn.

Training of Radio Operations Group and Police Link Command staff regarding "mental state" of a caller

The Court was advised of the following proposed change within the NSW Police Force Police Link and Radio Operations Group ("ROG") Command regarding the management of suicidal callers:

"An increase in awareness during triple '000' initial training programs of ROG and PoliceLink in relation to the current SOPs for providing relevant information in real time via CAD relating to the "mental state" of a person. This may include information that will assist police managing the scene, such as information provided in relation to the subject matter of the conversation and any relevant information such as the reasons for a suicide attempt, all of which assist in determining the mental state of a person".

S/Sgt. Cooney, relevantly the Manager of the Education and Development unit within the PoliceLink Command (since August 2011), gave oral evidence at the inquest. Her role includes the training of telephonists. In oral evidence, S/Sgt. Cooney explained that:

"…What we also want to include in our training is … to make sure that they're [telephonists] aware that other information that may be relevant for the police who are - whether they be trying to build rapport or conduct unplanned negotiations so the information that would go into that may not be on appearances going to assist the police in terms of managing the specific incident, for example firearms, weapons, but it might be information about how a change in their psychological state, might be happy to talk about the football team on the weekend, that might be something that the negotiators or police can use for rapport building, so that might be important information that can go into the CAD, so that's the sort of stuff that we want to expand, about psychological state."

S/Sgt. Cooney confirmed that the circumstances of Mr Bale's death were "heavily involved" in informing this proposed training reform.

Additionally, in relation to PoliceLink telephonist training material, Dr Diamond commented upon a NSW Police training document, extracted in the statement of S/Sgt. Cooney. In relation to certain material set out under the heading 'Mental health issues', Dr Diamond stated that training telephonists as to mental health issues was an "extraordinarily complex task". However, he had no idea what certain medical disorders referred to in it were (notwithstanding his efforts to find out) – ie. Mitoliaisa disorder; further, certain comments within the document were "ignorant and not useful".

He suggested it was a good idea for the document to be revisited. In response S/Sgt Cooney accepted that the material wasn't as comprehensive or as up to date as it might be and stated "we can look at that certainly". The Court trusts that this important task can occur with expert advice as soon as practical.

S/Sgt. Cooney was an impressive witness clearly dedicated to identifying systemic improvement within her command, and ensuring that any lessons which can be extracted from Mr Bale's tragic death are taken on board.

Given the changes to the training program which have been proposed (and indeed, may already be operative), and the apparent commitment of the NSW Police Force (and in particular, S/Sgt. Cooney) in this regard, it is not apparent that any specific recommendation is necessary.

Proposed amendments to NSW Police Force telephony and dispatch training and procedures

The Court was advised of proposed amendments to the Standard Operating Procedures ("SOPS") of the ROG and PoliceLink Command in relation to the management of suicidal callers. Specifically, it was proposed that the triple '000' emergency PoliceLink/ROG Telephony and Dispatch SOPs would be amended to provide for a specific procedure to allow telephonists to transfer suicidal callers to nominated police officers, and provide a relevant "live" briefing to the receiving officer during an initial introductory phase, and then 'hand-over' the call after completing their involvement.

Certain safeguards are incorporated into the procedure to ensure that the nominated officer is apprised (via VKG) that they are about to receive the call.

Mr X for his part stated that in terms of any learnings to take from Mr Bale's death, he believed that the "transition from [the '000' call] to people at the scene may have been done in a more positive way", expanding as follows:

"…The transition of that phone call and having spoken to senior members of the communications branch, it is something that could be looked at or will be looked at and trying to put things in place so that that transition will be more positive in the future and it may well be that those sorts of phone calls can transition to police at the scene who have the situational awareness of what's taking place, the information on the ground and then can be introduced and start making phone calls."

Inspector Seddon, the critical incident investigator, gave evidence that he agreed with the proposed amendments to the telephony and dispatch procedures of the NSW Police Force.

In oral evidence, Dr Diamond also confirmed that he had reviewed the proposed amendments to the telephony and dispatch SOPS of the NSW Police Force and agreed the proposals were sensible.

As to the status of the proposed changes, S/Sgt. Cooney stated that the proposed changes had been agreed to by both commanders of the ROG and PoliceLink, however following review there were some further "small changes" which were necessary. Otherwise, she anticipated there would not be any issues having the changes approved and put in place.

On 12 October 2016 however, Counsel for NSW Police advised the Court that the proposed changes were subject to the imprimatur of an Assistant Commissioner, and that no time-frame for approval had been provided. It is submitted that the NSW Police Force has been commendably reflective and proactive in dealing with the issues raised by the inquest and attempting to effect a change to the relevant procedures in advance of the inquest. However, the status of the proposed changes is presently unclear – whilst it initially appeared that they were soon to be ratified, it later emerged that a further level of approval is necessary.

Given the potential implications of the "completion" act of terminating a call with someone in the process of suicide, it is submitted there is a clear, and pressing need for amendment to the telephony and dispatch procedures in the general form proposed by the NSW Police Force. Accordingly, I make the following recommendation to the NSW Commissioner of Police,

Recommendation 1:

That the NSW Police Force seek to implement (with expedition) the proposed amendments to the triple '000' emergency PoliceLink/ROG Telephony and Dispatch SOPs (in the form of Annexure A or similar thereto) providing for telephonists to transfer suicidal callers to nominated police officers at the scene.

Training of NSW Police Force first responders

Dr Diamond was also asked about the need for corresponding training of first responders (who not infrequently find themselves attempting to deal with the scenario that unfolded on 29 September 2014):

"In ordinary policing and from my experience it has been police are focused on engaging in a situation, be it a high risk setting or general policing one, and making their presence relevant in that situation, dealing with control issues and bringing that situation into some sort of first control and then resolution and that fits standard operation procedures and it fits standard policing first responder requirements is to inject police protocols into disorganised, chaotic, dangerous, conflicted scenarios and to do it quite rapidly and to assert the position of police. However, I have had a number of experiences where it's been a suicide situation very close to a completed suicide where that same urgency is injected into the situation where it really shouldn't be. Something else is required**.** Now we train negotiators to understand that but if that information could be spread more widely amongst general duties and other first responder police that would be a helpful added knowledge to have."

Further, Dr Diamond stated that (by analogy with police negotiators), they would often simply observe what was going on where a first responder had made the initial contact,

and “then work out a way to introduce themselves into the dialogue”. He subsequently explained that:“… there is a simple message about not all jobs need to be attended to rapidly. Sometimes there is a place for slowing things down and gathering information and it's different information. You know, police information is often based on what is likely to amount to evidence. In this sort of world evidentiary material is not that important, it's contextual material, it's interpretative material and understanding what is occurring at a given time that is far more important and that's counterintuitive to most operational police officers. It's not a criticism, once again, it's just very different from what they are normally tasked with. … So if that idea could just be part of a more generic training for broader groups of first responders; that not every job needs a rapid response.”

Additionally, Dr Diamond explained that the first responder would be better served by understanding what had occurred in a situation to date; information conveyed by CAD only captured a certain aspect of what was occurring (address, age, weapons), but did not give much in the way of interpretive or contextual information. In this instance, transfer of information as to the nature of the incident (being a suicide in progress), and ensuring the first responder was aware of it, was important.

Mr X also agreed that there was a need for first responders to be trained as to the risks inherent in terminating a call with someone as intensely suicidal as Mr Bale.

For his part, Inspector Seddon also agreed as to the need for training of first responders in high risk situations in terms of the risks of terminating contact with a suicidal caller, and also regarding operation of the new (proposed) procedures for the transfer of callers by telephonists.

It is submitted that the evidence also underscores the need for further training of first responders in dealing with suicidal persons (including where there is a suicide in progress), in appreciating that terminating contact with such persons may be an act of completion – and hence ought to be avoided at all costs. This is the clear evidence of Dr Diamond, an experienced expert witness in the area whose evidence was uncontested. As set out above, the need for such training was also unequivocally accepted by Mr X and also Inspector Seddon.

Further, such training is the corollary of the proposed amendments to the telephony and dispatch SOPS.

Moreover, training of first responders as to the need to obtain relevant contextual information (beyond pure evidentiary material), as advanced by Dr Diamond, would seem highly desirable. Accordingly, I make the following recommendation to the NSW Commissioner of Police,

Recommendation 2: That the NSW Police Force give consideration to appropriate training for first responders in dealing with suicidal persons in high risk situations including with respect to the potential implications of terminating existing communication, the possibility of having telephonists transfer calls to the scene, and the need for gathering contextual information.

Formal Finding:

Identity of the deceased

As to identity, the deceased was Mr John Inman Bale, aged 60.

Place of death

The place where Mr Bale died was his home, 36 Arndill Avenue, Baulkham Hills, Sydney.

Date of death

The date that Mr Bale died was 29 September 2014.

Cause of death

The Court has the benefit of the autopsy report of Dr Kendall Bailey dated 31 March 2015.

Dr Bailey found, in unequivocal terms, that the cause of death was a single gunshot wound **to the** head.

Manner of death

From the evidence, it is submitted that the precise manner of Mr Bale's death is clear. The evidence establishes that sometime between 7.39 am (being the time Mr Bale's call with the PoliceLink telephonist concludes) and 10.47 am (being the time Mr Bale is first seen deceased on his bed by police) on 29 September 2014, Mr Bale used an unregistered a .22 calibre Lithgow bolt action rifle to shoot himself.

Mr Bale's intention

It is submitted that the evidence overwhelmingly establishes Mr Bale intended to take his own life.

ANNEXURE A – AMENDMENTS PROPOSED BY NSW POLICE FORCE

1. Adding the following to the current Self Harm/Suicide – Threat/Attempts in Progress – Telephony SOP:

    a. In the event that a request for the telephonist to terminate the call is received:

        i. Prior to terminating the call, ensure dispatch have advised requesting police that the caller is currently engaged in conversation and that the call can be transferred to a nominated phone number at the scene instead of terminating.

    b. If the decision to terminate the call is confirmed, the telephonist will terminate the call accordingly.

    c. If a decision is made to transfer the call:

        i. prior to conferencing the call with the nominated officer, confirm police at the scene are aware that a suicidal caller will immediately hear the police at the scene on the call from the time the call is answered (this confirmation is coordinated by ROG Dispatcher via CAD);

        ii. obtain the first name and phone number for the nominated officer receiving the transferred call;

        iii. advise the caller that the call is to be transferred to (insert transfer first name here) who wants to talk to them, and advise the caller that they will hear a phone ringing. Confirmation to be provided to the caller that the telephonist will remain on the phone too;

        iv. advise the caller not to hang up;

        v. telephonist to initiate conference call via "consultant" (ROG: Conference) button

        vi. (the caller will be placed on hold for a short period hearing TZ recorded message).

vii. Telephonist dials nominated officer's phone number, then immediately clicks on the "instant call conference" (ROG: complete conference) button which will take the caller off hold so the caller will hear the ringing tone and then the nominated officer will answer;

viii. introduce the caller to the nominated officer – for example "John (caller), I have Sam (police at scene) on the line who wants to continue chatting to you."

ix. introduce the nominated officer to the caller and provide any relevant information that might assist with the communication with the caller – e.g. "Sam, I have John here who I have been talking to about his current situation, he's got an appointment at his psychiatrist next week and doesn't want to go back to hospital, so wants to end his life. John has also told me he's got four adult children and a family property in Bathurst";

x. once police at the scene have taken over the conversation with the caller, the telephonist is to terminate their line and the officer and the caller will continue on the call.

2. Add the following to the current Self Harm/Suicide – Threats/Attempts in Progress – Dispatch:

a. In the event that a request for the telephonist to terminate the call is received:

i. advise requesting police that the caller is currently engaged in conversation/still on a call with the telephonist and that the call can be transferred to a nominated phone number at the scene instead of terminating.

ii. If decision to terminate the call is confirmed and not to transfer:

1. advise the telephonist of the request to terminate and not transfer;

iii. If decision is made to transfer the call:

1. advise police on the scene that the caller will immediately hear the police at the scene from the time the call is answered;
2. record acknowledgement of this information in CAD as the telephonist will not attempt to transfer the call prior to confirming this;
3. obtain first name and phone number for transfer of call and add to CAD message for the telephonist.

9. 307093 of 2014

Inquest into the death of Garry Weigand. Finding handed down by Deputy State Coroner Lee at Glebe on the 16th November 2017.

Introduction

Garry Weigand died on 18 October 2014 whilst in lawful custody. He had been placed in custody only 17 days prior to his death after being arrested and charged with an extremely serious offence.

Why was an inquest held?

When a person's death is reported to a Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.

Section 23 of the *Coroners Act 2009* (the Act) makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. This is because when a person is imprisoned or held in lawful custody as a result of allegedly breaching a law, the State, by depriving that person of their liberty, assumes responsibility for the care of that person. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure that the State discharges its responsibility appropriately and adequately. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

Garry's life

Before going on to set out the findings from the inquest it is appropriate at this point to recognise, and say a few brief words about, Garry's life. Much of the evidence that is gathered in a coronial investigation relates to the final period of a person's life. That final period is often measured in hours, minutes and, sometimes, seconds. That final period is often intensely scrutinised during an inquest.

These circumstances rarely allow for much consideration to be given to the (usually) years of life that preceded a person's death, who that person was, and how their death has impacted their family and loved ones. Therefore it is important to recognise the life of that person in some small, but hopefully meaningful, way.

Garry was born in Sydney in 1958 to Jill and William Weigand. He and his older sister, Maria Doolan, lived with their parents in the Granville area before later moving to Pearl Beach on the Central Coast.

When Garry was 5 or 6 years old he was involved in an incident where he was struck by a motor vehicle whilst crossing the road. Garry suffered a number of injuries and it was later discovered that he had sustained damage to his brain leading to impairment of his intellectual functioning.

Garry initially went to Umina Primary School but his family later returned to Sydney due to a change in his father's work. Upon the family's return to the Granville area Garry attended a school which was able to provide specialist assistance with the learning difficulties that Garry had developed due to his brain injury.

Some years later, Garry and his parents returned to the Central Coast after his parents bought a house in Budgewoi. According to Ms Doolan, Garry enjoyed life on the Central Coast; he became an enthusiastic member of the local surf club and spent much of his time fishing. Garry also attended a local TAFE in order to improve his literacy skills.

Sadly both of Garry's parents passed away some years later. However Ms Doolan and her family had moved to the Budgewoi area by this time and they continued to see Garry regularly and support him. Ms Doolan asked Garry if he wanted to live with her family, but Garry was insistent that he was capable of living independently. Over the following years Ms Doolan continued to visit Garry regularly and proudly discovered that Garry was capably looking after himself and his parents' former house.

Sometime in 2002 Ms Doolan noticed a change in Garry's behaviour as he became more forgetful and would repeatedly talk about the same topic. Ms Doolan arranged for Garry to be seen by a specialist physician who informed them that due to Garry's brain injury as a child it was likely that his neurological functioning would deteriorate as Garry grew older.

In the years following this, Ms Doolan noticed that Garry began to drink alcohol more frequently and that he began to gamble. Despite having some concerns about Garry's ability to manage his own finances, Ms Doolan saw that Garry was still able to live independently.

Events in 2013 and 2014

Sometime in early 2013 Garry met Sandra Deacon at a social event organised by a not-for-profit organisation that engaged with people in the community with intellectual impairment. Garry and Ms Deacon formed a relationship shortly afterwards. Sadly, it appears that the relationship between Garry and Ms Deacon was a volatile one and was an on-and-off type relationship.

Sometime in March 2014 Garry began behaving erratically. He made a number of public accusations against Sandra, including that she was using illicit drugs. This erratic behaviour continued into the following month. In late April 2014 Greg Boulton, one of Garry's friends, told Ms Doolan that Mr Weigand was not well. Ms Doolan went to see Mr Weigand and discovered that he appeared to be terrified and repeatedly said that some unnamed people were going to harm him. Mr Weigand also said that he believed that listening devices had been placed in his home and that his phone calls were being monitored.

Ms Doolan thought that her brother was suffering from some mental health issues and so she took Garry to Wyong Hospital on 27 April 2014 for treatment. Garry was diagnosed as suffering from paranoid ideations and it was noted that he had been abusing alcohol. He was prescribed anti-psychotic medication.

After being discharged from hospital, Ms Doolan and her husband stayed with Garry for several days to make sure that he was well. During this period of time they noticed that Garry's mental well-being appeared to improve. It was also during this time that Garry told Ms Doolan that he had been seeing Ms Deacon regularly and described her as a "bad influence". Garry also said that he did not want to see Sandra anymore. According to Ms Doolan, Garry seemed to be somewhat scared of Sandra. Exactly why Garry made these comments, and the reason for this attitude towards Ms Deacon, is unclear on the available evidence. However, it appears that Garry's deteriorating mental condition was likely a contributory factor.

What happened on 30 September 2014 and 1 October 2014?

Several of Garry's neighbours noticed that he was behaving erratically during the day on 30 September 2014. They also noticed that the lights at the back of Garry's house remained on late into the night, which was unusual. At about 11:20pm on 30 September 2014, the residents of 152 Scenic Drive, Budgewoi saw Garry in the front yard of their neighbouring house. This house is approximately 500 metres from Garry's address. The residents saw that Garry was dressed only in his underpants and was behaving erratically. The residents contacted the police.

Two police officers arrived on the scene at about 11:34pm. They saw that Garry was still in the front yard of the house. They also saw that Garry had what appeared to be blood on his hands and feet. Arrangements were made for an ambulance to take Garry to Wyong Hospital for an assessment, accompanied by one of the police officers.

At about 12:10am on 1 October 2014 police officers went to Garry's address. They found the front door open and most of the lights on inside the house. The rear door was also open. At the back of the house the police officers found Ms Deacon, unresponsive, lying at the bottom of a set of steps, with her head resting on the bottom step.

It was immediately obvious to the police officers that Sandra was deceased and that she had suffered a number of serious injuries to her head. Paramedics were called. They arrived at the scene at 12:20am and confirmed that Sandra was deceased.

After Sandra's body was discovered the police officer who was in the ambulance accompanying Garry to hospital was alerted. The police officer placed Garry under arrest, whilst in the ambulance, and made arrangements for him to be transferred to a police vehicle. Garry was taken to Wyong police station, charged with Ms Deacon's murder, and placed into custody.

Custodial history

Due to the serious nature of the offence that Garry had been charged with, the fact that Garry had been placed in custody for the first time, and because he was identified as someone with mental health issues, a Risk Intervention Team (RIT) protocol was initiated. This required Garry to be placed under observation whilst in custody and eventually assessed by a psychiatrist.

Garry was initially kept at the Sydney Police Centre in Surry Hills but on 4 October 2014 he was transferred to the Metropolitan Remand and Reception Centre (**MRRC**) in Silverwater. The RIT protocol remained in place until 7 October 2014 when Garry was assessed by a psychiatrist.

Following that assessment Garry was placed in a cell on his own and kept under observation whilst waiting to be transferred to the MRRC Mental Health Screening Unit (**MHSU**). On 16 October 2015 Garry was transferred to the MHSU where he was assessed and placed in a cell on his own in the acute area of the unit.

What happened on 18 October 2014?

At 3:30pm on 18 October 2014 Garry and the other inmates in the MHSU were locked in their cells for the night. Sometime later Garry was given his evening meal by Corrective Services NSW (**CSNSW**) officers. He told the officers that he felt unwell and, as a result, only ate 2 pieces of fruit and not the rest of his meal.

Sometime during the afternoon, before 6:00pm, a Justice Health and Forensic Mental Health Network (**Justice Health**) nurse, Edwin Coronel, and 2 CSNSW officers went to Garry's cell in order to give him his prescribed medication.

When they arrived at the cell Garry was standing up and appeared alert, however he told the nurse that he was feeling nauseous. Mr Coronel told Garry that he would come back to see him after he finished his medication rounds.

After finishing distributing medication to the other inmates, Mr Coronel went to the dispensary and obtained a bottle of metoclopramide, medication used to treat vomiting and nausea. Mr Coronel and some CSNSW officers returned to Garry's cell sometime between 6:15pm and 6:30pmm and asked him if he was still feeling nauseous. Garry confirmed that he was and Mr Coronel gave him a 10mg tablet of metoclopramide. This was the last occasion that Garry was seen alive.

At about 10:50pm a CSNSW officer was carrying out a routine head check in the cell area where Garry was housed. The officer opened a flap on the door to Garry's cell and saw that Garry was lying motionless across his bed, with his feet on the floor and his head resting against the wall. Believing Garry to be asleep, the officer called out Garry's name and knocked on the cell door in an attempt to wake him.

When Garry did not respond the officer became concerned and alerted a fellow officer who in turn called Justice Health staff for assistance. An ambulance was called for and arrived on the scene a short time later. However, Garry could not be revived and was later pronounced deceased.

What was the cause of Garry's death?

Garry was later taken to the Department of Forensic Medicine at Glebe. Dr Kendall Bailey performed the post-mortem examination on 20 October 2014 and later prepared an autopsy report dated 23 March 2015.

In her report Dr Bailey noted that microscopic examination of the lungs revealed widespread acute bronchopneumonia. Dr Bailey ultimately concluded that this was the cause of Garry's death.

However, Dr Bailey also noted two other clinical findings from the autopsy. Firstly Dr Bailey found that microscopic changes in the heart (fatty change, fibrosis and focal inflammation) suggested that Garry may have had a condition known as arrhythmogenic right ventricular dysplasia (**ARVD**).

This is an inherited heart disease caused by genetic defects of parts of the heart muscle. Dr Bailey explained that ARVD is linked to cardiac arrhythmia (which may cause sudden death) and it could not be excluded as a contributory factor to Garry's death.

Secondly, Dr Bailey noted that Garry had a reported history of seizures on a background of brain injury as a child, and that he had not been prescribed any anti-epileptic medication. Given these factors Dr Bailey also noted that seizure activity could not be excluded as a contributory factor to death.

Given Dr Bailey's findings, an independent expert was briefed to consider the autopsy results and the circumstances of Garry's death. This second issue will be discussed in more detail below. Professor David Bryant, a specialist respiratory physician, was asked to consider these issues and to provide an expert report. Professor Bryant's report dated 19 April 2017 was tendered into evidence at the inquest.

Professor Bryant noted that Garry was last seen alive around 6:15pm on 18 October 2014 and was discovered to be deceased at 10:50pm, almost 5 hours later. Professor Bryant explained that, in his opinion, it is highly unusual for pneumonia to progress from minimal symptoms (such as the nausea that Garry was complaining of before 6:15pm) to death within a period of about 5 hours.

Professor Bryant concluded that the pneumonia which Garry had acquired was progressively fatal, but would not have proved fatal in itself. Given the autopsy findings in relation to possible ARVD, Professor Bryant concluded that it was likely that Garry was suffering from this condition at the time of his death.

Professor Bryant explained that if this was the case, the ARVD made the pneumonia severe enough to provoke a sudden and fatal cardiac arrhythmia. As cardiac arrhythmia is a physiological phenomenon it is not possible to demonstrate it at autopsy and there will be no clinical findings to confirm it.

CONCLUSION: I accept the evidence from Professor Bryant that it would be unusual for the cause of death to be pneumonia alone given the relatively short period of time between the onset of minimal symptoms and eventual death. The autopsy findings support a conclusion, on the balance of probabilities that Garry was suffering from undiagnosed and untreated ARVD. The combined effects of this condition and the pneumonia that Garry had acquired resulted in Garry suffering a fatal cardiac arrhythmia which caused his death.

Was Garry's care appropriately and adequately managed whilst in custody?

As Garry had complained of nausea and general malaise in the hours before his death, the response by Justice Health and CSNSW staff to these complaints needs to be considered and examined. This is done to answer the question of whether appropriate and adequate care was provided to Garry.

Professor Bryant was asked to consider this issue. Professor Bryant firstly noted that Garry had had a very high alcohol intake (up to 24 beers a day) prior to entering custody. Professor Bryant explained that heavy alcohol intake is known to suppress the immune system and make persons more susceptible to the risk of respiratory infection. In his report Professor Bryant also noted that in his interactions with Justice Health and CSNSW Garry had none of the symptoms that are usually associated with pneumonia such as cough, fever, breathless and pleuritic chest pain. On this basis Professor Bryant concluded that when Garry was last seen at about 6:15pm by Mr Coronel and the CSNSW officers, Garry had no symptoms to suggest a diagnosis of pneumonia.

In Professor Bryant's opinion there was no clinical reason to suspect that Garry was suffering from a serious medical condition. This is because his only symptoms were nausea and lack of appetite, both of which were non-specific. Professor Bryant also noted that when Garry was seen on 9 October 2014 he denied any respiratory symptoms and any past history of asthma, and that a chest examination disclosed no abnormality. In these circumstances, Professor Bryant explained that diagnosing Garry's pneumonia would have been problematic and could only have been done after very detailed examination and a chest x-ray.

It appears that Garry's immune system was suppressed by his heavy alcohol use prior to entering custody. This made him more susceptible to respiratory infection which led to acute pneumonia. However, Garry displayed none of the usual symptoms associated with pneumonia during any of his interactions with Justice Health and CSNSW staff and instead was showing only non-specific symptoms.

CONCLUSION: Based on Garry's presentation on 18 October 2014, and his earlier known medical history, there was no clinical reason for Justice Health or CSNSW staff to suspect that Garry was suffering from a serious medical condition. There was also no clinical reason for Justice Health or CSNSW staff to believe that any further medical investigation on 18 October 2014 was warranted. Therefore, I conclude that the care provided to Garry whilst in custody, particularly on 18 October 2014, was adequate and appropriate. There is no evidence to suggest that any inaction by Justice Health or CSNSW staff contributed to Garry's death.

Formal Finding:

Identity

The person who died was Garry Weigand

Date of death

Garry died on 18 October 2014.

Place of death

Garry died whilst in lawful custody at the Metropolitan Remand and Reception Centre in Silverwater NSW.

Cause of death

Garry died from a fatal cardiac arrhythmia due to complications from acute bronchopneumonia and arrhythmogenic right ventricular dysplasia.

Manner of death

Garry died from natural causes.

10. 315543 of 2014

Inquest into the death of Ronald Brizzolora. Finding handed down by Deputy State Coroner O'Sullivan at Glebe on the 17th March 2017.

Introduction:

This is an inquest into the death of Ronald Brizzolara, who died on 25 October 2014 in custody at Long Bay Correctional Centre, Malabar NSW. He is survived by his sister, Wendy.

The Inquest:

The function of this inquest, as reflected in s. 81 Coroners Act 2009 ("the Act"), is to identify who has died, the date and place of death, and the manner and cause of death. Section 82 of the Act permits the Coroner to make such recommendations she considers necessary or desirable in relation to any matter connected with the death. As Mr Brizzolara died in lawful custody, this inquest is one that is required to be held.

The Evidence:

Background:

Mr Brizzolara was born on 1 April 1954 and he was therefore 60 years old at the time of his death. He identified as Aboriginal. At the time of his death he was serving a 7-year term of imprisonment for sexual offences against children, commencing 12 March 2012, with an earliest parole date of 12 March 2017. Mr Brizzolara had a substantial criminal history, mainly for offences of dishonesty, commencing in 1964 when he was aged just 10. In about 1990 he moved from western Sydney to far western New South Wales, at Broken Hill, where he later committed the offences for which he was incarcerated.

Mr Brizzolara suffered from very poor health. He was diagnosed with end stage Chronic Obstructive Pulmonary Disease (COPD), congestive cardiac failure, ischaemic heart disease and hypertension, kidney and liver disease, in the context of a 40-year smoking habit and a family history of heart disease and stroke. His condition left him short of breath and with very restricted mobility and it resulted in regular admissions to hospital, most recently in April 2014 after suffering respiratory arrest.

Justice Health staff treated Mr Brizzolara in custody with various medications and reviewed his condition regularly, including by referral to respiratory specialists.

He had a nebulizer machine in his cell. In about August 2014 his treating specialist also applied to Enable NSW for funding for a Bi-level breathing machine, which had been recommended, but it does not appear that it was obtained prior to his death.

In view of Mr Brizzolara's poor health, he agreed to a "No CPR" order, accepting that CPR was not likely to be successful and should therefore not be initiated. The records show that he agreed to this course from September 2013 and he confirmed his intentions when he was last discharged from hospital on 30 April 2014.

There is ample evidence in the brief to show that Mr Brizzolara accepted he was likely to succumb to his illnesses, and at some stages he refused treatment, although he was not considered suicidal.

In May 2013, on account of his poor health, Mr Brizzolara had been transferred from Parklea CC to the Metropolitan Special Programs Centre ("MSPC") at Long Bay CC. He was held in cell 11, within the Kevin Waller Unit at MSPC1. That Unit accommodates older inmates and those with health issues. Mr Brizzolara was in a one-out placement, meaning he was the only occupant of the cell.

Events of 25 October 2014:

On Saturday 25 October 2014 at 2.05pm Corrections Officer ("CO") Djoeandy performed the daily lock-in. He attended Mr Brizzolara's cell, said "all good?" and in response Mr Brizzolara nodded and said "good night". Officer Djoeandy then locked the cell for the day. This is the last confirmed time that anyone saw Mr Brizzolara alive.

At about 6pm, CO Datta and CO Picker assisted the Justice Health nurse to issue medicines in the Kevin Waller Unit. The medical records show that Mr Brizzolara was given his evening medication that day, at 4pm and 8pm however, it does not appear that any officer actually entered Mr Brizzolara's cell at those times. The notes therefore probably just reflect the fact that Mr Brizzolara already had his medication within his cell.

Cell 12, next door to Mr Brizzolara's cell, was at this time occupied by an inmate called Kevin Smith. Mr Smith was later interviewed by police. He told them that Mr Brizzolara had complained of weakness in his legs during the day. During the evening, Mr Smith could hear the nebulizer machine which Mr Brizzolara used.

At around 8.30pm to 9.00pm, Mr Smith heard a banging noise that sounded like something heavy hitting the floor. Mr Smith knocked on the wall and yelled out to Mr Brizzolara but there was no response. Mr Smith then pressed his cell alarm. For reasons which will become clear, that cell alarm was never answered

At 10pm the "B" watch commenced duty. When the new watch commences, the routine includes checking all inmates. At about 10.57pm CO Kark attended the Kevin Waller Unit to perform that check. As he approached cell 12, Mr Smith says he told Officer Kark to check Mr Brizzolara. Officer Kark approached cell 11, turned on the light and observed Mr Brizzolara lying on the floor on his left side, facing the left side wall. A short while later, CO Kark went to get assistance from the Night Senior, Senior Corrections Officer Krishnan.

A few minutes later, SCO Krishnan, CO Heyne, CO Anstice and CO Kark attended cell 11. SCO Krishnan brought with her a rapid response kit containing personal safety equipment. The cell door was opened and SCO Krishnan called Mr Brizzolara's name, to which there was no response. Mr Brizzolara was blue and blood was observed coming from his mouth. Shortly afterwards CO Heyne and CO Kark commended CPR.

CO Anstice called the gatehouse, who asked Nurse Hinde to attend. At that time Nurse Hinde was located in the clinic in 13 Wing and she says it took her approximately 10 minutes to reach cell 11. En route to the cell she discovered that the person she was attending was Mr Brizzolara. Mr Brizzolara was known to her and she knew he was "Not for Resuscitation". Accordingly, she informed Correctional Officers they should cease CPR. She performed an examination when she attended Mr Brizzolara at 11.12pm and confirmed that he was deceased.

Ambulance officers attended the gaol at 11.26pm and they too confirmed that Mr Brizzolara was deceased. Police arrived at the scene at shortly after midnight.

Cause of death:

No autopsy was performed, as the available evidence allowed the cause of death to be established as arising from natural causes. The medical cause of death was certified to be Congestive Cardiac Failure, the antecedent cause being end stage COPD and other significant conditions being Ischaemic Heart Disease and Obesity.

Cell call alarm system:

As with all cells, Mr Brizzolara's cell was fitted with a distress alarm or cell call alarm system. This operates in the following way. Pressing the alarm causes an alarm chime or beep at an officer station located at the end of the wing.

Pressing the alarm also illuminates a red light in the cell which remains lit until cancelled. When the call is answered, the officers can speak to the inmate and cancel the alarm.

The system is also designed so that, after a timed delay, the alarm is relayed through a network and sounds at further locations in sequence. The alarm is relayed first to the Night Senior's office, then to Gatehouse and finally to the Complex monitor room. Provided the network is operational, the alarm call and the duration of the call is also recorded on a system log.

Given the obvious importance of having working cell call alarms located inside cells, Corrective Services NSW has a system of integrity checks in place. This is as follows:

- Every week, all cell call alarms are manually activated and checked.

- Every day, six cell alarms per unit are randomly selected and checked.

- One of those cell alarms is also checked to ensure it is relayed through the complete pathway (from officer station to monitor room).

- When an inmate is placed in a cell, the cell alarm's complete pathway is checked.

- These checks are recorded in the Inmate Accommodation Journal.

The system log supports a conclusion that these checks were conducted as required. Mr Brizzolara's cell call alarm was last activated during the weekly check on Sunday 19 October 2014. The next weekly check was due to take place on 26 October 2014, the day after Mr Brizzolara died.

SCO Krishnan performed the daily check on 24 Oct 2014, selecting two cells in the Kevin Waller Unit (cells 6 and 7). She recorded that these were operating correctly and this is confirmed in the system log. However, those cells are in a different part of the Kevin Waller Unit. Mr Brizzolara's cell (cell 11) was in "8 Wing", whereas cells 6 and 7 were in "32 Wing" (identified in the system log as "KWU").

As for the daily checks on 25 October 2014, there is no clear evidence as to which cells were checked, although the relevant Inmate Accommodation Journal records that checks were made as required.

The system log shows that a number of cell alarms were activated by inmates on the day of Mr Brizzolara's death. The several alarms are recorded from 7 Wing, mainly from cell 55, and also from cells 5 and 10, which are located in 32 Wing (the other part of the Kevin Waller Unit.) COs Datta, Letby and Picker recall that they attended cell 55 in 7 Wing at various times that day due to problems with the power to that cell.

No alarms are recorded at all in the system log for 8 Wing from the time of the weekly check on 19 October 2014 until after Mr Brizzolara's death. This is consistent with the evidence of the staff on duty at the time.

Mr Brizzolara's cell call alarm:

When the Officer in Charge Detective Senior Constable Young attended cell 11 after Mr Brizzolara's death, he observed that the cell call alarm light was lit, indicating that the alarm had been activated prior to the arrival of police. Checks demonstrated that the alarm did not relay through to the Night Seniors office as it was designed to, and also as a consequence did not register on the system log. It was therefore apparent that there had been some kind of failure which had affected the network itself.

In the absence of any evidence that another other person activated the alarm, I am satisfied that it was Mr Brizzolara who did so. The alarm must have been activated after Mr Brizzolara was locked in at 2.05pm. Mr Smith told police he heard the Mr Brizzolara activating the nebulizer machine and then at, 8.30pm to 9.00pm, he heard a banging sound. In those circumstances, it is more likely than not that Mr Brizzolara activated the alarm at this point because he was experiencing the difficulties that led to his death.

Investigation into the problem:

Following the discovery of the network failure, Stafford Schultz, a security technician, attended the gaol and examined the network equipment. This is housed within an equipment cabinet in the equipment room at one end of 8 Wing.

The network devices and other items are usually connected to an "uninterruptible power supply" or "UPS", which contains a backup battery that will provide continuous power in the event of a failure of mains power. Mr Schultz observed that the UPS was powered down and that some of the devices attached to it, including signal amplifiers for the inmates' televisions, had been reconnected directly to the power outlet via a power board. Vitally, the equipment that connected the cell call alarms to the network was not connected to a working power supply. The result was that the cell call alarms for 8 Wing were disconnected from the network.

Matt Damaso, who is the Manager Technical Security within Corrective Services NSW, attended the gaol on 27 October 2014 and investigated the problem. He tested the UPS and discovered that it had developed a fault and was not providing power. The records show it had been inspected only four months earlier, on 23 June 2014, when it was found to be in good working order, and it was due to be inspected again after 12 months.

Mr Damaso checked the system log and concluded that the UPS failed at 10:42am on 24 October 2014. From this point forward, cell call alarms activated within 8 Wing would have sounded in the wing inside the equipment room, but would not have been relayed through the network to other locations.

Changes since the death:

At the time of Mr Brizzolara's death, the system did not alert staff sufficiently to the fact that there was a network problem in 8 Wing. This is for the following reason. A separate part of the network, 10 Wing, was being renovated and power to the network equipment in that wing was disconnected. As a result, the system monitors had been displaying the text "network error" for a period of time. When a further network error occurred due to the power fault in 8 Wing, the system monitors did not reveal a new error had occurred; in other words, the problem in 8 Wing was masked by the existing problem in 10 Wing.

Mr Damaso took action to fix the immediate problem and he then made a number of recommendations for changes to the cell call alarm system. By and large these have been adopted, although Mr Damaso also made other recommendations that were not pursued.

A summary of the action taken in response to this death is as follows:

1. In the event of any new failure on the network, an alarm, described as a high pitched tone, is produced in Night Senior's office, Gatehouse and Complex monitor room. This alarm continues until it is manually cancelled.

2. Instead of displaying the message "*network error",* the system monitors now display all network errors in sequence, with a description of the location of the error, so that new errors can be readily identified.

3. The alarm will now be relayed to other locations on the network more quickly. It now sounds in the Night Senior's office after 10 seconds (previously there was a delay of 30 seconds) and it continues at each subsequent location until answered.

4. Staff at the gaol have been trained to identify and respond to network faults.

5. Equipment room locks have been changed and access to these rooms is restricted.

6. The changes have also been communicated to other gaols which operate the same cell call alarm system.

Formal Finding:

The identity of the deceased

The deceased person was Ronald James Brizzolara.

Date of death

He died on 25 October 2014.

Place of death

He died at Long Bay Correctional Centre, Malabar, NSW.

Cause of death

The death was caused by Congestive Cardiac Failure
Antecedent cause: Chronic Obstructive Pulmonary Disease
Other significant conditions: ischaemic heart disease; obesity.

Manner of death

He died in custody of natural causes.

In light of the changes already made by Corrective Services NSW following Mr Brizzolara's death, no further recommendations are necessary or desirable in this case.

10. 368701 of 2014

Inquest into the death of Tori Johnson. Finding handed down by State Coroner Barnes at Sydney on the 24th May 2017.

The identity of the deceased

The person who died was Tori Enstrom Johnson.

Date of death

Mr Johnson died on 16 December 2014.

Place of death

He died in the Lindt Café, Martin Place, Sydney, New South Wales.

Cause of death

The cause of his death was a gunshot wound to the head.

Manner of death

Mr Johnson died when a person who had held him and others hostage in the Lindt Café intentionally shot him in the back of the head with a shotgun at close range. Tori died almost immediately.

11. 368881 of 2014
Inquest into the death of Katrina Dawson. Finding handed down by State Coroner Barnes at Sydney on the 24th May 2017.

The identity of the deceased

The person who died was Katrina Watson Dawson.

Date of death

Ms Dawson died on 16 December 2014.

Place of death

She died in the Royal Prince Alfred Hospital in Camperdown, New South Wales.

Cause of death

The cause of her death was gunshot wounds.

Manner of death

Ms Dawson died when police stormed the Lindt Café in Martin Place in order to free her and others who had been taken hostage by an armed person. A bullet or bullets fired at that person by police officers ricocheted and fragmented and accidentally struck Katrina as she lay on the floor seeking safety, mortally wounding her.

12. 369898 of 2014

Inquest into the death of Man Haron Monis. Finding handed down by State Coroner Barnes at Sydney on the 24th May 2017.

The identity of the deceased

The person who died was Man Haron Monis.

Date of death

Monis died on 16 December 2014.

Place of death

He died in the Lindt Café, Martin Place, Sydney, New South Wales.

Cause of death

The cause of death was multiple gunshot wounds.

Manner of death

Monis died when police officers stormed the café where he had been holding hostages and they returned fire after Monis fired at them as they entered. The police officers who shot Monis reasonably believed that was necessary to protect themselves and others in the café.

The inquests into the deaths of Mr Tori Johnson, Ms Katrina Dawson and Man Monis was conducted by the NSW State Coroner, Magistrate Barnes over a two year period as a special fixture inquest and referred to as “The Lindt Café Siege Inquest”.

The deaths were regarded as deaths within *s 23 of the Coroners Act 2009*.

The findings delivered on the 24th May 2017 by his Honour are too lengthy to be reproduced in this report, they may be accessed at:

http://www.lindtinquest.justice.nsw.gov.au/Documents/findings-and-recommendations.pdf

14. 11170 of 2015

Inquest into the death of Kevin Norris. Finding handed down by State Coroner Barnes at Glebe on the 27th October 2017.

The Coroners Act in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Kevin Michael Norris.

Introduction

On 11 January 2015, shortly before 9.00 pm, Kevin Norris, 38, stormed out of the house he shared with his partner in Mittagong. A few minutes later he entered the local McDonald's outlet and began acting in a manner that caused staff to call police.

When two female officers responded, he did not comply with their reasonable commands and violently resisted them when they tried to take him into custody. With the assistance of two members of the public, Mr Norris was brought under control.

He was carried into a police van and driven to Bowral Police Station where an ambulance crew was waiting. He was carried into a holding cell and lost consciousness soon after.

Mr Norris was transported by ambulance to the Bowral Hospital but did not regain consciousness before he was declared dead at 10.20 pm.

The inquest

An inquest is required by law to be held as Mr Norris' death appears to have occurred while he was in police custody. The inquest must be presided over by a senior coroner.

Section 81 of the *Coroners Act 2009* requires a coroner presiding over an inquest to confirm that the death occurred and make findings as to:-

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

Under s. 82 of the Act a coroner may make such recommendations considered necessary or desirable in relation to any matter connected with the death, including in relation to public health and safety.

In this case, there is no doubt as to the identity of the deceased person, nor the date and place of his death. The inquest focused on attempting to ascertain the proximate and underlying causes of Mr Norris' death and to considering whether the police and the ambulance officers who interacted with him in the last hour of his life did all that was reasonable to prevent his death.

The inquest considered various aspects of police procedures and whether the officers involved adhered to them. It also examined the actions of the ambulance officers who attended at the Bowral Police Station and the circumstances of Mr Norris' physical deterioration.

For those unfamiliar with this jurisdiction, it may be of assistance for them to know that an inquest is not a forum for determining civil liability, or for apportioning blame. It is an opportunity to expose the facts of the matter, with a focus on considering any steps that might be taken to prevent similar deaths occurring, or to otherwise improve public health and safety and the administration of justice.

The evidence

Social history

Kevin Norris was born on 24 April 1976 at Camden. He had one sister and two brothers, one half-brother and one step-brother. He did not do well at school and left after grade 9.

He enjoyed what he described as a "*great childhood*" with both parents working in responsible positions. Although they separated when he was 7, they retained shared custody. He described his mother as "*beautiful*".

He moved out of home at 14 and became an apprentice jockey, later working as a stable hand at Rosehill. Later he attended TAFE and gained the qualifications necessary to become a roof tiler.

He first smoked marijuana at 13 and first took amphetamines when he was 16. He also drank heavily in his teens. This drug and alcohol abuse was to continue throughout his life. Whether it precipitated the chronic mental health problems described below or combined with it independently is unclear, but together this dual diagnosis resulted in Mr Norris having only intermittent employment and itinerant residential accommodation. It also hindered his forming lasting intimate relationships.

Mr Norris had been convicted of a number of relatively minor criminal offences from the age of 14 involving larceny, break and enter, possession of stolen goods, drug possession, property damage, assault and driving with a suspended licence.

Mr Norris continued to have contract with both his mother and father who provided him with emotional and financial support.

At the time of his death he had been living in a *de facto* relationship with Raylene Waters whom he had met in 2006. They formed a relationship and he moved to Goulburn to live with her soon afterwards.

While they were living together, from time to time, Mr Norris got casual work in the area with a tiling contractor.

They separated because of Mr Norris' drug abuse and his on-going need for in-patient psychiatric treatment. They resumed cohabiting about two years before his death. At Ms Waters' instigation they moved to Gunning where she was from because she considered it less likely that he would abuse drugs there because of limited availability.

While they lived at Gunning Mr Norris continued to work as a tiler in Canberra.

The couple and Ms Waters' 15 year old daughter moved to Mittagong only a few weeks before Mr Norris' death. They moved because it was easier for Mr Norris to get to a new job he had obtained in Penrith.

Ms Waters was adamant that Mr Norris had abstained from hard drugs during the period of their reconciliation, although he continued to smoke marijuana and drink alcohol.

Although Mr Norris had a life troubled by mental illness and drug abuse, it seems he was making a sustained effort to get his problems under control until he had a relapse in the days before his death. It is clear he had a loving relationship with his partner and his parents. I offer them my sincere condolences.

Medical history

Mr Norris had a long history of mental illness. As a child he engaged in behaviours that fit the definition of conduct disorder and he reported auditory hallucinations from that time onwards.

As an adult he had numerous involuntary and voluntary in-patient admissions to psychiatric facilities. Once discharged he invariably abused illicit drugs and discontinued his medication. Increased psychosis soon followed.

He was diagnosed with schizophrenia and drug induced psychosis.

He engaged in at least two episodes of reactive aggression which resulted in serious non-lethal physical violence, both associated with psychosis and drug abuse. These occurred in 2009 and 2013 respectively.

At the time of his death Mr Norris was the subject of a Community Treatment Order that required that he receive monthly depot injections of Invega Sustenna, an antipsychotic used to treat schizophrenia, and to take daily doses of Seroquel 200 mg.

In early December, the management of his treatment was transferred from the Goulburn Community Mental Health Service to the Bowral Community Mental Health Service (CMHS).

On 24 December 2014, Mr Norris was reviewed at home by his new case manager and a clinical nurse consultant from the Bowral CMHS. He was administered his depot injection of Invega Sustenna and subject to a mental health risk assessment. He was found to be suffering from no psychotic features and he willingly engaged with the mental health workers. It was planned for him to be seen by a psychiatrist for a routine review in due course. There were at that stage no acute concerns about his mental health.

Events preceding the death

Mr Norris came home from work on Friday 9 January 2015 and it was immediately apparent to his partner that he was under the influence of illicit drugs. He was playing loud music and was very restless. Ms Waters demanded to know if he had any drugs and searched him as best she could without finding any. He refused to take his daily dose of Seroquel.

His presentation deteriorated further the next day. He appeared disassociated and did not seem to understand his situation. He was making incoherent comments with religious references.

Ms Waters was so concerned that she rang his mother who came to the house and agreed that Mr Norris was under the influence of illicit drugs and that he was psychotic. His mother asked him if he wanted to go to hospital but he refused.

It seems Mr Norris again stayed awake all Saturday night and he again refused to take his daily dose of Seroquel.

The next morning, as previously agreed, Mr Norris drove Ms Waters' daughter to St Mary's to collect her boyfriend and to bring him back to Mittagong. The daughter said Mr Norris was quieter than usual on the trip.

On the way back he stopped at two houses in Tahmoor, he said to purchase marijuana. On both occasions when he got back into the car, he told his partner's daughter that he had been unsuccessful.

When he got back home he continued to be remote and distracted in his behaviour. He made bizarre and unfounded suggestions to his partner concerning her fidelity and other matters and insisted on playing music very loudly continuously.

In the evening things deteriorated further, with Mr Norris yelling and throwing things around the house. He demanded Ms Waters give him her phone saying he wanted to call the police. She refused to give it to him and he grabbed her roughly by the hair. Her daughter came out of her room and yelled at Mr Norris to leave her mother alone.

He let go of Ms Waters and ran out the door. As he did so, Ms Waters called the police. As he ran off, Mr Norris yelled out that he was going to report to police that he had been assaulted.

Mr Norris is arrested

Ms Waters' 000 call was received at 8.49 pm. She told the operator she spoke to that her partner, who she named, had assaulted her and that he was on "*ice*" and out of control.

Mr Norris must have gone almost directly to the McDonald's fast food outlet diagonally opposite their townhouse because only a minute and a half after his partner had called police, the manager of the McDonald's outlet also called police.

The manager, Danny Craker, reported that a customer had come in claiming to have been assaulted and requesting that police be called because it was *"a life and death situation".* Mr Craker formed the view that Mr Norris was drug affected – he was unsteady on his feet and had some whitish foam around his mouth.

While Mr Craker was in the back of the store calling police, Mr Norris became increasingly agitated, gesturing at staff and making deranged comments. One staff member gave him a glass of water and he went and lay down along some seats a little away from the main serving counter.

One of the staff members who had observed Mr Norris' behaviour went and found Mr Craker while he was still on the phone to police and reported that Mr Norris was agitated and becoming aggressive. This was also relayed to police and the manager requested assistance.

The information obtained from the call by Ms Waters and the call by Mr Craker was broadcast to all police working in the Bowral District. Senior Constables Amy Finch and Lisa Avnell acknowledged the first incident and headed towards Ms Waters' residence.

As they were making their way there, information provided by Mr Craker was also broadcast over the police radio and Senior Constables Finch and Avnell were redirected to McDonald's as it was correctly assumed that both calls related to the same individual.

After completing the phone call Mr Craker went to the front of the store to see where Mr Norris was. He found him lying down along the seats in the dining section of the café. Mr Norris had a cup of water in his hand and he was yelling out words to the effect; "*We are all going to burn in hell!"*

Other customers became apprehensive about Mr Norris' behaviour and left the store.

About a minute after Mr Craker went to speak to Mr Norris, he stood up and walked into another part of the café that was closed. Mr Craker attempted to stop him by grabbing his wrist but Mr Norris did not take any notice, nor did he react to the attempt to stop him.

Mr Norris walked behind the counter in the closed area and sat down on the floor. He apparently noticed customers leaving because he yelled out "*No one leaves"*. He then apparently changed his mind and told two customers they could leave but insisted that the McDonald's workers must stay.

Mr Craker continued to try and reason with Mr Norris asking him to come outside but he was ignored. Mr Craker signalled to another customer who was nearby to call the police. The customer obliged. That call was received at 8.56 pm.

Mr Norris remained sitting on the floor behind the counter until police arrived. That arrival is recorded in the police radio transcript as occurring at 8.57 pm.

Senior Constable Finch said that when she and Senior Constable Avnell walked into the McDonald's store she observed Mr Norris sitting on the floor behind the serving counter. He appeared to be drinking a cup of liquid. She said words to the effect "*Hey mate, how are you going? We have received information that you have been abusing staff and being disorderly. It is time to leave".*

Senior Constable Finch said that as she was saying this Mr Norris stood up. He appeared agitated and distressed. He repeatedly said, *"Shoot me! Shoot me!*" although at times she thought he may have said he was going to shoot her.

He wasn't coherent and appeared to be in a psychotic state. He then said "*OK I will go* ". Senior Constable Finch attempted to grab his right wrist to escort him out but he refused to leave. He began to pull away from her walking backwards, still behind the counter.

Both officers grappled with Mr Norris, trying to bring him under control. They were unsuccessful. In the struggle his shirt came off and he moved around behind the main serving counter. At this point Mr Norris adopted a fighting stance and both officers said he made some comment about wanting to fight them.

The officers continued to try and negotiate with Mr Norris but drew their oleoresin capsicum (OC) spray canisters just in case. That precaution was well warranted but it proved inadequate in that he suddenly launched himself at them, flailing punches at Senior Constable Finch in particular, and despite both discharging OC spray at his face from close range he continued with his attack.

Senior Constable Avnell was knocked to the ground and Mr Norris continued his attack on her colleague raining punches on her head and upper body. He grabbed her by her hair with one hand and while holding her down continued punching into her head with his other. He swung her around slamming her head against the cash registers.

At one point the officers seemed to get the upper hand and they had Mr Norris down on his haunches, but they were unable to completely gain control of him and he was able to get to his feet and continue the attack.

Because this happened in the confined space behind the serving counter, Senior Constable Avnell could not go to the assistance of her colleague. She was blocked from getting at Mr Norris by his swinging Senior Constable Finch back and forth across the passage way.

Senior Constable Avnell drew and discharged her conducted electrical weapon (TASER) at Mr Norris. The prongs stuck into his body and Senior Constable Finch claimed she felt current pass through him to her but the device had no effect on Mr Norris. As discussed later it was subsequently found the device malfunctioned due to poor maintenance.

The officers were not succeeding in gaining control of Mr Norris and Senior Constable Finch was in danger of sustaining very serious injuries when, fortunately, two bystanders came to their assistance.

The violent struggle between the two police officers and Mr Norris was witnessed by two young men sitting in their car waiting for their takeaway order to be filled.

One of the men, Harry Stephens, reported seeing the officers unsuccessfully attempt to subdue Mr Norris using OC spray and a TASER. Mr Stephens saw Mr Norris throwing punches at both officers. Mr Stephens got out of his car and rushed into the store to help. At about the same time another unidentified male member of the public joined in.

Mr Stephens said that when he got into the store Mr Norris still had hold of Senior Constable Finch's hair and was continuing to punch her. He and the other male member of the public got Mr Norris' hands away from the officer and grabbed hold of Mr Norris in a headlock. He says that about this stage Mr Norris appeared to "*give up*". He slumped to the floor and was lying face down.

Mr Stephens and the other male got hold of Mr Norris' hands and held them behind his back. One of the female police officers then handcuffed Mr Norris. At this point two other police officers arrived and the civilians stepped back.

At around 9.00 pm, Senior Constable David McManus was at the Bowral Police Station when he heard the job requiring assistance at McDonald's Mittagong broadcast via the police radio. He heard the car crew comprised of the two female officers accept the job and he also acknowledged it and indicated that he would provide backup.

When he heard the radio broadcast that indicated the incident was escalating, he and his partner Constable Joel Gray expedited their travel towards Mittagong.

On arrival at McDonald's, Senior Constable McManus found the two officers and two civilians restraining Mr Norris on the ground behind the service counter. He noticed that Mr Norris' hands were handcuffed behind his back. He recalled one of the male civilians kneeling near the head of Mr Norris and Senior Constable Finch kneeling around the mid-section of Mr Norris' back.

He said in his statement, however, that he did not recall her knees being in contact with Mr Norris; rather she was kneeling next to him while holding his arms.

Senior Constable McManus took over from the civilian near Mr Norris' head. He crouched with his shins and knees across Mr Norris's shoulders and upper back. Senior Constable McManus was adamant that he kept his weight off Mr Norris but "*hovered*" above him so that if he tried to roll or get up the officer could restrain him using his weight.

He said Mr Norris was struggling and squirming and trying to roll over. He allowed Mr Norris to roll over on his left side so he was not flat on his stomach. Senior Constable McManus said that he was conscious about not putting weight on Mr Norris that would prevent him from breathing.

Shortly after the first two back up officers arrived, two highway patrol officers, Senior Constable Dennis Rutland and Senior Constable Tyrone Halliday also entered the store. Mr Norris continued to struggle and yell out. Five officers picked him up and carried him out of the store in a horizontal position and placed him on the ground in the car park near where the police vehicles were parked. Civilians present confirm that he was still conscious and calling out incoherently at that stage.

Other police had arrived including Acting Inspector Catherine Schmidt, the Duty Officer, and Sergeant Darren Farr, the Shift Supervisor. As Mr Norris was carried out of the fast food outlet, the CCTV vision shows the cartridge and wire from the Taser being trailed behind him.

While Mr Norris was lying on the ground, civilian onlookers in the car park heard Mr Norris calling out "*Help me, Help me, Help me*" as he was placed on the ground, Sergeant Farr and Senior Constable Rutland also said that Mr Norris continued to swear and abuse police while he was lying on the ground.

He was searched while on the ground and nothing of interest was located. An ambulance had earlier been called to examine Mr Norris for the adverse effects of the OC spray and the TASER but it was determined to be more effective to take Mr Norris to Bowral Police Station and have the ambulance, which was also coming from Bowral, meet them at the station.

Constable Gray and Senior Constable McManus, with the assistance of other officers, picked Mr Norris up and slid him into the caged pod on the back of the police vehicle that the first responders had arrived in. Senior Constable McManus says Mr Norris immediately rolled over onto his back and as the door was being closed he kicked out at it.

At 9:21 pm, Constable Gray drove the vehicle with Mr Norris in it to the Bowral Police Station.

The Duty Officer and the Shift Supervisor briefly went into McDonalds and then Acting Inspector Smith drove the two female senior constables to Bowral Hospital to enable them to have a precautionary examination. The other officers drove the various police vehicles back to Bowral Police Station.

At the police station

At the station, the truck carrying Mr Norris was backed into the vehicle dock, the door to the pod was opened and Mr Norris was lifted out feet first. When the van door was opened Mr Norris was lying on his front. He was pulled out so that his feet touched the ground but he does not appear to be able or willing to support his own weight and so three officers carried him into the charge room.

His hands were behind his head in a position that suggested that during the journey he had passed his handcuffed wrists below the soles of his feet bringing them in front of himself.

A number of the officers claimed to have heard him mumble something while he was being carried in. According to Senior Constables Rutland and Halliday, Mr Norris said that he wasn't going to "*play up*" as he was carried out of the vehicle and his handcuffs were repositioned in the charge room. Senior Constable McManus said that Mr Norris made no effort to stand and did not resist as he was carried out of the police vehicle and into the charge room. An ambulance officer who observed the officers carrying Mr Norris into the charge room said that Mr Norris appeared to be struggling as he was carried in and heard police officers twice tell him to "*relax*" before he was placed on the charge room floor.

When Mr Norris was carried into the charge room he was placed on the floor outside the holding dock so that his handcuffs could be readjusted. The handcuffs are taken off and reapplied with his hands behind his lower back. The CCTV vision shows no movement by Mr Norris while this was occurring. An ambulance officer who was present in the charge room stood to one side.

A minute after Mr Norris had been brought into the charge room, he was slid and pushed into the holding dock that was 175cm wide and 99 cm deep and accessed via a door that was 67cm wide. There was a bench seat running along the length of the back wall and transparent Perspex panels across the front. Initially, Mr Norris was placed on the floor of the dock. One officer then picked him up and placed him on a bench seat but Mr Norris almost immediately toppled over onto his right hand side before slumping down onto the floor where he sat on his bottom with one foot under him and the other leg in front of him with his back up against the end wall beside the bench seat.

He can be seen to be in some discomfort until he is able to free his left foot which was pinned under his buttock. He then straightened his left leg so that both of his feet are then straight out in front of him. Slowly while moving his legs in a restless fashion, his hips moved away from the wall and he slid lower until he was almost flat on his back with the back of his head pressed against the wall and almost at right angles to the upper surface of his chest. At this stage he seems to be supporting the weight of his upper body on his elbows.

Gradually the movement in his legs subsides and he is still with his chin on his chest and his head held in an upright position as a result of it being against the end wall of the dock.

The last apparently purposive movement is seen at 2 minutes and 45 seconds after he was put into the holding dock. At about this stage the ambulance officers had begun preparing to enter the dock.

Medical treatment

Two ambulance officers were at the police station when Mr Norris was brought in. Those officers had originally been dispatched to Mittagong McDonalds to attend to a patient who was reported to have been sprayed with OC spray and shot with a TASER after a call from police on the scene made at 9.04 pm. However, before they could leave Bowral but while they were on their way, they received a computer message indicating the case location had moved to the Bowral Police Station.

They arrived there at about 9.14pm. The ambulance officers were David Brignall, an intensive care paramedic, and Glenn Ambrose, an ambulance officer. The police transporting Mr Norris had not yet arrived there.

They carried out an ECG heart monitor/defibrillator and oxygen equipment into the police station and waited for about 5 minutes until Mr Norris was brought into the charge room.

Mr Brignall saw Mr Norris being placed on the floor so that his handcuffs could be repositioned. He believed he had to wait unit the Shift Supervisor, Sergeant Farr told the ambulance officers it was safe for them to examine the prisoner.

Mr Brignall asked the shift supervisor, Sergeant Farr, what he wanted them to do with the patient. Sergeant Farr said; "*If he needs to go the hospital that's fine".* Mr Brignall was also told that the two officers involved in Mr Norris' arrest had been taken to hospital and that it was suspected Mr Norris may have been on "*an ice bender."*

This made Mr Brignall very apprehensive and he was pondering how he would examine Mr Norris.

After Mr Norris had been in the dock for about 2 and a half minutes, Mr Brignall walked over to the dock and crouched down so that he was near eye level with Mr Norris. He asked him his name. He said Mr Norris turned his head and looked at him but did not reply. Sergeant Far who was retrieving the detail of the original call for assistance from Mr Norris' partner told the paramedic that the prisoner's name was Kevin. The ambulance officer called out *"Kevin, can you tell me what's happened today".* Mr Norris did not reply.

According to Mr Brignall, at this stage Mr Norris was breathing without respiratory distress and he appeared normally perfused. Mr Brignall stood up and asked Sergeant Farr if he thought it was safe for him to go into the dock. Sergeant Farr agreed that it was and said; "*He doesn't look real good*".

Mr Brignall noted that Mr Norris had slipped so far down the wall that his chin was now resting on his chest. In his first statement Mr Brignall said he thought Mr Norris was unconscious but in evidence he changed that to say he wasn't aware whether Mr Norris was unconscious until he entered the cell and tried to rouse him.

Approximately 3 minutes and 20 seconds after Mr Norris had been placed in the dock, Mr Brignall entered it and examined him. He first rubbed his torso and got no result.

He then commenced to place on Mr Norris' chest the Red Dot monitoring electrodes that would be used to connect the ECG to enable Mr Norris' heart rhythm to be read.

Mr Brignall noticed that Mr Norris was not breathing. He felt for a carotid pulse and found none. This occurred 3 minutes and 40 seconds after Mr Norris had been placed in the dock. Mr Brignall then continued adhering the Red Dots.

While this was happening, a police officer moved Mr Norris' legs out through the doorway of the dock.

Mr Brignall could not measure the prisoner's blood oxygen saturation level or take his blood pressure because Mr Norris still had his hands cuffed behind him. Nor could chest compressions be commenced.

Mr Norris was moved partially out of the dock while Mr Brignall continued to apply the ECG traces.

A minute after it was established that Mr Norris had no pulse he was dragged out of the dock into the charge room, the handcuffs were removed and a bag valve mask was applied to Mr Norris' face to provide positive pressure ventilation to the patient. A police officer commenced chest compressions and while the paramedic continued to use the resuscitation bag and mask with oxygen to provide him with ventilation. Of concern is that nearly two minutes elapsed between Mr Brignall ascertain that Mr Norris did not have a detectable pulse and the commencement of compressions.

Mr Norris was cannulated and intubated and given a total of 5mg of Adrenalin in 1 mg increments. He also was given Naloxone in an attempt to revive him. According to Mr Brignall, the cardiac monitor showed that Mr Norris' heart rhythm was "*slow and wide*." A minute or so later he was shown to be in asystole. At no time at the police station was his heart rhythm one that could be helped with defibrillation.

Mr Brignall intubated Mr Norris and established that the endotracheal tube was correctly placed and that he was being effectively artificially ventilated. A stretcher was brought into the room and Mr Norris was loaded onto it, taken into the ambulance and driven to Bowral Hospital.

He arrived at the hospital at 9.58pm and was taken to the emergency department where medical and nursing staff took over the resuscitation. Bowral Hospital records record Mr Norris being admitted at 10:03pm and record his time of death as 10:20pm. There appears to have been only one brief instance of a shockable cardiac rhythm (at 10:05pm) during resuscitation attempts at the hospital and at all other times, Mr Norris' cardiac rhythm was shown to be in asystole.

Expert evidence

Autopsy evidence

On 14 January 2015 an internal and external autopsy was conducted on the body of Mr Norris by Dr Rebecca Irvine, an experienced forensic pathologist. Prior to undertaking the autopsy she reviewed the video footage of his arrest and his incarceration at the Bowral police station.

Dr Irvine expressed the view that there were no instances during the video footage where Mr Norris was placed in a dangerous restraint. She also observed that Mr Norris appeared to be consistently moving until just before he was removed from the dock.

She found two distinct round lesions in the central and left chest area consistent with TASER marks. Within the lateral right antecubital fossa there were probable puncture marks.

There were multiple but superficial external blunt force injuries over various parts of his body, but there were no gross injuries to the skull or any other part. No injuries were identified on or within the neck. None of the injuries were life threating or likely to cause loss of consciousness.

Internal examination identified no disease that would be expected to contribute to his death. Biochemical examination of vitreous fluid and blood found nothing of clinical significance. Toxicological examination of blood collected when he was admitted to the Bowral Hospital and at post mortem revealed methylamphetamine levels of 0.58 mg/L and 0.6 mg/L respectively.

Dr Irvine concluded that the concentration of methylamphetamine in Mr Norris's blood may have been responsible for his death. She observed:

It is generally thought that in the absence of another obvious cause of death, any detectible blood concentration may be an explanation of sudden and unexpected death. Methylamphetamine is strongly associated with both bizarre behaviour and sudden and unexpected death.

When she gave evidence, Dr Irvine referred to the significant overlap between the nontoxic, the toxic and the lethal blood concentrations of the drug.

Dr Irvine was subsequently asked further questions by those assisting me with a view to eliciting her opinion about other possible causes of death. In particular she was asked whether the position of Mr Norris's neck and body after he slid down the wall in the dock could have led to him suffering positional asphyxia.

Dr Irvine provided a supplementary report in which she expressed the view that Mr Norris' neck was not flexed to the point that there would be significant compromise of his airway.

She found support for that analysis by the fact that when Mr Norris was in the most prone position with his neck fully flexed he was being observed by the ambulance officer Mr Brignall whom she expected would have observed respiratory distress or compromise were it occurring.

Dr Irvine acknowledged that if positional asphyxia had occurred she would not expect to find evidence of it at autopsy. Dr Irvine noted that until just before he was removed from the dock Mr Norris was moving his legs indicating that he was conscious and therefore he would be able to adjust his body to avoid the effects of positional asphyxia.

However, when giving evidence at the inquest she acknowledged that the final movements of Mr Norris' seen on the CCTV may have been agonal twitching. She also acknowledged that there is a continuum of altered levels of consciousness that cannot be assessed simply by observation of leg movement and body tone. Dr Irvine indicated that she thought it likely that Mr Norris was already unconscious when his neck flexion may have caused asphyxia. For her, the real question was what caused the unconsciousness.

Toxicology evidence

Those assisting me also obtained a report from Professor Olaf Drummer, an eminent forensic pharmacologist and toxicologist, who reviewed the autopsy report, toxicology report and the Bowral Hospital records. Professor Drummer also gave evidence at the inquest. He noted that deaths due to methylamphetamine toxicity are uncommon and that most reported deaths involved cases in which blood concentrations of the drug at levels of or greater than 2.0 mg/L.

He said in his report;

I am of the view that Mr Norris did not die from toxicity associated with methylamphetamine or indeed a combination with cannabis. The blood concentrations were not remarkable and as outlined earlier the factors that might be associated with methylamphetamine and cannabis toxicity were not present.

Professor Drummer went on to say;

This does not mean that methylamhetamine could not have contributed (in a minor way) in some way to a death, perhaps caused by increased anxiety and stress associated with his agitated behaviour and or presence of excited delirium and perhaps associated with some unknown degree of postural asphyxia.

He confirmed at the inquest that in his view, absent other factors it is unlikely the drug would have caused the death by itself.

Emergency medicine

The court was also assisted by two reports from and the oral evidence of Dr John Vinen, an emergency medicine physician.

Dr Vinen viewed the material in the brief including the CCTV recorded vision at McDonald's and the Bowral Police Station. Dr Vinen reviewed the literature relating to a number of possible explanations of the medical cause of Mr Norris's death. He particularly focused on airway obstruction and noted *"airway obstruction unless rapidly recognised and effectively managed will result in the rapid development of hypoxia followed by respiratory and cardiac arrest."*

He noted that among the criteria to diagnose positional asphyxia included the victim being in a position that does not allow for adequate respiration, an example of which is flexion of the head onto the chest.

Reviewing the CCTV from the police station, Dr Vinen suggested that, after Mr Norris slid down the wall, his neck was markedly flexed forward and that soon after no further movement was seen from him. Dr Vinen noticed that soon after this occurred the ambulance officer entered the dock and found Mr Norris did not have a pulse and was not breathing.

Dr Vinen expressed the view that Mr Norris's behaviour at McDonald's was due to methylamphetamine intoxication-induced excited delirium which led to the subsequent events. In his initial report he suggested that the restraint process in McDonald's contributed to the outcome - the neck restraint by the two male civilians and the restraint on the floor prevented Mr Norris from breathing adequately. This he suggested led to Mr Norris becoming hypoxic and hypercapnic (inadequate oxygen and elevated carbon dioxide in his blood). He also speculated that Mr Norris may have had difficulty breathing during transit when he was lying face down with his hands handcuffed behind his back.

However, before he provided a second report and gave evidence Dr Vinen reviewed the evidence of eyewitnesses and accepted that Mr Norris was conscious when he was carried out of McDonald's and when he was carried into the charge room at the police station. This led him to conclude that even had Mr Norris been rendered unconscious by the restraint, he had quickly recovered and there was unlikely to be any residual effect of that loss of consciousness that contributed to the death.

However, Dr Vinen remained of the view that by the time he reached the police station it seemed likely that Mr Norris was dehydrated and exhausted and that he would have developed lactic acidosis as a result of an extreme interaction with police. He was firmly of the view that the level of amphetamine in Mr Norris' blood was not high enough to explain his death – in his view the lethal level was 1.4 mg/L and above. However, that did not mean that the drug intoxication did not contribute to the death as the diminished level of consciousness it may have produced allowed his airway to be obstructed.

Dr Vinen said he had no doubt that Mr Norris' airway was compromised from the time he slumped downwards with only the tops of his shoulders and his head against the wall with his neck flexed forward on his chin. "*If he was not unconscious when he slumped to his final position he would have become unconscious within a short period of time followed by cardio respiratory arrest".*

He was adamant that flexion of the neck so that the chin is on the chest will result in airway obstruction in an unconscious patient.

He wrote in his first report that:

The position Mr Norris was lying in directly contributed to his death, the other contributing factors were:

Decreased level of consciousness due to the effects of the events at McDonald's and hypoxia due to positional asphyxia in the cell.

He stood by this when giving evidence.

Conducted electrical weapons (TASER) policies and testing

The NSW Police Force Standard Operating Procedures (SOPs) relating to the use of TASERs state that a spark test must be performed whenever a TASER is taken by a police officer for operational use and at least once each week. A spark test involves the officer depressing the trigger of the device for a full 5 second cycle to verify it is working, the battery is adequately charged and to ensure the components in the high voltage section of the TASER are energised on a regular basis.

The TASER log from Bowral Police Station showed that a spark test had been performed at 6:00pm by Senior Constable Avnell on the TASER (TASER 4) that was deployed against Mr Norris at Mittagong McDonald's.

The SOPs also require that all TASERs are to be given an "*extended spark test*" every month to ensure there has been no degradation of the battery during the preceding month. An extended spark test is performed by placing the TASER battery under strain by completing a minimum of six spark tests in a row.

Following Mr Norris' death, TASER 4 was returned to the NSW Police Force Armoury for further review and testing. On 30 September 2015, Senior Armourer Christian Halbmeier performed an extended spark test on TASER 4, involving two separate pulse rate tests and a total of 12 trigger activations. Mr Halbmeier recorded that the pulse rate test failed on all 12 trigger pulls and concluded that TASER 4 had malfunctioned at Mittagong McDonald's due to battery degradation.

Mr Halbmeier found no evidence that an extended spark test had been performed on TASER 4 because he was unable to review the audiovisual footage that would normally record the testing being performed and downloaded to police servers.

He believed the audiovisual recording and downloading errors were also likely caused by battery degradation. Mr Halbmeier said that it was possible that either the extended spark test had been performed on TASER 4 but not recorded and downloaded to the server or alternatively, the test had not been conducted by officers as required under the SOPs.

Prisoner transport policies

The NSW Police Force handbook section outlining procedures relevant to escorting and transport prisoners specifies that "*detainees are to be transported by a single officer only if this is unavoidable*".

Police guidelines on the management of people affected by methylamphetamine further stipulate that when transporting a person who is affected by methylamphetamine, officers must ensure that they "*continuously observe the person*" because "*stimulant users can experience a rise in body temperature and dehydration which could lead to unconsciousness*"

Analysis conclusions and recommendations

The issues brought into focus by the circumstances of Mr Norris' death are:

- **The medical cause of his death;**
- **The malfunctioning of the conducted electrical weapons (TASER);**
- **The transport of him by a single officer;**
- **The assessment of him at the police station; and**
- **The provision of first aid.**

Cause of death

The pathologist who undertook the autopsy, Dr Irvine, came to the conclusion that the cause of Mr Norris' death was methylamphetamine toxicity because tests revealed he had substantial amounts of the drug in his blood when he died; he exhibited symptoms of being intoxicated by it and no other cause of death could be found at autopsy – that is she found no disease or injury that was likely to have caused the death.

In those circumstances, Dr Irvine was inclined to attribute the death to *any* level of methylamphetamine because her view is there is such a great overlap between nontoxic, toxic and lethal blood concentrations of the drug. However, she did not exclude the possibility that factors such as stress, dehydration, and/or electrolyte derangements contributed to Mr Norris losing consciousness with a resulting positional asphyxia precipitating a fatal arrhythmia. Dr Irvine was firmly of the view that positional asphyxia did not cause the unconsciousness that preceded Mr Norris' death.

Professor Drummer agreed there was little direct correlation between the blood concentrations of methylamphetamine and a fatal outcome but in his view it was *"most unlikely that this drug was the cause of death in this case."* His view was based on his extensive experience and review of the relevant literature which indicated most deaths were associated with far higher levels than found in Mr Norris' peri-mortem blood.

He was of the view that methylamphetamine intoxication may have contributed in other ways to the death.

Dr Vinen also considered the level of methylamphetamine was too low to be the sole cause of the death. He considered that the position Mr Norris was lying in in the minutes before his death predisposed him to the risk of positional asphyxia. Further, the biochemical effects of the drug when combined with the stress and exhaustion from the prolonged struggle at McDonald's and while Mr Norris was being transported to the police station may have combined to cause a fatal arrhythmia.

Conclusion

Based on the expert evidence given at the inquest, I don't consider methylamphetamine toxicity alone caused Mr Norris' death. Had he taken the same amount of the drug but remained in his house and avoided any violent interaction, I consider it unlikely he would have died on that night.

I consider his respiration was compromised by the extent to which his neck was flexed onto his chest at a time when he was already in oxygen deficit due to the earlier prolonged struggle with police at McDonald's and with wrestling the handcuffs from behind his back while being transported. In my view this led to his losing consciousness.

The extent to which the various other factors combined to precipitate a cardiac arrest cannot be quantified or even precisely identified, in my view. I can find no more than that methylamphetamine toxicity; positional asphyxia and the effects of a violent and prolonged struggle combined to cause the death.

TASER failure

The failure of the TASER to operate effectively had the potential to increase the risk of injury to the officers involved and Mr Norris, if the officers were forced to resort to more lethal means to protect themselves.

The tests undertaken after the events identified the source of the malfunction to be battery deterioration. As described earlier in this report, there were in place procedures which should have caused this to come to attention.

It seems that one of them, an extended spark test, may not have been undertaken because in Mr Halbmeier's opinion it is likely that had it been done, the fault would have been made apparent.

There is uncertainty about whether an extended spark test had been done when stipulated because another procedure, a monthly download of the files from the device was attempted but it too failed and this was also not detected.

Conclusion

The TASER used by one of the officers involved in responding to Mr Norris was defective in a number of ways. The tests designed to bring this to attention were probably not undertaken as required.

Newer devices have now been brought into service. In the short term this should eliminate the problem that caused the malfunction but if the testing regime is not scrupulously attended to there is a risk that similar problems will occur in future.

Recommendation 1 – Review of TASER testing

It is recommended that the NSWPF further investigate why the defects in the TASER used in this case were not detected before the death occurred and take remedial action either in the form of improvements to the data download software (if this is possible and still necessary) or in officer training.

Transport to police station

The policies described earlier in this report required that when a person in Mr Norris' condition was being transported in the pod of a police truck an observer should have accompanied the driver of the vehicle in the cabin.

All officers at the scene should have been aware of this. In particular, those officers with supervisory responsibility, the Shift Supervisor and the Acting Duty Officer should have ensured that the policies were complied with. This failure should be drawn to their attention to minimise the likelihood of a recurrence. In this case the failure to comply with the policy does not seem to have had any negative consequences but that would not always be the case.

Assessment at the police station

There is no doubt that Mr Norris' conduct at McDonald's was reprehensible, atrocious: he engaged in an unprovoked sustained violent assault of the two female officers who had reasonably sought to persuade him to leave the premises.

That he was psychotic and drug affected is an explanation but not an excuse: he chose to consume the substances that are likely to have precipitated the breakdown of his capacity to reason and from his long history of drug abuse and mental illness he would have known that this was likely to happen.

However, the emergency services personnel who were required to respond to Mr Norris also had to take into account that he was psychotic and drug affected. The apparent crimes he had committed before he was arrested did not mean that he was entitled to a lower standard of care after it. When assessing the adequacy of the subsequent response by police and ambulance officers to Mr Norris' health care needs and his safety in custody, the risk he posed to the safety of others was clearly relevant.

Those involved in assessing him were also well advised to take into account that methylamphetamine-affected persons can suddenly become violent after a period of apparent quiescence.

It is essential when considering the appropriateness of an individual's actions that preceded a critical incident or a sentinel event to guard against hindsight bias – exaggerating or distorting what the individual should have foreseen at the time because the assessor knows the outcome. However, if improved performance is to result it is equally important that another cognitive error – confirmation bias – is also addressed.

Responsibilities of the police

The provisions of Parts 9 and 16 of the *Law Enforcement (Powers and Responsibilities) Act 2002* (LEPRA), the regulations made under the Act and the NSWPF Code of Practice for Custody, Rights, Investigation, Management of Evidence (CRIME) place responsibilities on police to safeguard the welfare of persons taken into police custody.

The responsibilities generally fall on the custody manager but that role is defined to include whichever officer is at a particular time in control of and responsible for the care of a prisoner.

In this case, when Mr Norris was carried into the charge room at Bowral Police Station, the designated custody officer, the Shift Supervisor, had not yet returned to the station. Accordingly, the senior officer present was responsible for ensuring the requirements of the Act, the regulations and the Code of Practice were complied with. Mr Norris' handcuffs were removed because on the journey to the police station he had managed to manoeuvre them to in front of himself but they were then reapplied with his hands again secured behind his back.

His safety to be held in the dock was not assessed by the police officers involved in doing that and the ambulance officers who were present were not invited to examine him. I accept the evidence that to do this effectively, Mr Norris would have needed to have been unshackled and unrestrained. I accept that at that stage it was not unreasonable to refrain from doing so in view of his then quiet recent violence.

He was instead put in the holding dock with handcuffs on. The evidence of Acting Sergeant Hall, the acting principal tutor in Safe Custody Course at the NSW Police Force Specialist Skills Unit, Field Support Command, Education and Training Command, and the Acting Duty Officer indicated that should not be done unless there was a good reason for it. None was apparent in this case.

It is relevant because I am of the view that it made it more difficult for Mr Norris to protect his airway as his level of consciousness diminished. When he was put in the dock, it was immediately apparent that Mr Norris was severely affected by a drug or some other incapacity – he was unable to sit upright on the bench on which he had been placed, he fell to the floor and slid down the wall. He failed to respond normally to questions or conversation.

His condition was such that the Code of Conduct for CRIME called for him to undergo a medical assessment or to be sent to hospital. This did not happen promptly, primarily because the police officers and the ambulance officers were waiting to see whether Mr Norris would refrain from further violence. When the substantive custody manager returned to the station he gave priority to establishing Mr Norris' identity.

The paramedics said they were waiting for the custody manager to indicate it was appropriate for them to enter the dock to examine Mr Norris and it is clear that the senior paramedic took steps to facilitate this by seeking to establish some rapport with him by crouching near his head and trying to speak to him through the Perspex front of the dock.

Conclusion

In view of obvious signs that Mr Norris was severely intoxicated and the very significant change in his presentation during the time he had been in custody, the custody manager should have given more active consideration to whether he needed to be examined by the paramedics sooner.

Although Mr Norris had been violent at McDonald's, there was a sufficient number of police available at the police station to restrain him if that became necessary. I readily accept, however, that the custody manager could not have foreseen the rapid further deterioration that led to Mr Norris' death. It is a stark reminder of the precarious health of drug-affected prisoners.

Recommendation 2 – Learning from bad outcomes

I recommend that the CCTV from within the charge room and the sad outcome of this case be incorporated in the Safe Custody training material when the curriculum is next revised.

Paramedics

The paramedics had been summoned to examine Mr Norris because he had been sprayed with OC and tasered – a routine call out. They were told the patient had been very violent and was probably under the influence of methylamphetamines.

In accordance with their training their first priority was to ensure their own safety. The police officers who had custody of Mr Norris were also conscious of that and decided they would wait an undetermined length of time to see if Mr Norris exhibited any further violence before he was examined. In those circumstances the paramedics should not be criticised for delaying the physical examination of Mr Norris. As noted, the senior paramedic sought to progress that assessment by trying to speak with Mr Norris through the Perspex.

However, the CCTV vision shows that for much of the time before the senior paramedic entered the dock he and his colleague were not observing Mr Norris. It may be that his deterioration into unconsciousness would have been noticed sooner had they done so. It may also be the case that the paramedics had concluded that Mr Norris was drug-affected and not at risk and therefore failed to sufficiently consider the risks of that condition.

I am also concerned that when it was clear that Mr Norris had probably suffered a cardiac arrest – he wasn't breathing and a pulse could not be detected – there was unnecessary delay in commencing appropriate resuscitation. That could not happen until Mr Norris was removed from the dock and his handcuffs removed. I am confident that had the paramedics requested police to do so, both of those things would have happened much sooner.

Conclusion

I accept that paramedics are trained to plan their responses and to avoid rushing even in an emergency but the delay in commencing chest compressions in this case far exceeded what would be expected and was inconsistent with their training and protocols. I accept the evidence that the delay is unlikely to have had a bearing on the outcome.

Recommendation 3 – Reminder of cardiac arrest protocols

The paramedics involved in this case failed to demonstrate sufficient urgency in their response to a known cardiac arrest. This suboptimal performance should be drawn to their attention for remedial purposes. I recommend that their line supervisor do so promptly.

Formal Finding:

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was Kevin Michael Norris.

Date of death

Mr Norris died on 11 January 2015.

Place of death

He died in the Bowral Hospital, Bowral, New South Wales.

Cause of death

The cause of death was the combined effects of methylamphetamine toxicity, a violent struggle and positional asphyxia.

Manner of death

Mr Norris' death occurred in police custody as a result of misadventure

15. 24641 of 2014

Inquest into the death of Donald McKinnon. Finding handed down by Deputy State Coroner Ryan at Glebe on the 21 August 2017.

This inquest concerns the death of Donald McKinnon.

Introduction

Donald McKinnon died on 26 January 2015, aged 82 years. As he was serving a custodial sentence at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the *Coroners Act 2009* (NSW).

Section 81 of the Act requires that when an inquest is held a coroner must record his or her findings as to aspects of the death. These are the findings of an inquest into Mr McKinnon's death.

The role of the coroner

The coroner must make findings as to the date and place of a person's death, and the cause and manner of death: Section 81 of the Act. In addition a coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question: Section 82 of the Act.

Mr McKinnon's life

Mr McKinnon was born in the Singleton area of NSW on 21 October 1932. He was one of a large family of brothers and sisters. As an adult he spent three years in the Australian Army, and then lived in the United States for a period of time. He returned to Australia and lived in Victoria between 1957 and 1964. After that he moved to Sydney and lived in Redfern, Bondi and Surry Hills.

On 17 December 2012 Mr McKinnon was convicted and sentenced for historic offences of indecent assault upon a male and sexual intercourse with a male aged between 10 and 18 years. He received a custodial sentence of six years and six months imprisonment, with a non-parole period of three years and two months to expire on 21 January 2016.

Mr McKinnon's medical history

When Mr McKinnon went into prison on 23 November 2012 he was aged 79. He was medically assessed and was found to have a number of serious health conditions. These included diabetes mellitus, arthritis, ischaemic heart disease, sleep apnoea and hypertension. For this reason he was housed mainly in the Aged Care and Rehabilitation Unit at Long Bay Hospital. This Unit provides specialised care, assessment and rehabilitation services for older inmates. In this Unit Mr McKinnon had regular health reviews by specialist teams, as well as occupational therapy, physiotherapy and falls risk assessments.

In December 2014 Mr McKinnon was transferred to the Prince of Wales Hospital Secure Annex because he was suffering abdominal pain and swollen legs. He had also had some falls. Tests revealed he had developed pancreatic cancer with multiple hepatic metastases and liver failure.

Mr McKinnon's treating specialist Professor David Goldstein considered that surgery or chemo radiotherapy were not suitable management options for Mr McKinnon's cancer, because of its advanced stage and also Mr McKinnon's medical comorbidities. In his report dated 6 January 2015 Professor Goldstein noted that Mr McKinnon was also suffering longstanding cardiovascular disease and dementia. He estimated a life expectancy of three months taking into account Mr McKinnon's other medical conditions.

Mr McKinnon was transferred back to Long Bay Hospital's Medical Subacute Unit with a direction for full palliative care. After the medical treatment team consulted with Mr McKinnon's brother Lee, on 5 January 2015 he was classified as '*not for resuscitation',* including CPR, intubation or ventilation.

On 8 January 2015 Mr McKinnon suffered another fall and returned to Prince of Wales Hospital's Secure Annex. Medical staff noted his condition had further deteriorated and he was given a life expectancy of *'days or weeks, rather than months'*. He was treated for a fractured left neck of femur and made as comfortable as possible. His palliative care was maintained and he received additional visits from Lee.

During the evening of 26 January Mr McKinnon's condition deteriorated. At 9.30pm he was noted to be settled but unresponsive, and his death was recorded at 10.06pm.

What caused Mr McKinnon's death?

Prince of Wales Hospital recorded the cause of Mr McKinnon's death as *'end stage liver failure secondary to pancreatic cancer with hepatic metastases'*. Other significant conditions contributing to his death but not related to the disease or conditions causing it were noted as '*hip fracture, pulmonary emboli; ischaemic heart disease, ischaemic stroke, dementia and hypertension*.'

On 3 February 2015 Deputy State Coroner MacMahon issued a Coronial Certificate giving the cause of death as '*complications of metastatic pancreatic cancer'.*

Are there any other issues to investigate?

As Mr McKinnon was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. For this reason an inquest is required when a person dies in custody, to assess whether the State has discharged its responsibilities. This is the case even when as it appears likely the person died of natural causes. Having considered the evidence I am able to conclude that Mr McKinnon died as a result of natural causes. There are no suspicious circumstances, and no evidence that the care and treatment he received while he was in custody was inadequate or that it contributed to his death.

On 16 February 2015 Corrective Services Investigator Mark Farrell provided a report to the Management of Deaths in Custody Committee. Mr Farrell found there to be no issues arising out of the management and care of Mr McKinnon prior to his death, or in the response to his death. In Mr Farrell's assessment, these were appropriate and in accordance with Corrective Services policies and procedures. I have examined Mr McKinnon's Justice Health records. They support the assessment that he received proper medical care and treatment throughout his time in custody and in the weeks leading up to his death.

Mr McKinnon's Justice Health records show that when he first entered custody in 2012 his health needs were comprehensively assessed. As a result he was housed in a Unit which could better manage his ongoing health problems and his impaired mobility.

It is evident from the records that his mobility and hearing problems and his declining cognitive abilities were regularly assessed. He was provided with hearing aids, a walking frame and physiotherapy to assist him and to reduce his risk of injury. In October 2013 he received screening for dementia and was found to be in the early stages of this disease. He was frail and at various times during 2013 and 2014 he had visits and admissions to Prince of Wales Hospital for treatment and assessment.

When Mr McKinnon was diagnosed with terminal cancer in December 2014, appropriate decisions were made and were implemented about his treatment and palliative care. This was also the case when he suffered his fracture and throughout his final days at the Prince of Wales Secure Annex.

I note that Mr McKinnon had made no complaints as to his care and treatment; nor have any members of his family raised any such issues. I conclude that Mr McKinnon received health care of an appropriate standard throughout his time in custody. There is no evidence that any action or inaction by Corrective Services or Justice Health contributed to his death. From the outset of his time in custody he had many serious health problems which were properly managed, and nothing further could reasonably have been done to prevent his death.

Formal Finding:

The deceased person was Donald McKinnon.

Date of death

Donald McKinnon died on 26 January 2015.

Place of death

Donald McKinnon died at Prince of Wales Hospital Randwick, NSW

Cause of death

Donald McKinnon's death was caused by complications of metastatic pancreatic cancer'. Other significant conditions contributing to his death but not related to the disease or conditions causing it were hip fracture, pulmonary emboli; ischaemic heart disease, ischaemic stroke, dementia and hypertension.

Manner of death

Donald McKinnon died from natural causes.

16. 59013 of 2015

Inquest into the death of Warren Maguire. Finding handed down by Deputy State Coroner Barry at Glebe on the 13th July 2017.

The Coroners Act in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Warren Maguire

Introduction

1. The role of the coroner as set out in section 81 of the *Coroners Act* 2009, (the Act) is to make findings as to:

(a) the identity of the deceased;

(b) the date and place of the persons death;

(c) the physical or medical cause of death; and

(d) the manner of death, in other words the circumstances surrounding the death.

The focus of this inquest is the manner of Warren Maguire's death and the response by the police who were called to the location where Warren's body was ultimately found. There is also an issue surrounding the circumstances of Warren's death, in particular, whether there were any suspicious circumstances surrounding his death. A further issue relates to the manner of Warren's death and whether or not it can be found that Warren intended to take his own life.

Warren's death was reported to the Coroner because it occurred during the course of a police operation. In these circumstances an inquest is mandatory pursuant to the combination of ss. 27 and 23 of the *Coroner Act 2009. "The purpose of a s.23 inquest is to fully examine the circumstances of a death… in order that the public, relatives and the relevant agencies can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post death investigation.*

If appropriate and warranted in a particular case, the State or Deputy State coroner will make recommendations pursuant to s.82." (Waller, Coronial Law and Practice in New South Wales, p.106). Pursuant to s.37 of the *Coroners Act 2009* a summary of the details of this case will be reported to Parliament.

Background

Warren Joseph Maguire was born on 21 July 1974 at Casino. At the time of his death he was 40 years old. He was found deceased on the morning of 24 February 2015 outside his unit in Ballina, having fallen from a bathroom window onto the concrete below.

Warren was the youngest of 7 siblings and as a child he resided in a happy and stable home environment. According to his elder brother Barry, Warren was a happy and well -adjusted child, full of energy with "potential to burn". Tragically when Warren was only 10 years old his mother passed away and understandably this was to have a deep and continuing impact on Warren's young life. The care for the family was left to his father who took long service leave from his employment in order to raise the family. Warren completed primary school in Casino and completed his school certificate in 1990 at Casino High School.

From May 1991 until April 1996 Warren worked at the Casino Meat Works but this was the only period of continuous employment that Warren experienced. He was considered a good worker with a strong work ethic. In 2005 Warren entered into a relationship and as a result of that relationship his son Alexander was born in March 2006. The relationship was a troubled one and the parties separated in 2010. Warren remained interested in his son's welfare but had difficulties in gaining access to him and this was to cause considerable concern for Warren and to have a major impact upon his mental health.

Warren struggled with alcoholism and mental health problems and had been involved in rehabilitation programs over the last decade. He was involved with the Salvation Army, which played a crucial role in his rehabilitation. In the week prior to his death Warren had made arrangements to re-enter "Moonyah" a rehabilitation unit run by the Salvation Army. Captain Kingston-Kerr, a caseworker with the Salvation Army who was close to Warren, stated that Warren remained positive and focused about going into rehabilitation. He last spoke with Warren on 19 February 2015 when he had a 17 minute conversation. He stated that Warren was upbeat and still motivated but knew there was a long road ahead.

Warren's brother Barry told the court that Warren could be 'polite engaged witty and charming with 'normal' pursuits during his alcohol free periods'. Tragically his alcoholism and mental health issues gave rise to periods of long-term unemployment and some estrangement from a number of family members. At times he experienced suicidal ideation. Warren's family find it difficult to reconcile Warren's happy and carefree childhood with his unhappy and troubled adult life. He was loved by his family and a number of his quiet and dignified siblings attended the hearing.

Autopsy and cause of death

An autopsy report was prepared by Dr Allan Cala, senior staff specialist in forensic pathology. Dr Cala opines that the direct cause of death was 'multiple injuries'.

Dr Cala further noted;

1. extensive skull bruising in occipital region
2. right occipital base of skull fracture
3. right sided subarachnoid haemorrhage and cerebral contusions
4. left haemothorax – 110 mls
5. multiple rib fractures
6. pulmonary contusions

Dr Cala further commented;

1. Autopsy examination showed a full thickness laceration of the scalp in the left parietal region which would have bled significantly after infliction. The skull immediately under the laceration was normal, however there was a right sided occipital skull fracture associated with subarachnoid haemorrhage and cerebral contusions in the right cerebral hemisphere along the base of the brain. There was atlanto–occipital dislocation but no obvious evidence of spinal cord injury.

2. There were multiple rib fractures, particularly on the left side associated with a large left haemothorax (blood in pleural cavity). These fractures would have caused immediate and severe inability to breathe normally. The pattern of injuries is consistent with a fall from a height with heavy impact.

Dr Cala noted “the deceased need not have died immediately after infliction but could have survived for approximately 30 - 45 minutes after falling and impacting the ground”. When considering Ms Christina Smith’s evidence (a witness living in Warren’s unit block) to the effect that Warren was still making a gurgling/breathing noise at 1:45 AM, Dr Cala opined that had Warren been found at an earlier time, it was theoretically possible that he may have survived. Notwithstanding that comment Dr Cala considered that Warren’s death was,”almost inevitable”.

Toxicological analysis

Toxicological analysis returned a zero blood alcohol level. However there were non-toxic levels of other drugs identified, being drugs used to treat mental health conditions (such as citalopram and mirtazapine). Olanzapine was found to be in the high range but Dr Cala stated”toxicity would not necessarily be expected to occur at that level”. Dr Cala concluded that in his view drugs played no role in Warren’s death.

Manner of death

Was there any suspicion surrounding Warren’s death?

Detective Senior Sergeant Sgt Peter O’Reilly investigated Warren’s death and it was his view that Warren died as a result of injuries sustained during the fall which was ‘probably an act of self-harm.’ This cause of death aligned with the opinion of Dr Cala who noted that the injuries suffered by Warren were consistent with a fall from a height with heavy impact. Written and oral evidence of crime scene officer, Senior Constable Gerry Kemp, was that there was no evidence received of any obvious struggle inside Warren’s unit, nor any evidence of forced entry to Warren’s unit. Warren’s wallet, money and mobile phone were located inside his unit.

The bathroom window from which Warren exited was 69 cm wide by 53 cm high and the window was 152cm higher that the bathroom floor. It is unlikely that a person could be compelled against their will to exit in the manner that Warren apparently did falling 4.59m from the bathroom window sill to the concrete patio below. There is no suggestion of involvement by any other person.

Did Warren intend to take his life?

Warren’s history of suicidal ideation and attempts.

There had been a number of previous suicide attempts made by Warren in the years prior to his death.

Whilst living with his brothers in Casino, Warren overdosed on his prescription medication and passed out; almost daily, he spoke of committing suicide and had once tried to hang himself in the shed and was saved by his brother Barry. Warren's medical records, between March 2011and December 2014, identify ten occasions of attempts by Warren to self- harm. On some occasions he was taken to hospital by ambulance and on other occasions he contacted the mental health helpline presenting as intoxicated and overwhelmed.

The last occasion of self-harm prior to Warren's death was between 5 – 8 December 2014. On this occasion Warren was taken to Ballina hospital by ambulance, having overdosed by taking 24 diazepam tablets with alcohol. He stated that he wanted to kill himself. On 21 February 2015 Warren visited another resident, Mr Saebsch, who resided in the unit next to his own. Warren had been drinking beer, but it is noted that toxicology testing detected no alcohol in Warren's blood following his death.

Captain Kingston-Kerr, from the Salvation Army, gave evidence that Warren would go through cycles of anxiety, depression and suicidal thoughts and that these cycles would be at the tail end of a drinking session and revolve around Warren not being allowed access his son. As someone who knew Warren well, he told the court what happened to Warren on the night of his death did not fit Warren's previous pattern of self- harm attempts. He did indicate that in the past after Warren had been heavily drinking he had suffered hallucinations, believing that there was someone in his room. He stated that Warren could misinterpret things and at times he was anxious, but he also said it was Warren's practice to "cry out" for help from ambulance, police or call –centres, during these episodes.

When the mode of Warren's death is noted, that is, exiting a quite narrow bathroom window, in circumstances in which he had previously attempted other modes of suicide such as hanging or medication overdose, it would be reasonable to assume that Warren's exit from the bathroom window was not in relation to a suicide attempt. Indeed it would have been far easier if that was the mode of suicide to be attempted by Warren, for him to simply jump from the front of his unit over the balcony.

In addition, both Captain Kingston- Kerr and Warren's brother Stephen, believed that Warren, in the hours before his death, was sounding positive and happy and in fact Stephen commented that Warren was "the best he had sounded for a long time." What is compelling is that there was no alcohol or drugs of any significance in Warren's system. It may well be that Warren was in the throes of detoxification and suffering some psychotic event with hallucinations, as had happened in the past, and this led him to climb out the window.

What drove Warren to exit this small window is purely speculative. As his brother Barry stated the" circumstances that led to his death are a mystery and may well remain a mystery known only to God." Suicide may not be presumed – it must be proved by evidence. There must be clear cogent and exact proof of evidence before such a finding can be made. The lack of clarity about Warren's intent raises a doubt about whether Warren intended to take his own life. I am not satisfied that there is sufficient evidence to establish that Warren intended to end his life.

The telephone call by Ms Christina Smith.

Ms Smith was a resident of unit 9/126 Tamar Street Ballina. At about 12:15 AM on 24 February 2015 she heard a "commotion" in the rear common area of the unit block. She stated that it sounded as though things were" being knocked over or something". She heard a sound that she described as sounding"like a large dog panting." This sound was followed by a "gurgling" sound.

She went to her back door and turned on the outside light– she could see legs and a pair of patterned boxer shorts two doors up but she could not see the person's head nor torso as her view was obstructed. She continued to hear laboured breathing and "gurgling". At about 12:23 AM Ms Smith telephoned Ballina police station and spoke with then Probationary Constable Miezitis (now Constable Miezitis). The content of that conversation is contained in Ms Smith's statement that was taken by police on the morning of the incident at around 10 or 10:30 AM at the police station. Her statement was adopted in sworn evidence to the court:

"I have heard a commotion out the back of my place. The address is misleading. Its 126 Tamar Street that you enter from Winton Lane. Directly behind the back door of Domino's. There are often noises but this one has gone a bit further. I have gone outside and I can see a pair of legs laying on the ground. I can hear gurgling. I'm not too sure if its medical or intoxication but either way the person doesn't sound too good. Clearly they've had a fall something has taken place, I can tell because of the commotion was taken place.

The officer said" Can you tell me again where you are"

*I said"The front of our units are in Winton Lane, behind Domino's however the person is behind the units near the clothes line***."**

This conversation lasted 2 minutes and 59 seconds. Ms Smith stated that the police officer asked her name and phone number which was provided but her unit number was not requested.

Ms Smith was told that someone would be sent out. Ms Smith told the court she had included in her statement the fact that the officer did not ask her unit number because after she hung up from the conversation with the officer she had thought it was “strange she didn’t ask.” In order to assist and direct the police to the correct location, Ms Smith opened her front door and turned her front light on so that the police could see there was some activity in that unit.

During the almost 3 minutes of conversation, Ms Smith stated that she repeated the information about having to go behind the units to the clothesline “more than 3 times” because she thought that she was not being heard. In fact, she thought the officer was “skimming over” the information that she was providing. Ms Smith knew that the units were well known to police as they did not have a good reputation. She was also aware of the complicated layout of the block of units. She was seeking to stress to the officer the need to go behind the units - to drive by Winton Lane would serve no purpose at all as the person would not be visible.

Ms Smith left her front door open for approximately half an hour waiting for the police to arrive but she did not hear the police come past. During that half hour she could hear a loud male voice” talking but not making any sense”. Ms Smith was too scared to go outside as she did not have a torch and did not know if there was anyone else in the vicinity. At about 1:45 AM, Ms Smith lay down and could still hear the “gurgling” and the breathing noise, then must have dozed off. At all times she believed that the police would respond to her telephone call.

The next morning Ms Smith went out into the back yard area of the units and was horrified and ”livid” to find that the man was still there.

Constable Miezitis’ evidence of receiving the call from Ms Smith

Constable Miezitis gave a version of events at odds with the version given by Ms Smith. She said she had been at the station desk at the front counter of the police station when Ms Smith telephoned. She was on her own. She explained that her usual practice in recording information taken from callers was to write onto a piece of blank paper all information that she could gather from the phone call and then at some point enter that information into the Computer Aided Dispatch(CAD) system after the call. After the end of the shift, the paper would go into the bin.

Her evidence as recorded in a different set of notes of the conversation with Ms Smith (being notes recorded after Warren was found deceased) was as follows: *“At approximately 12.30 I got a call from a Christina. She said she heard a loud noise and can now see a man laying on the ground. I asked is he ok is he hurt? She said I can’t tell but he is groaning (sic).*

I said have you gone outside to see if he is ok? She said no I was too scared. I said where is he? She said outside the units in Winton Lane the ones behind Domino's Pizza. I asked what number? She said the ones in Winton Lane 126 Tamar Street address. I asked her to describe the male age/clothing? She said she couldn't really see because there was a basket like a washing basket like a washing basket in her way.

I asked if she could tell if he was hurt? She said she couldn't tell. I asked what had woken you did you hear an argument, voices? She said no not voices just loud noise like banging. I asked did you see or hear anyone else around? She said no. I asked are you able to check on him? She said no she is too scared. I said just confirming the units in Winton Lane behind Domino's Pizza 126 Tamar. She said yes. I said I'll put a job on we will have a look."

In her directed interview recorded on 29 April 2015 Constable Miezitis, stated that the conversation with Ms Smith was a four to five minute conversation that "went round and round in circles as "she wasn't very forthcoming with detail." Her assessment of the information given to her by Ms Smith was that there was nothing urgent about the information as "the caller was very calm. Nothing in her tone made me think anything else was happening".

Constable Miezitis stated that Ms Smith did not say that the incident was at the back of the units – "she just said it was the unit block at the back of Dominoes Pizza in Winton Lane" and that although Ms Smith confirmed the unit block as being 126 Tamar Street, she was not forthcoming with a unit number.

In her oral evidence Constable Miezitis agreed that she was at pains to confirm the address given was 126 Tamar Street because she accepted that the address was of considerable importance.
She maintained that she did ask Ms Smith the unit number and claimed that Ms Smith was not forthcoming with this information. In addition she stated that she had a clear memory of asking Ms Smith whether she had called an ambulance and was certain that Ms Smith did not refer to a clothesline at the back of the units - had she in fact done so she would have included that in the CAD message.

Constable Miezitis maintained that Ms Smith did not refer to the matter being either medical or intoxication nor would she accept, in her oral evidence, that Ms Smith may have said that. However, she accepted under cross-examination that the response" I'm not sure if it's medical or intoxication" was a response consistent with the question she agreed that she had asked the caller, that is:-"is he hurt is he okay."

Constable Miezitis was insistent that the only evidence given by Ms Smith as to the location of where this gentleman could be found was in “the units in Winton Lane, the ones behind Domino’s pizza”. She also insisted that Ms Smith had not used the word “gurgling” and in fact had that word been used she would have immediately called an ambulance. Her recollection and her evidence was that the only word used was that the man was “groaning”. According to her evidence, had Ms Smith mentioned that there could have been a medical issue that would also have prompted her to call an ambulance.

There is a clear factual dispute between the evidence of Ms Smith and the evidence of Constable Miezitis. Ms Smith was a compelling witness. She used the word “gurgling” because she said she had heard the sound before. Her son’s girlfriend had fallen from a balcony and that is the exact sound that she made as a result of that fall. That young woman was seriously injured. It was this sound that Ms Smith described as the “trigger” to her making the call to police. This is a powerful explanation for the use of that word and is highly credible.

In addition she was insistent that she told Constable Miezitis that the male was behind the units near the clothesline. She knew that was a crucial piece of information that needed to be conveyed to the police. Ms Smith was aware that if that information was not received then the police may simply drive down Winton Lane in a”drive by” and as a consequence not discover the male person. That of course is exactly what took place.

Ms Smith gave a statement to the police that morning, a matter of hours after the event and her statement was confirmed by her oral evidence to the court. Her evidence was clear and forceful. She was able to explain why the message given to the police during the telephone call had taken 3 minutes saying she was insistent on trying to have them understand exactly where the male was lying because of the difficult configuration of the block of units and because of her concern for the male person. This was the first time she had contacted police about any matter. She was calling police about a matter that was out of the ordinary for the type of commotion that she was used to in the unit block.

Constable Miezitis’ account of events was set out in notes she prepared after the incident, (as extracted above) specifically on the afternoon of 24 February after she became aware from Facebook that there had been a death of a man in Winton Lane. Her evidence changed in that initially she maintained she had prepared her notes in her notebook at home, although it was not normal for her to take home her official police notebook. Later she stated that she had attended the police station on 24 February and it was possible she prepared her notes there. She agreed she had access to the CAD entry when she prepared her notes.

Further, Constable Miezitis had initially told the court she was new to policing and did not know that a critical incident investigation would take place. She later agreed she was aware that any note she made would be significant in relation to the critical incident investigation. I do not accept her evidence regarding when she took notes and when she became aware of the critical incident investigation. She was given notice as an "involved officer" at 2.00pm on 25 February and at that time, according to her evidence, she was still in the process of preparing her notes. Her preparation of notes took place over a period of two to three days, noting they were signed and dated 26 February 2015.

Constable Miezitis claimed that her notes recorded a verbatim account of the conversation she had with Ms Smith. She would not accept the possibility that other matters were said during the phone call but not included in the notes. In her oral evidence she was emphatic that there were no matters mentioned by Ms Smith that did not appear in her notes. Her insistence on this issue is disturbing. She claims to have excellent recall about the conversation with Ms Smith. She was asked:

"Q. Do you accept that other information was given that you can't recall. Do you accept other things were said that do not appear in your notes.

A. No

Q. You don't accept that?

A. No

Q. You don't accept other things were said and not included?

A. No".

When her notes, which she claims contained a' verbatim' account of the conversation with Ms Smith, were read out in open court, her account fell short of the almost 3 minute conversation that Ms Smith stated took place. The note reading fell short by about 1 ½ minutes. Constable Miezitis claimed that the missing 1 ½ minutes of conversation in her verbatim account could be explained by Ms Smith repeating the address saying "She kept saying the unit block behind Domino's pizza". She maintained that the repetition lasted one and a half minutes. This explanation is ludicrous. I do not accept that Ms Smith repeated the same words to that effect for that period of time.

Even on her own evidence, Constable Miezitis' version cannot be relied upon. Despite insisting she had excellent recall, in her oral evidence she told the court she had a clear memory of asking Ms Smith if an ambulance had been called. This does not appear in her verbatim account of the conversation recorded in her notes. Further, in her oral evidence she stated she had done a Google search of the location because she was, "confused" about the location. However, later in her evidence she agreed she was not "confused" because she had in fact confirmed the location as 126 Tamar Street with Ms Smith and she was aware of that unit block because she had been to those premises before.

She agreed she was at pains to ensure the correct address and location was recorded because she knew how important that information was. She maintains she asked Ms Smith for her unit number, but Miss Smith was not forthcoming with the unit number. She agreed that the unit number would have been an important piece of information in pinpointing the exact location. Ms Smith gave her statement to the police the morning immediately following the incident and stated she was not asked for her unit number. In her oral evidence Ms Smith thought it "strange" that she was not asked this detail, and she sought to remedy the situation by turning on the lights of her unit and opening the front door.

Again, I find it ludicrous to suggest, as Constable Miezitis suggests, that Ms Smith would not have been forthcoming in relation to disclosing her unit number. Ms Smith provided her name and her mobile telephone number. She was keen for police to attend. She believed it was essential that police attend. To suggest that she was not forthcoming with the information concerning her unit number, having taken the trouble to call the police and disclose her mobile phone number and her address, defies belief.

It is accepted that there was some confusion about the configuration of the unit block on Tamar Street. Both Ms Smith and Constable Miezitis attest to this. That is why Ms Smith states she was adamant about explaining the exact location of the male. She stated "the front of our units are in Winton Lane behind Dominoes, however the person is behind the units near the clothesline".

Ms Smith was convincing in her oral evidence that this was a detail she was keen to impress upon Constable Miezitis. She knew that it would be difficult to locate the male without that piece of information and yet Constable Miezitis maintains that that piece of information was not given to her by Ms Smith. It is noted that Constable Miezitis does make reference in her notes to the presence of a "washing basket", but makes no reference to the vital piece of information concerning the area near the clothesline that Ms Smith is adamant she disclosed.

Constable Miezitis did not enter the details of the conversation into the CAD system until approximately 25 minutes after receiving the call. Regrettably the best evidence as to what was said in that phone call has been destroyed. Constable Meizitis destroyed the notes she had taken at the time of the telephone call. Counsel for the NSW Commissioner for Police submitted that the CAD entry was the best evidence, the notes merely being "tangential". Clearly that is not the case. On any understanding of the rules of evidence, the best evidence would be the notes being a contemporaneous record of the conversation.

In the absence of such notes, I am left with having to determine the dispute between the evidence of Ms Smith and Constable Miezitis. Constable Miezitis relies on her recollection and the entry in CAD system. I have already found on the evidence that Constable Miezitis' evidence is not acceptable on a number of issues:

1 Her evidence as to when she took notes in the notebook and when she became aware that it was to be called a 'critical incident'.

2 Her denial that she heard the use of the word "gurgling" by Ms Smith.

3 The purported failure of Ms Smith to provide her unit number.

4 The purported failure by Ms Smith to pinpoint the exact location of the male person behind the clothesline.

Ms Smith was an impressive witness. She has nothing to gain by not speaking the truth. She was a concerned member of the public who was clear in her evidence about the importance of the information that she wanted to give to the police. She knew it was vital that this information was given precisely. Constable Miezitis relies on an entry made 25 minutes later into the CAD system, following a period in which she states was busy taking other calls in relation to other matters. Her recollection has been shown to be faulty. For the reasons outlined above I find that the evidence of Constable Miezitis is not credible and I accept the evidence of Ms Smith.

The Computer Assisted Dispatch (CAD) system

The CAD system is the NSW Police Force's resource and incident management system. It is used to manage and support deployment of police resources in response to incidents generated by the community and other NSW response agencies.

Each CAD message requires an incident type assigned to it. This is an incident description relating to the nature of the incident based on the information to hand. There are 108 primary CAD incident types and 115 secondary incident types.

The 2 incident types relevant in this matter are:

i (105) check bona fides - this relates to tasking police to check persons who are acting suspiciously in some way to make sure their reasons for being there or whether they are acting in a manner that is genuine.

ii (017) concern for welfare - this relates to where police or a member of the public have concerns for another person, for example where an elderly person has not been seen for a number of weeks.

Each of these incident types is given a priority 3 (non-urgent) incident number by default. Priority 3 indicates a non- urgent response and suggests that a response be made as soon as possible. This priority relates to matters concerning noise complaints , break and enter complaints, motor vehicle accidents, et cetera. Constable Miezitis classified the job as a check bona fides job. She explained she had done this because she saw the category as “something that can’t be categorised by something else.” She had previously used this category in creating CAD jobs. She thought that because the person was outside and there was no clear evidence that he was hurt and from the calm tone in which the information was given, she could presume the person was intoxicated and that it was nothing serious.

Constable Miezitis stated that she had a “basic understanding of CAD” and explained that she had only had very brief training in relation to the CAD system. Detective Senior Sergeant O’Reilly noted that Constable Miezitis was a ”relatively inexperienced officer” and that there were a lot of things happening on the night of this incident. He further stated that ”using a system which, unless you are very proficient with it, would take some time to be able to complete a CAD”

Constable Miezitis, in her oral evidence stated that in hindsight she should have contacted VKG to put the CAD job on given she was busy and was not in a position to complete the CAD for 25 minutes. In addition she conceded that the information should have been entered into the system sooner. There seems little doubt that the training provided to young officers such as Constable Miezitis in the use of the CAD system was inadequate. However, Detective Senior Sergeant O’Reilly stated that even on Constable Miezitis’ own account of the telephone conversation the job should have been classified as a “concern for welfare”. Again with the benefit of hindsight Constable Miezitis acknowledged that this should have been the classification.

Response by Sergeant Kirk

At 12.53 am Sergeant Kirk responded to a VKG broadcast. The information that had been contained in that broadcast was :

"V.1 Ok. Ballina vehicle, check bona fides… Winton Lane at Ballina crossed with Kerr Street, caller says she was woken by loud noises, now she can see a male laying on the ground groaning at the unit block in Winton Lane behind Domino's Pizza. The address of the unit block is possibly 126 Tamar Street, entry via Winton Lane, caller was too scared to go outside and check on the male, Ballina vehicle."

This message was broadcast at 12.50.30.

The VKG broadcast essentially contained the same information as in the CAD job. The broadcast was the only information known to Sergeant Kirk regarding the job. He said he believed that the "check bona fides" incident related to a concern about a person lying on the ground. It was his assumption that the person "had come out of a hotel…taken drugs and passed out". Given the nature of the information, he did not consider it to be a 'concern for welfare' job.

Because the reference to the address being "possibly 126 Tamar Street", there was a doubt in Sergeant Kirk's mind about whether it was the unit block with which he was familiar.

In his directed interview, Sergeant Kirk gave an account of his response to the VKG broadcast:

"…*I turned left into Kerr Street. I did a u-turn at the end of the concrete median strip. I've come back along Kerr Street and turned left into Winton Lane. That's where I called off the job, at the end of the lane…I've put the high beam on and the alley and take down lights on the light bar, put the driver and passenger windows down and patrolled the section of Winton Lane between Kerr Street and Grant Street. When I got to the end of Grant Street, I called back on. I've then turned right into Grant Street and just to satisfy myself before I left I patrolled along River Street. Did a u-turn at the traffic lights in River Street, back along River Street to Grant Street. From Grant Street I went left into Tamar, left back into Kerr then left back into Winton Lane having another look."*

At no time did Sergeant Kirk get out of the car. He believed that the person had gotten up and walked away. He said he did not consider walking over to the unit block. He could see the rear of the yard from the car and there was no one visible. In the past when he had attended those units regarding noise complaints and other matters he understood that there was only one building.

Sergeant Kirk chose not to contact the informant, Ms Smith, because he assumed the person had walked away. He said he was also concerned about the late hour. Again, he made an assumption that if Ms Smith's concerns had not been addressed," there would have been another call".

In his oral evidence Sergeant Kirk agreed there was no requirement for Ms Smith to again call police; she was entitled to expect that police would respond. He further agreed that it was wrong to make an assumption that the job had resolved because there were no follow up calls. In his oral evidence, Sergeant Kirk also conceded he could have contacted VKG and asked them to call the informant, noting that the lateness of the hour could not have been a real issue as the informant herself had called police at a late hour. He further conceded that with the benefit of hindsight, he "absolutely" thought he should have done so.

Sergeant Kirk told the court that:

(a) He would have had the same response to the job even if the word "possibly" had not been used in relation to the address. This is curious in light of his oral statement that that there was "absolutely" a doubt in his mind about whether it was in fact those units.

(b) If the information: "The front of our units are in Winton Lane behind Dominos, however the person is behind the units near the clothes line" had been broadcast, he still wouldn't have looked behind the unit block at 126 Tamar Street.

(c) If the CAD message had been prefaced by 'concern for welfare', his response would have been different in that he would have had VKG again contact the informant when he was unable to see anyone.

Sergeant Kirk stated that, whilst saddened that he did not locate Warren, he believed that based on all the information provided to him at the time he "took all reasonable steps to address the concern of the complainant"

Detective Senior Sergeant O'Reilly told the court that whilst it was "adequate" that Sergeant Kirk did not get out of the car, he would have expected a call to have been made at the time of the job or shortly after. Irrespective of the assumptions made by Sergeant Kirk, Detective Senior Sergeant O'Reilly stated that it was Sergeant Kirk's "responsibility… to acquit the job and to ensure that it had been resolved" and "for the sake of this job… a phone call should have been made to the informant."

Given the information that Sergeant Kirk was relying upon it is perhaps understandable that he proceeded in the way he did. What is highlighted by his actions, however, is the danger in making assumptions when a fairly easy response in the form of a call to the informant or to VKG may have resulted in a more positive outcome.

Conclusion

This case raises a number of failings by the individual police and by the system.

i. I have found there was a failure by Constable Miezitis to accurately record the information being given to her by Ms Smith.

ii. There was a failure by Constable Meizitis to promptly enter the information into the CAD system:

iii. There was a failure by Constable Miezitis to accurately categorise the incident type in the CAD system:

iv. There was a failure by Constable Miezitis to precisely convey the relevant address by her use of the word “possibly”:

v. Sergeant Kirk failed to contact the informant to clarify the information as to the location and;

vi. Because of the assumptions made by Sergeant Kirk, he failed to properly ‘acquit’ the job.

Some of these failings may be characterised by inexperience in the case of Constable Miezitis and lack of training, but the cavalcade of failings had the effect of leaving Warren alone at a time when he most needed help. Detective Senior Sergeant O’Reilly gave evidence as to what he considered to be “shortcomings” in the training provided to officers in relation to the CAD system.

He believed that the training previously in place - being only about one-and-a-half or under two hours, was inadequate. Constable Miezitis gave evidence that she had completed an online tutorial and agreed there was a need for more detailed training.

Detective Inspector David Kay, a manager of the Constable Education Program at the NSW Police Academy in Goulburn, in a supplementary statement to the Court, detailed the developments in the training space relating to the CAD system.

i. Since 2014 there has been a doubling of the training provided to policing students on various police force computer systems.

ii. CAD training (delivered during the' compulsory on campus' study mode) consists of an overview of the CAD system and includes instructions on how to undertake the e-learning training for the system.

iii. The e-learning covers various subjects of the CAD system. A number of different subject areas are assessed and students cannot proceed to the next subject area without first passing the online assessment relating to each subject area. The training includes identifying the location of incidents and how to create incidents.

iv. The time taken to complete the CAD training outside of the timetable lessons is usually two to two and a half hours.

The 108 incident categories and their definitions are now printed in the student manual for future reference. The three main categories and their definitions – 'check bona fides', 'concern for welfare' and 'domestic' have been highlighted for discussion in the face to face component of CAD training. Detective Senior Sergeant O'Reilly stated that he believed these measures to change training in CAD to be a "particularly beneficial improvement".

Confirmation has now been received from NSW Police (and specifically, Detective Inspector Kay) that consideration is to be given to the inclusion of 'case studies' into the CAD training module to illustrate and inform selection of CAD incident categories regarding the three most common incident types, previously mentioned. As a result of these changes and noting the commitment from NSW Police concerning the implementation of these changes, I do not intend to make any recommendations in this matter.

Warren Maguire

Warren was a man who was troubled by longstanding mental health issues. It is not known what demons were in his mind to convince him to propel himself from the small bathroom window onto the ground below. On the evidence it appears that no one could have foreseen Warren taking that action that night nor does it seem that it could have been prevented.

The tragedy of this matter is that Warren remained alive on the ground for a considerable period of time and that a concerned member of the public had contacted police and alerted them to his presence shortly after his fall. It should be expected that police would respond quickly and professionally to such an occurrence.

Although Dr Cala acknowledged that in theory Warren may have survived if found at an earlier time, he said his death was “almost inevitable” given the nature of his injuries. What is particularly difficult for the family can be summed up in Barry’s words: “The family’s great sadness is that no one was with him to comfort him at the time of his death.”

Formal Finding:

I find that Warren Joseph Maguire died on 24 February 2015 in the rear yard of his unit at 126 Tamar Street Ballina. The cause of death was multiple injuries. The manner of his death was exiting a bathroom window, and colliding with the concrete ground. I am unable to find on balance that Warren intended to end his life.

17. 64099 of 2015

Inquest into the death of MC. Finding handed down by Deputy State Coroner Grahame at Glebe on the 17th August 2017.

This decision was written without the benefit of a transcript. Section 81(1) of the Coroners Act 2009 (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of MC.

Introduction

On 1 March 2015 MC was shot at close range by a policeman who was attending his home in response to a complaint of domestic violence. Immediately after the shot was fired, attending police commenced first aid. Unfortunately, although ambulance officers arrived and continued treatment, MC died prior to being transported by helicopter to hospital. MC's death is tragic and the loss and pain felt by his family is both significant and ongoing.

The role of the Coroner and the scope of the inquest

The role of the Coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The Coroner is also to address issues concerning the manner and cause of the person's death. In addition, the Coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.

In this case there is no dispute in relation to the identity of MC, or to the date and place or medical cause of his death. For this reason the inquest focused on the manner or circumstances surrounding MC's death. In particular, the inquest examined the response of the New South Wales Police Force to the call which had been made earlier in the day and to police actions at the scene.

This is a mandatory inquest, because MC's death occurred "during the course" or "as a result" of a police operation. Parliament requires that inquests of this kind are conducted by a Senior Coroner. This statutory position reflects the importance of independence and transparency when it comes to investigating deaths in this category. There is a significant public interest in understanding how it is that a person was shot and killed during what has been described as a routine arrest situation. The circumstances surrounding a death such as this should be carefully scrutinised and care must be taken to ensure that all relevant police policies and practices are most carefully reviewed.

Any opportunities for improvement should be identified and explored, particularly if they have the capacity to save lives in the future. At the same time it is important to remember that operational policing can be highly unpredictable and stressful. Police are often required to face great personal danger in the course of their work. One must always be careful when reviewing decisions made in the field from the relative comfort of the courtroom. The purpose of this inquest is not to lay blame on any individual, but rather to see if it is possible to identify opportunities to reduce the risk of tragedy in situations of this nature.

I am satisfied that, after the shooting, a proper investigation of the events surrounding MC's death took place pursuant to the relevant critical incident guidelines and that the necessary information was gathered by non-involved officers so that these matters can now be properly and fully reviewed. The inquest explored the New South Wales Police Force's policies and procedures in relation to a number of matters relevant to the events in this case. A guiding list of identified issues was circulated prior to the inquest commencing.

These issues included

- Did MC receive adequate and appropriate medical treatment following the shooting?
- What was the medical cause of death?
- Did MC's psychiatric history have an impact on the actions he took on 1 March 2015?
- Was MC's death self-inflicted?
- What information regarding MC was known to the responding police officers?
- What information did CB provide to the responding police officers?
- What steps did police take to plan their approach to arrest MC?
- Was an alternative approach to arresting MC available to police and warranted in the circumstances
- Following a brief outline of the chronological events, I intend to deal with each of these issues in turn.

The evidence

The court heard oral evidence over three days and received extensive documentary material including witness statements, expert reports, photographs and recordings. At the end of the evidence there was substantial agreement in relation to what had actually occurred. In setting out the brief chronology I intend to rely heavily on the summary of events reproduced in counsel assisting's opening remarks.

Background

MC was born in Lismore to RH and PC. His parents separated when he was two years of age. His mother re-partnered with LH, who then adopted MC and his sister, AT. MC's mother had a third child with LH, JH. While the family was at times close, by the time of his death MC was sadly estranged from members of his family.

Prior to the morning of his death, MC had not spoken to his mother for some years. He had last seen JH in 2010, and although he had seen his sister AT briefly in 2014, prior to that he had not seen her in many years. In the period just before his death, MC appears to have been somewhat socially isolated, with little meaningful contact with those outside his home. His mother and various other relatives apparently did not get on with CB and this may have exacerbated the family discord.

The records show that MC had a troubled childhood in many respects. There was some family violence and he reported having been sexually assaulted by a family member as a child. MC left school at 15 and commenced work as a painter, a trade he continued throughout his life.

Despite these difficulties, family members report that MC was often happy. He loved football, surfing and being in nature. He was warm and had a good sense of humour. When MC was about 20 years of age he commenced a relationship with a girl he had known for some time, CB. They remained together for 25 years, apart from a few periods of separation and conflict. They had three children, a girl and two boys, who were aged 17, 15 and five at the time of MC's death.

There is no doubt that the family circumstances had been difficult for a number of years prior to MC's death. They had experienced homelessness and poverty. There were several documented reports made to the Department of Family and Community Services regarding domestic violence, drug use, mental health issues and neglect of the children.

In January 2012, the children were removed from their parents and placed in care. The C's daughter soon returned, but the two boys remained in out-of-home placements. The removal of the children was a source of continuing distress and enormous pain for MC and CB. Despite the difficulties the family had suffered MC was focused on getting his family back together. Between around July 2012 and January 2014 the boys were placed in the care of MC's sister, AT, before being moved to other foster carers. Unfortunately this appears to have caused further animosity within the family.

Over the years MC had also suffered from a number of health problems. He had spondylolisthesis, which is an abnormality of the spine, and hyperthyroidism or Graves' disease. He also suffered various mental health problems throughout his life.

He was apparently first involved with mental health services around the age of five, when he was diagnosed with a conduct disorder. While the early records are not available it seems that he was treated by a psychiatrist as a child and also spent time as an inpatient at Ryde Hospital.

In his adolescence he was diagnosed with ADHD and then with symptoms of depression. A family member described how he attempted to hang himself at aged 15, tried to jump through a window at aged 16 and then how he jumped from the third storey of a building when he was about 20 years of age, causing a fracture to his spine. His mother also reports that MC threatened to throw himself off the cliffs at Curl Curl, although she and other family members were not sure whether he was "serious". Despite these reported issues, MC's mental health diagnosis appears to have been complex and somewhat unresolved.

In recent years the care MC received for his mental health issues was minimal and provided primarily by his GP, Dr Young. MC was prescribed antidepressants at various times, although Dr Young notes that MC was not always compliant with the regime. MC does not appear to have undertaken any long term counselling or behavioural therapy. While CB wanted him to engage in treatment, there was no way for her to force him to seek help.

MC's medical records include several references to self-harm and suicidal ideation. In January 1997, when MC was 27 years of age he was admitted to hospital following an attempted overdose. In February 2003, MC was found by police sleeping rough in bushland, and was taken to hospital for assessment. Records from that time state that he said he wanted someone to "finish him off". In October 2011, he again took an overdose of medication and was admitted to hospital.

However, MC discharged himself, against medical advice a few days later and refused to engage with any follow-up from the local Community Mental Health Team. It was shortly after this that his children were removed. Dr Young attempted to refer MC back to the Community Mental Health Team in 2012 and also to a psychiatrist, but these referrals do not appear to have been followed up. CB reports that MC continued to be depressed. During 2014, she reports that MC told her that he was going to kill himself. In October 2014 he asked for her medication, which she understood was in order to commit suicide. Significantly, after this point, when he was distressed, MC began to make repeated threats that he would get police to shoot him.

CB says that he told her this so many times that "she had lost count". CB says she spoke with Dr Young about MC's deteriorating mental state. Dr Young states that MC did not report any suicidal ideation to him.

In addition to his self-destructive tendencies, MC was also apparently increasingly aggressive to others. CB describes MC as being “often volatile”, saying he could go from “crazy angry” to calm very quickly. His GP states that staff at the surgery reported that MC would become aggressive if he had to wait for an appointment.

His Aikido instructor also recalls that MC failed the test to achieve his black belt due to his lack of control and aggression. CB reports that after failing his test MC made a decision to immediately quit studying Aikido, even though he had been very happy there and the structure it offered had been helpful to the whole family.

MC was also violent towards CB. At times police were called and several apprehended violence orders were taken out to protect CB. MC was charged with breaching these orders on three occasions. In August 2003, MC assaulted his partner by kicking her and was convicted of assault occasioning actual bodily harm.

In June 2005, MC is alleged to have again assaulted CB. He was also given a suspended sentence around this time for damaging her car. Just prior to Christmas 2012, CB made an allegation that MC had sexually assaulted her. Charges were never brought because CB did not continue to cooperate with the investigation.

MC’s criminal record is not lengthy but it includes various offences of violence and offensive behaviour and convictions for resisting arrest. A few of the interactions with police are of significance because they resulted in warnings about MC being placed on the police COPS system. In June 1993, MC was arrested for offensive behaviour and on that occasion he resisted arrest. As a result, a warning was placed on the COPS system stating that MC “may assault police”.

In November 2013, MC was involved in a “road rage” incident. MC lost his temper at the conduct of another driver and proceeded to intentionally ram another vehicle. Police were called. When they arrived it appears that MC admitted his conduct. Senior Constable Kirk, one of the police officers who attended MC’s home on the day of his death, recalls having dealt with MC during this earlier incident. As a result of the incident a further warning was added to the COPS system, stating MC “can be extremely aggressive.”

MC failed to appear at court in relation to that matter. He was convicted in his absence and a warrant was issued. In January 2014, police attended MC’s home to arrest him on this outstanding warrant. They found him near the garage holding a sharp metal spatula which they asked him to put down. He complied.

However, he then moved towards police officers aggressively and proceeded to violently resist arrest. Further police had to be called and in the course of the eventual arrest MC was sprayed twice with capsicum spray. This was the last encounter he had with police, prior to his death. An additional warning was added to the COPS system at that time which stated "has LoR [level of resistance]; unarmed; resisted control: wrestle."

The days leading up to MC's death

It is clear that in the weeks prior to his death, MC was in a distressed and depressed state. His mental health was deteriorating. It is not known whether he was taking his antidepressant medication. CB describes MC as being suicidal for most of 2015. She was worried about MC and spoke with friends in relation to her concerns.

The couple were also becoming increasingly concerned about their eldest son whom they had not been able to see for a period of time. They were worried about his state of mind and were concerned that people were trying to turn him against them.

On 27 February 2015 a meeting was held between the Department of Family and Community Services, the agency managing the children and MC, CB and their daughter. MC and CB were understandably emotional during the meeting and MC became so upset and angry that he walked out before the meeting had finished. He was reportedly distressed and felt that his concerns had not been adequately listened to or resolved.

According to CB, despite her efforts to calm the situation, MC remained angry and upset the following day. He was "raging around the house". He worked on his car for a while and later they watched a movie together. During the day he received an offer of work for the coming days, which he apparently accepted. That night CB says that MC was acting in a bizarre manner, rummaging around his room and turning all the lights on in the house, but not responding to her when she spoke to him.

The events of 1 March 2015

On Sunday 1 March 2015, MC and CB woke around 8 am. MC was intending to go to work. However, a short time later MC discovered that some of his clothes had fallen down behind the washing machine and had been ruined. He became immediately angry and accused CB of "sabotaging" his clothes, and deliberately trying to ruin them. When CB tried to calm him he told her that he "hated her guts" and said that he was going to let the house and everything "go down the tubes". He broke a coffee cup and smashed his mobile phone.

MC then assaulted CB. He grabbed her by the hair and punched her, grinding his fist into her face. The noise of the argument apparently woke their daughter KC, and she heard a sound “like someone getting punched”.

MC then went to the kitchen and rummaged through a drawer, apparently looking for knives. CB screamed at her daughter to get out and later they both left the house. It was CB’s evidence that as she left the house MC called out “you call the cops and I’ll make sure I’ll cause a scene and get them to shoot me. All I need to do is get a knife. It doesn’t take much to get them to shoot me” or words to that effect. It was CB’s evidence that she had previously heard threats such as this repeated on other occasions.

CB and her daughter ran to a house three doors along, which was a group home operated by Catholic Care. Two staff members Mr Hoad and Ms D’Adam answered the door. They took the pair inside and at 8.22 am Mr Hoad called Triple 0 from the internal office. The police VKG operator broadcast a “priority two” message about a minute later. The message identified MC and stated that he had a knife and had gone “crazy”.

The broadcast was acknowledged at 8.25 am by Senior Constable Rhys Kirk and Constable Michael Bridgeman. They were at Woy Woy Police Station and immediately proceeded with lights and sirens to the location. A minute or so later a third police officer, Constable John Vrana, who was then at Gosford Police Station, also acknowledged the job and proceeded to the Ettalong Beach area.

While the police were *en route*, the VKG operator checked the relevant information held on the NSW Police system. The operator informed the responding police that there were three warnings in relation to MC, namely that MC had a “level of resistance - unarmed, resist control, wrestle”, “can be extremely aggressive”, and “may assault police”. Officers Kirk and Bridgeman arrived at the location shortly after 8.30 am. Senior Constable Kirk entered the Catholic Care home and spoke with CB while Constable Bridgeman mostly spoke with her daughter outside. Constable Vrana arrived about five minutes later. He did not speak to either witness.

After speaking with the witnesses a decision was made to arrest MC as it appeared the offences of intimidation and assault had been committed. Senior Constable Kirk initially stated that Constable Vrana should take CB and her daughter back to the police station to obtain full statements. However, Constable Vrana said that as he was already there he should help with the arrest. Constable Vrana was aware that there were warnings about MC and he suggested that he should therefore help with the arrest in case MC made any trouble.

There appears to have been no discussion about the role each officer would take during the arrest. There does not appear to have been any discussion about whether MC was known to have weapons on the premises.

About 15 minutes after their arrival, Senior Constable Kirk radioed VKG and informed the operator that no weapons had been produced, “it seems to be a case of intimidation and common assault”. He said they were going to “pop over and arrest MC”. The officers then proceeded to the family’s home. Senior Constable Kirk drove his caged vehicle, parking on the verge outside so that it was conveniently placed for the arrest which was about to take place. The other two officers walked the short distance and entered the boundary of the property first.

Unbeknownst to police, MC was inside the premises preparing for their arrival. He seems to have taken out his Aikido weapons, which had been stored in the bedroom. Police later found a wooden staff called a Jo stick and a wooden sword called a Bokken positioned near the front door. A Samurai sword was also found under the blanket on the bed. Police also found that on a computer near the kitchen, MC had apparently typed a message in the search bar of the web browser which read “I’m dead hope your happy”.

Perhaps, most significantly, while police had been talking to CB and her daughter, MC had made a phone call to his mother, RH. It had been 3 years since MC had spoken to his mother and she was surprised to hear from him. He told her that he was held up in the house, surrounded by police and that he was about to die. He said “I’ve got a Samurai sword in my hand, and when the police come to the door, I’m going to attack them, and they’re going to shoot me, dead”. While RH tried to reason with her son, he ended the call. It is unclear exactly how seriously she took the threat.

The three officers approached the front door of the family home. They were walking in a V formation with Constable Vrana on the left, in front, Constable Bridgeman slightly behind him to the right, and Senior Constable Kirk at the rear. Senior Constable Kirk was the only officer who possessed a Taser. As Constable Bridgeman was approaching the steps leading to the front door, he turned and apparently asked Senior Constable Kirk if CB had mentioned any weapons. Immediately after this, as Constable Vrana drew level with the front porch, MC burst out of the door.

The evidence in my view clearly establishes that MC was brandishing two large kitchen knives. He ran straight at Constable Vrana, who backed away slightly towards the rear of the house. As he did so, Constable Vrana drew his firearm. It is likely that he shouted or told MC to drop the knives. MC continued towards him.

Constable Vrana shot MC once in the right chest area and he fell to the ground. Ballistic evidence establishes that MC was between 90 cm and 130 cm from the muzzle of the gun at the time it was fired. Emergency services were called and first aid was immediately commenced. Tragically MC did not survive his injury.

Identified issues

Did MC receive adequate and appropriate medical treatment following the shooting?

I am satisfied that MC received appropriate and adequate care after the shooting. Unfortunately in the circumstances he could not be saved. I am satisfied that Senior Constable Kirk promptly radioed for an ambulance and that each of the officers assisted, as best they could, by providing first aid equipment or applying pressure to MC's wound.

The ambulance arrived within about eight minutes and a Care flight helicopter was summoned. MC was taken by ambulance to Ettalong Oval to meet the helicopter, but unfortunately went into cardiac arrest before he could be airlifted. I have had the medical and ambulance records reviewed by an independent expert and I accept his opinion that given the substantial loss of blood, where access to a trauma centre was not immediate, MC's death is likely to have been the inevitable result of his injuries.

What was the medical cause of MC's death?

MC died of a gunshot wound to the chest.

Did MC's psychiatric history have an impact on the actions he took on 1 March 2015?

There is little doubt that MC was suffering from a deteriorating mental state from at least October 2014. He had been making frequent references to ending his own life and to getting police to shoot him. He was under enormous pressure and felt hopeless and angry about losing his children. There is evidence that he was increasingly unable to control his mood and temper. He had been medicated for depression but it is likely that he was non-compliant with his medication. There is however no evidence of a prior firm diagnosis of psychosis or schizophrenic illness.

MC's medical records were reviewed by a consultant psychiatrist, Dr Diamond. He found no evidence of schizophrenic illness and thought MC was more accurately described as someone who was suffering from a "persistent disabling personality disorder". He based this opinion on reviewing past medical records and on descriptions of MC's behaviour at various times.

He was of the view that MC's depressive symptoms were not an underlying cause for psychiatric disturbance, but "secondary to his dysfunctional lifestyle resulting from his personality disorder".

Dr Diamond was of the view that MC was struggling with longstanding features of a serious personality disorder. He had a limited coping repertoire and had developed a range of dysfunctional mechanisms for dealing with his considerable stress. His personality vulnerabilities could produce enormous rage, aggression and constant feelings of being overwhelmed. However, he was not in a state where he had completely, "lost touch with reality" nor had he entered a recognised psychotic state on the morning of his death. I accept this opinion on the evidence before me.

MC was under enormous pressure at the time of his death. He had never engaged with long term professional help, aside from the intermittent use of anti-depressants. He lacked coping skills and the ability to control the rage he felt. He had developed a range of completely dysfunctional coping mechanisms which culminated in the plan he hatched on the morning of 1 March 2015.

Was MC's death self-inflicted?

A finding that a death is intentionally self-inflicted should not be made lightly .The evidence should be extremely clear and cogent in relation to intention. In my view the weight of authority suggests that the proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard.

- There is overwhelming evidence that MC intended to die that morning, not all of which was available to the attending officers, prior to their approach. There is, in my view, sufficient evidence to establish that MC engaged in a deliberate and conscious course of conduct which he intended, as he embarked upon it, would have the result of ending his own life. The evidence includes,

- MC had committed self-harm and threatened suicide on previous occasions. MC had apparently repeatedly told CB that he would make a fuss and cause police to shoot him over the past few years. MC had seen a news report of a police shooting in 2015 and commented that he could get police to shoot him. He communicated this fact to CB. When CB left home on the morning of MC's death, he said "If you call the police I will make sure that I make such a scene that they will kill me".

- MC called his mother by telephone at 8.39 am on 1 March 2015, only 9 minutes before he was shot, saying “I’ve got a samurai sword in my hand and when the police come to the door, I’m going to attack them, and they’re going to shoot me, dead”.

- He had not contacted her in some time. At some stage, just prior to his death, MC left an improvised suicide message on the search bar of the computer in his home. The message read *“I’m dead hope your happy”*. MC made preparations to ambush police by placing weapons near the door and getting his samurai sword out of its usual storage place. This suggests that he planned to make a significant scene, if necessary. MC ran towards Constable Vrana brandishing two knives. He is likely to have felt confident that this would provoke a lethal response. He did not stop or drop his weapons when commanded to do so.

- After he had been shot and was lying on the ground, he spoke to police, saying “why didn’t you shoot me in the head?” and “I want to die”. He did not remonstrate with police about what had happened or appear to blame them for shooting him. Although distressed and angry, it does not appear that MC was suffering from psychosis at the time of his death. He appears to have understood what was happening.

- Toxicological results do not indicate that his reasoning is likely to have been greatly affected by drugs or alcohol. I have carefully considered whether or not it is possible that MC just wanted to “cause a scene”, rather than die, but the weight of the evidence suggests otherwise.

- I have also considered whether he was so overwhelmed by anger and distress that he cannot be said to have been acting in a voluntary manner. However, the evidence is that he planned the placement of weapons and rang his mother to announce his intention just minutes before rushing at Constable Vrana. In reviewing the available evidence I have come to the view that he appears to have been acting on a plan that he had already carefully formulated. I am of the view that as MC ran at Constable Vrana, he intended and planned to die. His death was self-inflicted in the limited sense that he intentionally carried out an action that he believed would provoke a lethal response. I note that CB’s legal representative did not appear to reject this view in his submissions.

- Dr Diamond described what had occurred as a classic “suicide by cop”. While I accept that it is a term widely understood in the public arena, it is in my view a most unfortunate term that tends to have the effect of trivialising or even glamourizing the tragedy of the situation. Nevertheless, I accept that it appears to have been a concept that MC was aware of and had discussed with his partner in the months before his death.

- In my view it is not particularly useful or appropriate to state that MC "committed suicide" in the way the term has been used in the criminal law for many years. However, I am satisfied that pursuant to the *Coroners Act* 2009 (NSW) the circumstances of his death are sufficient for it to be classed as "self-inflicted" and thereby attract the protections provided by section 75."

What information regarding MC was known to the responding police officers?

Each of the officers attended the job, knowing what had been broadcast, namely that MC had gone "crazy" and had hit CB. They knew that they were going to a potentially dangerous domestic incident. All three officers heard the warnings that had been broadcast on VKG, but none of them considered these to be particularly unusual or noteworthy.

Constable Vrana stated that he would pay attention to warnings that suggested a specific threat, but otherwise accepted that given the common nature of the warnings, he had a degree of complacency about them. Senior Constable Kirk explained that he always "expected that a person could be dangerous" when going to a job such as this. He recognised the name of MC, but only remembered his previous dealings with MC as he approached the house just prior to the shooting, so that prior contact offered him little extra information in weighing up the risk police faced that morning.

I accept that there was nothing about the warnings given which would have made them stand out. It is important to stress that police did not know that while they were on the scene, MC was calling his mother to convey his specific plan. Police did not become aware of that until well after MC's death.

What information did CB provide to the responding police officers?

On arrival, Senior Constable Kirk had a brief discussion with CB in the office of the Catholic Care home. Constable Bridgeman and Ms D'Adam were also present for a short time. According to KC, during this discussion CB said that MC "might have a knife", but KC contradicted her, saying that she had not seen her father with a knife and she had remained in the house longer than her mother and had actually seen him last. CB denied this conversation took place, but Senior Constable Kirk recalled it. After this point, the witnesses were separated and Constable Bridgeman took KC outside.

Senior Constable Kirk then obtained further information from CB about MC. CB said, in her original statement, that she had told Senior Constable Kirk that MC had a mental illness, and she had asked police to Taser MC rather than to shoot him. Senior Constable Kirk acknowledged in evidence that she had said each of these things, although he had not recalled this information during his directed interview. In retrospect he agreed that it was an unusual and memorable request. CB also said that she had clearly warned Senior Constable Kirk that MC would make a scene and encourage police to shoot him.

She stated that she knew he would cause a scene and she hoped police would "just" Taser him, rather than have to kill him. I accept her evidence on this issue. During the inquest CB gave emphatic evidence that she had seen MC holding two knives and advancing towards her in the kitchen, before she fled the home. She told the court that she had told Senior Constable Kirk of this at the time. Senior Constable Kirk denied that CB had told him about two knives. He stated that she had told him that she had seen MC rummaging in the drawer and that she believed he was going to get a knife. As a result, Senior Constable Kirk later informed VKG radio "no weapon produced".

In my view the totality of the evidence does not support the conclusion that Senior Constable Kirk was told in clear terms that MC had armed himself with two knives whilst in the house. There are a number of factors which suggest the evidence was more confused than that. Certainly KC had contradicted her mother about MC having a knife when she last saw him.

Ms D'Adam remembered a suggestion that "obviously" there were knives in the house, but not a specific report of MC holding knives in a threatening manner. Mr Hoad can be heard on the Triple 0 recording finding it difficult to obtain from CB a clear answer to questions about this issue. I have no doubt CB was extremely distressed and fearful, this may have affected her subsequent recollection about what had occurred and exactly what information she had imparted at the time. In any event, I am not satisfied that I can rely on her later confidence that she saw MC holding two knives whilst still in the house, in the manner she described in court, or that she clearly conveyed this to Senior Constable Kirk at the time they spoke in the Catholic Care house.

On the other hand, I am well satisfied that CB did tell Senior Constable Kirk that MC had made a threat that he would cause a scene and get police to shoot him. Both KC and Ms D'Adam support the fact that this was said, and this much was accepted by Senior Constable Kirk himself. However, Senior Constable Kirk appears to have believed that this was unlikely to happen or that these words were some kind of empty threat.

While CB denied using the words “usual mantra” she accepted that she probably told Senior Constable Kirk that MC “usually” made the threat when they argued. This appears to have had a diluting effect on the information in Senior Constable Kirk’s mind. Senior Constable Kirk told the inquest that he believed that if the threat had been repeated it was “less likely” to happen. Accordingly, he discounted its significance and appears to have regarded it as an “empty threat”. In my view, Senior Constable Kirk wrongly discounted what CB was saying in relation to this issue. It is a real skill to obtain and evaluate information from a distressed person and in this case it may have needed more time that Senior Constable Kirk gave the task.

With hindsight it is clear that he put little value on her warning. Discounting the importance of this information was an error of judgement on his part.

After speaking with CB, Senior Constable Kirk made a decision to arrest MC. He was of the view that a domestic violence offence had been committed. He decided that CB appeared to be in need of protection. In his view it was New South Wales Police Force policy to support a proactive approach to investigating a situation like this and arresting a perpetrator if appropriate.

Senior Constable Bridgeman and Constable Vrana did not have any significant discussion with CB that morning and they therefore relied on Senior Constable Kirk to inform them about what CB had said. It appears that Senior Constable Kirk did not discuss with his police colleagues the view that he had formed that MC did not have a knife. This is apparent from the fact that Constable Vrana still believed MC had produced knives, relying on what had been said in the original broadcast.

The more significant issue is whether he shared the report that MC intended the police to shoot him that morning. In evidence Senior Constable Kirk stated that he believed he had told his colleagues about the threat MC had made to cause a scene and “get police to shoot him”. However in cross examination he accepted that it was possible that he had not told his colleagues about the threat, stating that while he still believed he did, “he had been wrong before”.

In evaluating all the evidence on this issue it is extremely significant that Senior Constable Kirk did not mention telling his colleagues about this threat during his directed interview, which occurred so soon after the events themselves. I also note that Constable Bridgeman and Constable Vrana did not mention the threat in their directed interviews. It is particularly striking that neither Constable Bridgeman nor Constable Vrana recalled hearing about the threat, given that the threat accurately described what MC went on to do. When questioned before this court both Constable Bridgeman and Constable Vrana did not recall hearing about the threat at any stage prior to the shooting or even immediately afterwards.

The weight of the evidence supports the fact that Senior Constable Kirk did not pass on this threat to his colleagues. I am of the view that this is because he simply failed to understand its importance.

Senior Constable Kirk was the senior officer present, he was the one who had spoken with CB, and it was incumbent upon him to inform the other officers about what she had said. The threat was, on any view, highly relevant to the assessment of the risk at hand. It was information which should have been assessed prior to arresting MC. It was important for Senior Constable Kirk to pass on this information on to his colleagues, even if he had already discounted it himself. Failing to do so deprived them of vital information which could have informed their own assessments of the risks they were about to face.

As a result, the two more junior officers did not turn their minds to the possibility that MC might try to provoke a lethal response from police. They were missing an important piece of information, as they approached a dangerous and difficult situation.

What steps did police take to plan their approach to arrest MC?

The three officers undertook minimal planning about how the arrest would be affected. Their evidence suggested that they approached the arrest in a routine way. The extent of their planning comprised of two steps. Firstly, Constable Vrana said that he should accompany the others because he was already there and because the warnings suggested that MC might "bung it on". It was his view that three officers would be better than two. Secondly, Senior Constable Kirk said that he would drive the caged vehicle across to MC's house, so that if they had to wrestle MC into the vehicle they would not have far to go.

Other strategies they adopted were not discussed. Senior Constable Kirk informed his supervisor via VKG that they were going to arrest MC. Constable Vrana saw his role as providing backup. The officers adopted a V formation on approach to the house. This formation prevented them blocking each other's line of sight.

Senior Sergeant Davis, the Police and Training Coordinator attached to Weapons and Tactics Policy and Review (WTPR) in the NSW Police Force gave evidence in relation to this issue. He stated that it was indeed important that officers plan their approach and that the NSW Police Force already has extensive training to assist officers in doing just this. He said that planning need not involve a long discussion or be documented or elaborate in detail. However in this factual scenario, he would have expected the officers to discuss what each witness had said and to discuss any risks or safety concerns they had identified before agreeing on a course of action.

It appears clear that further planning was called for in the circumstances of this case. Given that both CB and KC were safe, and that there were no other known potential victims or people at immediate risk, there was time to share information before approaching the house. While it is impossible to say whether or not this would have changed the ultimate outcome, it was certainly a missed opportunity.

Was an alternative approach to arresting MC available to police and was it warranted in the circumstances?

It is always important to guard against a hindsight bias when reviewing action taken in the field. However, it can be useful to consider what other options may have been available to the path taken.

A number of more cautious approaches were potentially available to the officers involved in the arrest of MC. However, given that the officers did not appreciate the risk that MC intended to cause police to shoot him, it is not surprising a more cautious approach was not considered at the time.

Nevertheless, a number of alternative approaches were canvassed during the inquest. Firstly, the officers could have attempted to contact MC by telephone. Dr Diamond said that he had experience of this technique being used with success, in the context of high risk negotiation situations, where specially trained police were involved. However, this is a different situation to the one faced by these officers on 1 March 2015.

It is the kind of approach used by trained police negotiators when they are present on the scene and where the scene has already been effectively contained. In contrast, Senior Sergeant Davis conceded that whilst this approach was a possibility, it would reveal to the person inside the premises that the police were present and that could then increase the risk of the suspect fleeing the scene or could potentially expose police to an ambush situation. We will never know for sure if MC would have responded favourably, had he been telephoned in this particular situation, although it is probably unlikely.

Secondly, it was canvassed in evidence that police could have remained at a distance from the house and shouted or used a loudhailer in an attempt to contact MC. This may have had the possible advantage of allowing officers a greater “reactionary gap” when and if MC emerged. It is clear that Constable Vrana only discharged his firearm because he believed his life was in immediate danger.

A greater reactionary gap may have allowed more time for the possibility of placating or subduing MC. However, it is certainly not clear that using this strategy would have led to any different outcome, given MC's stated intention to get police to shoot him.

Thirdly, police could have called for backup, either from other general duties officers or from tactical or specialist police prior to making contact. However, Senior Sergeant Davis stated that the first responding police would firstly need to establish that MC was actually inside the house. Tactical police would not respond until the general duties officers had confirmed that MC was present and that they had commenced to "triage" the situation. The same may be said of other personnel such as mental health specialists.

A further option canvassed in evidence was whether the police officers present could have anticipated using a Taser as a tactical option or planned their approach accordingly. Senior Constable Kirk was the only officer present with a Taser. As the officers approached the house he was at the rear, too far from the property to use his Taser effectively, particularly given the two other officers were standing between him and MC. Greater planning would have made it possible for Senior Constable Kirk to position himself where he could have used his Taser against MC more easily, had it been necessary.

The court considered whether it was open for Senior Constable Kirk to use the "draw and cover" technique with his Taser. The Taser policy describes this technique as being where a Taser is withdrawn from the holster and pointed at the suspect so that it can be deployed quickly. However, it is worth noting that Senior Sergeant Davis, who performs a role in reviewing the use of Tasers, did not believe that the Taser policy requirements for "draw and cover" were actually made out in the circumstances of this case.

Given the way MC emerged from the house, it is far from clear that the "draw and cover" technique would have resulted in a different outcome. While the Taser may have been deployed, it may not have connected with or indeed stopped MC. It is worth noting that each of the officers present was adamant that upon seeing MC running towards Constable Vrana with knives drawn, their only thought was to use a firearm. Each officer believed that attempting to use a baton, Taser or OC spray in these circumstances would have been too dangerous as the time taken to try these less lethal options would have meant the opportunity to use a firearm, if necessary, was lost.

Each officer was of the view that in the circumstances as they presented, Constable Vrana had time for a single approach. The court accepts that when MC emerged from the house and ran towards Constable Vrana brandishing two knives, Constable Vrana was in a very vulnerable position, effectively hemmed in on three sides by the fence, wall and rubbish bins.

Once MC charged at Constable Vrana, the officer had no chance to use conflict resolution skills or negotiate. It was too quick and too dangerous. It is likely that all Constable Vrana had time to shout was something like “drop the knives”. The whole interaction was over in a number of seconds.

Senior Sergeant Davis did not consider that the other tactical options available to police officers such as a baton, OC spray or Taser would have been appropriate options to use in these circumstances, given the effective limitations of the range and reliability of those weapons.

He also stated that he would have been very concerned if either Senior Constable Kirk or Constable Bridgeman had discharged their firearms because they would have been firing directly towards Constable Vrana.

I accept that even if Constable Vrana had a Taser it would have been a risky weapon to choose in the circumstances. Equally, OC spray does not appear to have been a viable option. Its use may have disabled the officer himself and may not have had the necessary coverage to be effective against MC. It is also well known that many offenders will continue to attack, while feeling the first effects of the spray, sometimes with added aggression.

I note that it was Senior Sergeant Davis’s evidence that Constable Vrana’s action in discharging his firearm was legally justified in the circumstances, particularly, in light of his obligations pursuant to section 230 of the *Law Enforcement (Powers and Responsibilities) Act* (2002). My own task is not to involve myself in tests appropriate to civil or criminal law, however, I accept that at the time Constable Vrana shot MC he genuinely believed that he was acting to save his own life and possibly the lives of his colleagues. I accept that he was faced with a frightening and dangerous situation and needed to make an urgent decision. I accept, without reservation that Constable Vrana was faced with a man rushing towards him with two large kitchen knives. I commend each officer present for immediately attending to first aid after experiencing the shock of such a frightening situation.

When one carefully examines what occurred in this tragic situation, the opportunities for learning and improvement are not found in the split second that MC took to run at Constable Vrana, but occur in the period before police attended the house. The opportunities to learn from these tragic events will be found in revisiting police training with regard to information gathering and in adequate planning for arrest.

In my view there is great merit in developing targeted training so that police will be more aware of the possibility that a distressed person may be acting to provoke a lethal response. Any warnings received with regard to this particular kind of threat need to be taken extremely seriously.

Senior Sergeant Davis, the Police and Training Coordinator attached to the Weapons and Tactics Policy and Review (WTPR) in the NSW Police Force accepted that the tragic circumstances of MC's death may be a useful case study for his unit to consider in planning this kind of future training. I intend to formalise this suggestion as a recommendation.

Conclusion

MC told his mother that police would shoot him on 1 March 2015, minutes before they did. His psychological distress had been continually escalating for months. His partner knew best how precarious his grip on life had become. She warned police that MC would create a scene and provoke police to kill him. Unfortunately, that warning was not taken seriously enough.

Police approached the arrest as a "routine" domestic violence job, with little information sharing or planning by the senior officer involved. Unfortunately, once MC charged from the house, it is understandable that Constable Vrana acted swiftly to protect himself. The ultimate result had been tragically foreshadowed by CB in her warning to Senior Constable Kirk only minutes before. MC's suffering at the end of his life is a tragedy. Unfortunately, there is no simple solution to prevent the despair MC felt as he ran at Constable Vrana. This pain and anger had been brewing for many years. CB had urged MC to seek further help and support on countless occasions, but he would not.

Equally, there is no simple remedy for correcting any errors of judgement or planning made by police that morning. It is easy to be critical from the safety of a courtroom, but I recognise the situation was extremely dangerous and that there would have been substantial risks involved, even if Senior Constable Kirk had taken more time to consider the importance of the warning he had received. I hope a close analysis of the circumstances of police involvement in this death, by those who conduct police training, will provide learning opportunities for other police officers who find themselves in similar dangerous situations in the future.

Finally, I once again offer my sincere condolences to MC's partner, children and extended family. Although divided, I see the pain they all share and acknowledge their great loss. I strongly urge that any published report of this death include reference to suicide prevention and mental health treatment contact points. I thank the involved officers for their open cooperation with these proceedings.

Formal Finding:

Identity

The person who died was MC.

Date of death

The date of death was 1 March 2015.

Place of death

MC died at Ettalong Oval, NSW.

Cause of death

MC died of a gunshot wound to the chest.

Manner of death

MC was shot by a police officer, as he ran towards that officer with two kitchen knives. MC's death was self-inflicted in the sense that he engaged in a deliberate and conscious course of conduct with the intent of ending his own life.

Recommendations

Pursuant to section 82 of the *Coroners Act* 2009 (NSW) I make the following recommendation to the NSW Commissioner of Police.

That the NSW Police Force consider using the circumstances of the death of MC as a guide for future training to highlight the risks arising from a person who intends to use police to commit self-harm.

18. 254391 of 2015

Inquest into the death of KE. Finding handed down by Deputy State Coroner Grahame at Young on the 25th October 2017.

Non-Publication Orders

Pursuant to section 75 of the *Coroners Act 2009*, I order that there be no publication of the name of the deceased or his family members. Initials may be used as pseudonyms. Pursuant to section 75(5) of the *Coroners Act 2009,* I permit publication of the information contained in these findings, in accordance with the above restrictions.

Pursuant to section 75(6) of the *Coroners Act 2009*, I have formed the opinion that it is desirable in the public interest to permit a report of the proceedings of the inquest to be published, subject to the below redactions.

This decision was written without the benefit of a transcript. Section 81(1) of the Coroners Act 2009 (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. Formal findings were delivered orally at Young Local Court on 25 October 2017. This is a written record of my findings as delivered on that day, incorporating my reasons for the conclusions then expressed.

Introduction

Late in the evening of 28 August 2015 KE attended the vicinity of the Young Police Station. He was holding a single barrel shotgun. Despite police attempts to calm and speak with KE, he remained distressed. After about twenty minutes he put the gun into his mouth and shot himself. It was immediately clear that he was dead. Ambulance officers who had been waiting nearby on standby were unable to assist. KE's death is tragic and the loss and pain felt by his family is both significant and ongoing.

The role of the Coroner and the scope of the inquest

The role of the Coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The Coroner is also to address issues concerning the manner and cause of the person's death. In addition, the Coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.

In this case there is no dispute in relation to the identity of KE, or to the date and place or medical cause of his death. For this reason the inquest focused on the manner or circumstances surrounding KE's death. In particular, the inquest examined the actions of the New South Wales Police officers who responded to the crisis.

This is a mandatory inquest because KE's death occurred "during the course" or "as a result" of a police operation. Parliament requires that inquests of this kind are conducted by a Senior Coroner. This statutory position reflects the importance of independence and transparency when it comes to investigating deaths in this category. There is a significant public interest in understanding how it is that a person died on the veranda of a police station, so soon after engaging with police. The circumstances surrounding a death such as this should be carefully scrutinised and care must be taken to ensure that all relevant police policies and practices are most carefully reviewed. Any opportunities for improvement should be identified and explored, particularly if they have the capacity to save lives in the future.

At the same time it is important to remember that operational policing can be highly unpredictable and stressful. Police are often required to face great personal danger in the course of their work. One must always be careful when reviewing decisions made in the field from the relative comfort of the courtroom. The purpose of this inquest is not to lay blame on any individual, but rather to see if it is possible to identify opportunities to reduce the risk of tragedy in situations of this nature.

I am satisfied that, after the shooting, a proper investigation of the events surrounding KE's death took place pursuant to the relevant critical incident guidelines and that the necessary information was gathered by non-involved officers so that these matters can now be properly and fully reviewed in an independent manner.

The inquest explored the NSW Police Force's policies and procedures in relation to a number of matters relevant to the events in this case. A guiding list of identified issues was circulated prior to the inquest commencing. These issues included:

Whether the applicable NSW Police Force policies and procedures were followed by police, attending the 'concern for welfare' job relating to KE on the evening of 28 August 2015.

What mental health services, if any, were available as at 28 August 2015 and what mental health services, if any, are now available to the greater community of Young, including how members of the community may access those services.

Following a brief outline of the chronological events, I intend to deal with each of these issues.

The evidence

The court heard oral evidence and received extensive documentary material including witness statements, expert reports, photographs and recordings. A view was conducted around the vicinity of the police station to place the CCTV footage and written statements in context. In setting out the brief chronology I intend to rely heavily on the summary of events reproduced in counsel assisting's opening remarks.

Background

KE was born on 31 March 1979 in Hull, United Kingdom. He met KA in England in 2004 and moved to Australia with her in March 2006, eventually settling in Canberra. KE and KA married in October 2007 and their daughter TI was born in 2012. KE had two other children living in the United Kingdom from earlier relationships.

The records show that KE had a troubled childhood in many respects. He lost his father at an early age and experienced care in a number of foster homes. He appears to have had his first contact with mental health treatment at approximately 11 years of age.

KE had a long standing history of psychiatric treatment. He had been admitted as an inpatient in the UK and later received mental health treatment in the ACT and New South Wales. He had been prescribed a range of medication by various mental health professionals. He was not always compliant and from time-to-time stopped taking his prescribed medication as directed.

KE also had a history of drug and alcohol abuse. Around the time of his death, he was reportedly drinking alcohol and smoking cannabis on a daily basis. Post mortem toxicology results also indicate the presence of prescription drugs and amphetamines.

KE had a long history of self-harm and had reportedly attempted suicide on a number of occasions. Some of the documented incidents include the following examples. In October 2007, KE was involved in an incident, whilst at his own wedding, where the police were called in response to him threatening self-harm. In July 2009, police located KE locked inside a caravan on his own property in the ACT, where he was reportedly making or intending to make an attempt at suicide. On 18 June 2015, KE again threatened self-harm as a result of which police were notified and conducted a welfare check.

Police conveyed KE to Young Hospital for assessment and he was discharged the following day. KA told the inquest that she had also been present on a number of other occasions when KE had attempted or threatened to take his own life.

On 7 July 2015, KE was assessed by Dr Anthony Barker on behalf of the ACT Forensic Services, Court Assessment and Liaison Services. This was the last known psychiatric assessment undertaken. Dr Barker diagnosed KE with borderline personality disorder, antisocial personality disorder, substance use disorder and possible neurocognitive disorder, due to traumatic brain injury with behavioural disturbance.

Contact with police and subsequent bail conditions

KE Logan had a limited criminal history. In 2012 KE and his wife were allegedly involved in a dispute with a neighbour in the ACT. An interim apprehended violence order (AVO) was subsequently granted in the ACT Magistrates Court protecting KE's neighbour. It appears that the situation did not improve and a final order was made in 2014.

On 31 March 2015, KE was involved in an altercation with the same neighbour. During the incident he allegedly used a crossbow to fire an arrow at his female neighbour. KE was arrested, charged and refused bail. On 13 May 2015 he was granted conditional bail by the ACT Magistrates Court. One of the conditions of bail was that he resides in Young with his wife's mother and stepfather, NA and PH. Another condition was that he report to the Young Police Station on a regular basis.

Whilst living with his parents-in-law KE threatened to self-harm and was taken to Young Hospital on 18 June 2015 for assessment. He was discharged the next day.

On 27 August 2015, KE appeared before the ACT Magistrates Court again in relation to the allegation relating to the crossbow incident. At that time he made an application to vary his bail conditions. Although the application was granted in part, it was unsuccessful with respect to the residential condition and KE was unable to move back to Canberra to live with his wife and then three year-old daughter, as he had wished. After the hearing KE returned to Young and resumed living with his parents-in-law on their property.

The weeks leading up to KE's death

It is clear that in the weeks prior to his death, KE was in a distressed and depressed state. His mental health was unstable and deteriorating. As has been indicated he was assessed at the Young Hospital on 18 June 2015.

Although he presented from time-to-time in emergency situations it appears that KE was somewhat resistant to engaging in long term therapeutic counselling and had not developed a strong rapport with a mental health provider. KE had been extremely hopeful that he would be able to go back to live with his partner and child in the ACT and when the bail variation application was refused he became distressed. He was reported to have been concerned about his wife and child living in the ACT without him. Despite the support shown to him by his parents-in-law, he also felt somewhat isolated and adrift.

The events of 28 and 29 August 2015

On 28 August 2015, KA and TI came from the ACT to visit KE on her parent's property in Young. They arrived around 3.20pm and went straight to the caravan where he was staying.

That evening KA and KE talked about their relationship. She reported that he seemed depressed and in retrospect there were aspects of the conversation which indicated that he was unwell. TI was asleep at the house and KA got ready to join her. KE told her how much he loved her and that he was going back to the caravan to get a beer. Shortly after this, KA heard the car start. KA had a slightly uneasy feeling. Later she checked the position of his telephone, using an application on her own telephone. On seeing that it was at the caravan, she thought KE must have fallen asleep in the caravan. She nodded off herself and early the next morning, about 1.26am, she checked again. His phone still appeared at the caravan. She sent a message, which read "Where are you babe – are you ok xx".

There was no reply.

It appears that KE left the property at approximately 10.30pm that night, leaving his telephone in the caravan. He was next seen in the town of Young, near the police station. It is not known if he drove directly there.

That evening Inspector Ashley Holmes was rostered on a night shift. Young Police Station comes under the Cootamundra Local Area Command, where Inspector Holmes worked in the role of Duty Officer. The Young detective's office, where he had been working, is located on Cloete Street, directly across the road from the Young Police Station.

At 11.44pm, when Inspector Holmes was leaving his office, he noticed a man standing near the marked police car which was parked outside Young Police Station. At that time Inspector Holmes saw that the man was holding "a length of something".

We now know that this man was KE. Inspector Holmes thought he might be trying to break the driver's door window and so he called out to KE, something like "Oi, what are you doing?"

Inspector Holmes continued to move closer to KE, who he now thought may be holding a stick. Shortly afterwards there was a loud bang and Inspector Holmes realised that KE had discharged a firearm. Using a police radio, Inspector Holmes called in a foot pursuit. He followed KE, calling on him again to drop his firearm. At some stage Inspector Holmes drew his own gun.

Around this time Sergeant Paul Colefax walked out of the Young Police Station and moved onto the roadway of Cloete Street, where Inspector Holmes was situated. KE reloaded the firearm, walked into the grounds of the police station and placed the muzzle of the firearm into his mouth, his hand was on the trigger. He walked up a ramp at the front of the police station. KE initially knelt on the veranda, before moving to a seated position beside the public entry door to the police station.

Inspector Holmes spoke with KE for a period of approximately 20 minutes. During the conversation Inspector Holmes tried to convince KE to put the firearm down. Inspector Holmes did not know KE, but he tried his best to engage him in non-threatening conversation. Inspector Holmes asked KE what the problem was and whether he could help. It was obvious to Inspector Holmes that KE "didn't want to talk". Eventually he managed to get KE to say a few things. KE explained that all he wanted was to be a husband and father, but that there was an AVO against him.

Inspector Holmes engaged him on this issue and eventually KE told him a little more. According to Inspector Holmes KE "told him he had a three year old daughter TI and in an effort to try and get him, to…drop the firearm and to I suppose feel better about himself so…he didn't want to harm himself I engaged him about, um, his three year old daughter…

I recall saying that his daughter would want him in her life. That it might look bad at the moment but in years to come…I'm sure that his daughter would want him in her life and that in the passage of time things will get better". Inspector Holmes did all he could to engage and build rapport with KE. While he had no formal negotiation training he worked intuitively in an attempt to help KE focus on the future and look for hope.

While he did not say much, Inspector Holmes described KE's tone when he spoke as "just very sad, very sorrowful". At one point KE apologised for having fired the gun earlier and Inspector Holmes tried to reassure him, telling him "that's ok. That's in the past". I had the opportunity to observe Inspector Holmes give evidence and I am confident his gentle manner offered some brief solace to KE at that difficult time.

The conversation continued, with Inspector Holmes continually trying to calmly engage KE and KE not saying too much in reply. Inspector Holmes assured KE that he would not be “Tasered” as he feared. He offered to try to assist him in any way he could. At one point KE blamed the police for keeping him from his wife and daughter, but he did not express personal hostility towards Inspector Holmes. During this conversation Inspector Holmes had re-holstered his gun and in doing so he placed himself at considerable risk.

At one point Inspector Holmes believed that he was gaining a bit of trust. KE asked him for a cigarette and Sergeant Colefax, who was by that stage somewhere behind Inspector Holmes assisted. He came onto the front veranda and placed a cigarette on the concrete floor. He also took the opportunity to give Inspector Holmes a ballistic vest for his protection. It was Sergeant Colefax’s belief that Inspector Holmes was establishing some rapport and he did not wish to interrupt the flow.

Unfortunately, shortly after KE finished his cigarette, he discharged the firearm. Inspector Holmes was about eight metres from him at that time. Police approached KE. His head was slumped and there was a considerable amount of blood on his chest. Ambulance officers attended, but it was abundantly clear that KE had not survived his significant injury.

Preparations and arrangements made during the negotiation

While Inspector Holmes tried to establish rapport with KE, Sergeant Colefax involved himself in coordinating a range of other necessary tasks. He provided a situation report via police radio and kept police radio updated as the incident unfolded.

He arranged for Young 25 (Senior Constable Aston Williams and Constable Thomas Marshall) to block the intersection of Cloete and Zouch Streets, to the east of the Young Police Station. Slightly later Senior Constables Dreverman and Senior Constable Mitchell arrived. They were in body vests and took up position near the fence. Senior Constable Dreverman drew his firearm to provide cover and protection. Senior Constable Sirol arrived and took a concealed position at the front of the police Station with his Taser drawn. The vest he brought for Sergeant Colefax was given to Inspector Holmes.

Sergeant Colefax busied himself organising these resources and making contact with the State Protection Support Unit (SPSU) and negotiators from Goulburn and Junee. He made immediate arrangements for them to start making their way to Young. He attempted to make a safe exclusion zone, using crime tape so that no member of the public could be hurt.

He tasked Constable Watts to commence a crime scene log. Sergeant Colefax also contacted the local Ambulance Officers and had them on standby. All of this was achieved in a timely manner.

Although he assisted Inspector Holmes by providing a cigarette to KE, it was Sergeant Colefax's view that he should hold back and not disturb the building of rapport. I accept his decision in this regard was correct.

The firearm

The firearm used by KE to inflict the fatal wound upon himself was legally registered to his mother-in-law NA. KE did not have his mother-in-law's permission to use the gun. It appears that the firearm had been removed from an approved gun safe at her home. NA told the court that the key to the gun safe was always hidden and to her knowledge KE did not know where the key was kept. It remains somewhat of a mystery as to how KE came to find a key to the safe. I accept NA's evidence that the gun safe had not otherwise been opened for some months before KE's death.

The ammunition used does not appear to have any connection to NA or her husband. There is nothing to suggest that their ammunition safe had been opened. The court heard evidence that KE had an interest in guns and ammunition and sometimes purchased ammunition from garage sales.

Were the actions of the police officers present appropriate, in all the circumstances?

Sergeant Shayne Irwin of Weapons & Tactics Policy and Review (WTPR) attached to the Operations and Skills Command, New South Wales Police Force, reviewed the circumstances of the police response to KE's death from a standpoint of operational safety. He examined the conduct of both officers against existing NSW Police Force policy. He confirmed that the situation was clearly a "high risk" situation. He was of the opinion "that the overall management of the incident is consistent with NSWPF Standard Operating Procedures for the resolution of High Risk incidents". In his view the police present understood and executed a strategy to contain and negotiate. At the same time there was timely management of the logistics of the situation. Within five minutes of the incident commencing, negotiators and the State Protection Support Unit had been notified. Sergeant Colefax had also commenced creating an exclusion zone for the safety of the public.

Sergeant Irwin carefully reviewed whether or not it would have been appropriate for officers to have used weapons in response to the situation they faced. It was his view that the officers were severely limited in the range of tactical options available to them.

I accept without reservation that the use of weaponless control, OC Spray, baton, or Taser would have been inappropriate in all the circumstances. I agree that tactical disengagement would also have presented considerable danger to the police and community and was not an option.

Inspector Holmes drew his gun at an early stage of the initial interaction. The fact that he re-holstered it at a later point, in an attempt to try to calm KE and establish rapport showed enormous bravery. If anything, he put himself at risk in an attempt to establish rapport. I offer no criticism of Inspector Holmes or of any of the police officers who supported him in responding to this incident. I note that during her family statement to the Court, KE's wife, KA expressed directly to the involved officers that they were in no way to blame for what had happened. Her approach to them, under such difficult circumstances, was extremely generous and I commend her for it.

What mental health support was available in Young?

Throughout his life it appears that KE showed some reluctance to seek help, except perhaps in emergency situations. Unfortunately at the time of his death he is likely to have needed drug and alcohol counselling and other therapeutic intervention.

However, it appears that even after his brief admission to Young Hospital in June 2015, he was unwilling to engage and instead focussed his energy on returning to the ACT.

The court heard that Young had a number of relevant services at the time of KE's death, including a number of general practitioners, private psychologists and the Mental Health Emergency Service located at Young Hospital. The Murrumbidgee Local Health District Mental Health Team also offered assessment, ongoing case management and referral services. Those services remain in existence today.

It is worth noting, that seeking help in a small town can sometimes be confronting and those needing assistance can also have access to more anonymous telephone services such as Lifeline, Beyond Blue, Black Dog and Men's Health care services.

How did KE die and was his death self-inflicted?

An autopsy was conducted after KE's death. It clearly identified that his death was caused by a single gunshot wound to the head. The bullet hit the hard palate of his mouth and entered the brain. His death would have been instantaneous.

Toxicological findings revealed a blood alcohol level of 0.057 g/100mL. Codeine and its metabolites, benzodiazepines and oxycodone were all present at therapeutic levels. An anti-depressant medication was present in slightly supratherapeutic levels. Illicit drugs were detected including cannabinoids and amphetamine. The amphetamine was not at a high or toxic level.

KE's clear cause of death was the single gunshot wound.

A finding that a death is intentionally self-inflicted should not be made lightly. The evidence should be extremely clear and cogent in relation to intention. In my view the weight of authority suggests that the proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard.
There is overwhelming evidence that KE intended to die that evening. The evidence includes;

KE had committed self-harm and threatened suicide before. He is reported to have spoken of killing himself on many occasions. In hindsight, KE's wife KA saw indications that something was wrong when he parted from her that evening. Inspector Holmes spoke to KE during the twenty minutes before his death and clearly understood that he was suicidal. KE had taken a gun from his parents-in-law's gun cabinet with the intention of killing himself. It appears that he obtained ammunition from another source in preparation for using the weapon.

Although distressed, it does not appear that KE was suffering from psychosis at the time of his death. He appears to have understood what was happening. While KE would have been affected to some degree by the substances he had consumed, it is not likely that his ability to reason or make decisions was seriously altered. KE's wife spoke to him shortly before he arrived at the Police Station and does not report him being seriously affected by drugs or alcohol. Neither does Inspector Holmes who spoke with him during the twenty minutes before his death.

I am satisfied KE's death by gunshot wound to the head was intentionally self-inflicted.

Conclusion

KE's death is a tragedy and it continues to affect his wife and children. It is apparent that the profound despair KE felt that evening had been with him on and off since childhood. He had come back from the brink on many occasions and focused himself on the joy his family brought him. Unfortunately, in the early hours of 29 August 2015, he lost all hope.

In my view, Inspector Holmes made a valiant attempt to dissuade KE from the action he eventually took.

He reached out to a fellow human who was in deep despair and he did it at great personal risk, with bravery and compassion. I commend his courage and his humanity. Sergeant Colefax recognised Inspector Holmes's attempt to build rapport. He assisted with a cigarette and a ballistic vest for Inspector Holmes. Importantly, Sergeant Colefax also commenced the necessary planning, the radio contact, the request for police back up and the contact with trained negotiators that was required. Both men then had to face the horror of the tragic outcome.

I have carefully considered whether there are any recommendations arising directly from the evidence. I have no criticism of the conduct of the police involved and think it unlikely that a trained negotiator, even if available in Young in the middle of the night, could have established stronger rapport than Inspector Holmes did. Unfortunately, there is no simple solution to prevent the despair KE felt. While the court's decision to bail him away from Canberra and his family was a trigger, the pain and anger he felt had, on all accounts, been brewing for many years.

I make no recommendations arising from the evidence I have heard. However, it is worth reiterating that KE's death should remind us all to encourage those in need to seek professional help wherever possible and to reach out to others in our own communities who are suffering. Finally, I once again offer my sincere condolences to KE's wife, children and extended family. I acknowledge their great loss. I strongly urge that any published report of this death include relevant references to suicide prevention and mental health treatment contact points. I thank the involved officers for their open and honest cooperation with these proceedings.

Formal Finding:

Identity

The person who died was KE.

Date of death

The date of death was 29 August 2015.

Place of death

KE died outside the Young Police Station at 30 Cloete Street, Young, NSW.

Cause of death

KE died of a shotgun wound to the head.

Manner of death

KE shot himself with the clear intention of taking his own life. Police were actively engaged in trying to diffuse and calm the situation at the time of the shot.

19. 377772 of 2015

Inquest into the death of Bruce Thomas. Finding handed down by Deputy State Coroner O'Sullivan at Glebe on the 7th September 2017.

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Bruce Thomas.

Introduction:

Mr Bruce Thomas was born on 8 September 1946. At the time of his death he was serving a custodial sentence at Long Bay Gaol, however was being treated at Prince of Wales Hospital Randwick. As Mr Thomas was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act.

The Inquest:

The role of a Coroner, as set out in s 81 of the Coroners Act, is to make findings as to:

(a) the identity of the deceased;
(b) the date and place of the person's death;
(c) the physical or medical cause of death; and
(d) the manner of death, in other words, the circumstances surrounding the death.

Pursuant to s 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

The Evidence:

Background:

Mr Thomas was 69 when he died. Born in Gosford to Lesley and Muriel, Mr Thomas was one of 15 children.

In 1959 the Thomas family moved to Pyrmont where Mr Thomas attended Ultimo Public School. Mr Thomas' younger brother Robert describes Mr Thomas as the 'black sheep' of the family and it was as a young man that Mr Thomas began to fall foul of the law. Unfortunately Mr Thomas' life was chequered with incarceration.

Mr Thomas was married to a woman named Lyn and they had a daughter Kylie. The marriage ended with Lyn and Kylie moving away and becoming estranged from Mr Thomas. Kylie was 3 years old at the time. Throughout his life, Mr Thomas was supported by his family in attempts to guide him on the 'straight and narrow' to use the vernacular. Ultimately these attempts proved unsuccessful, with Mr Thomas spending most of his life incarcerated.

Custodial History:

Mr Thomas first spent time in gaol in 1969 when he was convicted of buggery and sentenced to 7 years in custody. In 1978 Mr Thomas was sentenced to 8 years imprisonment for rape with a non parole period of 3 years. In 1986 he was sentenced to 9 months imprisonment for indecent assault and in 1987 he was imprisoned for an assault occasioning actual bodily harm.

In 1988, Mr Thomas was sentenced to 11 years gaol for an assault upon a fellow prison inmate. This conviction was later quashed. A corrupt Police officer had given false evidence at Mr Thomas's trial. Mr Thomas had served most of his sentence prior to the conviction being quashed. In 1996, Mr Thomas was sentenced to 12 years gaol for an aggravated sexual assault.

Due to the nature of his crimes, Mr Thomas was placed on an Extended Supervision Order and was monitored by Corrective Services whilst in the community. This involved being fitted with an electronic anklet and living in supported accommodation. However, Mr Thomas repeatedly breached his conditions upon release, leading to more periods in custody. At the time of his death, he was serving a sentence for failing to comply with conditions of his Extended Supervision Order.

Due to his failing health, Mr Thomas was transferred from gaol to hospital and was being guarded whilst being treated. He had spent about 40 years of his life in gaol.

Medical History:

A review of the medical records that form part of the brief reveal Mr Thomas had a heart condition and had a pacemaker installed. He was also suffering hepatitis C, Asthma, and had a history of kidney and neurological conditions. He had previously been diagnosed with paranoid schizophrenia.

The events of leading to his death:

In May 2015, while in custody, Mr Thomas was admitted to Auburn Hospital with fainting episodes. At this time, two suspicious masses were discovered in his lungs. These turned out to be cancerous. In September 2015, Mr Thomas was admitted to Prince of Wales Hospital due to deteriorating health. The masses in his lungs were confirmed to be stage 3 cancers. Medical specialists at Prince of Wales Hospital determined this was not treatable due to Mr Thomas's other health conditions. Mr Thomas was given palliative care, stabilised and was transferred back to gaol.

On 12 November 2015, Mr Thomas was again transferred to Prince Of Wales Hospital. His pacemaker had become infected. While in hospital, Mr Thomas began to suffer seizures. Medical investigations revealed the lung cancer had spread to his brain.

Over the ensuing weeks, Mr Thomas deteriorated. On 21 December, the medical registrar at Prince of Wales Hospital determined a resuscitation plan for Mr Thomas. In essence, Mr Thomas was given comfort care only, with no invasive breathing support given. No CPR was to be administered in the event of cardiopulmonary arrest. This decision complied with the relevant NSW Health Policies regarding end of life care. At about 6:35am on 23 December 2015, Corrections Officer, Chris Daniels, noticed Mr Thomas had stopped breathing. Nurses were notified who attended to Mr Thomas. Mr Thomas had died.

What caused Mr Thomas death?

Based on the medical records obtained as part of the investigation, it is clear that Mr Thomas died as a consequence of metastatic non small cell lung cancer. This was on a background of dilated cardio myopathy, chronic obstructive pulmonary disease and hypertension.

Care and treatment:

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility. The Corrective Services and Justice Health records reveal Mr Thomas' care and treatment were appropriate. Mr Thomas was transferred to appropriate facilities as his health deteriorated.

Mr Thomas' family have raised no issues with his care and treatment preceding his death.

Conclusion:

I find that Mr Thomas' death is not suspicious and that he died as a consequence of a natural cause process. I also find that Mr Thomas received health care of an appropriate standard whilst in custody. There is no evidence to suggest any third party involvement in this incident. There is also no evidence to suggest that any action or inaction by either Corrective Services or Justice Health contributed to Mr Thomas death in any way.

Given Mr Thomas' age and health issues and his rapid deterioration whilst in hospital, it does not appear that anything could have reasonably been done to prevent his death.

Formal Finding:

The identity of the deceased

The person who died was Bruce Malcolm Thomas.

Date of death

Mr Thomas died on 23 December 2015

Place of death

Mr Thomas died at Prince of Wales Hospital, Randwick New South Wales

Cause of death

The cause of death was metastatic non small cell lung cancer on a background of dilated **cardio** myopathy, chronic obstructive pulmonary disease and hypertension.

Manner of death

Mr Thomas died of natural causes whilst serving a custodial sentence.

20. 11257 of 2016

Inquest into the death of LP. Finding handed down by Deputy State Coroner Barry at Glebe on the 11th July 2017.

The role of a Coroner as set out in section 81 of the *Coroners Act 2009* is to make findings as to:

(a) The identity of the deceased

(b) the date and place of the persons death;

(c) the physical or medical cause of death and

(d) the manner of death, in other words, the circumstances surrounding the death.

LP's death was reported because it occurred during the course of a police operation. In these circumstances an inquest is mandatory pursuant to the combination of ss. 27 and 23 of the *Coroners Act 2009.*

"The purposes of a s. 23 inquest are to fully examine the circumstances of a death... in order that the public, the relatives and the relevant agencies can become aware of the circumstances .In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post death investigation. If appropriate and warranted in a particular case, the State or Deputy State coroner will make recommendations pursuant to s.82." (Waller, Coronial Law and Practice in New South Wales, p106).

Pursuant to s.37 of the *Coroners Act 2009* a summary of the details of this case will be reported to Parliament.

LP was born on 30th of November 1943 and died at the age of 72. LP was adopted as a child and was close to his adoptive sister N. N passed away in 2010, but LP stayed in contact with his brother-in-law Dennis, seeing him 2 to 3 times per year and speaking by telephone every few months. LP never married and had lived alone in a town on the Central Coast for about 10 years. He had a number of good friends including James and Kris.

LP struggled with mental health issues and had been prescribed medication for schizophrenia and antidepressants, but it appears that in the years prior to his death he had failed to have his prescriptions filled.

A feature of his illness was that he heard voices of “spirits from a higher plane” which guided him and which he found comforting. From time to time he would speak with his friend Kris about his frustration over the power that these” spirit guides” had over him.

In the months before his death, the “spirit guides” appeared to have deserted him and he told Kris he was sleeping on the floor to try and get the “spirit guides” back into his life and if they weren’t going to come back and help him he would end his life. Over the years he had attended a number of mental health facilities and had spoken of jumping from a bridge or a building and had told Kris that he had a place at Chatswood lined up.

In each of the four afternoons and evenings before his death LP was at the house of his friend James and his wife Ruth. He appeared to be in good spirits and there was no indication he was suicidal. On the afternoon before his death he told James that his “spirit guides” had told him they would no longer guide him. However, he appeared happy and told James he would see him and Ruth soon. That evening he called his friend Kris asking when he could visit.

On 12th of January 2016 LP travelled to Westfield at Chatswood. On the inside of the shopping centre, he climbed over the balustrade of level 7 near the top of the escalators. About 22 minutes later he fell to his death. LP is remembered fondly by his brother-in-law, Dennis and friends. LP had a good relationship with Dennis and his family. Dennis tried to convince LP not to proceed with his plan because he was part of the family. Kris considered LP to be one of his best friends. James also considered LP to be one of his best friends. They are all saddened and upset by LP’s death.

Autopsy Report

A limited autopsy report was prepared by Dr Tim Lyons, Pathologist, Department of Forensic Medicine, Sydney.

Dr Lyons found the direct cause of LP’s death was *“multiple injuries resulting from a catastrophic head injury with massive disruption of the skull and facial bones, multiple rib fractures and a complex pelvic fracture and multiple bilateral limb fractures”.*

The Evidence

January 12, 2016

At about 8am LP called Dennis asking for his postal address – "just in case I want to write to you." About 2:30pm LP called Kris and said he would be dead in half an hour. He told Kris he could have his books and videos. At about 2:40pm LP called Dennis again and told him he had decided to kill himself by jumping from a 13 story building. His brother-in-law pleaded with him not to go through with the plan but LP said: *"don't try and stop me, I've made up my mind. Today's the day"* and *"nothing will change my mind."*

He was adamant he did not want to end up in an institution, on medication, looking at 4 walls. He indicated he had left notes in his home about items to be distributed and had left house keys in the letterbox. He wanted his body to 'lay in state' 5 days so his spirit would be gone. He stated he would see his sister N in the spirit world. His brother-in-law said that he sounded calm. At about 3:05pm Dennis called his son and 000.

Fifteen minutes later officers from Parramatta police station attended Dennis' house. After Kris had received the call from LP, he and his girlfriend drove to LP's place on the Central Coast. When they arrived police were already outside. Kris then went to James's house and they all went back to LPs place and met Dennis there. Police informed them that it was suspected that LP had died at Chatswood earlier that afternoon.

The Police response

Parramatta police attended Dennis' house in response to the 000 call. Dennis gave them LP's mobile telephone number and they contacted Tuggerah Lakes LAC to have a crew attend LP's home to see if LP could be located before any attempts at triangulation were made.

This was an appropriate response. According to the Officer in Charge, Detective Inspector Baker, the first response must be to the informant in order to triage the information and obtain more detail. He stated that trying to contact the person of interest via mobile phone poses a "dilemma" as there can be a tension between not alarming the person and trying to negotiate with him. Police arrived at LP's place just before 4 PM.

They found his house keys in the letterbox and spoke with Kris and his girlfriend. Police entered the house and discovered the notes and personal items left by LP. At 4:14 PM Tuggerah police called senior police for backup and informed Parramatta police they would attempt to triangulate LP's phone. Regrettably by this time LP was already deceased.

The Police response at Westfield.

At about 3:44 PM a female customer was in a coffee shop on level 5 of the Westfield shopping centre in Chatswood. She saw LP standing on the ledge on level 7 within the shopping centre. She called 000.

At about 3:45 PM Senior Constable Wark and Senior Constable Toby heard a police radio broadcast indicating a priority job/incident. The message indicated that there were concerns for a man who might be about to jump from Westfield Chatswood. They were police officers on the Police Transport Command (PTC) based out of Chatswood police station. Generally the duties of PTC officers involved high visibility policing and patrolling public transport and transport interchanges with a view to preventing crime and antisocial behaviour on public transport.

If the matter became urgent, however PTC officers were expected to respond to other matters. Senior Constable Wark and Senior Constable Toby were close by Westfield at the time of the call and because of the urgency they responded. Initially, Senior Constable Wark assumed that the person they were looking for was outside the building. When he approached Westfield he met and conversed with Leading Senior Constable Roberts from Chatswood LAC.

Leading Senior Constable Roberts was one of the first officers "on scene" and arrived at the escalator below where LP was standing. This was at about 3:48 PM. He had noticed the job whilst watching the mobile terminal data in his police vehicle. He observed LP to be shaking, and he was facing towards the void with his back to the glass.

Leading Senior Constable Roberts called urgent on the VKG asking for cars to remove pedestrians and shoppers so that they would not observe what was taking place. He requested negotiators be called urgently and was told a short time later that they were on the way.

He was aware from previous experience that police were to try to speak with the person before negotiators arrived. Leading Senior Constable Roberts had completed online training in relation to mental health issues but was not a trained negotiator. From the bottom of the escalator on level 6, Leading Senior Constable Roberts called out to LP:

"*Don't do it, we are here to help, don't do it. I don't want the kids to see it, please don't jump."*

He saw LP motion to move everyone out of the way. Leading Senior Constable Roberts kept calling out to him calling him 'Sir 'and repeating similar words to the words he had already used. Leading Senior Constable Roberts started to move up the escalators, which had been stopped, but LP told him to go back. Leading Senior Constable Roberts then met Detective Kyneur who arrived at the escalators at about 3:54 PM.

Detective Kyneur had responded to a radio broadcast he heard whilst at Chatswood police station. Because of the proximity to Westfield he had walked to the shopping centre. Detective Kyneur saw LP standing on the incorrect side of the glass barrier fence, next to the escalators that rose to the Hoyts cinema facility. He does not remember conversing with Leading Senior Constable Roberts and was aware that there was an area that had appeared to have been cordoned off, with people being isolated from the area.

He walked up the escalator - about half way in order to establish a dialogue with LP. He observed LP to be nervous and agitated.

He said words to the effect:

"Come back over, nobody gets hurt, wants to get hurt, we can sort this out. Just come back over""

LP motioned to Detective Kyneur to get back and said words to the effect: "*You can't help me".*
Detective Kyneur continued to attempt to persuade LP to get back over the fence, but he stated: "in my view he was intent on jumping from his position on the ledge".

Third Person Intervention

Anne-Marie James was in a shop at Westfield when she became aware of the drama unfolding outside.

Ms James was a trained nurse and explained that she was able to deal with stressful situations and had experience working with the elderly. She stated that as an acute care nurse she had to deal with stressed patients and stressed doctors from time to time and although she had not dealt directly with patients with mental health issues she had training in core mental health matters. Her experience in the past with persons who wanted to die was when she was nursing palliative care patients either in hospital or at home.

Ms James saw LP standing on the ledge on level 7 and spoke with Senior Constable Wark who was standing nearby. She told him:

"I am a nurse. I work with the elderly. Can I help?"

She stated Senior Constable Wark replied "*Come with me* "and they both went up two levels using the escalators. She observed Leading Senior Constable Roberts and heard him calling out to LP.

Senior Constable Wark said to Leading Senior Constable Roberts:

"This is Ann, she is a nurse. She works with the elderly."

Her evidence is that she heard a police officer (apparently Senior Constable Wark) say *"Go"* and she quickly ran up the escalator towards the man . She was stopped halfway up the escalator by Detective Kyneur who would not let her advance any further. She attempted to engage LP from that position over the following minutes until his death.

There is some tension between the version given by Ms James and the version given by the police officers at the scene. Senior Constable Wark agrees that Ms James approached him, but rather that he told her that he was not in charge and he referred her to Leading Senior Constable Roberts. He walked with her towards Leading Senior Constable Roberts.

Senior Constable Wark stated he focused on the word "nurse" and thought it might be useful to have someone available with first aid training if needed. At no time did Senior Constable Wark expect Ms James to attempt to negotiate with LP. Leading Senior Constable Roberts stated that he noticed Ms James standing next to Senior Constable Wark and said:

"Stop. You're not going up, what, what are you doing."

He heard her reply:

"I work in aged care."

He then observed her move quickly toward Detective Kyneur who was halfway up the escalator, where she was stopped.

Leading Senior Constable Roberts described Ms James as 'pushing' past him to make her way up the escalator. Certainly, CCTV footage reveals a very determined Ms James heading up the escalator past the police. Senior Constable Wark called words to the effect "*come back down*" and he believes Leading Senior Constable Roberts said something similar. Leading Senior Constable Roberts stated in his oral evidence that he was shocked by Ms James' presence and did not know why she was there.

He was wanting to focus on LP and was taken by surprise by Ms James' approach. She was a civilian and he did not know what she intended to do. He knew police would not want a civilian present. He was adamant he did not say the word "Go" to Ms James and he said that he did not hear Senior Constable Wark say "Go".

In response to Ms James claim that she wanted to inject" calm" into the situation he stated:

"I was in control and calm. I wanted to keep him (LP) talking."

Detective Kyneur stated Ms James tried to push past him and he said to her:

"Who are you, what are you doing?"

Detective Kyneur, in his oral evidence, stated that on hearing her tell him that she was an aged care worker he was initially relieved that she was not a family member. Detective Kyneur has had mental health training - mental health issues being a large component of police work. In the past he has been able to engage with persons wishing to self-harm and has observed persons change their mind. He knew Leading Senior Constable Roberts had already started engaging with LP and he was aware that a third person, such as Ms James, does not assist as it introduces confusion, especially when it is not known what the third person is going to say.

He thought Ms James was very focused, and he could see that she was intent on being there and did not direct her to stand down because he did not want to have an altercation in front of LP and further distract from the negotiations underway. I accept that Ms James was acting in the genuine belief that she could assist. In her oral evidence she could not recall being asked to come back down, although Senior Constable Wark and Leading Senior Constable Roberts attest to this.

She does not recall being told: "You are not going up" although again Senior Constable Wark and Leading Senior Constable Roberts also attest to that.

Similarly, she does not recall a conversation with Detective Kyneur but does recall his arm coming out to prevent her progressing further on the escalator. Given her lack of recall and the consistency of the evidence of the police officers, I accept that police did not say the word "Go" to Ms James although I accept that Ms James believed she had been given permission to proceed.

Detective Acting/Inspector Hales is the commander of the Negotiation Unit with the New South Wales Police Force. She acknowledged that the situation involving Ms James was a unique occurrence. In her evidence she stated that a time span of 12 minutes from when police first engaged LP until he jumped was a very short time span to enable police to have engaged with LP.

She stated it is a "stressful and difficult encounter to try and talk a person back from the brink of self – harm." Ms James was unknown to police and LP and in Detective Acting /Inspector Hales' view, "her involvement may have had the potential to confuse and distract LP by introducing another voice into the negotiations." It also had the potential to distract police.

She further stated that non-trained negotiators have a lack of understanding of police policy and procedure and a lack of "knowledge and understanding of negotiation tactics and techniques".

Her evidence is:

"When under stress these people (third persons) revert to their most comfortable behaviour, which is not always conducive to good negotiation and peaceful resolution. It is particularly undesirable that a third person be used to intervene when negotiations are being carried out in a 'face-to-face' situation. Most importantly it can become an unsafe and dangerous situation for a civilian negotiator."

Conclusion

All the available evidence points to LP's determination to end his life. After trying to negotiate with LP, Leading Senior Constable Roberts stated:

"I was of the belief that LP wanted to kill himself"

Detective Kyneur described LP's actions as a" rehearsal":

"He (LP) was asking people to get out of the way. At some stage he bent his knees… I did not form the view at any time that he would change his mind."

These observations coupled with the evidence of LP's planning and telephone calls to family and friends made before he arrived at Westfield certainly suggest that LP was determined to carry through his plan.

It is unlikely therefore, that the intervention by Ms James had a negative impact on the unfolding scenario. Ms James had no intelligence about LP. She could not assess the risk. It is the duty of police to put themselves at risk in difficult situations. Whilst it cannot be said that Ms James contributed to the death of LP, her actions give rise to a broader concern about the intervention of third persons. What is clear in this case is that the police response was professional and timely, as was the reaction by Westfield security staff. Staff and security at Westfield acted promptly and professionally.

Ms Messina, a manager at Hoyts Cinema on Level 7, called security immediately she became aware that there was a man on the incorrect side of the barrier. Another staff member called police. Ms Messina travelled down the escalator to stop people walking up the escalator. LP shouted to her that she needed to clear the area because he did not want to fall on anyone.

Six security staff from Westfield attended the site. Mr Kapoor, a Risk and Security Manager, approached LP and had a conversation with him and asked for time to clear away children and families. When police arrived Mr Kapoor concentrated on the evacuation and safety of customers. He instructed that tape be used to barricade the area, escalators be blocked, cleaners be called in to assist and void areas to be cleared. Myer shut its roller doors and entry doors were secured.

A trauma tent and screens were established on level two. When LP fell, those tents were erected within seconds by police. The attempts by police to engage LP in negotiation were professional and appropriate in a stressful situation, especially given that the police directly involved were not trained negotiators.

Leading Senior Constable Roberts took calm and admirable control in a distressing scenario. Detective Kyneur's measured response in restraining Ms James without creating further drama was commendable. At the request of Counsel for the New South Wales Commissioner of Police prepared a document which encapsulates the type of scenario that arose in this matter, concerning the intervention by Ms James.

The document prepared by Counsel for the NSW Police is a useful case study. She submitted that, that document may be able to be used for training purposes.

Given the rarity of the occurrence of uninvited third persons moving towards a person of interest it may be most appropriate to draw the case study to the attention of the Commander of the Training and Education Command for possible inclusion in their training programme. I intend to leave it to police to best determine the way this training scenario should be directed.

Formal Finding:

I find that LP died on 12 January 2016 at Westfield Shopping Centre, Spring Street Chatswood. The Cause of Death was Multiple Injuries. The Manner of his death was intentionally self inflicted.

21. 131207 of 2016

Inquest into the death of RP. Finding handed down by Deputy State Coroner Grahame on the 22 November 2017 at Glebe.

Inquest:	Inquest into the death of RP
Hearing dates:	22 November 2017
Date of findings:	22 November 2017
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – self-inflicted death, death in a police operation
File numbers:	2016/00131207
Formal Findings:	As a result of reviewing the documentary and oral evidence presented in this matter, I make the following findings pursuant to section 81(1) of the *Coroners Act* 2009 (NSW)

The person who died was RP.
Date of death
He died on 28 April 2016.
Place of death
He died at Turrella Reserve, Earlwood, NSW.
Cause of death
He died from hanging.
Manner of death
RP died in the course of a police operation. Police attended his property to execute a search warrant. RP left the property, went to the nearby Turella Reserve and hanged himself with the intention of ending his life.

Non Publication Order The detailed reasons for these findings are subject to a non-publication order pursuant to section 75 of the *Coroners Act* 2009 NSW.

22. 26063 of 2016

Inquest into the death of Kerry Forrest. Finding handed down by Deputy State Coroner Lee at Glebe on the 6th July 2017.

Introduction

Kerry Forrest died on 26 January 2016. At the time of her death Ms Forrest was serving a custodial sentence that had been imposed in November 2014. Two years prior to being sentenced Ms Forrest had been diagnosed with a terminal illness. Much of Ms Forrest's time in custody following her sentence was spent in different hospitals where she was admitted due to the effects of her terminal illness, and to the decline in Ms Forrest's general health.

Why was an inquest held?

When a person's death is reported to a Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.

Section 23 of the *Coroners Act 2009* (the Act) makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. This is because when a person is imprisoned or held in lawful custody as a result of breaching a law, the State, by depriving that person of their liberty, assumes responsibility for the care of that person. It is necessary to ensure that the State discharges its responsibility appropriately by examining the circumstances surrounding that person's death.

What is known about Ms Forrest's personal and custodial history?

Ms Forrest was born in Sydney on 20 October 1959. Ms Forrest's parents separated shortly after her birth and she was raised by her paternal grandparents. Ms Forrest finished year 12 at school but had not been working for many years prior to when she last entered custody in 2014. Ms Forrest was married for 26 years from 1981 and has 2 adult daughters.

Ms Forrest first came to the attention of police in 1974 for a dishonesty offence.

Her criminal history reveals that, regrettably, Ms Forrest repeatedly appeared before the courts, mostly for dishonesty-related offences, in the years that followed. The outcome of some of these court appearances resulted in Ms Forrest spending various periods in custody at different times.

On 14 February 2011 Ms Forrest was arrested and charged with a murder committed in April 2010. Following her arrest Ms Forrest was held on remand pending her trial. Ms Forrest was later found guilty of murder following a judge-alone trial. On 27 November 2014 Ms Forrest was convicted and sentenced to a term of imprisonment of 25 years with a non-parole period of 19 years dating from 14 February 2011 and expiring on 13 February 2030.

At the time of her sentencing, information was provided to the sentencing court that Ms Forrest was suffering from a terminal illness. In October 2012 Ms Forrest was diagnosed with advanced stage cancer of the cervix. She also suffered from a number other conditions including swelling of the left kidney (hydro nephrosis), chronic regional pain syndrome, and required insertion of uretic stents. During an application in 2013 to permanently stay Ms Forrest's criminal proceedings, evidence was provided to the Supreme Court that there was only a low possibility that Ms Forrest's life expectancy would extend beyond 2 years.

Ms Forrest was initially treated with radiation therapy. However, by August 2014 Ms Forrest's radiation oncologist noted that any further radiotherapy or chemotherapy treatment would be counterproductive and recommended that Ms Forrest be provided with palliative care only. In a medical report written shortly during Ms Forrest's November 2014 sentencing proceedings Ms Forrest's oncologist noted that Ms Forrest had recently been admitted to Prince of Wales Hospital, following a collapse whilst in gaol because of low haemoglobin. Ms Forrest's oncologist indicated that the best estimate of Ms Forrest's life expectancy at that time was between 6 to 18 months.

After her sentence was imposed Ms Forrest was primarily housed at Silverwater Women's Correctional Centre. On 27 June 2015 Ms Forrest was admitted to Long Bay Hospital following several earlier admissions to Westmead Hospital due to renal deterioration and a decline in her general health. On 8 October 2015, during one of these admissions, Ms Forrest signed a not for resuscitation order due to the grave nature of her illness.

On 29 December 2015 Ms Forrest was admitted to Prince of Wales Hospital where she was found to be acidotic secondary to acute renal failure. During this admission Ms Forrest confirmed the earlier not for resuscitation order.

Ms Forrest was later admitted to Long Bay Hospital on 19 January 2016 for palliative care but only a day later Ms Forrest was returned to Prince of Wales Hospital as her deteriorating condition made it difficult to administer her medication. At this time Ms Forrest decided that any treatment she was to be given would be limited to relieving her symptoms only. Ms Forrest told her treating physicians that she understood the consequences of her decision. Corrective Services NSW made appropriate arrangements for Ms Forrest's family to be able to visit her.

On 21 January 2016 a senior staff specialist in palliative medicine at Prince of Wales Hospital advised Corrective Services NSW that Ms Forrest was bed bound and intermittently unconscious.

At about 5:30am on 25 January 2016, during a routine observation check, a nurse and corrective services officer discovered that Ms Forrest was unresponsive in bed with nil vital signs. Ms Forrest had last been observed at 5:15am where she was noted to be breathing and not in any distress. Ms Forrest was subsequently pronounced deceased.

What was the cause of Ms Forrest's death?

Following the report of Ms Forrest's death to the Coroner's Court, Dr Riannie Van Vuuren, a forensic pathologist with the Department of Forensic Medicine, conducted a review of Ms Forrest's medical records. Dr Van Vuuren noted that on Ms Forrest's final admission to Prince of Wales Hospital Ms Forrest had acute kidney injury, severe metabolic acidosis secondary to renal dysfunction, nausea, a urinary tract infection and anaemia. Dr Van Vuuren also noted that management of Ms Forrest's pain was made difficult by her inability to have oral intake and that her wasting syndrome (cancer cachexia) meant that pain relief medication in the form of fentanyl patches was unlikely to be absorbed.

Having reviewed all of the relevant medical records Dr Van Vuuren recommended that the cause of Ms Forrest's death be recorded as complications of cervical cancer.

What conclusions can be reached?

Having considered the available records held by both Corrective Services NSW and Justice Health in relation to Ms Forrest, I cannot identify any matter associated with her care and treatment whilst in custody that contributed to her death. It is clear that Ms Forrest was diagnosed with terminal cervical cancer whilst she was in custody on remand pending her criminal trial. By the time of her sentencing, Ms Forrest's terminal illness was at such an advanced stage that active treatment was no longer being considered and her treating physicians regarded her prognosis as poor.

It is evident that much of the treatment that Ms Forrest received after being sentenced was focused on palliative care only. During the course of the police investigation following Ms Forrest's death the officer-in-charge, Inspector Ben Johnson, spoke to Ms Forrest's ex-husband. Mr Forrest informed Inspector Johnson that neither he, nor Ms Forrest's daughters, had any issues with, or concerns regarding, the care and treatment that Ms Forrest received from Corrective Services NSW and Justice Health.

In summary, the available evidence establishes that Ms Forrest received health care that was within an expected standard of care whilst in custody. There is no evidence to suggest that any action or inaction by either Corrective Services NSW or Justice Health contributed to Ms Forrest's death in any way. As already noted, much of the treatment that Ms Forrest received whilst in custody was palliative in nature only. Prior to this appropriate treatment was provided to Ms Forrest in an attempt to combat the terminal illness that Ms Forrest had been diagnosed with but this treatment was, ultimately, unsuccessful. There is no evidence to suggest that any other treatment or care afforded to Ms Forrest could have prevented her death.

Formal Finding

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

Identity

The person who died was Kerry Forrest.

Date of death

Ms Forrest died on 26 January 2016.

Place of death

Ms Forrest died whilst she was a patient in the Secure Unit Annex of Prince of Wales Hospital, Randwick NSW. At the time Ms Forrest was serving a custodial sentence.

Cause of death

The cause of Ms Forrest's death was complications of cervical cancer.

Manner of death

Ms Forrest died of natural causes.

23. 234818 of 2016

Inquest into the death of Bruce Burrell. Finding handed down by Deputy State Coroner Lee at Glebe on the 9th May 2017.

Introduction

Bruce Allen Burrell died on 4 August 2016. At the time of his death Mr Burrell was serving custodial sentences for a number of offences and had been incarcerated most recently at Lithgow Correctional Centre. Only about a month before his death Mr Burrell had been diagnosed with an end stage terminal illness.

Why was an inquest held?

When a person's death is reported to a Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.

Section 23 of the *Coroners Act 2009* (the Act) makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. This is because when a person is imprisoned or held in lawful custody as a result of breaching a law, the State, by depriving that person of their liberty, assumes responsibility for the care of that person. It is necessary to ensure that the State discharges its responsibility appropriately by examining the circumstances surrounding that person's death.

What is known about Mr Burrell's personal and custodial history?

Mr Burrell was born in Goulburn on 25 January 1953, making him 63 years old at the time of his death. Unfortunately, very little is known about his personal like other than he previously worked as an advertising executive and that he is survived by his sister, Deborah Esposito.

On 6 June 2006 a jury found Mr Burrell guilty of murder and kidnapping. On 9 August 2006 Mr Burrell was sentenced to life imprisonment in relation to the murder charge, and 16 years imprisonment, with a non-parole period of 12 years, in relation to the kidnapping charge.

Following a number of appeals between 2006 and 2009 the convictions and sentences were later confirmed by the NSW Court of Criminal Appeal on 17 June 2009.

On 17 September 2007 a jury found Mr Burrell guilty of a separate offence of murder. On 8 February 2008 Mr Burrell was sentenced to 28 years imprisonment with a non-parole period of 21 years. An appeal against this conviction was later dismissed by the Court of Criminal Appeal on 31 July 2009.

Mr Burrell was received into custody at the Metropolitan Remand and Reception Centre (MRRC) on 6 June 2006. Mr Burrell was initially transferred between a number of correctional centres but eventually placed permanently at Lithgow Correctional Centre on 28 May 2009, where he remained until July 2016.

What is known about Mr Burrell's medical history?

Upon entering custody, Mr Burrell had a history of a number of various medical conditions including hypertension, asthma, rheumatoid arthritis, ulcers and dermatitis. Following cardiac bypass surgery in 2003 Mr Burrell had experienced ongoing chest pain and shortness of breath.

Whilst in custody between 2007 and 2015 Mr Burrell presented to the health centres at the correctional centres where he was housed with a number of different conditions. Mr Burrell was treated for dermatitis and pain in his legs and lower back, lower back pain, flu-like symptoms and respiratory difficulties, and reflux. A review of the medical records kept by Justice Health indicates that these conditions were managed with appropriate examination, investigation and treatment, usually by way of prescription of medication.

What happened in July and August 2016?

On 11 July 2016 Mr Burrell presented to the health centre at Lithgow Correction Centre and reported that he was experiencing nausea, diarrhoea, lethargy, abdominal cramping, shortness of breath and swelling to his lower extremities. As a result, Mr Burrell was subsequently transferred by ambulance to Lithgow District Hospital. Subsequent abdomen and pelvis CT scans revealed numerous lesions in Mr Burrell's left lung and liver.

On 15 July 2016 a biopsy of one of the liver lesions showed that Mr Burrell had Stage IV metastatic small cell carcinoma of pulmonary origin. On 18 July 2016 Mr Burrell was transferred to the Secure Unit Annex of Prince of Wales Hospital.

Upon admission the oncology team discussed with Mr Burrell the use of palliative chemotherapy to prolong life. Mr Burrell was informed of the risks and benefits of such treatment: namely, that if he did not have treatment his condition would rapidly worsen, but whilst the treatment might improve his symptoms, it might also result in life-threatening side effects such as bone marrow suppression.

With the assistance of a palliative care consult, a decision was made to commence chemotherapy treatment and three doses were delivered to Mr Burrell on 19, 20, and 21 July 2016. On 23 July 2016 Mr Burrell became neutropaenic (a common side effect of chemotherapy where there are low levels of a type of white blood cells) and required intravenous antibiotics. Mr Burrell's clinical situation continued to worsen with ongoing deterioration of liver function and blood counts. This resulted in a decision being made on 29 July 2016 for a not for resuscitation order, with treatment only in the form of supplemental oxygen, and clinical and rapid response calls to be provided. As Mr Burrell's condition continued to deteriorate further, a second not for resuscitation order was made on 2 August 2016, further limiting the scope of any treatment.

On 3 August 2016 Mr Burrell's condition deteriorated significantly and he developed acute respiratory distress. Although that symptom improved briefly, Mr Burrell subsequently went into acute renal failure and both he and his sister, Deborah, were informed of the poor prognosis. Further chemotherapy treatment was ceased. After being reviewed by the oncology and palliative care teams, and following discussion with Mr Burrell's family, a decision was made to provide end-of-life comfort care and pain relief only.

Throughout the course of 3 August 2016, Mr Burrell's breathing became increasingly laboured and he became increasingly drowsy and refused to drink fluids. Mr Burrell was last seen alive during a routine check at 10:30pm. At 12:05am on 4 August 2016 Mr Burrell was found to be unresponsive and not breathing. No resuscitation was attempted due to the standing not for resuscitation order, and Mr Burrell was later pronounced life extinct.

What was the cause of Mr Burrell's death?

Mr Burrell was later taken to the Department of Forensic Medicine at Glebe.

On 5 August 2016 Dr Jessica Reagh, pathology registrar, conducted a post-mortem examination and subsequently reviewed Mr Burrell's medical history. Dr Reagh noted that Mr Burrell's sclerae (eyes) and skin were markedly yellow, and that there were numerous faint bruises and contusions on Mr Burrell's skin; all of these features are indicative of abnormal liver function.

In her autopsy report dated 20 October 2016 Dr Reagh concluded that the cause of Mr Burrell's death was metastatic small cell lung carcinoma, and noted that Mr Burrell also had ischaemic heart disease, which was a significant condition that contributed to his death.

What conclusions can be reached?

Having considered the available records held by both Corrective Services NSW and Justice Health in relation to Mr Burrell, I cannot identify any matter associated with his care and treatment whilst in custody that contributed to his death. It is clear that the onset of the disease which caused Mr Burrell's death was rapid and at the time that it was diagnosed it was already in an advanced stage with no possibility of life-saving treatment. As such, only palliative care could be provided to Mr Burrell following diagnosis of his terminal disease.

In summary, the available evidence establishes that Mr Burrell received health care that was within an expected standard of care whilst in custody. There is no evidence to suggest that any action or inaction by either Corrective Services NSW or Justice Health contributed to Mr Burrell's death in any way. Given the nature of the terminal disease that Mr Burrell was suffering from, there was nothing that could have reasonably been done to prevent Mr Burrell's death.

Formal Finding:

Identity: The person who died was Bruce Burrell.

Date of death: Mr Burrell died on 4 August 2016.

Place of death: Mr Burrell died whilst he was a patient in the Secure Unit Annex of Prince of Wales Hospital, Randwick NSW. At the time Mr Burrell was serving a custodial sentence.

Cause of death: The cause of Mr Burrell's death was metastatic small cell lung carcinoma with ischaemic heart disease a significant condition that contributed to death.
Manner of death: Mr Burrell died of natural causes.

24. 259112 of 2016

Inquest into the death of BJ. Finding handed down by Deputy State Coroner Grahame at Glebe on the 1st August 2017.

Inquest:	Inquest into the death of BJ
Hearing dates:	1 August 2017
Date of findings:	1 August 2017
Place of findings:	Glebe Coroners Court, NSW
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in a police operation
File number:	2016/259112
Findings required by section 81(1) *Coroners Act* 2009 (NSW)	**Identity of deceased**: The deceased person was BJ. **Date of death**: BJ died on 27 August 2016, between 12.54pm and 1.40pm. **Place of death**: She died near Prune Street, Lavington, NSW **Manner of death:** The death was intentionally self-inflicted **Cause of death:** The medical cause of the death is neck compression, as a result of hanging.

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death. The detailed reasons for these findings, (along with all the evidence presented to the court), are subject to a non-publication order pursuant to section 75 of the *Coroners Act* 2009 (NSW).

25. 314488 of 2016

Inquest into the death of Colin Hay. Finding handed down by Deputy State Coroner Lee at Glebe on the 9th June 2017.

Introduction

Colin Hay died on 21 October 2016. At the time of his death Mr Hay was serving custodial sentences for a number of offences and had been incarcerated most recently at Long Bay Correctional Centre. Only 2 months after Mr Hay was sentenced in November 2013 medical tests revealed that Mr Hay was suffering from a type of non-Hodgkin lymphoma. Initial treatment was successful and resulted in a remission but Mr Hay suffered a relapse in September 2015. Despite further treatment Mr Hay eventually succumbed to this devastating disease.

Why was an inquest held?

When a person's death is reported to a Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.

Section 23 of the *Coroners Act 2009* (the Act) makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. This is because when a person is imprisoned or held in lawful custody as a result of breaching a law, the State, by depriving that person of their liberty, assumes responsibility for the care of that person. It is necessary to ensure that the State discharges its responsibility appropriately by examining the circumstances surrounding that person's death.

What is known about Mr Hay's personal and custodial history?

Mr Hay was born in Stockton NSW on 2 December 1946 and was therefore 69 years old at the time of his death. Unfortunately very little is known about Mr Hay's personal history other than that he is survived by his 3 brothers and sister.

On 29 November 2012 Mr Hay was charged with a number of a number of sexual assault and indecent assault offences. He was later convicted of these offences and on 13 November 2013 Mr Hay was sentenced to a number of terms of imprisonment. The overall effective sentence that Mr Hay received was a term of imprisonment of 10 years dating from 29 November 2012 with a non-parole period of 6 years and 6 months from the same date. This meant that Mr Hay was eligible for release from custody on 28 May 2019.

After the sentences were imposed Mr Hay was initially kept at Cessnock Correctional Centre. He was later transferred to Parklea Correctional Centre and, ultimately, Long Bay Correctional Centre so that he could more readily access health care services that were required at the time.

In January 2013 some routine blood tests taken from Mr Hay suggested that he had a type of non-Hodgkin lymphoma. This diagnosis was later confirmed and it was discovered that Mr Hay was suffering from Waldenstrom's Macgroglobulinemia (WM). This is a type of cancer where WM cells make large amounts of an antibody known as a macroglobulin. The build-up of these antibodies can lead to the symptoms of WM which include excess bleeding and nervous system impairment. WE cells grow mainly in the bone marrow where they can crowd out normal cells which can lead to low levels of red blood cells (anaemia). It can also cause low levels of white blood cells making it harder for the body to fight infection, and cause a reduction in platelets leading to increased bruising.

On 18 February 2013 Mr Hay commenced chemotherapy treatment at Westmead Hospital which was completed on 14 June 2013. Subsequent examination indicated that the treatment had been successful.

However in October 2015 Mr Hay began experiencing shortness of breath and chest pain. On 28 October 2015 he was admitted to the Prince of Wales Hospital where a subsequent bone marrow biopsy confirmed that Mr Hay had suffered a relapse of his earlier WM. Chemotherapy treatment was again commenced on 14 October 2015.

On 10 February 2016 Mr Hay was reviewed by a consultant haematologist who reported that Mr Hay's bone marrow had almost been completely replaced by the lymphoma (group of blood cell tumours) and that he had progressive reduction in the number of red and white blood cells, as well as platelets (pancytopenia).

A Justice Health GP explained the available treatment options to Mr Hay, advising that further chemotherapy treatment might provide him with short term remission. Mr Hay decided not to undergo further chemotherapy but instead agreed to blood transfusions to relieve his symptoms.

However on 15 February 2016 Mr Hay decided to recommence chemotherapy which began on 26 February 2016. Upon review on 11 March 2016 a bone marrow biopsy revealed that Mr Hay showed some signs of improvement. However, further review on 29 June 2016 revealed that Mr Hay had only minimal response to the treatment. Mr Hay was reviewed again by a consultant haematologist on 12 July 2016 and, with Mr Hay's agreement, further cycles of more aggressive chemotherapy treatment were commenced 4 days later.

On 10 August 2016 Mr Hay was admitted to the Prince of Wales Hospital with severe anaemia and consequent cardiac ischemia. After receiving blood transfusions and having changes made to his regular cardiac medication Mr Hay was discharged on 19 August 2016. On 12 September 2016 Mr Hay was again admitted to the Prince of Wales Hospital complaining of chest pain secondary to myocardial ischemia. He received a transfusion of platelets and was discharged 2 days later. Mr Hay was reviewed on 15 September 2016 and, in light of his poor prognosis, an end-of-life care plan was implemented which included a not-for-resuscitation order.

On 20 September 2016 Mr Hay was admitted to the Secure Unit Annex of the Prince of Wales Hospital suffering from symptomatic anaemia secondary to WM. Mr Hay received a number of blood transfusions and was discharged 3 days later, only to be readmitted on 30 September 2016 when his condition failed to improve and further blood transfusions were required.

Mr Hay's condition continued to deteriorate from 30 September 2016 and on 14 October 2016 a decision was made that only palliative care would be provided. At about 2:15am on 21 October 2016 Mr Hay complained of chest pains and a nurse noted that he had a high temperature. When the nurse returned to check on Mr Hay at 2:30am he was found to be unresponsive, and was later declared life extinct.

What was the cause of Mr Hay's death?

Mr Hay was later taken to the Department of Forensic Medicine at Glebe.

On 25 October 2016 Dr Elsie Burger, forensic pathologist, conducted a post-mortem examination and subsequently reviewed Mr Hay's medical history. In her autopsy report dated 30 November 2016 Dr Burger concluded that the cause of Mr Hay's death was Waldenstrom's Macroglobulinemia.

What conclusions can be reached?

Having considered the available records held by both Corrective Services NSW and Justice Health in relation to Mr Hay, I cannot identify any matter associated with his care and treatment whilst in custody that contributed to his death. It is clear that once the WM was discovered rapid action was taken to commence chemotherapy treatment through a number of different cycles. Although Mr Hay initially showed a positive response to the treatment, further treatment to treat a relapse of the disease was unsuccessful. The opinion of the haematologist who treated Mr Hay is that his death was not preventable.

In summary, the available evidence establishes that Mr Hay received health care that was within an expected standard of care whilst in custody. There is no evidence to suggest that any action or inaction by either Corrective Services NSW or Justice Health contributed to Mr Hay's death in any way. Appropriate treatment was provided to Mr Hay in an attempt to combat the serious disease that Mr Hay had been diagnosed with but this treatment was, ultimately, unsuccessful. There is no evidence to suggest that any other treatment or care afforded to Mr Hay could have prevented his death.

Formal Finding:

Identity

The person who died was Colin Hay.

Date of death

Mr Hay died on 21 October 2016.

Place of death

Mr Hay died whilst he was a patient in the Secure Unit Annex of Prince of Wales Hospital, Randwick NSW. At the time Mr Hay was serving a custodial sentence.

Cause of death

The cause of Mr Hay's death was Waldenstrom's Macroglobulinemia, a type of non-Hodgkin Lymphoma.

Manner of death

Mr Hay died of natural causes.

26. 94667 of 2016

Inquest into the death of Glennon Johnstone. Finding handed down by Deputy State Coroner Grahame at Glebe on the 20th November 2017.

Introduction

Glennon Johnstone (also known as Ronald James Baker) was 87 years of age at the time of his death. He was serving a term of imprisonment, having been convicted on 14 October 2011 in relation to a number of child sexual offences. He had been remanded in custody since 22 September 2010. He was serving a term of ten years with a non-parole period of seven years.

Mr Johnstone was transferred to Kirkconnell Correctional Centre on 2 March 2016. He was placed in cell 3 of Unit One. The placement took into account his age and the cell's proximity to the health clinic. At the time of his death, Mr Johnstone was classified as a minimum security prisoner. His status was of limited association, at his own request due to the nature of his offending.

About 12.30 am on 21 March 2016, Mr Johnstone woke his cell mate, LC and told him that he had suffered a fall and had tried to clean up the blood. LC activated the "knock up button" or cell alarm and correctional officers attended soon afterwards to check on Mr Johnstone's welfare. They found that he had a cut above his right eyebrow and abrasions to both arms and his right knee. Simple first aid was provided and Mr Johnstone appeared to be lucid. He explained to officers present that he had fallen and struck his head on the metal tread in the day room of the unit. The after-hours nurse was called and Mr Johnstone was taken by ambulance to Bathurst Hospital. In all the circumstances, there does not appear to be any worrying delay in his transportation to hospital.

When Mr Johnstone arrived by ambulance around 2.25 am, he was able to walk and talk in full sentences. He was taken to have his wound sutured but began to deteriorate. He vomited and was subsequently transferred to a resuscitation bed. Testing began and he was found to have a large left sided acute subdural haematoma measuring 20mm in depth. An urgent neurosurgical review was recommended. At 6.47 am Mr Johnstone was transported via helicopter to Liverpool Hospital. Mr Johnstone was unconscious and non-responsive during the flight. He was seen by Dr Jeremy Rajadurai, who conducted further testing and then recommended against surgery due to his age, co-morbidities and current clinical state.

Mr Johnstone's next of kin was informed that a palliative care path was advised. A non resuscitation order was made the following day. At about 1 am on 26 March 2016 Mr Johnstone was heard to breathe loudly and make choking sounds. At about 2.20 am a nurse entered Mr Johnstone's room and informed the corrective services officer who was guarding the room that Mr Johnstone was dead. He was officially recorded as deceased at 3.21 am on 26 March 2016.

A post-mortem examination was conducted on by forensic pathologist Dr K Bailey on 30 March 2016. She confirmed that Mr Johnstone's death was caused from "complications of subdural haematoma". No other acute conditions or injuries were recorded and while toxicological testing detected multiple medications they were all in keeping with the documented therapeutic intervention.

The role of the Coroner

The role of the Coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the Coroner may make recommendations in relation to matters that may have the capacity to improve public health and safety in the future.

In this case there is no dispute in relation to the identity of Mr Johnstone, or to the date and place of his death. For this reason the inquest focused on the manner and cause of Mr Johnstone's death. It was also necessary to consider whether or not his death was in any way avoidable and if so what mechanisms, if any, could be put in place to help prevent such a situation recurring.

Where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is detained in custody the state is responsible for his or her safety and medical treatment. For this reason it is especially important to examine the circumstances of each death in custody and to understand how it occurred. The need for careful examination of the circumstances is particularly important when the inmate appears to have had few visitors and little contact with people outside the prison system.

Section 81 (1) of the *Coroners Act* 2009 (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Glennon Johnstone.

Scope of the inquest

A number of issues relevant to Mr Johnstone's death were identified prior to the inquest commencing. These issues included

- Would aids that allow prisoners to manoeuvre around Unit One be effective in reducing the risk of falls?
- What steps, if any, have been taken to ameliorate the risk of falls since Mr Johnstone's death?
- Was Mr Johnstone the victim of violence from other inmates?

The inquest took place on 6 November 2017. A large number of statements were tendered, along with recordings, gaol and medical records. Sergeant Damien Babb gave short oral evidence. A short adjournment was granted to allow Corrective Services the opportunity to supply further material to the Court in relation to initiatives currently in place for caring for aged inmates.

Background

Glennon Johnstone was born on 18 October 1928 in Turrella NSW. He appears to have had a difficult childhood and was living at Kings Cross independently from a young age. In about 1978 he became involved with JF and later lived with her in Miranda. In the 1980s they moved to Nambucca Heads and lived there together until JF died in early 2010.

Prior to the offences which brought him into custody in 2010, Mr Johnstone had a limited history of criminal convictions. He was first charged by police in 1947, at the age of 19 with stealing offences. In 1948 he was charged with rape, which was later dismissed. In 1964 he was charged with an indecent assault for which he was fined. In 1994 he was charged with aggravated indecent assault, which was also dismissed.

In September 2010, Mr Johnstone was arrested in relation to a number of serious offences including, sexual intercourse with a person under the age of 10. He was remanded in custody awaiting trial. Mr Johnstone was subsequently convicted. He spent the first years of his sentence at Junee Correctional Centre. He had limited contact with his step family whilst in custody.

Medical history whilst in custody

During his time in custody Mr Johnstone had some contact with Justice Health. The file reveals that a medical history had been taken on his reception and that Justice Health was aware of his prior conditions including hypercholesterolemia, Type 2 Diabetes and hypertension. Whilst in custody Mr Johnstone received various regular medications in accordance with his needs. Over the years he had eye surgery and an operation to remove a varicose vein from his right leg in 2010. No general care or treatment issues have been raised for consideration.

On entry into custody in 2011, Mr Johnstone was given a routine mental health assessment. There appear to have been no ongoing concerns in relation to this issue. On 8 December 2015, Mr Johnstone presented to the MSPC clinic after nearly falling over. In preventing the fall he had sustained skin tears to his right elbow and hand. He was placed on a list for review by the general practitioner. On 21 December 2015 he presented at the clinic complaining of diarrhoea and vomiting. He was treated and later in the evening complained of muscular cramps as well. He was transferred to the Emergency Department at Prince of Wales Hospital, where he apparently experienced two syncopal episodes while sitting on his bed and some shortness of breath.

On 2 March 2016, Mr Johnstone was transferred to Kirkonnell Correctional Centre. He was placed in the bottom bunk of a two person cell, due to his age and frailty. He was placed in this area as it was close to the health clinic, should an emergency occur.

What steps, if any, have been taken to ameliorate the risk of falls since Mr Johnstone's death

Mr Johnstone did not use a walking stick or walker. His cell mate described him as "fairly good" for his age, stating that "he got around fairly well". On 21 March 2016, Mr Johnstone appears to have fallen while walking back to his cell. The inquest considered whether there were steps which could be taken to have reduced the risk of falls in his environment. The Court received a statement from Mark Kennedy, currently the Governor of Bathurst, Mannus and Kirkonnell Correctional Centres. At the time of Mr Johnstone's death he was employed by Corrective Services NSW (CSNSW) as the Manager of Security at Kirkonnell Correctional Centre.

Governor Kennedy informed the court that as a result of becoming aware that Mr Johnstone had tripped and hit his head, he undertook an assessment and inspection of the area.

On 22 March 2016, with the assistance of Overseer George Hancock he examined the route that Mr Johnstone had taken from the bathroom to his cell through the common room. As a result of this and later inspections, a number of hand rails were installed at the cell doors in the area. There was also a handrail installed at the step in the common area. It was decided that the lighting in the area was adequate.

Is there a need for a more coordinated response to making a safe environment for geriatric prisoners?

The Court was supplied with a report called “Old and inside; Managing aged offenders in custody” The document is dated September 2015 and represents an attempt by CSNSW to acknowledge and plan for the ever-increasing aged population in NSW correctional centres. The report accepts that as demographic changes occur CSNSW is becoming a significant provider of aged care services to a growing cohort of aged and frail inmates, many of whom will die in custody.

The report was prepared by the Inspector of Custodial Services, assisted by two expert consultants. Four correctional centres in metropolitan Sydney, chosen to represent both specialized aged-care and mainstream centres were inspected. Kirkonnell Correctional Centre, where Mr Johnstone was housed was not specifically considered, although many of the general recommendations arising from the report would be applicable to that centre and to his care. Five key areas were examined in relation to the management and care of older inmates including correctional centre environments and facilities, centre regimes, relationships, healthcare and pre-release support.

Although specialist units exist, the majority of aged inmates are placed within mainstream correctional centres, in accordance with the CSNSW classification process. At present there is only limited capacity to provide specialist care in aged-care units for those who have mobility issues or are functionally impaired. As a result many aged prisoners are housed in physical environments that have not been designed with their specific needs in mind. The report acknowledges that there still a great deal to be done to improve conditions for aged prisoners to live and function with dignity in the correctional setting.

I have carefully reviewed the report and the more recent responses to the recommendations that have been provided by both Justice Health and Corrective Services NSW. I do not intend to refer to them in specific detail. It is clear that a number of the significant recommendations made have been largely supported internally and that there have already been some changes. That is to be commended. However, some important reforms appear to have been delayed while funding can be identified. Of particular relevance to this inquest, is the difficulty that can emerge for Corrective Services NSW when trying to find a suitable placement for an aged inmate who is somehow restricted by classification from being considered as suitable for a wide range of otherwise available options. Mr Johnstone was a convicted sex offender who was limited in his associations. He was also 87 years of age and in the community would have qualified for residential aged care or for various forms of government assistance and support. There is little doubt that there will continue to be a growing number of prisoners in this category.

The level of care provided to Mr Johnstone in custody, in relation to his specific aged health care needs should have resembled the quality of care that any citizen would expect within the public system in the community. Unfortunately as the report makes clear, this kind of standard has not yet been reached across the board. Recommendation 13 of the report looks to the need for creating new accommodation for aged and infirm inmates in the Sydney metropolitan area, either by building a new facility or by acquiring an existing aged care facility. CS NSW states that at February 2017, facilities outside the metropolitan area were being investigated for this purpose and that there is a long term plan for aged and frail inmates in the metropolitan area.

Making these proposals a reality is in my view an urgent task. Mr Johnstone died after falling. Falling creates a well-recognized risk of death or serious harm in the aged population generally. A well-planned aged care facility will be designed to minimize this kind of potential harm. While I accept that *ad hoc* changes have already been made to improve the precise area where Mr Johnstone fell at Kirkonnell Correctional Centre, a wider problem is clearly identified. CS NSW has limited facilities for the growing population of aged offenders it will continue to house. Housing an aged and at times frail population in facilities designed for an able population will continue to present ongoing risk, unless a real commitment is made to specifically addressing this growing issue.

Was Mr Johnstone the victim of violence from other inmates?

Mr Johnstone had placed himself on limited association as soon as he arrived in custody.

Prison authorities had placed him in a segregated unit with inmates who had been convicted of similar crimes, as a matter of safety. There are no reported complaints on file to suggest that Mr Johnstone had been threatened or assaulted in custody. His step family were also unaware of any specific incidents of this sort.

After his death a member of his step family saw an article in the Sunday Telegraph which stated that a white supremacist gang Willing to Kill (W2K), along with a newly formed gang "Eight Kings" had been "handing out its own form of justice", beating paedophiles and rapists at Kirkonnell Correctional Centre. The report stated that the problem was a "side effect" of overcrowding. It also stated that those responsible had been removed from the Centre and had their security classification increased. As a result of this information the Officer in charge of this coronial investigation was tasked with further investigations to ascertain whether this could have been an issue in Mr Johnstone's fall.

Detective Sergeant Damien Babb made a number of further inquiries and confirmed that there had indeed been a number of assaults at Kirkonnell, which had resulted in the moving some prisoners. However, there was no evidence that Mr Johnstone had been assaulted and there was no record of a still unidentified prisoner having been assaulted. Inmates who knew Mr Johnstone were re-interviewed and there was no suggestion that Mr Johnstone had been assaulted or threatened. I am satisfied that these incidents are unrelated to Mr Johnstone's injuries.

Conclusion

While appropriate local changes were made after Mr Johnstone's death, there appears to be a more general need to prioritise the provision of appropriate environments to house an aging prison population to mitigate the risk of falls and other preventable accidents. Comprehensive change will require commitment of significant resources by Corrective Services NSW.

Finally, I offer my condolences to those who cared for Mr Johnstone and to all those affected by his death.

Formal Findings

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

Identity

The person who died was Glennon Johnstone.

Date of death

Mr Johnstone died on 26 March 2016.

Place of death

Mr Johnstone died at Liverpool Hospital, Liverpool, NSW.

Cause of death

Mr Johnstone died from complications of a subdural haematoma.

Manner of death

Mr Johnstone's death was accidental. He had been injured when he fell in custody on 21 March 2016.

Recommendation pursuant to section 82 of the *Coroner's Act* (NSW) 2009

To the NSW Minister for Corrections

I recommend that Corrective Services NSW prioritise the establishment of specific residential facilities for accommodating aged and infirm prisoners in both metropolitan Sydney and in regional NSW, as a matter of urgency. These plans should include specific consideration of the growing number of aged prisoners whose classification is restricted.

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2017

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	435610/10	24/04/10	Silverwater	18	In Custody
2	192526/12	19/06/12	Randwick	27	In Custody
3	273783/12	01/09/12	Silverwater	49	In Custody
4	354840/13	24/11/13	Westmead	33	In Custody
5	343092/14	20/11/14	Hurstville	18	Police Op
6	6538/15	06/01/15	Malabar	32	In Custody
7	23577/15	24/01/15	Malabar	30	In Custody
8	42730/15	10/02/15	West Hoxton	22	Police Op
9	116507/15	19/04/15	Randwick	91	In Custody
10	124745/15	27/04/15	Camden	43	Police Op
11	125390/15	27/04/15	Cessnock	32	In Custody
12	139332/15	10/05/15	Berkshire Park	48	In Custody
13	141693/15	12/05/15	Silverwater	31	In Custody
14	155740/15	25/05/15	Silverwater	31	In Custody
15	208086/15	15/07/15	Maryvale	18	Police Op
16	265616/15	09/09/15	Warners Bay	51	Police Op
17	268972/15	12/09/15	Goulburn	23	In Custody
18	288035/15	01/10/15	Malabar	67	In Custody
19	289369/15	02/10/15	Parramatta	15	Police Op
20	323840/15	03/11/15	Malabar	74	In Custody
21	323811/15	03/11/15	Wellington	34	In Custody
22	329568/15	09/11/15	Camperdown	25	In Custody
23	336444/15	13/11/15	Malabar	65	In Custody
24	351469/15	26/11/15	Goulburn	46	Police Op
25	373099/15	19/12/15	Penrith	54	In Custody
26	381722/15	29/12/15	Malabar	26	In Custody
27	1459/16	31/12/15	Malabar	44	In Custody
28	18089/16	18/01/16	Lismore	23	Police Op
29	19119/16	19/01/16	Quakers Hill	46	Police Op
30	24535/16	22/01/16	Malabar	19	In Custody
31	56536/16	20/02/16	Marayong	37	Police Op

32	56558/16	20/02/16	Marayong	35	Police Op
33	56518/16	20/02/16	Westmead	36	Police Op
34	71814/16	05/03/16	Malabar	64	In Custody
35	72079/16	05/03/16	Allandale	43	Police Op
36	73098/16	07/03/16	Ingleburn	33	Police Op
37	82254/16	15/03/16	Concord	51	In Custody
38	87470/16	18/03/16	East Lismore	33	Police Op
39	88742/16	21/03/16	Bradbury	36	Police Op
40	94829/16	27/03/16	Randwick	76	In Custody
41	107266/16	07/04/16	Parklea	58	In Custody
42	110830/16	11/04/16	Malabar	37	In Custody
43	149781/16	14/05/16	Westmead	84	In Custody
44	151275/16	17/05/16	Coraki	51	Police Op
45	186812/16	19/06/16	Westmead	28	In Custody
46	199540/16	30/06/16	Waterloo	78	Police Op
47	214323/16	14/07/16	Parklea	43	In Custody
48	218940/16	19/07/16	Maitland	36	Police Op
49	231300/16	31/07/16	Bathurst	46	In Custody
50	273191/16	11/09/16	Parklea	44	In Custody
51	280295/16	17/09/16	Malabar	73	In Custody
52	290240/16	27/09/16	Sth Windsor	46	Police Op
53	291951/16	27/09/16	Orange	23	Police Op
54	329687/16	03/11/16	Bonville	36	Police Op
55	334771/16	08/11/16	Narromine	22	Police Op
56	347726/16	20/11/16	Terrigal	64	Police Op
57	350477/16	22/11/16	Westmead	22	Police Op
58	361528/16	01/12/16	Appin	62	Police Op
59	371530/16	09/12/16	Camperdown	52	Police Op
60	5348/17	05/01/17	Kings Park	56	Police Op
61	24726/17	24/01/17	Malabar	74	Police Op
62	39421/17	06/02/17	Westmead	67	In Custody
63	39999/17	07/02/17	Malabar	53	In Custody

64	43731/17	10/02/17	Macksville	15	Police Op
65	63039/17	27/02/17	Randwick	72	In Custody
66	69506/17	02/03/17	Newcastle	27	In Custody
67	76874/17	10/03/17	Londonderry	18	Police Op
68	76969/17	12/03/17	Coogee	28	Police Op
69	81862/17	15/03/17	Girrards Hill	58	Police Op
70	95138/17	27/03/17	Randwick	82	In Custody
71	96394/17	29/03/17	Bathurst	35	Police Op
72	99958/17	02/04/17	Silverwater	32	In Custody
73	100899/17	03/04/17	Parklea	38	In Custody
74	121886/17	24/04/17	Malabar	72	In Custody
75	136779/17	05/05/17	Parklea	52	In Custody
76	142803/17	09/05/17	Blacktown	20	In Custody
77	157550/17	25/05/17	Goulburn	49	In Custody
78	185430/17	20/06/17	Camperdown	47	In Custody
79	188495/17	23/06/17	Goulburn	21	In Custody
80	199884/17	29/06/17	Westmead	24	In Custody
81	202885/17	04/07/17	Westmead	35	In Custody
82	225703/17	23/07/17	Malabar	67	In Custody
83	225920/17	22/07/17	Lithgow	56	In Custody
84	228552/17	26/07/17	Sydney	30	Police Op
85	256295/17	22/08/17	Malabar	57	In Custody
86	256693/17	06/08/17	Grafton	44	Police Op
87	264782/17	30/08/17	Kelso	47	Police Op
88	266269/17	31/08/17	Bendeneer	29	Police Op
89	272539/17	04/09/17	Albury	19	Police Op
90	275511/17	08/09/17	Parklea	81	In Custody
91	275550/17	10/09/17	Randwick	49	In Custody
92	286401/17	20/09/17	St Leonards	64	Police Op
93	288854/17	22/09/17	Tamworth	22	In Custody
94	297414/17	29/09/17	Silverwater	34	In Custody
95	3113913/17	15/10/17	Randwick	49	In Custody

96	312005/17	14/10/17	Taree	17	Police Op
97	327738/17	29/10/17	Malabar	79	In Custody
98	343689/17	13/11/17	Nth Narrabeen	27	Police Op
99	344706/17	14/11/17	Coffs Harbour	27	Police Op
100	350282/17	19/11/17	Randwick	49	In Custody
101	358109/17	25/11/17	Villawood	68	Detention Centre
102	371691/17	07/12/17	Parklea	37	In Custody
103	373943/17	10/12/17	Penrith	35	Police Op
104	381497/17	17/12/17	Westead	18	Police Op
105	387508/17	20 /12/17	Watsons Bay	40	Police Op