



Forensic Medicine &
Coroners Court Complex

Deaths in Custody/Police Operations Report

REPORT BY THE NEW SOUTH WALES
STATE CORONER

for the year

2024



Deaths in Custody/Police Operations Report

FOR THE YEAR

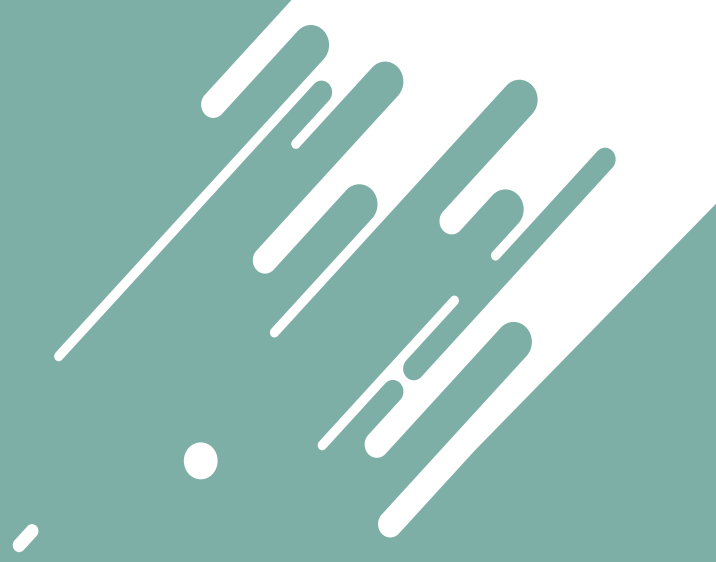
2024

REPORT BY THE NEW SOUTH WALES STATE CORONER

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
ISSN NO: 1323-6423




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 Coroners Court NSW 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 as a result 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://www.13yarn.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**



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>.



CONTENTS

Contents	VII
Acknowledgements	1
2024 Summary in brief	3
Statutory appointments	6
Introduction by the state coroner	8
The coronial process	10
About this report	14
Overview of deaths in custody and police operations, 2004-2024	15
Reported deaths in 2024	18
Inquests finalised in 2024	20

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

30 April 2025

Dear Attorney General,

Section 37(1) of the *Coroners Act 2009* ('the Act') requires that I provide to you annually, a summary of all deaths in custody and deaths 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 2024 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, or
- 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 2024 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://dcj.nsw.gov.au/legal-and-justice/laws-and-legislation/legal-assistance-and-applications/responses-to-coronial-recommendations.html>

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.

Yours faithfully,



Magistrate Teresa O'Sullivan
NSW State Coroner

ACKNOWLEDGEMENTS

Acknowledgement of Country

The Coroners Court NSW 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.



“Cultivating Healing” By Wodi Wodi Walbunja Artist Lauren Henry ©Yirra Miya 2023

This artwork tells part of our story, journey, and purpose of the Coroners Court. The artwork embodies the notion of supported healing for individuals, families, and communities through their loss. This artwork also highlights the importance of recognising that healing is not a linear process and that collaboratively the Coroners Court is a safe and respectful space.

This artwork represents the significance of the Coroners Court as a space integral to the healing journey for those who enter its doors. Supporting people through the loss of a loved one while creating a space where everyone can grieve in their own way, with cultural understanding and support.

At the centre of the artwork is a yarning circle, symbolising community, and the importance that community holds for the Coroners Court. This yarning circle represents a sense of belonging, kinship and unity which are held in high regard by the

court. This sense of community is reflective of the community-based approach taken by the court in walking alongside families in the midst of a dark and painful time in their lives.

Journey lines extend from this yarning circle to two gathering places which reflect a safe space for all community members to feel supported during their journey within the court process. These gathering places highlight the start of inner healing with the knowledge sticks within representing the sharing of knowledge to assist people on their healing journey with their grief, as shown by the journey lines extending off the canvas.

The yarning circle centred at the bottom is surrounded by people and knowledge sticks. This meeting place represents truth telling and is where we acknowledge the events of the past and empower people to be fearless in their pursuit of understanding and obtaining the knowledge behind the loss of a loved one. This space represents and reflects the understanding of trauma that families and communities go through and the importance of providing tailored, culturally safe support for people to start on their healing journey.

On either side of the central yarning circle are elements that represent the diverse paths of healing that the court supports with individuals, families, and communities. The journey lines make their way off the canvas to represent that healing is a non-linear process, unique to each individual. The knowledge sticks symbolise the sharing of resources and support provided by the court, while acknowledging the weight carried by the findings surrounding a loved one's passing.

Directly beneath the central yarning circle are three interconnected meeting places, symbolising how the past and present are connected in order to impact and influence the future. You cannot have one without the other. These connected meeting places reflect the court's ongoing process of listening, learning, and reflecting, emphasising that moving forward requires understanding of the past. The court strives to leave a legacy or hope, where the knowledge gained from the findings of a passed loved one can help prevent other families from feeling a similar loss and pain.

Above the central yarning circle are stars to represent the guidance provided by our Ancestors, that they are always with us, watching and leading us in the space and journey of navigating loss and grief. From our Ancestors, we draw strength to persevere and continue to learn from those around us in order to heal.

At the top of the artwork are connected watering holes to represent the sharing of knowledge but also the continuous efforts by the court to improve in providing culturally safe and appropriate ways of working with people. The court is committed to listening, reflecting, and growing, both within itself and in its broader impact in community. The kangaroo tracks signify progress and movement, reflecting the ongoing journey of uncovering the truth behind a person's passing.

The different Country Lines acknowledge the diverse lands across this nation, honour the fact that this land Always Was and Always Will Be Aboriginal Land.



2024 SUMMARY IN BRIEF

Deaths reported to the Coroner in 2024

- In the calendar year 2024, 48 deaths were reported to the Coroner as occurring in custody or as a result of a police operation.
 - This is an overall increase of 9 deaths from the number reported in 2023.
 - 30 deaths were reported as occurring in custody.
 - This is an increase of 14 deaths in custody from the number reported in 2023.
 - 18 deaths were reported as occurring as a result of a police operation.
 - This is a decrease of 5 deaths occurring as a result of a police operation from the number reported in 2023.

Overrepresentation of First Nations peoples

- 13 of the 48 deaths reported to the Coroner were First Nations peoples. This represents 27% 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).
- This is an overall increase of 10 First Nations deaths reported to the Coroner as having occurred in custody or as a result of a police operation from the number reported in 2023.
- This is the second highest number of First Nations deaths in custody or as a result of police operations reported to the coroner for the period 2003 to 2024.
- A review of the information currently available for these reported matters appears to show a growing number of intentional, self-inflicted deaths often involving hanging points, despite the recommendation to remove all hanging points in correctional centres having been made by the Royal Commission into Aboriginal Deaths in Custody 34 years ago and recommendations made by coroners in numerous inquests.



This element represents healing – this can be individual healing and collective healing journeys that require deep understanding about how their family member lived their life, and how their passing has impacted their family and those who knew them. This element highlights the importance of receiving culturally appropriate supports, acknowledging their loss, being heard, and showing compassion. The grieving process is an individual thing that must be respected and for some healing can be a lifelong journey.

Deaths in custody in 2024

- 30 deaths were reported to the Coroner as having occurred in custody. Of these, 8 deaths (27%) were of First Nations peoples.
- The majority of these deaths (27) occurred in Corrective Services custody:
 - 16 of those persons who died were serving a full-time sentence, and
 - 11 of those persons who died were being held on remand.
- Of the remaining 3 deaths, 1 death occurred in forensic mental health custody, 1 death occurred in other lawful detention, and 1 death occurred in police custody.
- In most cases reported to the Coroner in 2024, 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:
 - 15 deaths were reported as a result of natural causes*,
 - 8 deaths were reported as a result of intentional self-harm,
 - 5 deaths were reported as a result of other external causes, including accidental overdose, assault or accidents and
 - In 2 deaths, 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.*

- Of the 8 deaths of First Nations peoples in custody, all 8 (100%) were reported as having occurred due to an external cause, such as assault, intentional self-harm or accidental overdose.

- For the 22 other reported deaths in custody, only 7 (32%) were reported as having an external cause. The other 15 (68%) were reported to have been due to natural causes.

Deaths as a result of a police operation in 2024

- 18 deaths were reported to the Coroner as occurring as a result of a police operation. Of these, 5 (28%) involved the death of a First Nations person.
- The deaths were reported to have occurred in the following types of police operations:
 - 5 (28%) deaths occurred in the course of a police operation to contain or restrain the person,
 - 5 (28%) deaths occurred in connection with a police motor vehicle pursuit,
 - 3 (17%) deaths occurred in the course of an operation to engage a person,
 - 3 (17%) deaths occurred in connection to an operation to assist the person,
 - 1 (5%) death occurred in connection to an execution of a writ, or a warrant, or other service of process,
 - 1 (5%) death occurred in connection with an operation to apprehend a person.
- In most cases reported to the Coroner in 2024, 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:
 - 5 deaths were reported to have been as a result of a motor vehicle collision.
 - 5 deaths were reported to have been as a result of intentional self-harm.
 - 4 deaths were reported to have been as a result of police discharge of a firearm.
 - 1 death was reported to have been as a result of assault, and
 - 1 death was reported to have been as a result of an accident.

- All deaths except 2 (1 of which is under investigation, and 1 of which was reported as being of natural causes) appear to be due to external causes.

Inquests finalised in 2024

In 2024, the State Coroner and Deputy State Coroners delivered findings in 33 inquests involving the death of a person in custody or as a result of a police operation. Of the 33 inquests that were finalised, 22 involved a death in custody, and 11 as a result of a police operation.

Overrepresentation of First Nations peoples

- 6 of the finalised inquests involved a First Nations person. This represents 18% of all finalised inquests, despite First Nations peoples comprising only 3.4% of the NSW population (ABS Census, 2021).
- It is necessary to place these deaths in the wider social context. In NSW, First Nations peoples make up around 25% of the adult prison population compared to around 3% of the general population. It follows that First Nations peoples are also more likely to be detained or held in police cells/correctional services custody. Statistics collected by this Court highlight the fact that the majority of Aboriginal deaths in custody or detention are described as “natural” or medical causes rather than being caused accidentally, by self-harm or in suspicious circumstances. However, while these deaths may ultimately be recorded as “natural deaths”, it is clear that many occur in situations where prior medical treatment has been lacking or even at times inappropriate.

- In contrast, for deaths of First Nations peoples reported to the Coroner in 2024, all 8 (100%) were reported as having occurred due to an external cause, such as assault, intentional self-harm or accidental overdose.

Deaths in custody

- 22 of the inquests that were finalised involved the death of a person in custody.
 - 4 inquests (18%) involved the death of a First Nations person,
 - 21 inquests (96%) involved the death of a male person, and
 - 7 inquests (32%) involved the death of a person serving a full-time custodial sentence, 12 (55%) involved the death of a person being held on remand, and 2 (9%) involved a person held in police custody and 1 (4%) involved a person held in other lawful custody.
- Further information regarding the 8 deaths determined to have been as a result of intentional self-harm was collated from the inquest findings. From the information presented at inquest, all 8 people had a mental health diagnosis known to Corrective Services NSW, 6 of whom were receiving medication.
- An additional person was found to have died as a result of undetected treatable natural causes while involuntarily detained as a ‘mentally ill person’ within the general prison population, having waited 17 days for a bed in a mental health facility.



This element represents learning. The three connected meeting places represent how the past and present are connected in order to impact and influence the future. This element highlights the importance of honouring those who have passed and the creation of an ongoing legacy through systemic change and improvement. By listening, reflecting and growing we can focus on the future and make sure similar deaths are prevented.

Deaths as a result of police operations

- 11 of those inquests that were finalised involved the death of a person which occurred as a result of a police operation.
 - 4 inquests (36%) found that the death occurred due to the discharge of a firearm by police as a result of/in the course of a police operation,
 - 3 inquests (27%) found that the death was due to an accident,
 - 2 inquests (18%) found that the death was due to multiple external causes resulting in cardiac events occurring in the context of physical struggle with and/or restraint by police,
 - 1 inquest (9%) found that the death was due to an accidental overdose and
 - 1 inquest (9%) found the death was due to intentional self-harm by the person.
- These finalised inquests reveal the continuing growth in matters involving the intersection of policing and mental illness, and often concerning the death of a mentally ill person after a knife or bladed weapon was produced or used. In a number of previous inquest matters, Coroners have made recommendations aimed at improving mental health training and assistance for Police when they encounter a person experiencing a mental health crisis. This remains a live issue and one in urgent need of attention.

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 2023)

His Honour Magistrate Derek Lee (appointed 2016)

Her Honour Magistrate Elizabeth Ryan (appointed 2017)

His Honour Magistrate David O’Neil (appointed 2023)

Her Honour Magistrate Kasey Pearce (appointed 2024)



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.

INTRODUCTION BY THE STATE CORONER

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 a person, or to contain/detain a person
- An operation to engage a person, or an operation to assist a person
- A police motor vehicle pursuit or other pursuit
- Any operation in which police discharge a firearm
- Execution of a writ, or execution of a warrant, or other service of process
- A police siege
- An evacuation
- A traffic control or enforcement
- A roadblock
- 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 as a result of police operations until the Coroner, having considered all the evidence and submissions presented at the inquest, has made such a determination.

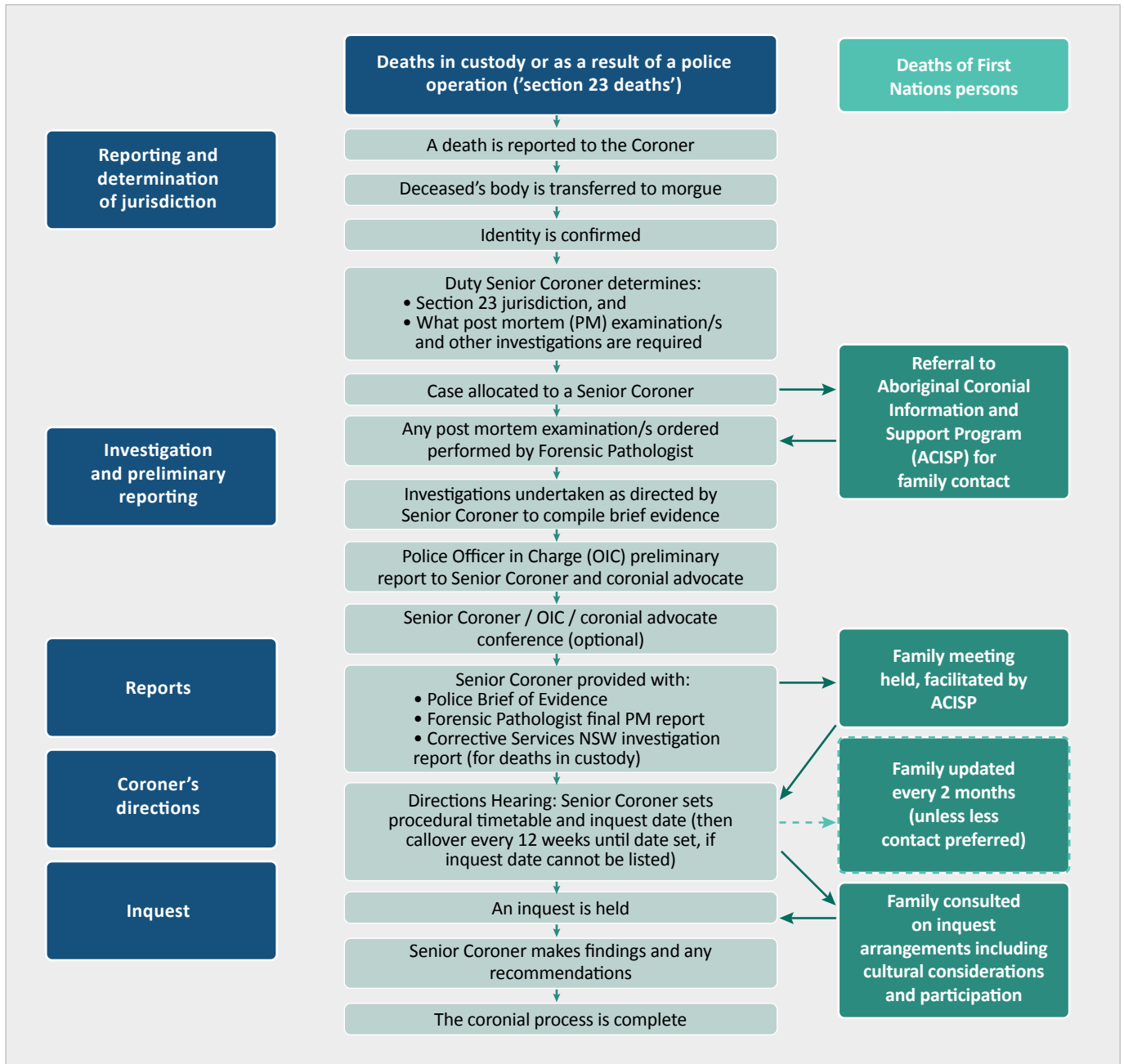
Conversely, a matter that was not initially reported as having occurred in custody or as a result of a police operation may be determined to be so after the Coroner has reviewed all the evidence.

For the purposes of this report, the following is used to classify types of police operations:

- Operation to apprehend- situations where police are attempting to arrest the deceased.
- Operation to contain/restrain – situations where police are responding to an incident report indicating the deceased may be acting violently towards others.
- Operation to engage – situations where police are responding to an incident report indicating the deceased may intend self-harm or is experiencing a mental health crisis.
- Operation to assist – situations (not covered above) where police are responding to a call for assistance, or on the scene of an incident, such as a welfare check.
- Police Motor Vehicle Pursuit – situations where police are or had been pursuing, or the person believes police to be pursuing, the deceased in a motor vehicle.
- Execution of a writ, warrant, or other service of process- situations where police are attempting to execute a writ, or a warrant, or other service of process.
- Police Siege – situations where police are attempting to negotiate a resolution to a siege.
- Roadblock – situations where police are utilising roadblock techniques for policing purposes.
- Traffic control/enforcement – situations where police are engaged in traffic control or enforcement, including random breath testing or speed detection.

THE CORONIAL PROCESS

The following diagram provides an overview of the coronial process when a death that occurs 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 State Coroner, with the approval of 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 2023, 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 to 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 member, 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.

A review of the timeframes set out in Coronial Practice Note 3 of 2021 is currently underway, to ensure that they are appropriate and serving the purpose of improving timeliness of coronial investigations in mandatory inquests.

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. The Objects in [section 3](#) of the *Coroners Act 2009*, enable the Coroner 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 and to make recommendations in relation to matters in connection with the inquest.

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 similar 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://dcj.nsw.gov.au/legal-and-justice/laws-and-legislation/legal-assistance-and-applications/responses-to-coronial-recommendations.html>

For recommendations and responses for coronial inquests between 2009 and 2022, these are hosted on the Responses to Coronial Recommendations Archive and published at:

<https://www.justice.nsw.gov.au/lsc/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 2024 and 31 December 2024, 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 2024 and 31 December 2024 (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 collecting Court data. These were then 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 postmortem 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, 2004-2024

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 as a result of 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 as a result of police operations.

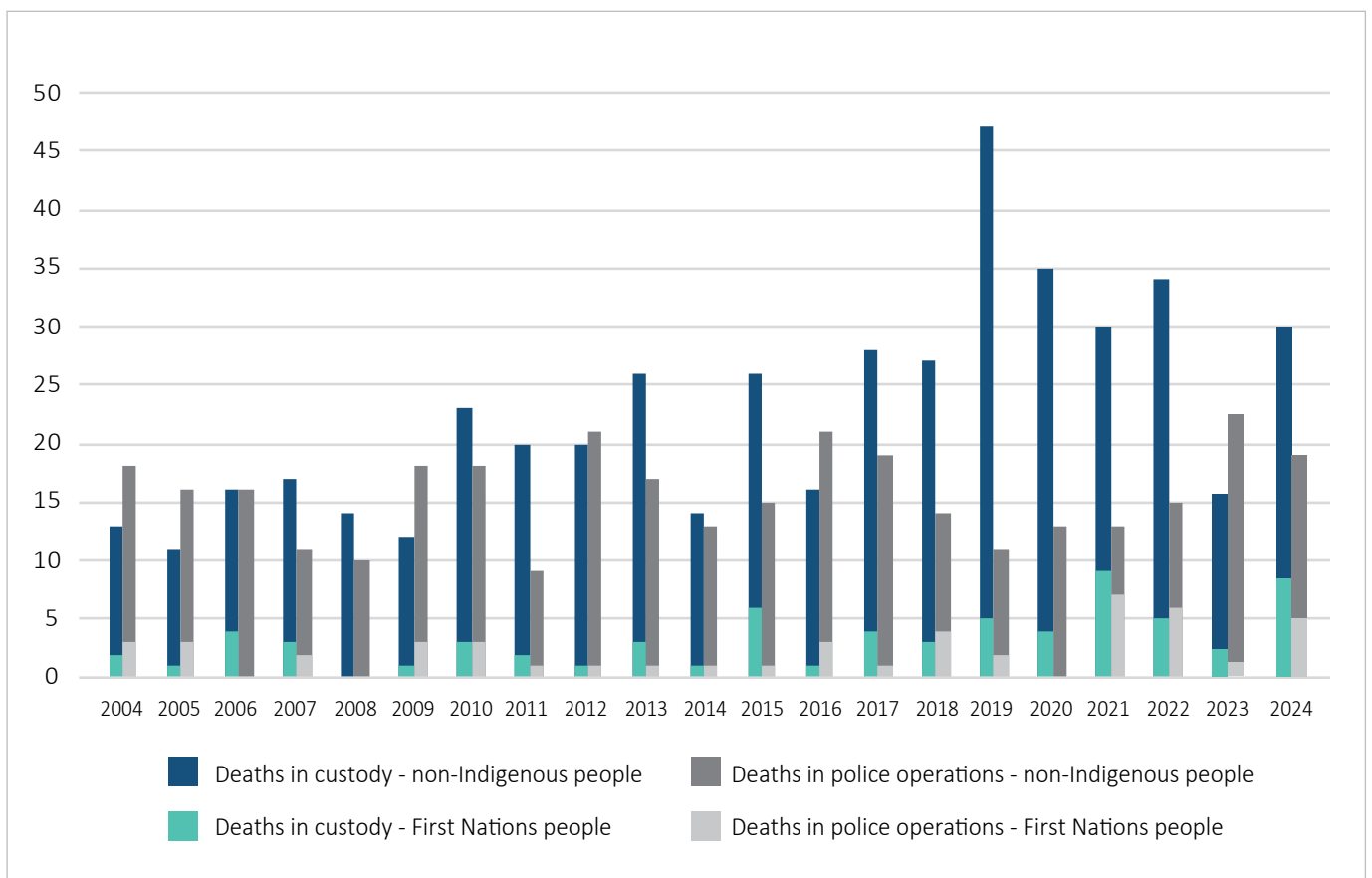


Figure 1: Deaths reported to the Coroner as occurring in custody and police operations in NSW, by First Nations status and year (2004-2024).

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	21	1	20
2009	18	3	15
2010	23	3	20
2011	20	2	18
2012	19	1	18
2013	27	5	22
2014	14	2	12
2015	28	6	22
2016	18	1	17
2017	30	6	24
2018	32	4	28
2019	47	5	42
2020	35	4	31
2021	30	9	21
2022	34	5	29
2023	16	2	14
2024	30	8	22
TOTAL	499	77	422

Figure 2: Table of deaths reported to the Coroner as occurring in custody in NSW, by First Nations status and year (2004-2024).



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
2024	18	5	13
TOTAL	329	48	281

Figure 3: Table of deaths reported to the Coroner as occurring in police operations in NSW, by First Nations status and year (2004-2024).

REPORTED DEATHS IN 2024

This section provides information about deaths reported to a Senior Coroner in 2024 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.

Deaths in custody

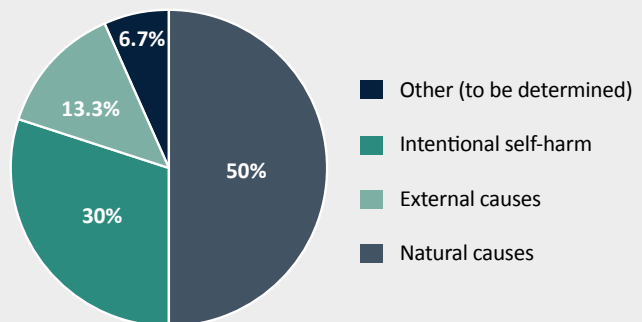
30 deaths reported to the Coroner in 2024
 ↑ 14 deaths from 2023



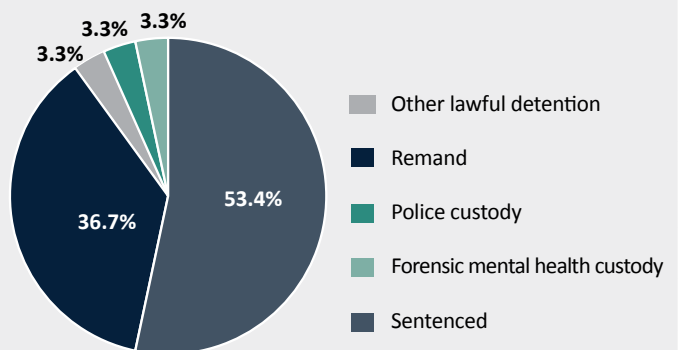
28 Male
2 Female

8 First Nations persons

Manner of death		
Intentional self-harm	9	30.0%
Natural causes	15	50.0%
External causes, including assault and accidental overdose	4	13.3%
Other (to be determined)	2	6.7%
TOTAL	30	100.0%



Custodial status		
Sentenced	16	53.4%
Remand	11	36.7%
Forensic mental health custody	1	3.3%
Other lawful detention	1	3.3%
Police custody	1	3.3%
TOTAL	30	100.0%





Deaths as a result of police operations

18 deaths reported to the Coroner in 2024
 ↓ 5 deaths from 2023



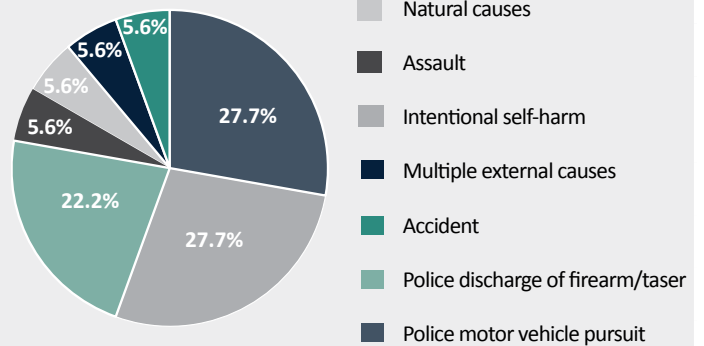
16
2

Male
Female

5

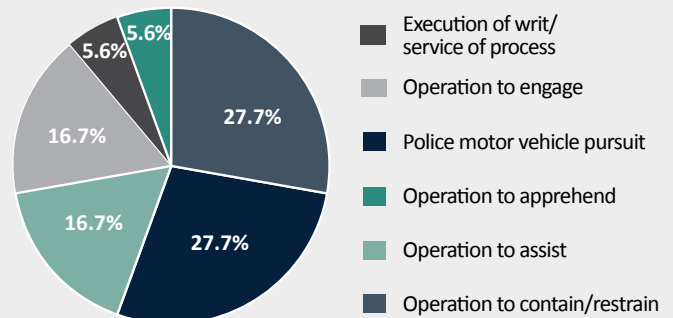
First Nations
persons

Manner of death		
Police motor vehicle pursuit	5	27.7%
Intentional self-harm	5	27.7%
Police discharge of firearm*	4	22.2%
Assault	1	5.6%
Accident	1	5.6%
Natural causes	1	5.6%
To be determined	1	5.6%
TOTAL	18	100.0%



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

Type of police operation		
Operation to contain/restrain person	5	27.7%
Police motor vehicle pursuit	5	27.7%
Operation to assist person	3	16.7%
Operation to engage person	3	16.7%
Execution of writ/warrant/service of process	1	5.6%
Operation to apprehend	1	5.6%
TOTAL	18	100.0%



INQUESTS FINALISED IN 2024

In 2024, 33 inquests were finalised in relation to deaths occurring in custody (22 inquests) or as a result of police operations (11 inquests).

Deaths in custody

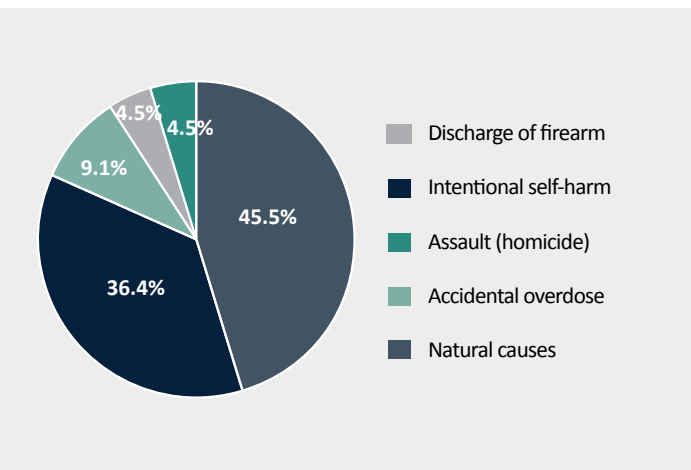
22 inquests finalised by a Senior Coroner in 2024
7 of these inquests made recommendations



21 Male
1 Female

4 First Nations persons

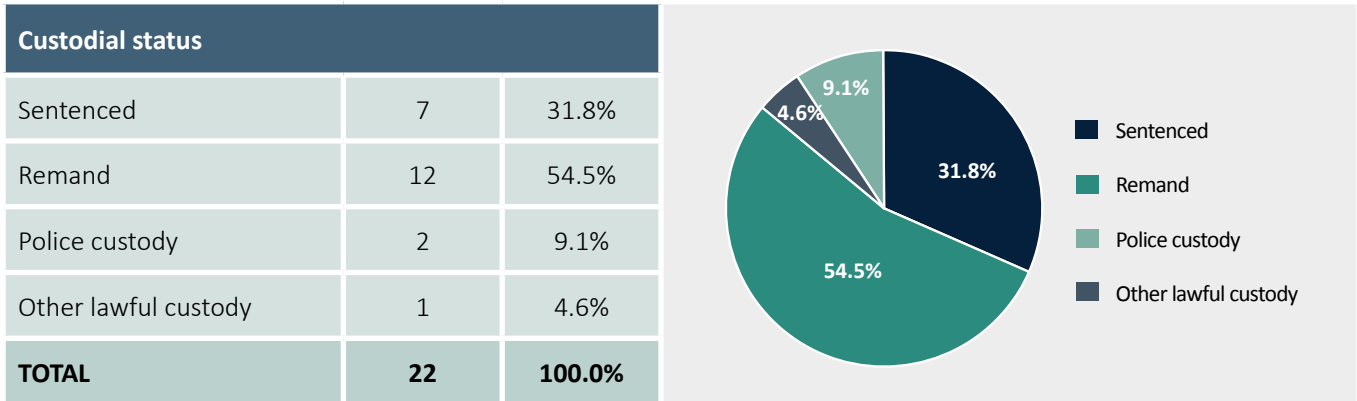
Manner of death		
Natural causes*	10	45.5%
Intentional self-harm#	8	36.4%
Accidental overdose	2	9.1%
Discharge of firearm	1	4.5%
Assault (homicide)	1	4.5%
TOTAL	22	100.0%



* 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.

Further information regarding the 8 deaths determined to have been as a result of intentional self-harm was collated from the inquest findings. From the information presented at inquest, all 8 people had a mental health diagnosis known to Corrective Services NSW, 6 of whom were receiving medication. An additional person was found to have died as a result of undetected treatable natural causes while involuntarily detained as a ‘mentally ill person’ within the general prison population, having waited 17 days for a bed in a mental health facility.

Coronial inquests examine the circumstances surrounding the person’s death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibilities appropriately and adequately. In some inquests, issues in relation to the nature and adequacy of the deceased mental health management by CSNSW and/or Justice Health may be examined.

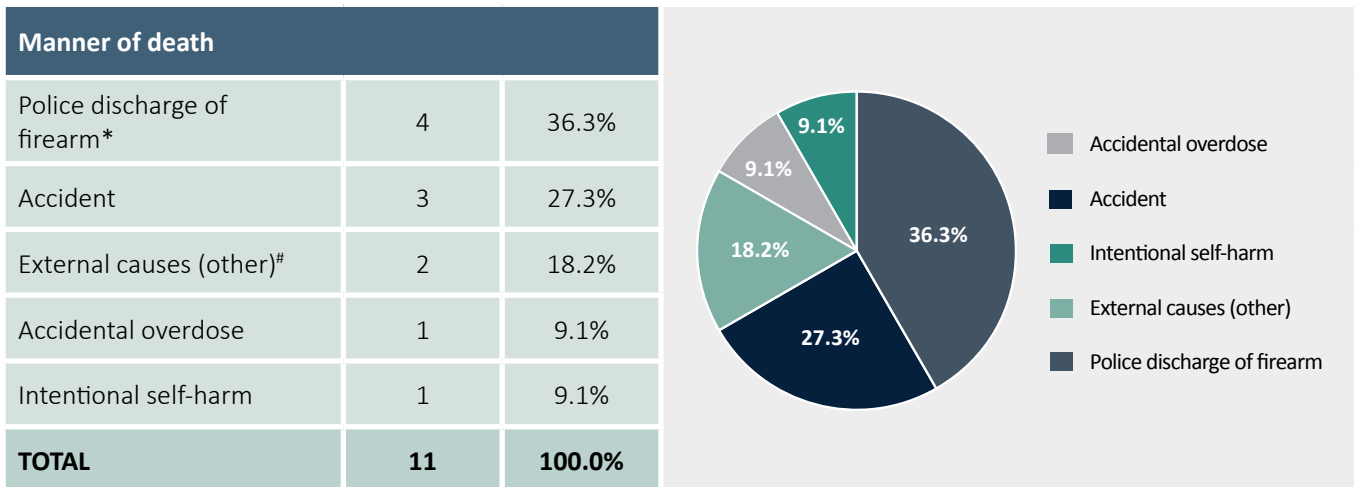


Deaths as a result of police operations

11 inquests finalised by a Senior Coroner in 2024
7 of these inquests made recommendations

11 Male
0 Female

2 First Nations persons

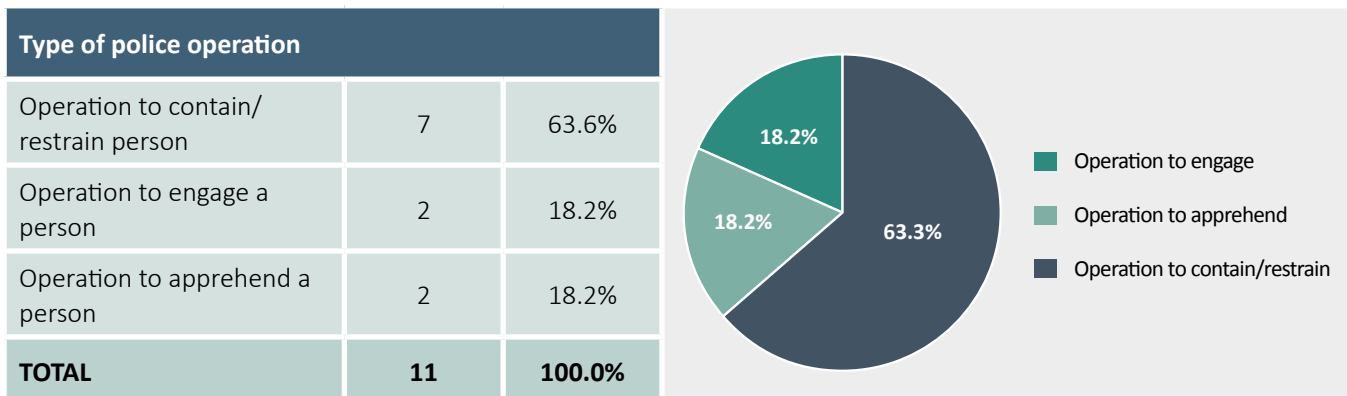


In 10 of these 11 inquests, the Coroner noted evidence that the deceased had a diagnosis of mental illness. In a number of the inquests involving the intersection of policing and mental illness, coroners made recommendations aimed at improving assistance for police and reducing the lack of mental health training or commenting on a lack of appropriate training.

* *Police discharge of firearm*: Four 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:

- were provoked to discharge their weapon when threatened with a weapon by a person, acting with the intention to end their own lives.
- were threatened by a mentally ill person after a knife was produced.
- were attempting to stop a prisoner from escaping during a medical escort.

External causes (other): Two deaths were found to have been caused by cardiac events occurring in the context of physical struggle with and/or restraint by police.



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 increase in deaths reported to the Coroner generally, 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	201800209734	Timothy Garner	Magistrate D. Lee
2	201800328285	Charles Yan	Magistrate E. Ryan
3	201900085457	Dwayne Johnstone	Magistrate T. O’Sullivan
4	202100268412	Simon Mark Cartwright	Magistrate E. Kennedy
5	202200264195	Phillip Boney	Magistrate E. Ryan
6	202100302441	Mohamed Warwar	Magistrate D. O’Neil
7	202200027663	Vicki Higgins	Magistrate C. Forbes



	Case number	Inquest into the death of	Senior Coroner
8	202400025834	Roger Rogerson	Magistrate E. Ryan
9	202300132562	' AAB '	Magistrate D. Lee
10	202300074097	Brett Furner	Magistrate D. Lee

	Case number	Inquest into the death of	Senior Coroner
11	202200023693	Alen Imbrisak	Magistrate C. Forbes
12	202200047320	Denis Ives	Magistrate K. Pearce
13	202100302513	Siosua Mateaki He Lotu Meyer	Magistrate E. Ryan
14	202100024674	' AB '	Magistrate K. Pearce
15	201900182081	Geoffrey Fardell	Magistrate E. Kennedy
16	202000235801	Name redacted (by request of family)	Magistrate D. O'Neil
17	202000103021	' WM '	Magistrate J. Baptie
18	202000277394	Russell Gary Zaska	Magistrate E. Kennedy
19	201900248597	Terry Grady	Magistrate T. O'Sullivan
20	201900200952	Michael Raymond Baker	Magistrate D. O'Neil
21	201800015711	' Mr S '	Magistrate E. Ryan
22	201700371691	Robert Phair	Magistrate E. Ryan

Deaths as a result of police operations

	Case number	Inquest into the death of	Senior Coroner
1	201900239447	Todd McKenzie	Magistrate H. Grahame
2	202000277315	Omar Mohammad	Magistrate H. Grahame
3	202000315984	Michael Murray	Magistrate E. Kennedy
4	202100369343	Brandon Rich	Magistrate H. Grahame
5	202100144151	Michael Peachey	Magistrate E. Ryan
6	202200203026	Brett Andrew Walker	Magistrate E. Kennedy
7	202200163555	Kevin Neil Edwards	Magistrate T. O'Sullivan
8	202000048323	'OA'	Magistrate E. Kennedy
9	202000118749	Andrew James Chee Quee	Magistrate H. Grahame
10	202200222793	'BC'	Magistrate J. Baptie
11	202300021244	Corey Selby	Magistrate C. Forbes



CORONIAL INQUEST RECOMMENDATIONS DELIVERED IN 2024

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.

A mandatory coronial inquest, held in accordance with section 23 of the *Coroner's Act 2009*, will necessarily involve examination of the conduct of staff predominantly from Corrective Services New South Wales, Justice Health and Forensic Mental Health Network and the New South Wales Police Force; and will often involve an examination of the adequacy of health care, including mental health care, provided to those detained in the State's care.

Importantly these recommendations seek to prevent future deaths and improve public safety. Key recommendations delivered in 2024 include:

Recommendations in the relation to the death of Todd McKenzie, directed to the NSW Police Force, that tactical police should wear body-worn video, and a review and audit of mental health training be undertaken to ensure that adequate and regular mental health training is being provided to NSW Police Force officers of all ranks.

Todd's passing was one of a growing number of deaths involving the intersection of policing and mental illness.

Recommendations in relation to the death of Simon Mark Cartwright, directed at Justice Health and Forensic Mental Health, recommending a medical transfer of psychiatrically ill patients to external hospitals pursuant to s 24 of the *Crimes (Administration of Sentences) Act 1999* in circumstances where no beds are available for a transfer pursuant to s 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* and directed at the Commissioner of Corrective Services, that a formal policy be implemented that addresses:

- i) the responsibilities of corrective services officers to ensure access of an inmate to water,
- (ii) the circumstances in which water to an inmate's cell can be turned off,
- (iii) and the measures to be taken to ensure that an inmate has had sufficient access to water for drinking.

Simon Cartwright was found to have died as a result of undetected, treatable, natural causes while involuntarily detained as a 'mentally ill person' within the general prison population having waited 17 days for a bed in a mental health facility.

Recommendations in relation to the death of Dwayne Johnstone, directed at the NSW Attorney General and the NSW Minister for Corrections, recommending an urgent review of the legislation and regulations relating to the use of firearms by officers of Corrective Services NSW in particular, clauses 131 and 303 of the *Crimes (Administration of Sentences) Regulation 2014*.

Dwayne Johnstone was found to have died while he was a prisoner being transported on medical escort, as a result of a gunshot wound inflicted by a Corrective Services New South Wales Officer who discharged his firearm to prevent Dwayne's escape.

Recommendations in relation to the death of Phillip Boney, directed to the Commissioner of Corrective Services NSW, that immediate steps be taken to remove all hanging points from the John Morony Correctional Centre and to expedite as a matter of urgency, the identification and removal of hanging points in correctional centres throughout NSW, and directed at the Attorney General of NSW, that the *Crimes (High Risk Offenders) Act 2006 (NSW)* to expressly recognise the importance of First Nations persons being reasonably supported to maintain their connection to family, community, culture and country; and require consideration to be given to a First Nations person's cultural needs, and the State's plan to support the person around those needs, in the determination of an application for an Extended Supervision Order, and directed at the

Minister for Corrections, that consideration be given to amending clause 20(1) of the *Crimes (Administration of Sentences) Regulation 2014* (NSW) to expressly require that regard be had to a preference expressed by a First Nations inmate for placement with family members who themselves are in custody.

Phillip Boney was found to have died at John Morony Correctional Centre from an intentional, self-inflicted death, despite the same recommendation to remove all hanging points in correctional centres having been made by the Royal Commission into Aboriginal Deaths in Custody 34 years ago.

Recommendations into the death of Michael Peachey, directed to the NSW Commissioner of Police, that the Commissioner consider formulating an independent policy on restraint which provides clear guidance to officers of the NSW Police Force about the risks of prone restraint, the ways in which to mitigate those risks, and the importance of moving a person from the prone position as soon as possible, particularly in cases where there has been acute behavioural disturbance and emergency sedation; and providing specific mandatory training to NSW Police Force officers on the above, as well as considering providing further guidance material in the NSW Police Force Handbook, on the importance of having regard to information provided, and concerns expressed by, family members or others close to the person about the person's behaviour, including changes in that behaviour, in determining whether a person appears to be mentally ill or disturbed for the purposes of section 22 of the *Mental Health Act 2007*.

Michael Peachey was found to have died of cardiac arrest due to cardiac arrhythmia, on a background of prone restraint (some of which was weighted); the administration of droperidol and midazolam; and a period of exertion in which he suffered the effects of oleoresin capsicum spray, taser discharges and psychosis, as a result of a police operation.

Recommendations in relation to the death of Kevin Neil Edwards, directed at the Commissioner of the NSW Police Force, recommending that the CPR/First Aid TECC PowerPoint presentation dated 2018-2019 be reviewed and updated to include the matters raised in Recommendation 3 from the inquest into the death of Omar Mohammad, with an emphasis being given to

starting CPR in cases of a person who is unresponsive/unconscious and is not breathing normally.

Kevin Neil Edwards was found to have died while experiencing a mental health episode, in the course of being restrained by the police who were attempting to prevent harm to Kevin and other road users on the M5 motorway, because the police officers at the scene were not properly trained to identify when CPR should be commenced and as a result failed to demonstrate knowledge, skills and current first aid practices.

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. Responses 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/response-to-coronial-recommendations-archive.html>

Of the 33 inquests finalised in 2024, 14 matters had recommendations delivered. 7 of these matters were deaths in custody, and 7 of these matters were deaths as a result of Police operations.



02.

RECOMMENDATIONS AND RESPONSES

All recommendations delivered in 2024 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 3 April 2025.

Where the response recorded is noted as 'awaiting', the agency has not yet responded to the recommendation but is still within the timeframe for response as set out in the Premier's Memorandum on responses to coronial recommendations. Where the response recorded is noted as 'overdue' the agency has not responded within the timeframe set out in the Premier's Memorandum on responses to coronial recommendations.

Inquest into the death of Todd McKenzie

Recommendation

1. Tactical police should be required to wear body-worn video.
2. A review and audit of mental health training be undertaken within two years to ensure that adequate and regular mental health training is being provided to NSWPF officers of all ranks.
3. The Commissioner consider updating the NSW Police Force's "Standard Operating Procedure – Negotiation Unit, Counter Terrorism and Special Tactics Command" to include an additional paragraph [REDACTED]

A copy of the findings is to be provided to the Minister for Mental Health, Minister for Police and Negotiation Commander.

Agency/Organisation

Commissioner of the NSW Police Force

Response

1. Supported in principle.

The NSWFP has established a working group to explore options for In-Car Video and Body Worn Video in a tactical environment. This project is expected to be finalised in 2025.

2. Supported.

In June 2023, the NSWPF endorsed a Mental Health Training Framework following a review of its mental health training. The revised training model requires all NSWPF personnel to complete mental health training each year. The training includes face-to-face, online, scenario based and experimental learning.

3. Not Supported.

In August 2024, the NSWPF endorsed the revised Negotiation Unit Operational SOPs [REDACTED].

The SOPs stipulate that the Team Leader is responsible for maintaining a record of a negotiation, including considerations on whether to engage independent advisors. The SOPs states that Negotiators should make every attempt to locate and engage with anyone involved in the treatment of a subject.

The purpose [REDACTED] is to assist the Team Leader where there may be a knowledge gap or discrete issue where specialist [REDACTED] advice may assist. It is not intended that a [REDACTED] be contacted as a matter of routine procedure or as a general contingency prior to implementing a negotiation objective or tactical option.



Inquest into the death of Omar Mohammad

Recommendation

1. As out-of-hospital cardiac arrests are one of the most common causes of death and because survival prospects are greatly improved where automatic external defibrillators (AEDs) are used, that urgent consideration be given to equipping all police response vehicles with AEDs for use as standard equipment by frontline police.
2. That as an interim measure pending the roll-out of AEDs for all police response vehicles, that urgent consideration be given to AEDs being provided to all mobile supervisor and duty officer vehicles in each Police Area Command.
3. That the NSW Police Force mandatory annual training for CPR include key emphasis upon the following messages:
 - a. That CPR should be started if the person is unresponsive and not breathing normally (abnormal breathing);
 - b. To assess breathing – rescuers should look, listen and feel: i. LOOK for movement of the upper abdomen or lower chest; ii. LISTEN for the escape of air from nose and mouth; and iii. FEEL for movement of air at the mouth and nose;
 - c. That palpation of pulse is unreliable and should not be used to confirm the need for resuscitation;
 - d. That abnormal breathing can be hard to identify- it is something that is “not normal”. Consider factors such as: i. Does the breathing look irregular or irregular? Is it very slow (which suggests it may be abnormal)? ii. Is the breathing noisy? If so, check that the airway is open. iii. Is there a colour change (for example, is the patient blue around the lips)? iv. Is there gasping or gulping?
 - e. If in doubt about whether a person is experiencing cardiac arrest or not, the rescuer should start CPR without concern about causing additional harm (rib fractures and other injuries are common but acceptable consequences of CPR given the alternative of death); that is – “If in doubt, have a go.”
 - f. That if unsure about ‘abnormal breathing,’ start CPR (even if the person takes occasional gasps or gulps);
 - g. That agonal breathing is common in the first few minutes after a cardiac arrest – it is sudden, irregular gasps or gulps of breath. This should not be mistaken for normal breathing and CPR should be given straight away;
 - h. That CPR should be continued until any of the following conditions are met: i. the person responds or begins breathing normally; ii. it is impossible to continue (e.g. exhaustion); iii. a health care professional arrives and takes over CPR; iv. a health care professional directs that CPR be ceased.
 - i. That CPR should not be interrupted to check for response or breathing;
 - j. That the faster the rescuer acts, the higher the chances of survival.
4. That CPR information as set out in (3) above is provided to all members of the NSW Police Force on an urgent basis (noting that the administration of CPR can be a matter of life and death), by way of:
 - a. A state-wide NEMESIS message; and
 - b. A module provided to officers who perform frontline general duties delivered via Police Education Training Environment (PETE) that requires the officer to acknowledge their review of the material; and
 - c. Appropriate scenario training.

5. That having regard to (3) and (4) above, urgent consideration be given to the introduction of an external training course delivered by an appropriate organisation within the next 6 to 12 months, to ensure that there is a baseline level of understanding within the NSW Police Force as to the essentials of CPR and basic life support (after which time, the Commissioner may consider that it is appropriate to revert to an internal training delivery model);
6. That urgent consideration be given to amending the 2023-2024 Session Plan for the CPR/Tourniquet Practical to ensure specific reference to the matters outlined in (3) above, together with inclusion of appropriate scenario training and an appropriate form of assessment to ensure that the content has been understood;
7. That consideration be given to introducing the requirement for police officers at the rank of Senior Constable and above who are involved in first response general duties policing, to be retrained and certified in first-aid every three years.

Agency/Organisation

Commissioner of the NSW Police Force

Response

1. The NSWPF is currently considering the use of AEDs following a trial in a NSWPF Command. It should be noted that whilst it may be beneficial for Police vehicles to be equipped with AEDs, officers should not be diverted intentionally from their core business. NSW Health and NSW Ambulance remain the main agencies for health related incidents and pre-hospital health care.
2. See response to recommendation 1.
3. The recommendation was implemented in the 2023/24 Operational Safety Mandatory Training (OSMTD) 'CPR/TECC' lesson plan and the 2024/25 OSMTD CPR/TECC.
4. CPR is consistently reinforced within operational safety training, both at the foundational and continuing police education and training. Internal NSWPF staff also provide First Aid training. a) A statewide email was distributed on 1 March 2024 to all NSWPF Police staff, outlining the main points of CPR as included in these recommendations. b) The module will be covered in face-to-face training as part of the Operational Safety Mandatory Training Directive. There are both formative and summative assessments that evaluate 3 officers' competency. PETE currently offers Six Minute Intensive Training (SMIT) on First Aid/Cardio-Pulmonary Resuscitation (CPR) that can be completed by any staff member. c) The Operational Safety Mandatory Training Scenario includes the scenario component.
5. Not supported. The recommendation is similar to the training process already implemented, the EOS – OSTG provide First Aid/CPR training within the Operational Safety Mandatory Training Directive. All Operational Safety Instructors (OSIs) involved in both the creation and delivery of operational safety training undertake regular First Aid training provided by an external agency. The currency of First Aid certificates is mandatory for OSI accreditation.
6. The 2023/24 Session Plan was already being delivered to NSWPF staff and includes part of the content as per this recommendation. The 2024/25 Session Plan has been enhanced to include ALL information in respect to the matters cited in (3) of these recommendations.
7. Partially supported. It is reasonable that all frontline Police Officers be expected to maintain a nationally recognised First Aid certificate that is renewed every three (3) years. As current practice all Police 4 undertake revision of cardio-pulmonary resuscitation (CPR) and basic life support (BLS) training at least annually as per national accreditation standards.



Inquest into the death of Michael Murray

Recommendation

1. That NSW Health give consideration to investigating the feasibility of establishing Dialectical Behaviour Therapy (DBT) courses for mental health clients that are accessible outside of weekday business hours.
2. So far as NSW Health may be considering the utility of broadening the availability of access to Electronic Medical Records (EMR) across different Local Health Districts (LHD), that NSW Health examine the findings in this matter as part of the evidence base that would support such broader availability.

Agency/Organisation

NSW Health

Response

1. The Mental Health Branch advise DBT is an evidence-based therapy for borderline personality disorder. LHDs provide care and therapy aimed at meeting the needs of their population, including provision of DBT.
2. The findings and recommendations made by the Deputy State Coroner have been shared with all LHD Chief Executives and Directors of Mental Health to inform clinical service planning.

The findings and recommendations made by Magistrate E Kennedy have been shared with eHealth NSW for review and consideration. eHealth is responsible for EMR records in NSW Health. NSW Health acknowledges the importance of having an integrated view of the care a patient receives across the NSW public health system.

Clinical Health Information Exchange- information sharing

In 2019, eHealth NSW implemented the Clinical Health Information Exchange (CHIE) to improve access to a patient's health history across public and private systems. This is a clinical repository that receives and stores patient information from multiple electronic medical record systems (eMR) in a single unified view, noting certain information is out of scope (radiology images and reports, pathology, secure or protected information). CHIE has been rolled out across multiple LHDs and one hospital network, with state-wide rollout anticipated to be completed this year.

Single Digital Patient Record (SPDR) implementation is underway

NSW Health has commenced planning and implementation of the SPDR which will consolidate multiple clinical information systems across NSW Health. Currently, there are 9 separate eMR systems, 10 separate Patient Administration Systems, and 5 separate Laboratory Information Management Systems across NSW Health. These systems were implemented over the past two decades with technology available at the time, and patient records are not fully accessible to clinical staff across LHDs in one system.

The SPDR will transform the way clinical information is shared across NSW Health, providing comprehensive, real-time electronic access to medical records. One statewide system will support consistency and continuity of patient care. Clinicians will be able to access to up-to-date comprehensive NSW Health medical, pathology, and patient administration records in one system.

The NSW Health Secretary has recently established the NSW Health Single Digital Health Record Implementation Authority to work with eHealth NSW, LHDs and Specialty Networks, MOH and Pillars to implement the SDPR. It is anticipated overall implementation will be completed by 2028.

During the course of the inquest Mr Murray's frequent presentations across differing LHDs was noted. In addition, Mr Murray's condition could compromise his capacity to provide a clear history of his current and past clinical picture. The integrated SDPR will support and inform critical decision making and care planning for complex patients such as Mr Murray.

Inquest into the death of Brandon Rich

Recommendation

That any training provided to officers undertaking operational duties in relation to the exercise of police powers as set out in NSWPF Domestic and Family Violence Standard Operating Procedures 2018 include a focus on the operation of the powers of direction and detention under s 89A of the *Crimes (Domestic and Personal Violence) Act 2007*.

Agency/Organisation

Commissioner of the NSW Police Force

Response

I can advise that the NSWPF Domestic Violence Fundamentals Workshop covers topics about Personal Violence Orders, direction and detention powers and circumstances and duration of time a person may be detained for.

Domestic and Family Violence is also included in the associate degree in Policing Practice covering sections 89 and 89A of the *Crimes Act (Domestic and Personal Violence) Act 2007*.



Inquest into the death of Michael Peachey

Recommendation

Recommendations to the NSW Commissioner of Police

1. That the Commissioner consider:
 - a. formulating an independent policy on restraint which provides clear guidance to officers of the NSW Police Force about the risks of prone restraint, the ways in which to mitigate those risks, and the importance of moving a person from the prone position as soon as possible, particularly in cases where there has been acute behavioural disturbance and emergency sedation; and
 - b. providing specific mandatory training to NSW Police Force officers on the above.
2. That the Commissioner consider:
 - a. providing further guidance material in the NSW Police Force Handbook, on the importance of having regard to information provided, and concerns expressed by, family members or others close to the person about the person's behaviour, including changes in that behaviour, in determining whether a person appears to be mentally ill or disturbed for the purposes of section 22 of the Mental Health Act 2007; and
 - b. providing additional training to NSW Police Force officers in the above.

Recommendations to the NSW Commissioner of Police and the Commissioner and Chief Executive of NSW Ambulance

3. That NSW Ambulance and NSW Police Force consider carrying out interagency training and/or development of guidance material, which would focus on the respective roles of the two agencies and the need for communication, where both agencies attend a scene involving acute behavioural disturbance, prone restraint and emergency sedation.

Recommendations to the Chief Executive Office of the Hunter New England Local Health District

4. That the Hunter New England Local Health District consider the introduction of polices for following up voluntary patients who present to an emergency department with symptoms of mental illness or disturbance, but leave without having received a medical assessment.

Agency/Organisation

Commissioner of the NSW Police Force

NSW Commissioner of Police and the Commissioner and Chief Executive of NSW Ambulance

Chief Executive Office of the Hunter New England Local Health District

Response Recorded as at 28 March 2025

Awaiting

Inquest into the death of Brett Andrew Walker

Recommendation

1. a. The Court's findings be provided to the CSNSW Quality Assurance Directorate for its consideration when undertaking its holistic review of offenders in custody and the community and specifically in relation to the examination of preparing offenders for release and managing of offenders with short or backdated sentences.
- b. That Correctives Services advise the Court of the outcome of the CSNSW Quality Assurance Directorate review specifically any changes to procedures or policies for preparing offenders for release and managing of offenders with short or backdated sentences.

Agency/Organisation

Commissioner of the NSW Police Force

Response

1. a. Supported. On 15 August 2024, the Findings and recommendations were emailed to AC McCarroll, AC Galouzis, A/DC Ripperger, AC Snell, Joanne Kennedy and Jason Hainsworth.
- b. Supported. CSNSW Quality Assurance Directorate completed a Holistic Review of any changes to procedures or policies for preparing offenders for release and managing of offenders with short or backdated sentences and presented it to the CSNSW Executive. Further discussions of the findings are ongoing.



Inquest into the death of Kevin Neil Edwards

Recommendation

1. The CPR/First Aid TECC PowerPoint presentation dated 2018-2019 be reviewed and updated to include the matters raised in Recommendation 3 from the inquest into the death of Omar Mohammad, with an emphasis being given to starting CPR in cases of a person who is unresponsive/unconscious and is not breathing normally.
2. That the annual mandatory CPR training be conducted in a venue with access to equipment allowing the playing of the PowerPoint presentation and any training videos (including videos which demonstrate what agonal breathing is).
3. That the CPR training materials and competency assessment (including the model and delivery) be reviewed by an independent external first aid expert to ensure compliance with the ARC Guidelines relating to the delivery of CPR with a particular focus on the recognition of when CPR should be initiated.
4. That the CPR training materials be reviewed and updated annually to ensure the information provided to police officers is up to date.
5. That scenario-based training be rolled out in relation to the identification of abnormal/agonal breathing.
6. Consideration be given by NSWPF to consider updates required to the content of NSWPF training PowerPoints (such as Professor Holdgate's opinion that there should be a low threshold for commencing CPR; ensuring content is in line with the Australian Resuscitation Council's guidelines including not putting a casualty in the recovery position if they are not breathing).

Agency/Organisation

Commissioner of the NSW Police Force

Response

Awaiting

Inquest into the death of Timothy Garner

Recommendation

1. I recommend that the Commissioner of Corrective Services New South Wales consider the introduction of, at a minimum, 5-yearly refresher training for all staff who are members of Risk Intervention Teams.
2. I recommend that the Commissioner of Corrective Services New South Wales continue to monitor the progress of refurbishments at the Metropolitan Remand & Reception Centre with the aim of ensuring that all inmates subject to Risk Intervention Team management are housed in O-Block or a refurbished cell in Darcy Pod by the end of 2024.

Agency/Organisation

Commissioner of the NSW Police Force

Response

1. Supported. A Corrective Services NSW (CSNSW) Academy working group is currently considering a refresher course. Consideration of face-to-face re-certification models and eLearning refresher models to comprehensively meet this recommendation are underway.
2. Supported. Refurbishment of the original cells at the Metropolitan Remand and Reception Centre (MRRC) is continuing. Cell refurbishment works completed to date are Darcy 3, Hamden 15, Hamden 16, Hamden 17, Hamden 18, Fordwick 7, Fordwick 8 and Fordwick 9.

Works have commenced at Darcy 2 and are due for completion by the end of December 2024. Next priority works include Darcy 1 and Darcy 4.

The CSNSW Reducing Deaths in Custody (Anti-Ligature Program) New Policy Proposal (NPP) has since been approved by NSW Treasury for \$4 million capital expenditure over the next four years. This funding will be used to urgently progress the removal of obvious ligature points from CSNSW cells.

Inquest into the death of Charles Yan

Recommendation

1. That CSNSW undertake a review of the information provided to inmates concerning drug toxicity/overdose, including recognising the signs of overdose, first aid management of persons experiencing overdose and seeking assistance for overdose, within the:
 - CSNSW's Health Survival Tips Program; and
 - inmate intranet portal, accessible through inmate tablet devices including in consultation with representatives of the inmate community and, where necessary, with the Justice Health and Forensic Mental Health Network, and any relevant external providers.
2. That consideration be given to consulting with an expert in first aid management of persons who are suffering from drug toxicity, for the purpose of determining if any improvements could be made to the information provided to inmates in recommendation 2 above.

Agency/Organisation

Commissioner of Corrective Services NSW

Response



1. Supported. Corrective Services NSW Correctional Practice will engage with JHFMHN and any other stakeholders to undertake a review, scheduled to commence in 2025, of the information provided to inmates concerning drug toxicity/overdose, including recognising the signs of overdose, first aid management of persons experiencing overdose and seeking assistance for overdose, within the Health Survival Tips Program.
2. Supported. Corrective Services NSW Correctional Practice will engage with JHFMHN and any other stakeholders. This includes giving consideration to consulting with an expert in first aid management of persons who are suffering from drug toxicity, for the purpose of determining if any improvements could be made to the information provided to inmates in recommendation 2.

Inquest into the death of Dwayne Johnstone

Recommendation

1. That there be an urgent review of the legislation and regulations relating to the use of firearms by officers of Corrective Services New South Wales, and, in particular, clauses 131 and 303 of the *Crimes (Administration of Sentences) Regulation 2014*, having regard to the findings in the inquest into the death of Dwayne Johnstone.

Agency/Organisation

NSW Attorney General
NSW Minister for Corrections

Response

1. CSNSW have developed operational enhancements to mitigate risks associated with the carriage and use of firearms on escort. These enhancements are subject to consultation with the Public Service Association. CSNSW are seeking regulatory amendments to the *Crimes (Administration of Sentences) Regulation 2014* to clarify and narrow when a correctional officer may discharge a firearm are being considered. A briefing note which seeks to progress the regulation amendments has been endorsed by DC Luke Grant and Anne Marie Martin and referred to the Commissioner's Office (as December 2024).

Furthermore, firearms will continue to be available for escorts.

1. The NSW Attorney General advises that the recommendation that there be an urgent review of the legislation and regulations relating to the use of firearms by correctional officers, and, in particular, clauses 131 and 303 of the *Crimes (Administration of Sentences) Regulation 2014*, falls solely within the portfolio responsibilities of the Minister for Corrections. The Minister is progressing work to address this recommendation, and I understand the Minister will be writing to you directly on this issue.

Inquest into the death of Simon Mark Cartwright

Recommendation

Recommendations to the Justice Health and Forensic Mental Health

1. That Justice Health consider a review of policies or procedures for monitoring the food and/or fluid intake of an inmate, with a view to ensuring that food and/or fluid monitoring is undertaken if recommended by a doctor.
2. That Justice Health consider investigating options for: a. employing psychologists to provide therapeutic services to inmates; and b. creating systematic support for people with personality disorders in custody.
3. That Justice Health give consideration to recommending a medical transfer of psychiatrically ill patients to external hospitals pursuant to s 24 of the *Crimes (Administration of Sentences) Act 1999* in circumstances where no beds are available for a transfer pursuant to s 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020*.

Recommendations to the Commissioner of Corrective Services

4. That Corrective Services consider the implementation of a formal policy that addresses:
 - a. the responsibilities of corrective services officers to ensure access to water;
 - b. the circumstances in which water to an inmate's cell can be turned off;
 - c. the procedures to be followed if the water to an inmate's cell is to be turned off;
 - d. the measures that must be taken to ensure than an inmate has sufficient access to water for drinking and hygiene if their water is turned off; and e. requirements for maintaining records in relation to the same.
5. That Corrective Services give consideration to taking steps to ensure adherence with COPP 1.4, subsection 3.4, that requires approval of the governor if an inmate's placement in an Assessment Cell exceeded 48 hours.
6. That Corrective Services give consideration to mandating Mental Health First Aid training for officers who are assigned to supervising inmates in observation cells and/or on RIT management.
7. That Corrective Services give consideration to the development of a system that ensures all of those officers who are assigned to supervising inmates in observations cells and/or RIT management are made aware at the start of each shift of the reason why each inmate has been placed in those cells.

Recommendations to both the Commissioner of Corrective Services and Justice Health and Forensic Mental Health

8. That Corrective Services consider the production of a memorandum outlining what level of service is provided by Corrective Services Staff of an inmate placed in an observation cell (including the 24-hour surveillance cell), to clearly identify and communicate what types of physical checks will occur, how often these can reasonably be performed, how often the surveillance camera is expected to be on, who is watching that camera and 4 how regularly it will be staffed and viewed, and what the officers are instructed to look for. That memorandum is to be provided to Justice Health for consideration of circulation to medical staff to allow development and management of treatment plans.



Agency/Organisation

Commissioner of Corrective Services NSW
Justice Health and Forensic Mental Health

Response

Awaiting

Inquest into the death of Phillip Boney

Recommendation

Recommendations to the Commissioner of Corrective Services NSW

1. That immediate steps be taken to remove all hanging points from the John Morony Correctional Centre and to expedite as a matter of urgency, the identification and removal of hanging points in correctional centres throughout NSW.
2. That consideration be given to developing a written procedure, whereby those who supervise offenders under the *Crimes (High Risk Offenders) Act 2006* should, unless it is not possible to adequately mitigate risk, supervise First Nations offenders:
 - in their own community and on country; or
 - if that is not possible, in a community and/or country to which they have strong family and/or cultural connections; and
 - where a First Nations offender is unable to return to country or their preferred community, maintaining their cultural connection must be incorporated into their ongoing supervision.
3. That the Acting Commissioner consider requiring as part of case plan reviews (which should occur every two months):
 - that the Extended Supervision Team assess whether its existing plan to support a First Nations person around their cultural needs remains appropriate; and
 - that the reasons for the conclusion reached is documented.
4. That the Acting Commissioner give consideration to the employment and/or engagement of culturally appropriate psychologists as part of the Violent Offenders Treatment Program.

Recommendations to the Attorney General of NSW

5. That consideration be given to amending the *Crimes (High Risk Offenders) Act 2006 (NSW)* to expressly:
 - recognise the importance of First Nations persons being reasonably supported to maintain their connection to family, community, culture and country; and
 - require consideration to be given to a First Nations person's cultural needs, and the State's plan to support the person around those needs, in the determination of an application for an Extended Supervision Order.

Recommendations to the Minister for Corrections

6. That consideration be given to amending clause 20(1) of the *Crimes (Administration of Sentences) Regulation 2014* (NSW) to expressly require that regard be had to a preference expressed by a First Nations inmate for placement with family members who themselves are in custody.

Recommendations to the Chief Executive Office of the Justice Health and Forensic Mental Health Network

7. That the findings in this inquest be considered, as part of the project into developing the Health Problem Notification e-form.
8. That the JH Network, in consultation with Corrective Services NSW, review the efficacy of systems concerning electronic alerts around mental health risks that are auto populated into Corrective Services' electronic system.

Agency/Organisation

Commissioner of Corrective Services NSW
Attorney General of NSW
Minister for Corrections
Chief Executive Officer of the Justice Health and Forensic Mental Health Network

Response

Commission of Corrective Services NSW response

1. CSNSW continues to undertake extensive works across our facilities to reduce the risk of self-harm and suicide, including:
 - a) building new cells designed to incorporate anti-ligature design principles;
 - b) removing aged cells from use; and
 - c) refurbishing existing cells to remove obvious ligature points.

CSNSW has a funded program of cell refurbishment. This program is premised on a risk assessed basis. Under this program, obvious hanging points are removed wherever practicable, as soon as possible. With more than 15,000 cells across the state, priority is assessed according to the risk of harm to inmates.

Those centres and cells housing inmate groups that are most vulnerable to self-harm or suicide are prioritised. Risk assessments for prioritising cell refurbishment utilise an analysis of historical data and consider both inmate cohort risks and previous recorded locations of self-harm incidents. Refurbishment works are scheduled in accordance with this prioritisation

2. Supported. CSNSW has commenced consultation to support the implementation of this recommendation. Intensive Rehabilitation (IR) Directorate has been tasked with completing the written procedure. Strategic Operations (SIRS) will provide a governance/supporting role to the ESO team in relation to the development of the written procedure.

Directors and senior leaders met and discussed the recommendations with staff from CSNSW Aboriginal Cultural Unit (ACU) and Aboriginal Cultural Connections Unit (ACCU). They also attended the CSNSW Aboriginal Advisory Group (AAG). Two workshops are scheduled for the end of 2024 to meet and discuss current practices, along with identifying case studies to inform practice considerations when exploring both the benefits and challenges of returning individuals on a ESO to country.



An additional workshop is scheduled to develop written guidelines to support the operational implementation of this recommendation.

3. Supported. A cultural audit of Community Corrections policies and procedures is planned to be undertaken by an Aboriginal-led external agency. The audit is intended to identify the points in an offender's supervision where consideration of his or her cultural needs will enhance supervision. It is anticipated that this will include offenders subject to Extended Supervision Orders. This work is planned to take place in the 2024/25 financial year. Following the audit, relevant policies and procedures will be updated accordingly.

4. Supported. CSNSW is currently consider this recommendation. Intensive Rehabilitation (IR) and Offender Transformation (OT) directorates met in November 2024 and are gathering further information to better understand current practices when working with Aboriginal offenders, review current recruitment strategies.

An audit is currently underway to review staff training and specifically, VOTP-M staff attendance at relevant cultural training.

Once the above information is collated, both directorates will further considerations will ensure VOTPM staff are provided the opportunity to build on their capabilities to deliver 'culturally appropriate practice'.

Attorney General of NSW response

5. Section 9(3) of the Crimes (High Risk Offenders) Act 2006 (CHRO Act) outlines the broad scope of matters that the Supreme Court must consider in making an Extended Supervision Order (ESO) under the Act, including any matter that the Court considers relevant. Section 11(1) of the CHRO Act also provides the Court with a broad discretion to impose such conditions on an ESO as it considers appropriate.

The Supreme Court has applied these provisions when considering making ESOs against First Nations offenders and imposing conditions on the order, including considering their background as First Nations persons, their cultural needs and other matters relevant to them as First Nations persons.

For example, in *State of New South Wales v De Vries* [2022] NSWSC 247 the Supreme Court stated at [54] that it had the considerable benefit of an Aboriginal expert's reports which were 'particularly helpful in coming to an appreciation of the cultural, family and social implications of the defendant's Aboriginal heritage and background as a man of the Gamilaraay people and how the contents of the conditions could best be formulated and expressed to take these matters into account in an appropriate way.

I note that recommendation 3 of the Coroner's Court's findings, which was accepted by Corrective Service NSW, was to consider requiring case plans to be reviewed every two months and require that:

- the Extended Supervision Team assess whether its existing plan to support a First Nations person around their cultural needs remains appropriate: and
- that the reasons for the conclusion reached is documented.

I am advised that Corrective Services NSW has commenced work in relation to implementation of recommendation 2 of the Coroner's findings. Recommendation 2 states 'that consideration be given to developing a written procedure, whereby those who supervise offenders under the Crimes (High Risk Offenders) Act 2006 should, unless it is not possible to adequately mitigate risk, supervise First Nations offenders:

- in their own community and on country; or

- if that is not possible, in a community and/or country to which they have strong family and/or cultural connections; and
- where a First Nations offender is unable to return to country or their preferred community, maintaining their cultural connection must be incorporated into their ongoing supervision.

Accordingly, I do not consider that amendments to the CHRO Act are necessary at this stage, given the Supreme Court's approach in ESO matters and the action being taken by Corrective Services NSW. The NSW Government will continue to monitor the operation of the CHRO Act.

Minister for Corrections Response

6. Not Supported. The statutory framework in the CAS Regulation already provides for a number of considerations, including:

- (a) Consideration of a placement in a Correctional Centre in close proximity to family;
- (b) Allowing inmates (who must be present during the process except in exceptional circumstances) to provide information to be taken into account during the placement assessment process; and
- (c) Providing a statutory review mechanism for inmates to request a review due to a change in their circumstances which was not considered at the time the placement decision was made.

CSNSW is reviewing relevant policies and procedures to ensure that CSNSW's obligations under clauses 20(1) and 34 of the CAS Regulation are reflected and will include the need for decision makers to consider an inmate's preference for placement with family members who are also in custody, as well as family members in the community. The changes are anticipated to take effect for all inmates, including Aboriginal and Torres Strait Islander persons.

CEO Justice Health Response

Both recommendations directed to Justice Health are supported and implementation activities are underway. See actions here.

7. The responsibility for implementing this recommendation has been assigned to the Director of Health Intelligence and Analytics, Justice Health NSW.

The new HPNF eForm is in the final stages of development and consultation with CSNSW and Justice Health NSW staff, with the aim of better integration with clinical workflows.

The newly developed eForm will include structured questions, dropdown lists, tick boxes and mandatory fields, providing clearer guidelines for clinicians.

The eForm is expected to go live by the end of October 2024.

The current HPNF remains operational with minor improvements for cell placement recommendations. Mandatory HPNF training will now be required every two years by all Justice Health NSW staff, following a recent coronial findings report (Mohamed Warwar, COR24/11).

Review of HPNF training and education is on the agenda of the Joint Recommendations Working Group. As of August 2024, compliance is at 88.1 % with 852 staff targeted.

The anticipated timeframe for completion of this body of work is 30 December 2024.



8. That the JH Network, in consultation with Corrective Services NSW, review the efficiency of systems concerning electronic alerts around mental health risk that are auto populated into Corrective Services electronic system.

The responsibility for implementing this recommendation has also been assigned to the Director of Health Intelligence and Analytics, Justice Health NSW.

Currently, Justice Health NSW and CSNSW exchange alerts through the Justice Health NSW electronic health record and the CSNSW Offender Management System. There are 14 mental health related alerts that are shared with CSNSW.

A working group will be convened to review the effectiveness of these alerts, including mental health specific alerts and the opportunity to improve the sharing of mental health information.

The Justice Health Alert Definitions document, which lists and defines each alert, has been shared with CSNSW.

The anticipated timeframe for completion of this body of work is 30 December 2024.

The two recommendations directed to Justice Health NSW relate to documentation processes. As outlined in the NSW Health response for the coronial inquest into the death of Mohamed Warwar (COR24/11), in addition to the above actions, the development and implementation of the NSW Health Single Digital Patient Record (SDPR) is underway.

Inquest into the death of Mohamed Warwar

Recommendation

Recommendations to the Commissioner of Corrective Services NSW

1. Consideration be given to ensuring HPNFs are easily available and accessible to staff managing inmates in accommodation areas.
2. Consideration be given to:
 - (a) the deficiencies in practice and procedure revealed in the evidence such as, (i) not attending handover; (ii) failing to keep appropriate records; and (iii) correctional officers not referring to HPNFs,
 - (b) the qualifications, training, and experience of those responsible for the deficiencies,
 - (c) the policies and/or other documentation directing attention to the correct practice and procedure, and
 - (d) the volume of policies and training that employees are currently exposed to, with a view to exploring and implementing better ways to minimise the risk of employees not following policy and deficiencies being repeated.
3. That there be mandatory refresher training on HPNFs for all current and future serving Correctional Officers. The frequency of the mandatory refresher training is to be determined after consultation with relevant stakeholders.

Recommendations to the Chief Executive of the Justice Health and Forensic Mental Health Network

4. Consideration be given to:
 - (a) the deficiencies in practice and procedure revealed in the evidence such as, (i) not attending handover; (ii) failing to keep records; and (iii) not filling in HPNFs appropriately;
 - (b) the qualifications, training, and experience of those responsible for the deficiencies,
 - (c) the policies and/or other documentation directing attention to the correct practice and procedure, and
 - (d) the volume of policies and training that employees are currently exposed to, with a view to exploring and implementing better ways to minimise the risk of employees not following policy and deficiencies being repeated.
5. That there be mandatory refresher training on HPNFs at least once every 2 years for all current and future serving Justice Health clinical staff statewide.
6. That a shadow study be undertaken to determine what work is required on a regular evening shift at MRRC, where time pressures arise, and what support would best assist staff on evening shift.
7. That once the shadow study has been undertaken, steps be taken to put in place the identified support requirements.

Agency/Organisation

Commissioner of Corrective Services NSW
 Chief Executive of the Justice Health and Forensic Mental Health Network

Response

Response

1. Supported. The Corrective Services NSW (CSNSW) cell placement policy amendments were published 14 August 2024. Amendments have been made to require a copy of the Health Problem Notification Form (HPNF) copy is to be kept in the accommodation area.
2. Supported. Corrective Services NSW (CSNSW) current Health Problem Notification Form (HPNF) online short course is undergoing review. The HPNF is also being addressed in primary training and Managing At-Risk Inmates training.

 Additionally, CSNSW is currently reviewing option to draft and potentially implement a handover procedure document for officer shift changeovers.
3. Corrective Services NSW (CSNSW) current Health Problem Notification Form (HPNF) online short course is undergoing review. The HPNF is also being addressed in primary training and Managing At-Risk Inmates training.

 Response from Chief Executive of the Justice Health and Forensic Mental Health Network
4. All four recommendations directed to Justice Health NSW are supported and were endorsed on 24 June 2024 in a meeting at Justice Health NSW between the Executive Director Nursing, Midwifery and Clinical Governance; General Manager Primary Care and Associate Director Clinical Governance.

 The recommendations were also support by the Justice Health NSW Close the Loop meeting on 10 July 2024. See all actions [here](#).



Inquest into the death of Vicki Higgins

Recommendation

I recommend that Corrective Services NSW record information conveyed to correctional officers from the control room directing the correctional officer to attend to respond to an urgent cell call from an inmate for medical attention.

Agency/Organisation

Commissioner of Corrective Services NSW

Response

1. Supported. Corrective Services NSW (CSNSW) updated COPP 5.5 Cell security and alarm calls on 11 March 2024. CSNSW officers who receive an urgent cell call that requires an immediate and urgent physical response are required to record key information into the 'Cell call alarm request and physical response register' which is also to be emailed to the relevant health centre of the correctional centre at the conclusion of each shift.

