Deaths in Custody/Police Operations Report

REPORT BY THE NEW SOUTH WALES STATE CORONER

for the year

2023

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FOR THE YEAR

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A REPORT PREPARED PURSUANT TO S 37(1) OF THE *CORONERS ACT 2009* (NSW)
OFFICE OF THE NSW STATE CORONER
NSW DEPARTMENT OF COMMUNITIES AND JUSTICE
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Aboriginal and Torres Strait Islander peoples should be aware that this publication contains the names of deceased persons.

The NSW Coroners Court acknowledges Australia's First Nations peoples as the Traditional Custodians of the lands, waters and seas of Australia.

We pay our respects to ancestors and Elders, past and present, and recognise the strength, resilience, and diversity of First Nations peoples of this land.

HELP AND SUPPORT

Condolences

The NSW Coroners Court wishes to offer its sincere and respectful condolences to the families and loved ones of all the people whose coronial matters are referred to in this report. We recognise their lives, and convey our appreciation to their families and loved ones for their participation in the coronial process.

Content warning

This report contains information about the circumstances and cause of death of persons who have died in custody or in the course of a police operation. Some people may find the content of this report confronting or distressing.

First Nations readers should be aware that this report contains information, including in some cases the names, of First Nations people who have passed away.

If you need support, please contact one of the support services listed. In an emergency, dial 000.

Lifeline: 24/7 crisis support and suicide prevention services.
Call: **13 11 14** Web: **https://www.lifeline.org.au/about/our-services/**

13YARN Crisis support for Aboriginal & Torres Strait Islander people: 24/7 confidential one-on-one over the phone yarning opportunity and support for mob who are feeling overwhelmed or having difficulty coping.
Call: **13 92 76** Web: **https://www13yarn.org.au**

Beyond Blue: 24/7 advice, referral and support from trained mental health professionals.
Call: **1300 22 4636** Web: **https://www.beyondblue.org.au/**

Suicide Call Back Service: 24/7 counselling and support for people at risk of suicide, carers and bereaved.
Call: **1300 659 467** Web: **https://www.suicidecallbackservice.org.au/**

Griefline: Operates midday-3am 7 days a week. Phone and online counselling for people experiencing loss or grief.
Call: **1300 845 745**

Blue Knot Helpline: Operates 9am- 5pm, Monday to Friday. All Blue Knot counsellors are experienced trauma counsellors. Call: **1300 657 380** Web: **https://www.beyondblue.org.au/**

NSW Mental Health Line: 24/7 telephone helpline available to everyone in NSW. Call: **1800 011 511**
Web: **https://www.health.nsw.gov.au/mentalhealth/Pages/mental-health-line.aspx**

The National Indigenous Postvention Service: 24/7 after suicide support for Aboriginal and Torres Strait Islander individuals and families impacted by suicide.
Call: **1800 805 801** Web: **https://thirrili.com.au/postvention-support**

Free Translating and Interpreting Service (TIS): Call: **13 11 44**

Further resources are available at: **https://www.ruok.org.au/findhelp**

TERMINOLOGY

This report adopts the terminology of First Nations people in recognition that Aboriginal and Torres Strait Islander people are the sovereign people of Australia. This term also recognises the various language groups as separate and unique sovereign nations. (Common Ground, 2020).[1]

1 At https://www.commonground.org.au/learn/aboriginal-or-indigenous.

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The Hon. Michael Daley MP
Attorney General
GPO Box 5341
Sydney NSW 2001

30 April 2024

Dear Attorney General,

Section 37(1) of the *Coroners Act 2009* ('the Act') requires that I provide to you annually, a summary ofall deaths in custody and deaths that are the result of police operations that were reported to the Coroner in the previous year. Inquests are mandatory in such cases but the coronial investigation into most of the deaths that occurred last year have not yet been finalised. I have also included information about inquests into deaths that were reported in earlier years and finalised in the past year.

I attach a hard copy and an electronic copy of the 2023 report.

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

The deaths in question are defined in section 23 of the Act, and include deaths that occur:

- While the deceased person is in the custody of a police officer or in other lawful custody,
- While the person is attempting to escape from lawful custody,
- While the person is in or temporarily absent from a juvenile detention centre or an adult correctional centre, and
- As a result of a police operation.

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 also attract significant public and media attention.

Inquest findings for those matters that were finalised in 2023 and are referred to in this report are available on the Coroners Court New South Wales webpage at: https://www.coroners.nsw.gov.au/coronial-findings-search.html. A register of coronial recommendations directed to, and responses by, government agencies to those recommendations which is maintained by the Department of Communities and Justice is available at: https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx

I would like to recognise and acknowledge the lives of the people whose deaths are reported herein and extend my sincere condolences to their families and loved ones for their passing.

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.

Magistrate Teresa O'Sullivan
NSW State Coroner

2023 SUMMARY IN BRIEF

Deaths reported to the Coroner in 2023

- In the calendar year 2023, 39 deaths were reported to the Coroner as occurring in custody or as a result of a police operation.
  - This is an overall decrease of 10 deaths from the number reported in 2022.
  - 16 deaths were reported as occurring in custody.
  - This is the lowest number of deaths reported as deaths in custody since 2014 (equal to 2016).
  - 23 deaths were reported as occurring as a result of a police operation.
  - This is the highest number of deaths reported as a result of a police operation in the last 10 years.

Overrepresentation of First Nations peoples

- 3 of the 39 deaths reported to the Coroner were First Nations people. This represents 7.7% of all deaths reported to have occurred in custody or as a result of a police operation, despite First Nations peoples comprising only 3.4% of the NSW population (ABS Census, 2021).

Deaths in custody in 2023

- 16 deaths were reported to the Coroner as having occurred in custody. Of these, 2 deaths (12.5%) were of First Nations peoples.
- The majority of these deaths (10) occurred in Corrective Services custody:
  - 6 of those persons who died were serving a full-time sentence, and
  - 4 of those persons who died were being held on remand.
- Of the remaining 6 deaths, 3 deaths occurred in forensic mental health custody, 2 deaths occurred in immigration detention, and 1 death occurred in police custody.
- In most cases reported to the Coroner in 2023, information about the circumstances of the person's death, including the medical cause of death, is still under investigation. However, at the time of writing:
  - 9 deaths were reported as a result of intentional self-harm,
  - 6 deaths were reported as a result of natural causes*, and
  - In 1 death, the manner was reported as 'unknown'.

* Where a death appears to be due to natural causes, a Coroner may still find that the death may have been caused or contributed to by preventable issues such as the quality of care, treatment and/or supervision received by the person prior to their death, including a lack of culturally appropriate care. These issues will be addressed by the Coroner in the inquest and/or the recommendations made at inquest.

Deaths as a result of a police operation in 2023

- 23 deaths were reported to the Coroner as occurring as a result of a police operation. Of these, 1 (4.3%) involved the death of a First Nations person.
- The deaths were reported to have occurred in the following types of police operations:
  - 8 (34.8%) deaths in the course of a police operation to contain or restrain the person,
  - 4 (17.4%) deaths in connection with a police motor vehicle pursuit,
  - 4 (17.4%) deaths in connection to an operation to assist the person,
  - 2 (8.7%) deaths in connection to a Police siege,

- 2 (8.7%) deaths in connection of an operation to attend a residence,
- 2 (8.7%) deaths in circumstances which require further information, and
- 1 (4.3%) death which occurred whilst the person was in Police custody.

- In most cases reported to the Coroner in 2023, information about the circumstances of the person's death, including the medical cause of death, is still under investigation. However, at the time of writing:
  - 7 deaths were reported to have been as a result of Police discharge of a firearm or weapon.
  - 4 deaths were reported to have been as a result of a motor vehicle collision.
  - 4 deaths were reported to have been as a result of intentional self-harm.
  - All deaths except 3 (2 of which under investigation, and 1 of which was reported as being of natural causes) appear to be due to external causes.

Inquests finalised in 2023

In 2023, the State Coroner and Deputy State Coroners delivered findings in 43 inquests involving the death of a person in custody or as a result of a police operation. Of the 43 inquests that were finalised, 33 involved a death in custody, and 10 as a result of a police operation.

Overrepresentation of First Nations peoples

- 13 of the finalised inquests involved a First Nations person. This represents 30.2% of all finalised inquests, despite First Nations peoples comprising only 3.4% of the NSW population (ABS Census, 2021).

Deaths in custody

- 33 of those inquests that were finalised involved the death of a person in custody.
  - 8 inquests (24.2%) involved the death of a First Nations person,
  - 33 inquests (100%) involved the death of a male person, and
  - 24 inquests (72.7%) involved the death of a person serving a full-time custodial sentence, and 9 (27.3%) involved the death of a person being held on remand.

Deaths as a result of police operations

- 10 of those inquests that were finalised involved the death of a person which occurred as a result of a police operation.
  - 2 inquests (20.0%) found that the death occurred due to the discharge of a firearm by police in the course of a police operation,
  - 2 inquests (20.0%) found that the death occurred due to a motor vehicle collision in connection with a police operation,
  - 2 inquests (20.0%) found that the death was due to drowning, and
  - 4 inquests (40.0%) found the death was due to intentional self-harm by the person.

STATUTORY APPOINTMENTS

Under the *Coroners Act 2009*, all Magistrates in New South Wales are Coroners by virtue of their office. However, under section 22, only a Senior Coroner who has been appointed as the State Coroner or a Deputy State Coroner is permitted to hold an inquest into the death of a person occurring in custody or as a result of a police operation.

The inquests detailed in this report were conducted before the following Senior Coroners:

NSW State Coroner

Her Honour Magistrate Teresa O'Sullivan (appointed 2019)

Deputy State Coroners

Her Honour Magistrate Joan Baptie (appointed 2021)

Her Honour Magistrate Carmel Forbes (appointed 2011)

Her Honour Magistrate Harriet Grahame (appointed 2015)

Her Honour Magistrate Erin Kennedy (appointed 2022)

His Honour Magistrate Derek Lee (appointed 2016)

Her Honour Magistrate Elizabeth Ryan (appointed 2017)

His Honour Magistrate David O'Neil (appointed 2023)

01.
INTRODUCTION

Under **section 23** of the *Coroners Act 2009*, a death must be reported to a Senior Coroner (the State Coroner or a Deputy State Coroner) if it appears to have occurred while the person is in custody or as a result of a police operation, and an inquest must be conducted into the circumstances of that death.

The requirement for a Senior Coroner to hold a public inquest in relation to a death in custody or as a result of a police operation reflects the important role of coronial investigations in monitoring standards of custodial care or police operations. The inquest process provides an opportunity for the Senior Coroner to make carefully considered recommendations with the objective of preventing deaths occurring in similar circumstances in the future.

What is a death in custody?

Section 23 of the *Coroners Act 2009* provides a Senior Coroner with jurisdiction to hold an inquest into a death where it appears that the person has died while:

- In the custody of a police officer, in prison custody or in other lawful custody including detention pursuant to the *Migration Act 1958* (Cth),
- Escaping, or attempting to escape, from the custody of a police officer, prison custody or other lawful custody,
- In or temporarily absent from a detention centre, prison or lock-up where the person was an inmate, or
- Travelling to a detention centre, prison or lock-up for the purpose of being admitted there as an inmate and while in the company of a police officer or other official charged with the person's care or custody.

These categories broadly align with the range of circumstances that were agreed by all mainland State and Territory governments as constituting deaths in custody in their responses to recommendations of the Royal Commission into Aboriginal Deaths in Custody (1991).

Deaths occurring in other circumstances may also be investigated by the Senior Coroner as if they are deaths in custody, including where:

- A person is serving a custodial sentence in the community (e.g. an Intensive Correction Order), or
- A prisoner has been released from custody by Corrective Services NSW prior to death (e.g. where hospitalised for the remainder of their life).

The decision as to whether a death has occurred 'in custody' is made by the Senior Coroner on careful consideration of all the evidence.

What is a death as a result of a police operation?

Section 23 of the *Coroners Act 2009* provides a Senior Coroner with jurisdiction to hold an inquest into a death where it appears that the person has died as a result of a police operation.

A 'police operation' is defined broadly to mean:

> any activity engaged in by a police officer while exercising the functions of police officer other than an activity for the purpose of a search and rescue operation.

In practice, this definition has been interpreted broadly by Senior Coroners. It can include:

- An operation to apprehend or detain a person
- A police siege
- A police motor vehicle pursuit or other pursuit
- An operation to contain or restrain a person
- An evacuation
- A traffic control or enforcement
- A road block
- Execution of a warrant
- Execution of a writ or service of process
- Any operation in which police discharge a firearm
- Any other circumstance considered applicable by the Senior Coroner

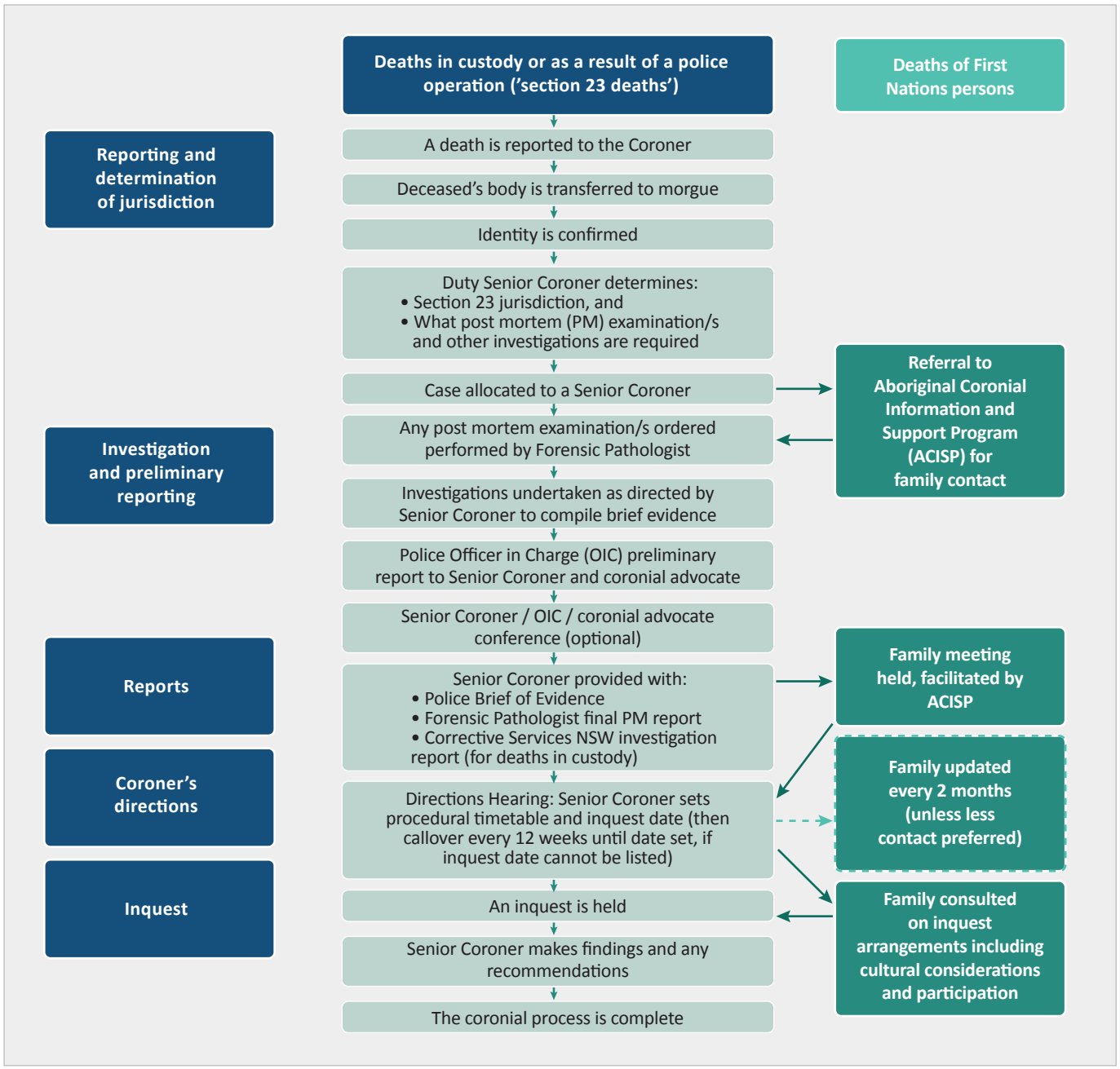
The reason for a broad approach is to enable the adequacy and appropriateness of police processes and conduct to be investigated where it appears necessary, and provide the family of the deceased, the New South Wales Police Force and the public with the opportunity to be made aware (as far as possible) of the circumstances surrounding the death.

It is important to note that for matters reported under section 23 where an inquest is yet to be heard and completed, no conclusion can be drawn that the death occurred in custody or during the course of a police operation until the Coroner, having considered all the evidence and submissions presented at the inquest, has made such a determination.

Conversely, a matter that was not initially reported as having occurred in custody or as a result of a police operation may be determined to be so after the Coroner has reviewed all the evidence.

THE CORONIAL PROCESS

The following diagram provides an overview of the coronial process when a death occurring in custody or as a result of police operations is reported to the Coroner, as outlined in Coronial Practice Note 3 of 2021 and where applicable, the First Nations Protocol (see below).



This diagram is not exhaustive, and does not capture all interactions between the Coroner, parties who assist the Coroner and the family of the deceased person that are integral to the completion of the coronial process.

Notification of deaths in custody or police operations

When a death occurs in custody or as a result of a police operation in New South Wales, local police are to promptly inform the State Operations Co-ordinator (SOC) at VKG, the police communications centre in Sydney. The SOC is to immediately notify the on-call duty Senior Coroner.

Once informed, the duty Senior Coroner will assume responsibility for supervising the initial investigation into the death, a critical part of any coronial inquiry. The Senior Coroner will:

- Give directions to Police.
- Check that arrangements have been made to notify the relatives and, if necessary, the deceased person's legal representatives. If the deceased person is identified as a First Nations person, the Aboriginal Legal Service is contacted by NSW Police.
- If warranted, inspect the scene where the death occurred. Later, the Senior Coroner may also inspect the scene of death before commencing or during the inquest.
- Give directions for any post mortem examinations to determine the deceased person's cause of death. All post mortem examinations are conducted by experienced Forensic Pathologists at specialist forensic medicine facilities.

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

In cases involving the NSW Police

When notified of a death in police custody or as a result of a police operation, the Senior Coroner may request the NSW Crown Solicitor's Office to instruct independent legal counsel to assist the Coroner with the investigation into the death. Counsel, in consultation with the Senior Coroner, will:

- Oversee the conduct of the investigation,
- Oversee the preparation of the brief of evidence,
- Confer with the deceased person's family members and witnesses,
- Prior to the inquest, appear at directions hearings and participate in conferences with the Coroner, legal representatives, interested parties and the deceased person's family members, to ensure that all relevant issues for the inquest are identified, and
- Appear as Counsel assisting the Coroner at the inquest, to ensure that all relevant evidence is brought to the attention of the Coroner to enable them to make proper findings and appropriate recommendations.

Case management of the coronial process

The Senior Coroner will case manage the coronial investigation and preparations for the holding of an inquest into a death in custody or as a result of a police operation in accordance with formal arrangements that aim to foster consistency, timeliness and inclusiveness of the family in the coronial process. This includes providing culturally appropriate support for First Nations families. These arrangements are:

Coronial Practice Note 3 of 2021 - Case Management of Mandatory Inquests Involving section 23 Deaths

On 24 September 2021, the Chief Magistrate issued Coronial Practice Note 3 of 2021, containing revised guidelines for Senior Coroners for the case management of deaths in custody or deaths as a result of police operations ('s 23 deaths'). The practice note aims to improve the timeliness of coronial investigations in these mandatory inquests, irrespective of the background of the deceased.

State Coroner's Protocol - Supplementary arrangements applicable to section 23 deaths involving First Nations People ('First Nations Protocol')

On 11 April 2022, the State Coroner issued the First Nations Protocol, which works in conjunction with Coronial Practice Note 3 of 2021, which sets out supplementary arrangements where a First Nations person has died in custody or as a result of a police operation. The aim of the

Protocol is ensure that each stage of the coronial process is managed in a culturally sensitive and appropriate manner and is established in recognition that every First Nations death in custody represents the loss of a valued individual, family and community, and needs to be understood in the context of the history and harmful results of dispossession and colonisation that continue to be experienced by First Nations peoples today.

The inquest

An inquest is a public hearing held in court by a Senior Coroner into the circumstances of a particular death. Coroners are concerned not only with how the person died, but also the circumstances of their death. Under section 3 of the ***Coroners Act 2009***, the object of the Coroner is to investigate a death to determine the identity of the deceased person, the time and date of their death, and the manner and cause of their death.

Deaths occurring in custody or police operations are personal tragedies that rightly continue to attract significant public attention and require thorough consideration by the Senior Coroner.

When inquiring into a death in custody, the Senior Coroner's investigation of the cause and circumstances of the death will include the quality of care, treatment and supervision of the person before their death, and whether custodial officers observed all relevant policies and instructions.

For example, at an inquest into a suspected death by suicide occurring in custody, the Senior Coroner will typically examine the circumstances to identify any improvements in the psychological/psychiatric care provided as well as the physical surroundings, with a view to reducing the risk of deaths by suicide in the future.

When inquiring into a death as a result of a police operation or in another form of detention, the Senior Coroner will investigate the appropriateness of actions of police or other officers and review standard operating procedures. The Senior Coroner will critically examine each case in order to identify whether shortcomings exist and if so, to ensure (as far as possible) that remedial action is taken and appropriate recommendations made.

Role of the Coroner

The purpose of an inquest into a death in custody or police operation is to enable the Senior Coroner, at the end of the inquest process, to make findings about the death and any recommendations about issues connected with the death. The ***Coroners Act 2009*** outlines a number of responsibilities of the Coroner in the inquest process, including:

- **Written findings**: At the conclusion of the inquest, the Coroner must provide written findings as to whether a person has died, their identity, the time and date of their death, and the manner and cause of their death. However, the findings must not indicate or suggest that an offence has been committed by any person (s 81).
- **Suspension in the event of criminal charges**: If it appears that a person has been charged with an indictable (serious) offence or on the evidence that a jury would convict a known person of an indictable offence in relation to the death, the Coroner is to suspend the inquest and, if applicable, refer the matter to the Director of Public Prosecutions for consideration of criminal proceedings (s 78). For inquests into deaths in custody or police operations, the inquest process will not resume until after the conclusion of any criminal proceedings (s 79).
- **Recommendations**: The Coroner may make such recommendations as they consider necessary or desirable in relation to any matter connected with the death the subject of the inquest. The purpose of any recommendations is to prevent, if possible, other deaths from occurring in the same circumstances in the future. There is no limit on the subject matter of recommendations, although issues of public health and safety are specifically indicated (s 82). A copy of any recommendation is to be provided to the State Coroner, the person or body to whom the recommendation is directed, and the relevant Minister/s.

Responses to recommendations

The *Coroners Act 2009* does not contain formal mechanism for monitoring responses to coronial recommendations. A Coroner may request but is not empowered to require that a response to a recommendation be provided by the person or body to whom it is directed.

However, a government agency to whom a recommendation is directed is required to adhere to the Department of Premier and Cabinet Memorandum 2009-12 Responding to Coronial Recommendations, which generally provides for:

- Acknowledgment of receipt of a recommendation to be provided to the State Coroner within 21 days, and
- Relevant Ministers to write to the Attorney General within 6 months to outline action being taken to implement a recommendation, and provide further progress updates as needed.

Government agency responses to coronial recommendations are compiled by the Department of Communities and Justice and published at: https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.

Timeframe for hearing of inquests

Before any inquest into a death can be held, the coronial investigation must be conducted. The Coroner supervises the investigation of any death from beginning to end. The time taken for this process to occur will vary considerably depending on the circumstances of the case.

Investigations into deaths in custody or police operations can take many months and up to several years to complete, due to the importance of ensuring cases are fully and properly investigated and a comprehensive brief of evidence provided to the Senior Coroner. This typically involves a large number of witnesses being spoken to and statements being obtained. A comprehensive investigation process assists to ensure all relevant issues are identified and evidence is sought to address those issues, so that the conduct of the inquest is as efficient as possible.

The interaction of other processes can also affect the timeframe in which an inquest can be held. In some cases, concurrent investigations into a death may occur (for example, by the Professional Standards Command of NSW Police or the Investigations Branch of Corrective Services NSW). The Senior Coroner may need to await and give consideration to the results of those investigations, which in turn may raise further issues for investigation and/or consideration at the inquest.

ABOUT THIS REPORT

This report provides information about:

- Deaths occurring in custody or as a result of police operations in NSW that were reported to the Coroner between 1 January 2023 and 31 December 2023, and
- Inquests into deaths occurring in custody or as a result of police operations in NSW that were finalised by a Senior Coroner between 1 January 2023 and 31 December 2023 (regardless of the date that the death occurred and/or was reported to the Coroner).

The cases comprising each dataset have been extracted from JusticeLink, the electronic case management system used by the Department of Communities and Justice for the collection of court data, and cross-checked against physical files managed by court staff. This process was undertaken to ensure that for each dataset:

- All cases meeting the inclusion criteria were identified and included, and
- Any cases that did not meet the inclusion criteria were excluded.

The aggregate data presented in relation to each dataset has been manually collected for each case within the dataset from sources including:

- Data fields in JusticeLink, which contain information manually entered into the system from original documents provided to the Coroner,
- Original documents, including the Police report of death and the Forensic Pathologist's post mortem report, and
- The Coroner's written findings, if applicable.

Data indicating a person's First Nations status is drawn from JusticeLink. This information is reported in the Police report of death to the Coroner where known, and/or is subsequently confirmed or identified by the Court's Aboriginal Coronial Information and Support Program (ACISP) officers or other coronial family liaison staff. All cases identified as relating to First Nations persons included in this report have been confirmed by ACISP staff.

OVERVIEW OF DEATHS IN CUSTODY AND POLICE OPERATIONS, 2004-2023

The following material provides an overview of all deaths that were reported to the Coroner, within the relevant year, as deaths occurring in custody or police operations.

This is a compilation of annual reported deaths and is not indicative of Coroners' final findings as to whether or not the deaths in fact occurred in custody or police operations.

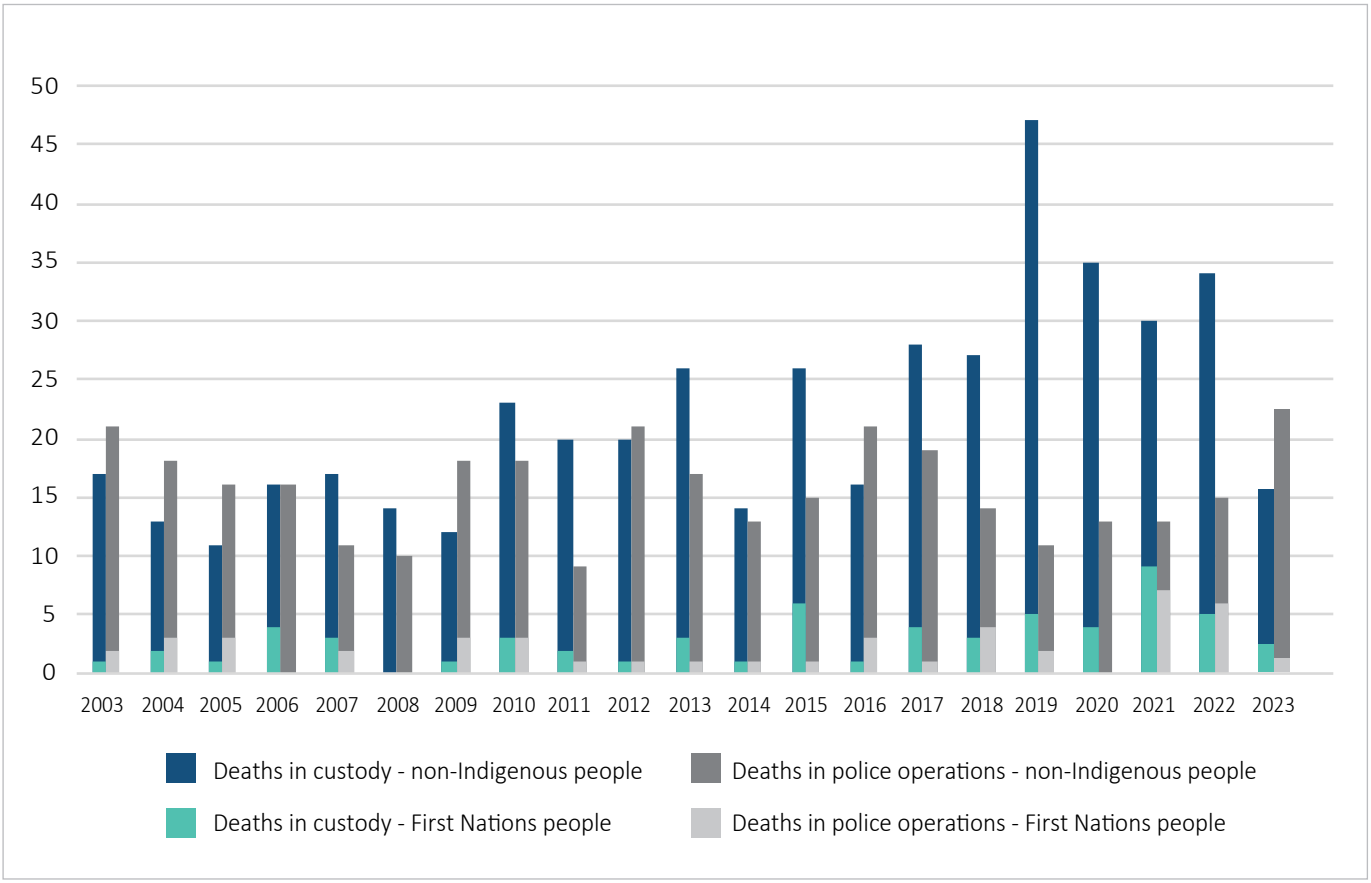


Figure 1: Deaths reported to the Coroner as occurring in custody and police operations in NSW, by First Nations status and year (2004-2023).

Deaths in custody

Year	Total	First Nations people	Non-Indigenous people
2004	13	2	11
2005	11	1	10
2006	16	4	12
2007	17	3	14
2008	14	0	14
2009	12	1	11
2010	23	3	20
2011	20	2	18
2012	20	1	19
2013	26	3	23
2014	14	1	13
2015	26	6	20
2016	16	1	15
2017	28	4	24
2018	27	3	24
2019	47	5	42
2020	35	4	31
2021	30	9	21
2022	34	5	29
2023	16	2	14
TOTAL	**445**	**60**	**385**

Figure 2: Table of deaths reported to the Coroner as occurring in custody in NSW, by First Nations status and year (2004-2023).

Deaths as a result of police operations

Year	Total	First Nations people	Non-Indigenous people
2004	18	3	15
2005	16	3	13
2006	16	0	16
2007	11	2	9
2008	10	0	10
2009	18	3	15
2010	18	3	15
2011	9	1	8
2012	21	1	20
2013	17	1	16
2014	13	1	12
2015	15	1	14
2016	21	3	18
2017	19	1	18
2018	14	4	10
2019	11	2	9
2020	13	0	13
2021	13	7	6
2022	15	6	9
2023	23	1	22
TOTAL	**311**	**43**	**268**

Figure 3: Table of deaths reported to the Coroner as occurring in police operations in NSW, by First Nations status and year (2004-2023).

REPORTED DEATHS IN 2023

This section provides information about deaths reported to a Senior Coroner in 2023 as having occurred in custody or as a result of a police operation. In most of these cases, an inquest had not yet been held at the date of this report. As a result:

- Only limited information is available about deaths which have been reported as the matters are not yet finalised, and
- Information is provisional in nature. No conclusion can be drawn that a death occurred in custody or as a result of a police operation until this is determined by the Senior Coroner after hearing all the evidence and submissions presented at an inquest.

Due to rounding, the data presented in the following tables may not add to exactly 100.0%.

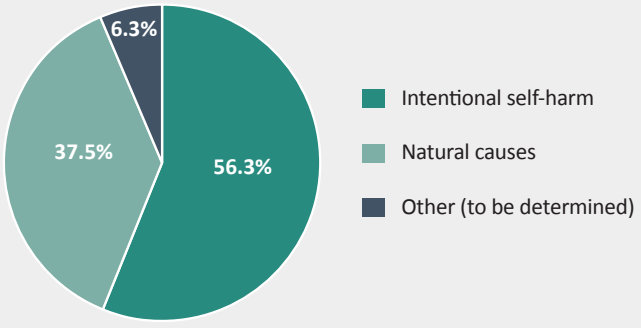
Deaths in custody

16 deaths reported to the Coroner in 2023
↓ 18 deaths from 2023

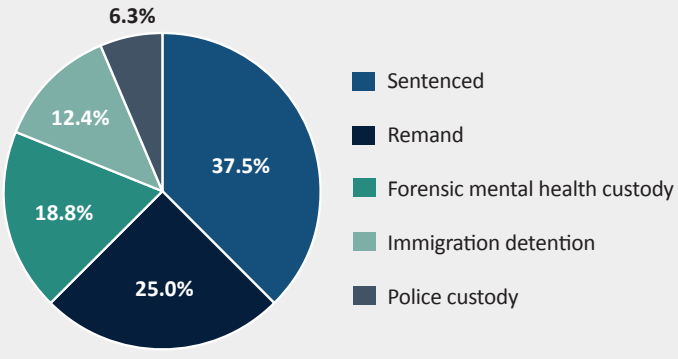
16 Male
0 Female

2 First Nations persons

Manner of death		
Intentional self-harm	9	56.3%
Natural causes	6	37.5%
Other (to be determined)	1	6.3%
TOTAL	**16**	**100.0%**



Custodial status		
Sentenced	6	37.5%
Remand	4	25.0%
Forensic mental health custody	3	18.8%
Immigration detention	2	12.4%
Police custody	1	6.3%
TOTAL	**16**	**100.0%**

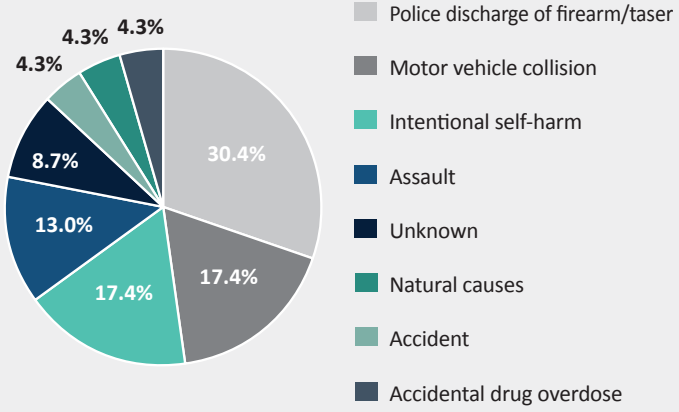


Deaths as a result of police operations

23 deaths reported to the Coroner in 2023
9 deaths from 2023

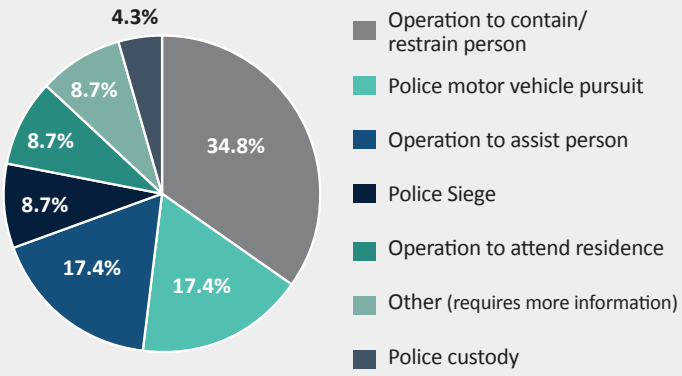
19 Male
4 Female
1 First Nations persons

Manner of death		
Police discharge of firearm/ taser*	7	30.4%
Motor vehicle collision	4	17.4%
Intentional self-harm	4	17.4%
Assault	3	13.0%
Unknown	2	8.7%
Natural causes	1	4.3%
Accident	1	4.3%
Accidental drug overdose	1	4.3%
TOTAL	**23**	**100.0%**



* *Police discharge of firearm/taser* refers to a death occurring in a police operation where the deceased was shot or tasered by police. It makes no assessment as to whether or not the discharge of the firearm or taser by police occurred in lawful circumstances.

Type of police operation		
Operation to contain/ restrain person	8	34.8%
Police motor vehicle pursuit	4	17.4%
Operation to assist person	4	17.4%
Police Siege	2	8.7%
Operation to attend residence	2	8.7%
Other (requires more information)	2	8.7%
Police custody	1	4.3%
TOTAL	**23**	**100.0%**



INQUESTS FINALISED IN 2023

In 2023, 43 inquests were finalised in relation to deaths occurring in custody (33 inquests) or as a result of police operations (10 inquests).

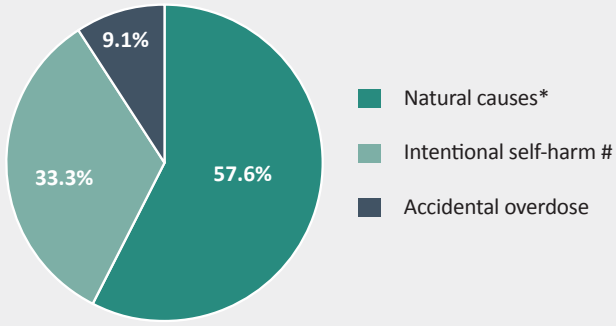
Deaths in custody

33 inquests finalised by a Senior Coroner in 2023

33 Male
0 Female

8 First Nations persons

Manner of death		
Natural causes*	19	57.6%
Intentional self-harm #	11	33.3%
Accidental overdose	3	9.1%
TOTAL	**33**	**100.0%**

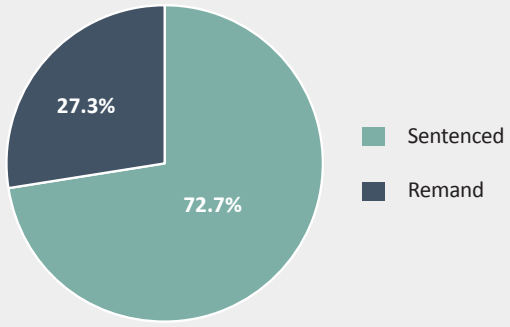


* Note: where the Coroner has found that a death was due to natural causes, they may have also identified causal or contributory issues regarding the quality of care, treatment and/or supervision of the person prior to their death that may be the subject of recommendations aimed at preventing similar deaths in the future. These recommendations are contained in the Coroner's written findings, which are accessible as outlined below.

\# Note: further information regarding the 11 deaths determined to have been as a result of intentional self-harm was collated from the inquest findings. From the information presented at inquest, 7 (64%) of the persons had previously been diagnosed with a mental health issue, 3 of whom were currently receiving medication. 4 of the persons had indicated suicidal ideation or made threats of suicide, and 5 had a noted history of actual self-harm and/or suicide attempts.

3 of the persons were noted to have been on a waiting list to see a mental health professional at the time of their deaths, 1 of the persons had had a mental health review ordered but not yet actioned, and 1 of the persons had spoken with a psychologist only five days before their death.

Custodial status		
Sentenced	24	72.7%
Remand	9	27.3%
TOTAL	**33**	**100.0%**



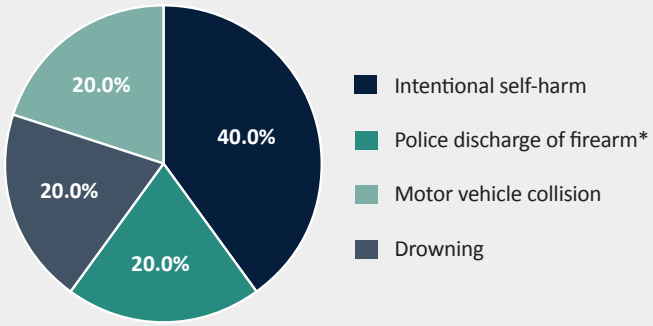
Deaths as a result of police operations

10 inquests finalised by a Senior Coroner in 2023

10 Male
0 Female

5 First Nations persons

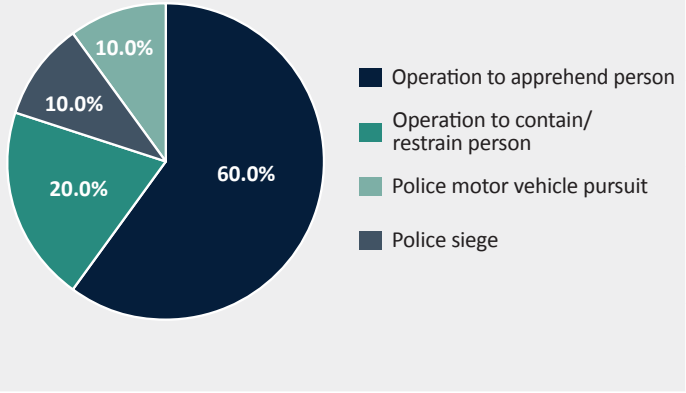
Manner of death		
Intentional self-harm	4	40.0%
Police discharge of firearm*	2	20.0%
Motor vehicle collision	2	20.0%
Drowning	2	20.0%
TOTAL	**10**	**100.0%**



* *Police discharge of firearm*: Two deaths were found to have occurred when the deceased person was shot by police in the course of a police operation. The circumstances of each death in this category varied, occurring in the following situations where police officers:

- Entered the deceased's home in an attempted to execute an arrest warrant for the deceased, where they were confronted by the deceased armed with an axe and a knife.
- Attended the deceased's mother's home in response to reported assault, and entered the premises where they were confronted by the deceased holding a shotgun.

Type of police operation		
Operation to apprehend person*	6	60.0%
Operation to contain/ restrain person	2	20.0%
Police motor vehicle pursuit	1	10.0%
Police siege	1	10.0%
TOTAL	**10**	**100.0%**



* In 5 of these inquests, the Coroner noted evidence that the deceased had a diagnosis of mental illness.

Written findings

The electronic version of this report contains a link to the written findings made in each finalised inquest in the tables below. Written findings are published on the NSW Coroner's Court website at:

https://www.coroners.nsw.gov.au/coroners-court/coronial-findings-search.html

The written findings set out the Coroner's determinations about the deceased person's identity and the date, time, manner and cause of death. They include a description of the circumstances surrounding the death and any recommendations that were made.

Where the Coroner makes a finding that a person's death was self-inflicted, section 75 of the *Coroners Act 2009* prevents the person's name from being published unless the Coroner directs otherwise. In the tables below and in the written findings for such cases, the names of deceased persons have been replaced with pseudonyms.

Note that, due to the time required to complete the coronial investigation to inform the inquest process, and the impact of the COVID-19 pandemic, the substantial majority of cases in the lists below were reported to the Coroner in years prior to 2023.

Deaths in custody

	Case number	Inquest into the death of	Senior Coroner
1	201800060363	John Cribb	Magistrate D. O'Neil
2	201800281398	'GS'	Magistrate E. Kennedy
3	201900126969	'LT'	Magistrate E. Ryan
4	201900146621	'KT'	Magistrate E. Ryan

	Case number	Inquest into the death of	Senior Coroner
5	201900269131	Roy Joseph Roberts	Magistrate D. Lee
6	201900324097	Matthew Grieve	Magistrate D. O'Neil
7	201900280398	John Paul O'Donnell	Magistrate E. Kennedy
8	201900002380	Peter Gretton	Magistrate D. Lee
9	201900179888	Stefan Wakeman	Magistrate E. Ryan
10	201900252231	Melville Schrader	Magistrate E. Ryan
11	202000091972	James Brown	Magistrate E. Kennedy
12	202000257665	Reuben Clarke Button	Magistrate H. Grahame
13	202000026654	Barry Faulkner	Magistrate D. Lee
14	202000135219	'JS'	Magistrate E. Kennedy
15	202000022402	'SH'	Magistrate C. Forbes
16	202000257581	Paul Hannan	Magistrate D. O'Neil
17	202000139754	Philip Nguyen	Magistrate J. Baptie
18	202100118189	William Haines	Magistrate C. Forbes
19	202100002579	'CJ'	Magistrate C. Forbes
20	202100259055	John Dodd	Magistrate E. Kennedy
21	202100248509	Daryl Suckling	Magistrate C. Forbes
22	202100339043	Simon R Miles	Magistrate E. Ryan
23	202100261655	David Colin Winner	Magistrate E. Kennedy
24	202100317032	'RRC'	Magistrate C. Forbes
25	202100057723	Manuel Katsaros	Magistrate E. Ryan
26	202100087081	Anthony Sampieri	Magistrate E. Ryan
27	202100094740	'DP'	Magistrate H. Grahame
28	202200062168	Azhar Abdul	Magistrate E. Kennedy
29	202200126719	Jay Lee Crich	Magistrate D. O'Neil
30	202200131088	Matthew Geoffrey Smith	Magistrate D. O'Neil

	Case number	Inquest into the death of	Senior Coroner
31	202200096193	'JM'	Magistrate E. Kennedy
32	202200153319	'TH'	Magistrate D. O'Neil
33	202200095990	Steven McHugh	Magistrate E. Kennedy

Deaths as a result of police operations

	Case number	Inquest into the death of	Senior Coroner
1	201900256729	Jacob Daniel Carr	Magistrate J. Baptie
2	202000304043	Daniel Bolton	Magistrate D. O'Neil
3	202000231668	'TE'	Magistrate E. Ryan
4	202100286356	Gordon Copeland	Magistrate T. O'Sullivan
5	202100319041	Stanley Leonard Russell	Magistrate C. Forbes
6	202100176671	Trent Nathan Carter	Magistrate E. Kennedy
7	202200020548	Brandon Clark	Magistrate E. Kennedy
8	202200075390	'SB'	Magistrate D. O'Neil
9	202200358360	'DO'	Magistrate E. Ryan
10	202200280628	Andrew Stark	Magistrate E. Kennedy

CORONIAL INQUEST RECOMMENDATIONS HANDED DOWN IN 2023

In accordance with section 81 of the *Coroner's Act 2009*, written findings are published after the conclusion of coronial inquests held by the NSW Coroner's Court. The written findings set out the coroner's determinations about the deceased person's identity and the date, time, manner and cause of death, as well as a description of the circumstances surrounding their death and any recommendations that were made. Recommendations related to the circumstances of the matter may be made pursuant to section 82 of the *Coroner's Act 2009* where they are deemed to be necessary or desirable.

Recommendations can be made around issues of public health and safety or can be aimed specifically at a person or agency to recommend a matter or issue be investigated or reviewed. The majority of recommendations made in inquests finalised in 2023 were aimed a specific agency, head of agency or Minister responsible for the specific agency. It is a legislative requirement that the coroner making the recommendations provide a copy of the recommendations to the State Coroner, the person or agency to whom the recommendation is directed, the Minister, and any other Ministers responsible for the person or agency or responsible for the administration of the legislation to which the recommendation relates.

However, there is no reciprocal legislation that requires or compels the persons, agencies or Ministers responsible to respond to, nor action, these recommendations. It is considered standard practice for responses to recommendations to be provided to the NSW Attorney General's Office within 6 months of the recommendation being received[2]. Reponses to coronial recommendations from 2009 onwards are publicly available on the Government Responses to Coronial Recommendations webpage on the Department of Communities and Justice website: https://dcj.nsw.gov.au/legal-and-justice/laws-and-legislation/legal-assistance-and-applications/responses-to-coronial-recommendations/response-to-coronial-recommendations-archive.html

Of the 43 inquests finalised in 2023, 18 matters had recommendations handed down. 13 of the matters were deaths in custody, and 5 were deaths as a result of Police operations. For the 18 matters, a total of 60 recommendations were made. Responses were received by the NSW Attorney General for 32 of the 60 recommendations. 17 responses were on behalf of the Justice Health and Forensic Mental Health Network and 15 responses were from the NSW Police Force. Recommendations may well have been implemented without the response being provided to the NSW Attorney General.

2 This practice is in accordance with the recommendation provided in the NSW Premier's Memorandum *M2009-12 Responding to Coronial Recommendations* (issued 6 April 2009), at https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations.

02.

RECOMMENDATIONS AND RESPONSES

All recommendations handed down in 2023 are outlined in the tables below. This information includes the agency or agencies to which the recommendations were addressed to, and any responses received by 19 April 2024. Where the Response Recorded is noted as ‘nil’, the agency has not yet provided a response to the NSW Attorney General.

Inquest into the death of 'GS' (2018) Published 14 July 2023

Recommendation

1. That Corrective Services NSW (CSNSW) and the Justice Health and Forensic Mental Health Network (Justice Health) give consideration to the implementation of a written policy or procedure whereby inmates who are being processed for transfer to another correctional centre because of safety concerns at the existing correctional centre, and who are in one-out cell placement pending transfer, are to be referred to Justice Health for assessment.

Agency/Organisation

Corrective Services NSW
Justice Health and Forensic Mental Health Network

Response Recorded as at 19 April 2024

By undated letter, Ryan Park MP, Minister for Health, provided the following responses:

Recommendation 1

Justice Health NSW notes that a health assessment pending transfer will allow Justice Health NSW clinicians to update the patient's Health Problem Notification Form. The form provides important information to Corrective Services NSW in relation to clinical needs, both physical and mental, and risks of adult patients, including cell placement recommendations. In addition, Justice Health NSW advises Corrective Services NSW Policy 5.2 Inmate Accommodation has been reviewed to include guidance on a range of criteria for cell placement decisions.

Further, Justice Health NSW advises Corrective Services NSW also supports the recommendation.

Recommendation

2. That Justice Health examine the Patient Administration System (PAS) Waiting List Priority Level Protocol and consider clarifying the clinical priority of a mental health patient who has put in multiple requests for review of their psychiatric medication while on the waitlist for such review.

3. That Justice Health consider introducing a written policy requirement that staff record on the PAS waitlist each time that a patient on an existing waitlist makes a further request for review by the corresponding clinician.

4. That Justice Health consider amending the PAS Waiting List Priority Level Protocol to guide nursing staff in triaging patients who have not been seen off a waitlist within the timeframe corresponding with their clinical priority category (as set out in the PAS Waiting List Priority Level Protocol) and who are therefore overdue for assessment.

5. That Justice Health, considers clearly separating the current reporting of overdue patients on the "Overdue PAS report" into discrete individual clinical priority categories to allow proper analysis of the delays experienced particularly by inmates currently delayed on the waitlist, category 3.

Agency/Organisation

Justice Health and Forensic Mental Health Network

Response Recorded as at 19 April 2024

By undated letter, Ryan Park MP, Minister for Health, provided the following responses:

Recommendation

2. Justice Health NSW is undertaking a Patient Administration System (PAS) Priority clinical redesign project to improve PAS functionality and governance. Review of triage of clinical priorities in PAS is a critical patient safety factor for the project team. The project team will seek recommendations of appropriate protocol considerations from the Mental Health Stream to be incorporated into the new PAS protocol. The project will also focus on revision of PAS waitlist priority categories including differentiating new patients and problems from follow-up care. The project team meets regularly with the external provider to progress project solutions for PAS enhancements.

3. Justice Health NSW supports the intent of the recommendation however notes that the Patient Administration System is a booking administration tool. Justice Health NSW considers the health record to be the appropriate location for such health documentation and will include clear guidance in the Justice Health NSW Patient Self-Referral Policy 1.362 for clinicians in the review, triage, and escalation of patients with repeat self-referral. The revised policy is expected to be completed in January 2024. The information will be duplicated in the PAS Priority Protocol.

4. Justice Health NSW will consult broadly with clinical streams to develop guidance for escalation pathways for re-triaging of patients to be included in the Justice Health NSW Patient Self-Referral Policy 1.362 and in the PAS Waitlist Priority Protocol DG73200/20. PAS Priority Protocol is currently being reviewed and will be sent for stakeholder consultation. This is expected to be completed by the end of December 2023, with approval finalised in January 2024.

   Further, Justice Health NSW will develop processes for review of overdue waitlists and escalation for waitlists about to be breached and educate administration staff and managers regarding reporting tools and analytics dashboards.

5. JHNSW Health Intelligence and Analytics Unit delivered education to staff throughout September and October 2023 on the use of the Waiting List App within the Central Analytics Reporting Portal (the Portal) and demonstrated bookmarking tips to identify delays experienced by patients currently on the waitlist, including category 3. There is an expectation set for Nurse Unit Managers/ Clinical Support staff to undertake a weekly triage of categories 1, 2 and 3 using the Portal.

   JHNSW continues to provide weekly overdue waiting list reports for each priority (Pl, P2, P3, P4) to clinical specialties to enable analysis of the delays and appropriate action. Additionally, there is existing functionality to separate waitlist clinical priorities categories using the Waiting List App within the Portal.

   The JHNSW Health Intelligence and Analytics Unit will continue to distribute weekly reports and increase awareness and support clinicians to increase their data literacy skills as part of the business-as-usual service delivery. Tipsheets on bookmarking and an important notice have been made available on the intranet within the Portal and JHNSW Intranet on 9 October 2023. JHNSW will disseminate useful education and tips by January 2024.

Recommendation

6. That St Vincent's Correctional Health (SVCH) examine the policy titled "St Vincent's Correctional Health: Triage and Priority Waitlist" and consider clarifying the clinical priority of a mental health patient who has put in multiple requests for review of their psychiatric medication while on the waitlist for such review.

7. That SVCH consider introducing a written policy requirement that staff record on the PAS waitlist each time that a patient on an existing waitlist makes a further request for review by the corresponding clinician.

8. That SVCH consider amending the Triage and Priority Waitlist policy to guide nursing staff in triaging patients who have not been seen off a waitlist within the timeframe corresponding with their clinical priority category (as set out in the Triage and Priority Waitlist policy) and who are therefore overdue for assessment.

Agency/Organisation

St Vincent's Correctional Health

Response Recorded as at 19 April 2024

Nil

Inquest into the death of 'LT' (2019) Published 23 March 2023

Recommendation

1. That the Commissioner, Corrective Services NSW in consultation with the Justice Health and Forensic Mental Health Network, reintroduce the Drug Use in the Inmate Population Research Project or equivalent, to examine:
   a) the nature of drug use reported during inmate screening processes by the JH Network;
   b) the nature of drug use otherwise reported during inmate surveys conducted during periods of imprisonment;
   c) treatment options within CSNSW Corrective Centres; and
   d) security responses attempting to interdict the supply of illicit drugs into NSW correctional centres.

Agency/Organisation

Corrective Services NSW

Response Recorded as at 19 April 2024

By undated letter, Ryan Park MP, Minister for Health, provided the following responses:

Recommendation

Research groups from Justice Health and Corrective Services NSW will coordinate efforts with Justice Health Drug and Alcohol Service providing subject matter expertise. Their project is part of a partnership between both agencies to achieve better patient/inmate outcomes.

Justice Health will use funding from the special commission into the ice inquiry to establish 17.5 full-time equivalent positions to develop a new model of care of patients with amphetamine use problems. The implementation of the model of care will be rigorously evaluated by Justice Health.

Inquest into the death of 'KT' (2019) Published 23 March 2023

Recommendation

1. That consideration be given to a procedure whereby, if an inmate is classified for normal cell placement and has recently experienced a traumatic event in their life, including the death of a family member, Corrective Services NSW consider the appropriateness of their cell placement, and take steps to:

a) ask the inmate whether they have a preference to be placed with a cellmate (noting that a range of other factors will also influence the ultimate decision as to cellmate placement), and

b) where the inmate is alone, consider whether it is necessary to make observations or otherwise check in on the inmate at reasonable appropriate intervals.

2. That consideration be given to a procedure whereby the Serious Incident Report author reporting on a death in custody contact the police officer in charge of the investigation, to request updating information as to cause of death, prior to signing off on the Serious Incident Report.

Agency/Organisation

Corrective Services NSW

Response Recorded as at 19 April 2024

Nil

Recommendation

3. That consideration be given to providing a copy of the Court's findings in this inquest to the team working on the Pathology Review Project, with a view to informing that Project's consideration of how to regularise the ordering and signing off of clozapine serum level tests.

Agency/Organisation

Justice Health and Forensic Mental Health Network

Response Recorded as at 19 April 2024

By undated letter, Ryan Park MP, Minister for Health, provided the following responses:

Recommendation

3. The A/Director, Clinical and Corporate Governance, Justice Health, discussed KT's coronial findings with the project clinical lead, and provided a copy of the coronial findings report to be shared with the Pathology Review Project team.

   The project clinical lead acknowledged receipt of the coronial findings. Further, the project clinical lead also confirmed two improvements in progress for pathology order sets and pathology reports.

Inquest into the death of Roy Joseph Roberts (2019) Published 3 February 2023

Recommendation

1. I recommend that, in consultation with Corrective Services New South Wales, appropriate steps be taken to ensure that adequate education and guidance is provided to Justice Health clinicians so that they may inform inmate patients of:

    i. the confidentiality requirements that attach to provision of any health information by an inmate to a clinician; and

    ii. the ability to request a consultation with a clinician in the absence of a Corrective Services New South Wales officer, subject to any safety and security considerations that may attach to such a request.

2. I recommend that consideration be given to providing ongoing education and training to all nursing and medical clinicians regarding the clinical features and identification of primary epilepsy.

3. I recommend that a review be conducted to ensure that Aboriginal Health Worker positions in New South Wales correctional centres are sufficiently staffed to provide inmate patients with access to culturally appropriate healthcare.

Agency/Organisation

Justice Health and Forensic Mental Health Network

Response Recorded as at 19 April 2024

By undated letter, Ryan Park MP, Minister for Health, provided the following responses:

Recommendation

Recommendation 1

Resources are available to support patients' understanding of their healthcare rights and Justice Health clinicians are provided with guidance in relation to these resources.

Justice Health note that clinical consultations without a Corrective Services Officer present occur in the correctional setting, at the request of health staff and/or patients. Justice Health clinicians work with Corrective Services Officers to identify the most appropriate and safest approach. Justice Health advise that when asked, Corrective Services Officers often agree to requests to wait outside the consultation space during a healthcare discussion.

Justice Health will amend Policy 4.030, *Requesting and Disclosing Health Information* and Guideline 9.036, *Guidelines on use and disclosure of health information* to include guidance for clinicians to strengthen clinical communication and advocacy for patients in their care. Justice Health will also include this in health reception training and orientation sessions. Internal communications will be sent to clinical staff notifying them of the amended policy and guideline.

Recommendation 2

Justice Health Clinical Nurse Educators will use best practice resources to facilitate refresher education over the next 4 months to clinicians on the clinical features and identification of primary epilepsy. Additionally, epilepsy training and education material has been sourced in collaboration with the Department of Neurology and Prince of Wales Hospital. The Justice Health general practitioner education day scheduled in September 2023 and Justice Health Grand Rounds, which is open to all clinical staff, will include epilepsy education. The recorded education component will be made available to all staff via targeted in-service, and on the Justice Health intranet.

Recommendation 3

Justice Health continue to promote and develop their Aboriginal workforce. Justice Health acknowledge a long-standing challenge in relation to First Nations health care worker roles and prioritise recruitment and retention of First Nations workforce in the Justice Health Strategic Plan and the new Workforce Enabling Plan. A Justice Health Director of Aboriginal Health position has been created an will be instrumental in informing the strategic direction including Closing the Gap initiatives, strengthening culturally appropriate services and creating a sustainable Aboriginal workforce. Justice Health has two First Nations Board members.

Justice Health has initiated discussions with TAFE NSW regarding pathways for students completing the Certificate IV in Aboriginal & Torres Strait Islander Primary Health Care Practice into full time employment with Justice Health – Aboriginal Health. The Justice Health Aboriginal Chronic Care Program is aimed at the detection and management of chronic and complex health conditions in Aboriginal and Torres Strait Islander people within the custodial environment. The program workforce includes 7 full time Aboriginal Health Workers, with recruitment efforts to fill an additional 7 positions, with support and guidance of the Director of Aboriginal Health and Director of People and Culture.

Inquest into the death of Matthew Grieve (2019) Published 15 August 2023

Recommendation

1. In its ongoing review into cell placement CSNSW consider the implementation of audit processes for Health Problem Notification Forms and further education of its employees so as to ensure that HPNFs that are being relied upon are appropriately completed and current.

2b. CSNSW, as part of its cell placement review, consider appropriate steps to take in relation to cell placement, when provided with a new cell placement recommendation from Justice Health (in a new HPNF) when an inmate stops taking prescribed medication.

Agency/Organisation

Corrective Services NSW

Response Recorded as at 19 April 2024

Nil

Recommendation

2a. That the Justice Health Forensic and Mental Health Network consider updating its policy/procedure to require review of a patient's HPNF specifically as it relates to recommendations which may guide CSNSW cell placement decisions, when the patient stops taking prescribed mental health medication for a clinically significant period.

3. The Justice Health and Forensic Mental Health Network consider the implementation of audit processes for HPNFs so as to ensure that they are appropriately completed and current.

Agency/Organisation

Justice Health and Forensic Mental Health Network

Response Recorded as at 19 April 2024

By undated letter, Ryan Park MP, Minister for Health, provided the following responses:

Recommendation

Recommendation 2a

JHNSW notes that review and update of the patient's Health Problem Notification Form (HPNF) policy in relation to cell placement recommendations is essential as it provides guidance to CSNSW, and further enhances a culture of shared accountability and collaboration between JHNSW and CSNSW in delivering integrated care services.

HPNF/Cell Placement working party. The working party's program of work included cell placement decisions when a patient stops taking prescribed mental health medication for a clinically significant period. The working party developed an electronic HPNF (eHPNF) that outlines the patient's health problem and cell placement recommendations, with sign off by a JHNSW clinician and the receiving Custodial Officer.

The e-HPNF has been provided to the JHNSW electronic Health system vendor who will finalise the e-form build before progressing to user testing in early 2024. The JHNSW and CSNSW Online Training Module, and Policy 1.231 *Health Problem Notification Form* and 6.051 *Psychotropic Medication Prescribing Guidelines* will be updated accordingly.

Recommendation 3

JHNSW notes that evaluation of the HPNF process supports accurate, safe, high quality, reliable health advice is provided to CSNSW.

JHNSW will develop an audit to ensure e-HPNFs are completed appropriately and reflect current clinical concerns, recommended health advice and appropriate receipt from CSNSW. The audit process will be included in JHNSW Clinical Audit Schedule and reported through JHNSW governance structures. Further, Policy 1.231 *Health Problem Notification Form* will be updated to highlight completion of e-HPNF audits to inform quality improvement activity.

Inquest into the death of John O'Donnell (2019) Published 27 September 2023

Recommendation

1. That the Justice Health and Forensic Mental Health Network give consideration to amending the template the Health Problem Notification Form to include a field expressly prompting assessment and advice relating to cell placement including as to any recommendations for group cell placement, lower or upper bunk placement and top or lower landing placement

Agency/Organisation

Justice Health and Forensic Mental Health Network

Response Recorded as at 19 April 2024

By undated letter, Ryan Park MP, Minister for Health, provided the following response:

Recommendation

The Health Problem Notification Form is undergoing re-design and development of an electronic form (e-Form) to replace the current Heath Problem Notification Form in the Patient Administration System. The design will incorporate a field to prompt assessment of cell placement and bed placement recommendations.

In June 2023, a Health Problem Notification Form Working Party was established by Justice Health NSW with Corrective Services NSW representation, to design, develop and implement the e-Form.

The e-Form is in development and expected to be available in the Justice Health NSW Electronic Medical Record by late 2024. E-Learning modules for staff training will be developed to complement the introduction of the Health Problem Notification e-Form.

As an interim solution, the current Health Problem Notification Form was revised to incorporate a field prompting bed placement and cell placement recommendations.

Inquest into the death of Peter Gretton (2019) Published 1 August 2023

Recommendation

1. I recommend to the Managing Director, The GEO Group Australia Pty Ltd, that consideration be given to the following matters:

(a) amending the Pathology Services Policy (MP334) to provide that pathology requests are to be reviewed weekly by clinical staff to ensure that results are obtained in a timely manner, consistent with pathology service expected turnaround times, and that senior nursing clinicians are to be advised of any outstanding result of more than seven days so that the pathology request can be escalated;

(b) formulating a list of presenting symptoms or vital sign observations in a patient that will cause a nursing staff member at Junee Correctional Centre to automatically request review of the patient by a medical officer, whether during hours or after-hours;

(c) providing further education and training to nursing staff at Junee Correctional Centre to ensure competency regarding use of the i-STAT machine, and for these skills to be audited;

(d) conducting an audit of patients presenting to the clinic at Junee Correctional Centre to ensure that vital sign observations are being taken in accordance with the Recognition and Management of the Deteriorating Patient Policy; and

(e) ensuring that clinical staff are appropriately trained regarding how care for a patient may be escalated if one or more of the patient's vital signs are documented to be in the Yellow Zone.

Agency/Organisation

GEO Group Australia Pty Ltd

Response Recorded as at 19 April 2024

Nil

Recommendation
2. I recommend, pursuant to section 151A(2) of the Health Practitioner Regulation National Law (NSW), that a transcript of the evidence of Registered Nurse Loice Magazini given during the Inquest into the death of Peter Gretton be forwarded to the Executive Officer of the Nursing and Midwifery Council New South Wales.
Agency/Organisation
Nursing and Midwifery Council New South Wales
Response Recorded as at 19 April 2024
Nil

Inquest into the death of Reuben Button (2020) Published 21 July 2023

Recommendation
1. That GEO Group prioritises improvement of the staffing ratios of doctors, Aboriginal health workers and nurses to inmates at Junee Correctional Centre to reduce waitlists and to provide culturally appropriate care for the increasing numbers of inmates at the centre
Agency/Organisation
GEO Group Australia Pty Ltd
Response Recorded as at 19 April 2024
Nil
Recommendation
2. That, consistent with the recommendation in the Inquest into the death of Kevin Francis Bugmy, JHFMHN should continue its work advocating for a trial for access to Medicare for Aboriginal inmates. In this context, JHFMHN should consider liaising with its equivalent or counterpart bodies in other States to coordinate and advocate for a trial process involving Medicare being made available by the Commonwealth to Aboriginal inmates.
Agency/Organisation
Justice Health and Forensic Mental Health Network
Response Recorded as at 19 April 2024
By undated letter, Ryan Park MP, Minister for Health, provided the following response:

Recommendation

Recommendation 2

In August 2022, the Executive Medical Director, Justice Health NSW, submitted a briefing note to the Board and Sub-Committees detailing the benefits of access to Medicare for people in custody. The Board supported the recommendations within the briefing note, being:

- That the recommendations from The Medicare Benefits Schedule Review Taskforce Report from the General Practice and Primary Care Clinical Committee: Phase 2 August 2018 in relation to prisoner access to Health Assessments be adopted.
- That a Ministerial exemption be granted for the use of Case Conferencing Item Numbers for people in prison.
- That Aboriginal people in custody are granted access to Medicare Item Numbers for Health Assessments for Aboriginal and Torres Strait Islander People and follow up Allied Health Services for people of Aboriginal or Torres Strait Islander descent.

The brief and supporting documents from Royal Australian College of General-Practitioners and Australian Medical Association were sent to the NSW Minister for Health, and the Federal Minister for Health and Aging, as implementation will require changes in legislation or ministerial exemption.

Further, approximately 9,000 item numbers have been retrieved from Medicare for patients in NSW custody and had been uploaded into the Justice Health NSW Patient Administration System, including for Aboriginal and Torres Strait Islander patients.

In terms of existing health services and interim improvements for Aboriginal health while in custody, Justice Health NSW Aboriginal Chronic Care Team focusses on implementing the elements of the 715-health check, which contain checks on heart health, vision, hearing, movement and mental health (including family health) in their annual health check.

The benefit of introducing Medicare Item Numbers for Aboriginal people in custody will result in funded in-reach services in partnership with Aboriginal Medical Services, more funding for Justice Health NSW primary care services and better continuity of services with health providers upon return to their communities.

Justice Health NSW actively engages stakeholders regarding the advocacy and progression of Medicare for Aboriginal patients. Firstly, Professor Tony Butler, University of NSW, is leading a group funded by the Ian Potter Foundation, for a trial of 715 assessments, involving inclusion of WA and SA. Secondly, the Royal Australian College of General Practitioners Specific Interest Group in Custodial Health discussed Medicare for people in custody on 13 November 2023, with participants from NSW, Victoria, ACT, Tasmania, WA, and SA. Thirdly, there was a Medicare round table led by the Australian Medical Association and Senator Thorpe on this matter recently in Canberra and Minister Butler had discussions with the Royal Australian College of General Practitioners Special Interest Group Chair Tom Turnbull from SA. Lastly, JHNSW Chief Digital Health Information Officer and Director Medical Services are implementing a trigger to Medicare that a 715 assessment has been completed in custody and will allow the follow-on items for when people are released.

Inquest into the death of 'SH' (2020) Published 16 August 2023

Recommendation

1. I recommend that Corrective Services NSW and Justice Health NSW conduct inter-agency consultations and implement measures aimed at further improving the provision or accessibility of information to families and next of kin who are concerned about an inmate's mental health.

Agency/Organisation

Corrective Services NSW
Justice Health and Forensic Mental Health Network

Response Recorded as at 19 April 2024

By undated letter, Ryan Park MP, Minister for Health, provided the following response:

Recommendation 1

Justice Health NSW is committed to further strengthening a collaborative partnership with Corrective Services NSW to delivery Integrated Care Services and improve information to families and next of kin who are concerned about an inmate's mental health. Further, Justice Health NSW strives to ensure that carers and families have positive experiences and do not experience barriers in accessing inter-agency information.

A working group with representatives from both agencies is focused on implementing solutions to improve accessibility of information to families and next of kin. Solutions include improving both agencies' websites, improving JHNSW staff capability in engaging with families and carers, and developing a virtual hub of clinicians to receive family and carer queries. In addition, the working group will ensure the Justice Health NSW Mental Health Helpline number is prominent on both agencies' websites and is available to patients in-cell via the use of tablets.

Inquest into the death of 'CJ' (2021) Published 6 June 2023

Recommendation

1. I recommend that the Justice Health and Forensic Mental Health Network ("Justice Health") make it clear on its public-facing web page, that the Justice Health Mental Health Hotline does not operate in respect of inmates held at Parklea Correctional Centre and that the contact details regarding the mental health of inmates at Parklea Correctional Centre should be provided.

Agency/Organisation

Justice Health and Forensic Mental Health Network

Response Recorded as at 19 April 2024

Nil

Recommendation
2. I recommend that Management & Training Corporation Pty Limited ("MTC") implement changes to its website to make clear that members of the public who have concerns about the mental health of an inmate at Parklea Correctional Centre should contact MTC rather than Corrective Services NSW or the Justice Health and Forensic Mental Health Network. They should provide a direct link to the appropriate number, and it should all be on the front page of its public-facing website.
Agency/Organisation
Management & Training Corporation Pty Limited
Response Recorded as at 19 April 2024
Nil

Inquest into the death of Simon Miles (2021) Published 8 August 2023

Recommendation
1. Consider revising relevant Compulsory Drug Treatment Program (CDTP) policy (following consultation with relevant stakeholders) to provide guidance to staff on the following matters: a) describe how the CDTP, including its therapeutic programs, can be delivered to First Nations participants in a culturally competent and culturally safe manner, b) identify culturally appropriate services that are available for First Nations participants in the community, c) describe the process for assessing the suitability and practicability of a First Nations participant residing on country in a regional area, during Stages 2 or 3 of the CDTP.
Agency/Organisation
Corrective Services NSW
Response Recorded as at 19 April 2024
Nil
Recommendation
2. Consider revising relevant Compulsory Drug Treatment Program (CDTP) policy (following consultation with relevant stakeholders), to provide guidance to staff as to 28 Findings in the Inquest into the death of Simon Miles how the CDTP can be delivered to First Nations participants in a culturally competent and culturally safe manner.

Agency/Organisation

Justice Health and Forensic Mental Health Network

Response Recorded as at 19 April 2024

By undated letter, Ryan Park MP, Minister for Health, provided the following response:

Recommendation 2

Justice Health NSW advises an update of the CDTP Operations Manual is underway to include provisions for providing culturally safe care to First Nations participants. The final draft document is anticipated by December 2023, and will require endorsement by relevant stakeholders, including the Justice Health NSW Director, Aboriginal Health.

Furthermore, an Aboriginal Health Worker visits the CDTP weekly to provide culturally appropriate care to First Nations participants. This involves capacity building across the team, guidance to staff for cultural safety, review of all First Nations patients and support to patients.

Recommendation 3

3. Consider revising relevant CDTP policy (following consultation with relevant stakeholders) to:

a) provide guidance on the circumstances in which a participant can be required to undertake Opioid Substitution Therapy, as a condition of progressing to Stage 2 or 3 of the CDTP (including where a participant is deemed to be at high risk of relapse), and

b) describe how a determination about that issue should be documented.

Agency/Organisation

Corrective Services NSW
Justice Health and Forensic Mental Health Network

Response Recorded as at 19 April 2024

By undated letter, Ryan Park MP, Minister for Health, provided the following responses:

Recommendation 3

Justice Health NSW notes this joint recommendation is not supported by either agency as enforced opioid therapy to advance through the CDTP is inconsistent with the voluntary nature of the program, whereby patients are referred by their legal team to participate in the CDTP.

Justice Health NSW advises a range of actions are in place to meet the intent of the recommendation and to support CDTP participants deemed to be at high risk of relapse. Key actions are shared decision making embedded into the CDTP and therapeutic education at Stage 1 and 2 of the CDTP to improve patient awareness of triggers, risk factors, management strategies. Furthermore, patients are encouraged to engage in appropriate treatment according to their clinical needs, including Opioid Substitution Therapy where indicated, and patients are educated about managing an overdose with Naloxone and provided with Naloxone.

Inquest into the death of 'RRC' (2021) Published 6 July 2023

Recommendation
1. That Corrective Services NSW review the process of discharge from a RIT; with a view to considering whether the current process is effective in reducing the risk of an inmate committing a further act of self-harm after he or she has been discharged from a RIT; 2. That, in the course of conducting its review referred to in recommendation 1, Corrective Services have regard to the RIT model in Western Australia; 3. That, in the course of conducting its review referred to in recommendation 1, Corrective Services New South Wales consider notifying nominated carers of a RIT placement or suicide attempt 4. That Corrective Services NSW consider whether alternative models to the RIT process could be utilised to reduce the risk of an inmate committing a further act of self-harm after he or she has been discharged from a RIT 5. That, in the course of conducting its consideration referred to in recommendation 4, Corrective Services have regard to the HOPE Inside model in Victoria 6. That, in the course of conducting the review referred to in recommendation 1 and giving the consideration referred to in recommendation 4, Corrective Services NSW consider the importance of: i. Providing for continuity of care; and ii. Providing for a support person to be nominated 7. That Corrective Services, in conducting the review referred to in recommendation 1 and giving the consideration referred to in recommendation 4, consult the Aboriginal Medical Research Council for advice.
Agency/Organisation
Corrective Services NSW
Response Recorded as at 19 April 2024
Nil

Inquest into the death of 'DP' (2021) Published 16 November 2023

Recommendation
1. St Vincent's Correctional Health formalise a policy acquiring CPAP machines for inmates who require them in custody, including the source and funding of those machines 2. St Vincent's Correctional Health consider enhancing the system of patient self-referral at Parklea Correctional Centre, to include access to appointments via telephone.
Agency/Organisation
St Vincent's Corrective Health
Response Recorded as at 19 April 2024
Nil
Recommendation
3. The Commissioner Corrective Services NSW should continue to seek additional funding for the program of cell refurbishment, to progress the removal of obvious ligature points from cells in correctional centres as a matter of urgency.
Agency/Organisation
Corrective Services NSW
Response Recorded as at 19 April 2024
Nil

Inquest into the death of Jacob Carr (2019) Published 30 November 2023

Recommendation
1. Consideration be given to amending the Critical Incident Guidelines to provide instruction that where a Duty Officer is presented with immediate resourcing constraints that would prevent the separation of involved officers in strict compliance with the terms of the Critical Incident Guidelines, the Duty Officer should consider what alternative means may be available to meet the intent of the guidelines to ensure the integrity of the involved officers subsequent evidence, for example by ensuring any body worn cameras worn by the officers or relevant in-car-video are kept operational and recording until they are able to be properly separated in accordance with the Guidelines.

Agency/Organisation
NSW Police Force
Response Recorded as at 19 April 2024
By letter dated 2 April 2024, Karen Webb APM, Commissioner of Police, provided the following response:
Recommendation 1
In response to the Deputy State Coroner's recommendation, I can advise that the NSW Police Force (NSWPF) supports the recommendation for additional instructions to be included in the Duty Officer Checklist and training for inspectors on duty to guide decision making. These changes which will be considered as part of a NSWPF's review of the Critical Incident Guidelines. The NSWPF also recognises the need to satisfy the Critical Incident Guidelines requirements in relation to 'officer welfare' and 'separation of officers'.
Recommendation 2
2. Consideration be given to improving Incident Reporting concerning any equipment failures to ensure they are communicated to a specified person within each directorate using the particular equipment who has responsibility for the monitoring of the continued efficacy of the directorate's equipment.
Agency/Organisation
NSW Ambulance
Response Recorded as at 19 April 2024
Nil

Inquest into the death of Gordon Copeland (2021) Published 18 April 2023

Recommendation

1. That the NSW Police Force review their training in relation to the history of First Nations Peoples to ensure that it is as comprehensive as possible in relation to the history of colonisation and the ongoing impact of colonisation on First Nations peoples today. Where possible, Aboriginal Liaison officers should be engaged in delivering ongoing training for Police.

2. That the NSW Police Force consider providing officers with training on trauma-informed communication with families, particularly First Nations families, when they are concerned about a missing person.

3. That the NSW Police Force review their training, for both recruits and current employees, in relation to critical decision-making training, to improve critical thinking in situations such as the preliminary search along the river.

4. That the New England Police District, encompassing Moree Police, conduct a review of the available rescue resources, taking into account their unique environment, including the river systems, to determine what further rescue equipment should be kept at stations and in vehicles.

5. That the New England Police District, encompassing Moree Police, conduct a review of the available training courses, taking into account their unique environment, including the river systems, to determine whether further courses should be offered to police.

6. That the NSW Police Force review their formal debriefing to determine if it is adequate to provide NSW Police with the necessary advice and support after experiencing a trauma like Gordon's death, particularly to determine what can be learnt and how officers can support each other.

Agency/Organisation

NSW Police Force

Response Recorded as at 19 April 2024

By letter dated 18 November 2023, Karen Webb APM, Commissioner of Police, provided the following response:

Recommendation 1

The NSWPF offers training specific to working with and engaging with the First Nations communities. These training packages are available to all staff throughout the NSWPF with additional packages offered to staff to enhance their skills and to practically apply their knowledge of First Nations culture in the workplace and community.

Specific training packages are also delivered to Commands and regular localised training sessions conducted within Police Area Commands and Police Districts. These are led by the Aboriginal Engagement Officer and Education Development Officer in conjunction with the Aboriginal Community Liaison Officer and the First Nations communities.

Aspects of trauma informed communication is also contained in the 'Working with Aboriginal Communities' workshop which is under review to include updates and enhancements regarding:

- Cultural considerations when working within Aboriginal communities regarding missing persons;
- Trauma informed care and communication; and
- The history of First Nations Peoples, including colonisation and intergenerational trauma.

Recommendation 2

Refer also recommendation 1.

At the next 2024 Missing Persons Conference, an invitation to speak has been extended to Mr Copelands' family (or representative), the Aboriginal Coronial Information and Support Program representative, Coronial Jurisdiction and/or the Coronial Support Officer, Aboriginal Legal Service.

The Missing Persons Registry is working with the Police Academy to provide video messages from subject matter experts and additional training to Detectives, first responders and Academy students.

Recommendation 3

Students at the Police Academy receive training that currently addresses risk assessment and critical decision making across the Decision making & problem solving module.

The NSWPF is also developing updated training on the Missing Persons SOPs that will include critical decision-making training.

Recommendation 4

The NEPD has two marine vessels positioned at Inverell and Tingha, with both vessels utilised during the search for Gordon Copeland.

To supplement these resources, Marine Area Command has allocated a trailer boat to Moree/Muingindi. This vessel will be utilised in small creeks, rivers and water reservoirs within the Moree Sector of the NEPD.

In addition, the Coroner's findings and recommendations will be raised at the next Region Emergency Management Committee (REMC) meeting for New England.

Recommendation 5

A review has been completed and a number of NEPD Police have undertaken the NSWPF Inland – Regional Small Boat Course.

This allows them to operate Police vessels to better support person searches and compliment combat agencies during periods of flooding.

Recommendation 6

Policies relating to formal debriefing within the Critical Incident Guidelines have been reviewed and are considered appropriate.

In addition, NSWPF personnel involved in Potentially Traumatic Events (PTEs) are provided with same day psychological first aid through our state-wide external providers.

The psychological first aid is provided through the Incident Support process, which comprises face to face support with an experienced clinician.

NSWPF personnel involved in a PTE are provided with ongoing support. Supervisors are also informed of any concerns so they can better manage their staff post incident. Additional support services are available, which include:

- EAP Incident Support and general counselling;
- General support from Peer Support Officers; and
- General support from Police Chaplains.

NSWPF is presently preparing a PTE Policy and Policy Statement, which provides a service-wide approach to prevention and management of psychological risks to employee's health, following exposure to, or involvement in a PTE.

A central component of this policy is "psychological first aid" to assist a person who is distressed following their exposure to a PTE.

A training module is being made in respect of psychological first aid, which is intended to form part of mandatory online learning.

Inquest into the death of Stanley Russell (2021) Published 14 April 2023

Recommendation

1. Consideration be given by the NSWPF to updating the wording of the BWV Standard Operating Procedures Version 2.4 to make clear to officers of the NSWPF:

(i) when they are required to turn their BWV on to recording (as compared to turning on to standby mode);

(ii) the scope of their discretion not to record on BWV when their activities otherwise fall within the scope of "When to Use BWV" identified on page 7 of the BWV Standard Operating Procedures."

2. Consideration be given by the NSW Police Force to ensuring that that in Blacktown (and other communities with high populations of First Nations people):

(i) there is an Aboriginal Community Liaison Officer (ACLO) engaged at the relevant Police Area Command (PAC) or Police District (PD);

(ii) that the police within the relevant PAC or PD be required to complete a training module on Aboriginal cultural competency; and

(iii) that any such cultural competency training includes specific training on the role of an ACLO and the ways in which an ACLO can assist an officer undertaking general duties in respect of First Nations people.

3. Consideration should be given by the NSW Police Force to: (i) identifying appropriate ways for ACLOs to be involved prior to the execution of arrest warrants on First Nations people; and (ii) specifying the ways identified in accordance with recommendation 3(i) in the role description of ACLOs, the training given to ACLOs, and training given to other officers in the NSW Police Force as to the role of ACLOs.

4. Consideration be given to introducing a policy or standard operating procedure requiring that:

(i) officers who suspect that a person may be suffering from an intellectual disability make a record of that in COPS against the individual's COPS profile.

(ii) before seeking to execute a bench warrant by entering the home of a person identified on the COPS database, or otherwise known to police officers, as possibly suffering from an intellectual disability or mental health issues, officers consider:

a. available warnings and available information to ascertain the person's mental health issues, intellectual disability, and specific vulnerabilities.

b. available information suggesting a history of self-harm, increased risk of violence or the use of weapons.

(iii) the information set out in (i) and (ii) above be taken into account in deciding whether or not to execute a bench warrant by entering a person's home to attempt to locate them, and if it is decided to attempt to effect an arrest, in planning how best to undertake an operation to arrest the person to minimise the risk of harm to the person, the police and the public; and

(iv) other than in circumstances of urgency, the NSWPF consider alternatives to arrest as a means of executing a bench warrant where there is any indication that the person of interest has an intellectual disability, and that in such circumstances the NSWPF shall attempt to contact the person directly and indirectly, and to identify if there is a means of liaising with the individual, to encourage voluntary attendance at a police station by the person of interest and to elicit information relevant to the potential risk to the person, the public, or to police arising from any attempt to execute the warrant.

5. Consideration be given to the NSWPF working with the Justice Advocacy Service to introduce a procedure whereby if the Justice Advocacy Service (JAS), or other similar advocacy service on behalf of persons with an intellectual disability, has notified the NSWPF that they are involved in a case or as regards a person of interest, the NSWPF shall contact JAS, or that other service, before undertaking an operation to execute a bench warrant:

(i) to ascertain whether JAS, or the other service, can attempt to contact the person of interest to attempt to [Type here] pg. 5 persuade the person to attend a police station or court voluntarily; and

(ii) to seek information from JAS, or the other service, as to any vulnerability or disability that may be relevant to the execution of the warrant.

Agency/Organisation

NSW Police Force

Response Recorded as at 19 April 2024

By letter dated 8 February 2024, Karen Webb APM, Commissioner of Police, provided the following response:

Recommendation 1

Supported.

The updates to the BWV SOPs are being implemented in line with the recommendation.

All operational Police are trained in the use of the BWV which includes camera operation, recording vs standby mode. The updated BWV SOPs will contain a proposal to update as required.

Recommendation 2

Supported.

An ACLO position has been relocated to Blacktown PAC.

The NSWPF offers training packages on working and engaging with Aboriginal and Torres Strait Islander People and communities. These packages encompass many important cultural aspects, including the role of the ACLO within the NSWPF and how they assist Police in building and strengthening relationships in the community.

The training is available to all staff throughout the NSWPF and under the renewed Aboriginal Strategic Direction, it will be directed by the Commissioner of Police as mandatory. Additionally, local Aboriginal Cultural Awareness Training packages are available to PACs with high populations of Aboriginal people.

Recommendation 3

Partially supported.

The NSWPF ACLO program aims to foster positive partnerships and strengthen communication links between the NSWPF and the First Nations people, communities and community organisations.

It is not recommended to utilise ACLOs to communicate with an offender outside operational police being present as this potentially puts the ACLO in danger.

The liaison role that ACLOs perform with First Nations communities is based upon the development of mutual trust and respect. It is essential that ACLO's be regarded by their communities as being neutral in respect of the implementation of law enforcement. To directly involve ACLOs in the process for the execution of arrest warrants would jeopardise their standing and rapport with their communities and undermine their effectiveness in engaging with those communities.

It is therefore not considered appropriate to formally assign this task to ACLOs as it goes against the aims of the ACLO role. Police are encouraged to seek advice from ACLOs regarding community knowledge that could be of assistance in such situations.

Recommendation 4

Not supported.

The NSWPF adheres to established policies, including pre-arrest assessments, which are essential in ensuring the safety of both the community and officers.

Arrests, and particularly those arising from the issue of bench warrants, necessitate the careful evaluation of individuals and locations to mitigate potential risks to the community, victims and the offender. These procedures include options to prevent or reduce the risk of confrontation where achievable.

Police are trained as to how to best identify and de-escalate situations involving offenders with underlying symptoms of mental disorder or illness that may be causing behavioural disturbance. It may not always be possible to differentiate between a person under the influence of alcohol, illicit substance or substance induced psychosis as opposed to someone with mental illness or intellectual disability.

In these instances, officers can and do document on COPS their concerns regarding the mental state of the person and their behaviours, arising from their own interactions with the person and the person's history of mental health incidents where Police have been required to attend.

The NSWPF have current procedures in place for persons with outstanding court notices including warrants. PAC/PD Intelligence personnel are required to conduct checks and provide assistance by creating intelligence products including Persons of Interest profiles and intelligence slides to frontline Police. Recent Police holdings regarding the person named in the warrant will be considered by Police prior to arrest where it is practicable to do so.

Recommendation 5

Not supported.

The NSWPF already works closely with JAS and other relevant government and non-government stakeholders in ensuring persons with intellectual or physical disability are supported where appropriate. However, there are equally a number of inherent risks if the NSWPF were to use external agencies to contact persons of interest to surrender for the purposes of executing warrants and/or other arrest procedures.

Decisions whether or not to utilise external partners should be made on individual circumstances and cannot be adequately addressed by a blanket policy position. The multifaceted nature of law enforcement requires flexibility in decision making to best protect victims and the community. The NSWPF have current procedures in place to contact JAS when they engage a person with impaired cognitive ability that focus on supporting those persons in police custody and through the court process.

The NSWPF also works closely with JAS to continually improve service provisions and have recently met with DCJ to discuss the coronial recommendations.

Recommendation

6. That the NSW Police Commissioner and the Aboriginal Legal Service consider jointly developing a procedure for the execution of bench warrants on Aboriginal and Torres Strait Islander defendants which encourages defendants to hand themselves in to the police and/or to the court and which involves:

(i) the NSWPF, nominating a fixed period of time (to be determined as part of the policy and procedure) during which police will postpone execution of the warrant for the purpose of enabling the steps set out below to take place, with a view, if possible, to facilitating voluntary presentation by the person the subject of the warrant to a police station or court; and

(ii) mandatory notification by the NSWPF to the Aboriginal Legal Service within a fixed period of time of receiving the warrant:

a. of the fact that a warrant has been received; and

b. nominating a police officer as a contact for the warrant.

(iii) by the Aboriginal Legal Service, either directly or by referral to other services or persons, upon receipt of a notification by the NSWPF, seeking to communicate directly or indirectly with the person the subject of the warrant and seeking to advise about and support them in handing themselves into the police or a court, preferably by appointment;

(iv) by the NSWPF, additionally, using ACLOs engaged by the NSWPF to attempt to communicate directly or indirectly [Type here] pg. 6 with the person the subject of the warrant to seek to encourage and support them to hand themselves into the police or a court, preferably by appointment and providing information about appropriate legal and support services to advise and assist in that process.

(v) by the NSWPF, to establish clearly defined circumstances in which the notification requirement and the fixed period of time as set out in (i) above may be dispensed with; and

(vi) That any protocol that is developed be called the Stanley Protocol.

Agency/Organisation

Aboriginal Legal Service
NSW Police Force

Response Recorded as at 19 April 2024

By letter dated 8 February 2024, Karen Webb APM, Commissioner of Police, provided the following response:

Recommendation

Recommendation 6

Not supported.

The NSWPF works collaboratively with the Aboriginal Legal Service (ALS), holding membership on the NSWPF Police Aboriginal Strategic Advisory Council (PASAC). The key objectives of PASAC are to:

- Facilitate open communication between NSWPF, Aboriginal communities and stakeholders relating to culturally responsive policing;
- Monitor the impact of policing practices and strategies that affect Aboriginal people and their communities and initiate appropriate remedial action when needed;
- Connect activities to the NSWPF Strategic intent, Premier's Priorities – Closing the Gap targets and general better outcomes for Aboriginal people and their communities;
- Lead partnerships between NSWPF, Aboriginal organisations and/or communities and key stakeholders to address crime prevention and over representation in the criminal justice system; and
- Progress and promote positive policing practices at all levels.

There are issues and risks with engaging external agencies to directly communicate with offenders, which poses potential dangers to persons from those agencies and may inhibit the timely arrest of persons, which also increases the risks to the community.

The existence of the Custody Notification Scheme can be noted, whereby if an Aboriginal offender enters custody, notification to the ALS is mandated.

The Victim and Custody Support program is another significant strategy whereby support is offered to Aboriginal Persons of Interest, offenders and victims of crime.

Inquest into the death of Brandon Clark (2022) Published 16 June 2023

Recommendation

1. That the NSW Commissioner of Police ("the Commissioner") conduct a review of available water rescue equipment at Manning Great Lakes Police District and give consideration as to whether any further equipment should be made available to Police.

2. That the Commissioner give consideration as to whether any policy or training should be developed to guide Police in relation to engaging in water rescues.

Agency/Organisation

NSW Police Force

Response Recorded as at 19 April 2024

By letter dated 22 November 2023, Karen Webb APM, Commissioner of Police, provided the following response:

Recommendation

Recommendation 1

A review of available equipment at the Manning/Great Lakes Police District has resulted in four additional Angel Ring Lifebuoys being distributed to sector stations.

Recommendation 2

The NSWPF has a number of courses in the learning management system that relate to police and flood safety including an Emergency Exercise Toolkit, Flood Safety Microlearn Video and the Six Minute Intensive Training on Police Safety During Flood Operations.

As an outcome of the 2022 NSW Government Flood Inquiry, the State Rescue Board established a Flood Rescue Audit Implementation Working Group which is reviewing flood rescue training levels concurrently through the Flood Rescue Training Working Group and the development of the NSW State Emergency Service Flood Rescue Awareness Training Package. I understand that following endorsement by the State Rescue Board, this Package will be made available to all agencies involved in rescue operations (including the NSWPF) and will incorporate teachings about the risks associated with water rescues.

Inquest into the death of Andrew Stark (2022) Published 24 November 2023

Recommendation

1. That consideration be given to making amendments to the NSWPF Safe Driving Policy (2019 v9.2) [SDP] in the following (or similar) terms:

a) Paragraph 7-2-1 of the SDP be amended to replace the words "community and police" with the words "community, police and the offender".

b) A new paragraph be inserted in the SDP between paragraphs 7-2-1 and 7-2-2 as follows:

a. In weighing the need to immediately apprehend the offender, matters to be taken into account include:

- The seriousness of the offence for which the police were initially attempting to stop the vehicle, and in particular;
  - the need to engage in the pursuit of a vehicle in relation to a road traffic offence without evidence that another offence, being of a serious nature, is likely to have been committed
  - in relation to offences other than road traffic matters, whether the police are satisfied that a serious risk to the health and safety of a person exists
- the means that may be available to police to apprehend the offender at a later time (for example, the ability to use of a "form of demand" in relation to the registered owner, or where the identity of the driver is known).

c) Current paragraph 7-2-2 of the SDP be amended in the following terms:

  - insertion of the words "In weighing the degree of risk to the community, police and the offender" at the commencement of the paragraph; and
  - insertion of the additional factor as mater number (iv) under the second dot point:
  - uncertainties concerning the offending driver's age, abilities, state of mind, and the roadworthiness and number of occupants of their vehicle

d) Point (d) of paragraph 7-5-1 be amended so that the words "reason for pursuit" are replaced by the words "the offence for which police attempted to stop the vehicle, and any other reason for the pursuit"

2. That training provided by the NSWPF to officers who may become involved in the conduct of pursuits be updated and revised in the following respects:

a) to emphasise that in providing a "reason for pursuit" to VKG operators, what is required is a description of the offence for which the relevant vehicle stop was being attempted;

b) to reinforce the fundamental importance of officers turning their minds to the question of the need to immediately apprehend an offender as part of the weighing exercise under the SDP before initiating or continuing a pursuit, and that in doing so:

i) less serious offences (including most traffic offences) will in general carry a lower necessity to immediately apprehend; and

ii) that other means by which it may be possible to later apprehend the driver (including by utilising the 'form of demand') must be considered.

c) to provide education, based on statistics such as those in the 2013 report of the Australian Institute of Criminology, (Motor vehicle pursuit-related fatalities in Australia, 2000–11) concerning factors such as the extent to which drivers involved in pursuits are affected by drugs and alcohol, age, cultural background, and other characteristics that are frequently common to drivers involved in pursuit fatalities;

d) to discourage officers from making assumptions about the presumed "criminal intent" of drivers based on the mere fact of a failure to stop, and to appreciate the relevance of other factors such as age, mental state, cultural background, inability to pay fines and fear of loss of licence; and

e) to emphasise the need for officers to consider uncertainties concerning the offending driver's age, abilities, state of mind, and the roadworthiness and number of occupants of their vehicle when assessing the danger of initiating or continuing a pursuit.

Agency/Organisation

NSW Police Force

Response Recorded as at 19 April 2024

Nil

Recommendation 3

3.

a) That, with the co-operation of the Commissioner of the NSWPF, research be conducted and a report be produced by the Bureau of Crime Statistics and Research (BOCSAR), or another appropriate government agency, preferably one independent of the NSWPF:

b) in order to understand the reasons for the significant increase in the number of pursuits conducted by the NSWPF over the last decade;

c) with a view to proposing measures, including by reference to policies in other Australian jurisdictions, that might be taken to substantially reduce the number of pursuits undertaken by the NSWPF; and

d) that the relevant report be provided to the Minister of Police, the Attorney-General and be made publicly available.

Agency/Organisation

Attorney General, NSW
Minister for Police, NSW
NSW Police Force

Response Recorded as at 19 April 2024

Nil

Office of the NSW State Coroner
NSW Department of Communities and Justice