Report by the NSW State Coroner

into the deaths in custody/ police operations

2001

(Coroner's Act, 1980)

State Coroner's Office
NSW Attorney General's Department

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The Honourable Robert John Debus
Attorney General of New South Wales
Level 20, Goodsell Building
8-12 Chifley Square
SYDNEY NSW 2000

24 January 2001

Dear Attorney,

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

Under the provisions of Section 13A:

1 A Coroner who is the State Coroner or a Deputy State Coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the Coroner that the person has died or that there is reasonable cause to suspect that the person has died:

(a) while in the custody of a police officer or in other lawful custody, or while escaping or attempting to escape from the custody of a police officer or other lawful custody; or

(b) as a result of or in the course of police operations; or

(c) while in, or temporarily absent from, a detention centre within the meaning of the *Children (Detention Centres) Act 1987*, a prison within the meaning of the *Prisons Act 1952*, or a lock-up, and of which the person was an inmate; or

(d) while proceeding to an institution referred to in paragraph (c) for the purpose of being admitted as an inmate of the institution and while in the company of a police officer or other official charged with the person's care and custody.

2 If jurisdiction to hold an inquest arises under both this section and Section 13 (class of deaths which must be reported to the Coroner), an inquest is not to be held except by the State Coroner or a Deputy State Coroner.

Inquests into such deaths are mandatory and must be heard by the State Coroner, or a Deputy State Coroner. It is therefore part of the *Coroners Act* that deaths resulting from police operations, deaths in prisons, and deaths of persons proceeding to and from appropriate institutions are to be the subject of mandatory reporting and inquest, although in practice such was always the case.

78 cases in circumstances referred to in Section 13A were subject to investigation by the State Coroner and his Deputies in 2001 and are referred to in this report. Of those 78 cases, 41 were matters outstanding as at the 31 December 2000 and 37 were matters reported during 2001.

In 2001, 22 matters were completed by way of Inquest finding, including 3 that were terminated because of person/s being charged with an indictable offence in which an issue will be that the person charged caused the death. Of the outstanding matters, 24 cases have been listed for hearing in 2002 and 32 are currently under investigation with hearing dates yet to be allocated.

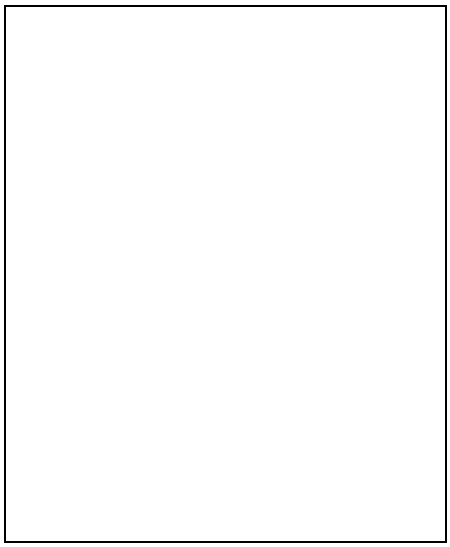
I hereby enclose my report for 2001 into deaths in custody/police operations deaths for your information and for the information of both Houses of Parliament.

Yours sincerely,

J B Abernethy
NSW State Coroner

STATUTORY APPOINTMENTS

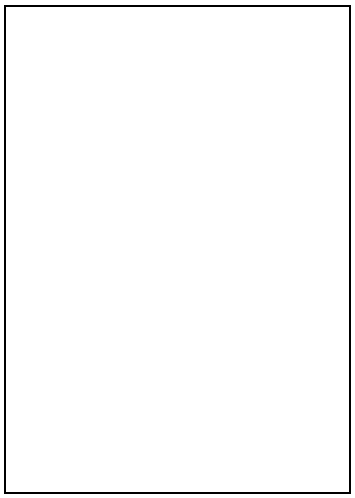
Under the 1993 amendments to the *Coroners Act 1980*, only the State Coroner or a Deputy State Coroner can preside at an inquest into a death in custody or a death in the course of police operations. The deaths, the subject of this report, were conducted before the following Coroners:



MAGISTRATE JOHN ABERNETHY

New South Wales State Coroner

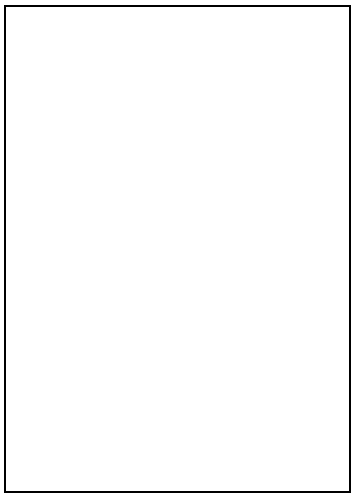
1965	Joined the (then) Petty Sessions Branch of the New South Wales Department of the Attorney General and of Justice
1971	Appointed Coroner for the State of New South Wales
1975	Admitted as a Barrister-at-Law in the State of New South Wales
1984	Appointed a Stipendiary Magistrate for the State of New South Wales
1985	Appointed a Magistrate for the State of New South Wales under the Local Courts Act 1982
1994	Appointed New South Wales Deputy State Coroner
1996	Appointed New South Wales Senior Deputy State Coroner
2000	Appointed New South Wales State Coroner



MAGISTRATE JANET STEVENSON

Senior Deputy State Coroner

1990	Magistrate and Coroner
1997	Deputy State Coroner
2000	Senior Deputy State Coroner



MAGISTRATE JACQUELINE MILLEDGE

Deputy State Coroner

1996	Magistrate and Coroner
2000	Deputy State Coroner

Contents

Introduction by the New South Wales State Coroner

What is a death in custody?

It was agreed by all mainland State and Territory governments in their responses to the Royal Commission into Aboriginal Deaths in Custody recommendations, that a definition of a death in custody should, at the least, include[1]:

1 the death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;

2 the death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care whilst in such custody or detention;

3 the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and

4 the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

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

1 while temporarily absent from a detention centre, a prison or a lock-up; as well as

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

It is important to note that in respect of those cases where an inquest has yet to be heard and completed, no conclusion should be drawn that the death necessarily occurred in police custody or during the course of police operations. This is a matter for determination by the Coroner after all the evidence and submissions from those granted leave to appear have been presented at the inquest hearing.

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

A death as a result of or in the course of a police operation is not defined in the Act. Following the commencement of the 1993 amendments to the *Coroners Act 1980*, New South Wales State Coroners Circular No. 24 contained potential scenarios that are likely deaths 'as a result or in the course of a police operation' as referred to in Section 13A of the Act.

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

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

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

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

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

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

In most cases where a death has occurred as a result of or in the course of a police operation, the behaviour and conduct of police was found not to warrant criticism by the Coroners. However criticism of certain aspects were made in the following matters:-

- 778/97 the Deputy State Coroner was critical of police response to the incident and made recommendations accordingly.

- 1751/00 the State Coroner expressed concern at the delay in deployment of specialist officers to a potentially life threatening situation. The State Coroner urged the NSW Police Service to analyse the facts of the case from an operational perspective and implement change where it is considered appropriate.

- 2028/00 the State Coroner stressed the need for the NSW Police Service to address the issue of immediately separating police when they are involved in a police operation or a death in custody so that their versions of the incident cannot be concocted.

In the following matters the actions of the police were commended:-

- 778/97 the Deputy State Coroner commended police for exercising exceptional judgments and showing a great deal of courage when dealing with a potentially life threatening situation.

- 182/01 the Senior Deputy State Coroner found that police acted professionally and appropriately.

191/01 the State Coroner commended the police officers for attempting to make the deceased safe. He found they nearly lost their lives in doing so.

We will continue to remind both the Police Service and the public of the high standard of investigation expected in all coronial cases.

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

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

> The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and it is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners

in a humane fashion, and satisfies the community that deaths in such places are properly investigated[2].

I agree also with Mr.Waller that:

In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution. When the death is by deliberate self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an event pertaining to an individual. The focus there is far more upon the individual and that individual's pre-morbid state. It is entirely proper that any death in custody, from whatever cause, must be meticulously examined[3],

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

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

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

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

Upon notification by the DOI, the State Coroner or Deputy State Coroner will give directions that experienced detectives from the Crime Scene Unit (officers of the Physical Evidence Section) and the local government medical officer or a forensic pathologist attend the scene of the death. The Coroner will check that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit (officers of the Physical Evidence Section) and the local government medical officer or the forensic pathologist. A member of the Coroner's Support Section must attend the scene that day if the death occurred within the Sydney Metropolitan area and, when practical, if a death has occurred in a country district. The Support Group Officer must also ensure that a thorough investigation is carried out. The Support Group Officer will continue to liaise with the Coroner and with the police investigators during the course of the investigation. In the course of the investigation the Coroner will, if necessary, direct investigators.

The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during it. If the State Coroner or one of the Deputy State Coroners is unable to attend a death in custody/police operations occurring in a

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

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

country area, the State Coroner will request the local Coroner in the particular district, and the local Government Medical Officer attend the scene.

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

In cases involving the police

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

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

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

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

Responsibility of the coroner

Section 22 of the *Coroners Act* provides:

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

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

Section 19 provides that:

1. if the Coroner is of the opinion that the evidence given at the inquest establishes a prima facie case against any known person for an indictable offence; and

2. the indictable offence is one in which the question whether the known person caused the death is in issue the Coroner must terminate the inquest.

The inquest is terminated after taking evidence to establish the death, the identification of the deceased, and the date and place of death. The Coroner then forwards to the Director of Public

Prosecutions a transcript of the evidence given at the inquest together with a statement signed by the Coroner and specifying the name of the known person and the particulars of the offence.

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

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

The role of the coronial inquiry has undergone an expansion in recent years. At one time its main task was to investigate whether a suicide might have been caused by ill-treatment or privation within the correctional centre. Now the Coroner will examine the system for improvements in management or physical surrounds which may reduce the risk of suicide in the future. In other words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist and, if so, to ensuring, as far as possible, that remedial action is taken.

Recommendations

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

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

Acknowledgment of the receipt of the recommendations made by a Coroner is received from Ministers of the Crown and other authorities promptly. Some weeks are required for the inquest evidence and exhibits to be studied and consideration given to the recommendations made by the Coroner. A formal reply as to the outcome of those considerations is then received by the Coroner. Recommendations were made arising from 14 inquests held during 2000.

Contacts with outside agencies

During 2001 the State Coroner's office maintained effective contact with the New South Wales Institute of Forensic Medicine (Department of Health), the Division of Analytical Laboratories at Lidcombe (Department of Health), the Aboriginal Prisoners and Family Support Committee (New South Wales Attorney General's Department) the Aboriginal Deaths in Custody Watch Committee, the Indigenous Social Justice Association, the Aboriginal Corporation Legal Service, the Aboriginal and Torres Strait Islander Commission, the Australian Institute of Criminology in Canberra, the Office of the State Commander New South Wales Police Service, and the Department of Corrective Services. Close links were also maintained with Senior Coroners in all other states and territories.

Overview of deaths in custody/police operations reported to the New South Wales State Coroner during 2001

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

Deaths in custody/police operations which occurred in 2001

There were 21 cases of deaths in custody and 16 cases of death as a result of or in the course of police operations reported to the State Coroner in 2001. These cases have either been listed for hearing in 2002 or are still under investigation.

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	**23**	**14**	**37**
1996	**26**	**6**	**32**
1997	**41**	**15**	**56**
1998	**29**	**9**	**38**
1999	**27**	**7**	**34**
2000	**19**	**20***	**39**
2001	**21**	**16**	**37**

Table 1: Deaths investigated by Coroners during 1995 to 2001

Aboriginal deaths which occurred in 2001

Of the 37 deaths reported during 2001 pursuant to Section 13A, Coroners Act 1980, 5 of the deceased were adult aboriginal males, all of whom died in custody in prison.

The inquest into the death of one adult aboriginal male has been heard and a finding given, a synopsis for this death is contained in this report. The deaths of the 5 adult aboriginal males reported this year are being investigated.

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	**7**	**0**	**7**
1996	**2**	**0**	**2**
1997	**6**	**2**	**8**
1998	**2**	**3**	**5**
1999	**3**	**1**	**4**
2000	**4**	**1**	**5**
2001	**5**	**-**	**5**

Table 2: Aboriginal deaths in custody/police operations during 1995 to 2001

Deaths investigated by the State/Deputy State Coroners during 2001

During the year 13 cases of "deaths in custody" and 9 "police operation deaths" were finalised (Appendix 1).

Findings were recorded as to identity, date and place of death, and manner and cause of death. No findings were entered as to the manner and cause of death in 3 "deaths in police operations" as the inquest in each case was terminated under the provisions of Section 19 of the Coroners Act 1980, on the basis that a known person had been charged with an indictable offence in which an issue will be that the known person caused the death.

Of the remaining 56 cases 24 have been listed for hearing in 2002 and investigations are still proceeding in the remaining 32 matters.

Information relating to the 17 deaths into which inquests were held and the 3 deaths in which the inquests were terminated.

Circumstances of death

Persons who died in the custody:-

- 5 by taking their own life by hanging
- 3 by way of accidental drug overdose
- 4 of natural causes
- 1 from injuries when hit by a train whilst in Home Detention.

Persons who died as a result of or in the course of police operations:-

- 4 from injuries received whilst in a vehicle being pursued by police
- 1 shot by police
- 2 self inflicted gun shot wound
- 1 from injuries when hit by a train
- 1 multiple injuries incurred as the result of a fall

Unavoidable delays in hearing cases

The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is unavoidable. There are many different reasons for delay.

One 1995 matter remains outstanding - the inquest is part heard before the then Senior Deputy State Coroner, John Abernethy who adjourned the matter generally for further investigation to be undertaken on his behalf. It is expected that this matter will be finalised during 2002.

Two 1998 matters remain outstanding - One is a homicide and is still being investigated. The other is listed for hearing on 1 February 2002.

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

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

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

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

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

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

Deaths occurring in police custody or during the course of police operations demand compliance by officers with the NSW Police Service Handbook as they relate to such a death. The Crown Solicitor instructs independent Counsel to assist with the investigation of this type of death. The official police instructions are closely analysed by the Coroner.

Only 20 deaths were finalised during 2001, in part because a substantial number of very long and complex inquests were heard by the State Coroner and Deputies. These included the Sydney/Hobart case (9 weeks), the Star City Casino case (6 weeks) and three or four other cases each taking at least 4 weeks.

Already 24 Section 13A deaths have been listed for hearing in 2002.

SUMMARIES OF INDIVIDUAL CASES COMPLETED IN 2001

Following are brief summaries of each of the cases of death in custody/police operations which were heard by the State Coroner, Senior Deputy State Coroner, Deputy State Coroner and the Acting Deputy State Coroner in 2001.

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

Further information about any of these cases can be obtained from the Executive Officer to the NSW State Coroner, Coroner's Court, Glebe.

778 OF 1997 Male aged 20 years died on 30 April 1997 whilst being conveyed to Orange Base Hospital. Finding handed down on 24 August 2001 at Glebe by Jacqueline Milledge, Deputy State Coroner.

A.C. was a 20 year old man who was shot dead by police during a police operation.

On 29 April 1997, A.C. had hired a taxi, argued with and threatened the driver who was forced to leave his cab. The taxi was taken by A.C. who took it home and smashed it into a tree. Police were alerted and when the general duties team approached his residence, the deceased confronted them with knives. He had an alcohol reading of .169 and toxicology revealed some breakdown products of cannabis in his system.

The Sergeant had called for back up when he arrived at the scene at 12.35am. He and his team of two constables were left to manage the situation unassisted until he was shot by another police officer at approximately 2.30am.

The sergeant's team continually talked to the deceased, and were forced to retreat on a number of occasions when A.C. moved towards them threatening them with knives. During the course of the confrontation, those police manoeuvred their police vehicles in an effort to tire A.C. and hopefully have him surrender. These officers had drawn their firearms as their lives were in real and immediate danger. Their commonsense approach to the life threatening circumstances enabled them to manage and contain A.C. for two hours.

The constable that fired the fatal shot had been sent by his local commander to conduct a reconnaisance of the area so that police would know what confronted them when the special operatives were dispatched. This was approximately 1.30am, and the sergeants team had still not been given the requested assistance. This particular officer had been a specialist trained SPSU operative and it was hoped that other specialists would be able to take control and negotiate a successful outcome.

The constable's reconnaisance was compromised when he was noticed by the deceased. After that he appeared to assume a general policing approach to the incident and was himself confronted by the deceased who lunged at him with a knife. The coroner was satisfied that given the immediate circumstances, the killing was justifiable, however the Coroner was not satisfied that this was an acceptable outcome.

Issues:

The main issue dealt with the police response to the incident. The Sergeant and his team were commended by the Coroner for exercising exceptional judgement and showing a great deal of courage when dealing with a potentially life threatening situation. The Coroner was not impressed with the approach taken by the specialist officer, who appeared to lack judgement and skill.

Having said that however, this officer, as well as the other police, had every right to expect 'back up' and assistance from their commanders, however that was not forthcoming.

Evidence is that deployment of the SPSU was requested at 1.10am. At the time A.C. was fatally shot, the SPSU deployment had still not reached the incident. Deployment was eventually authorised nearly 1 1/2hours after the incident. Many of the operatives then had to travel from Bathurst, suitable vehicles with towbars could not be located quickly to transport the equipment and equipment held locally was not easily accessed.

Other concerns by the police and the deceased's family focussed on the Mental Health System and its ability to adequately deal with those with mental illness or conditions on referral. It was also found during the inquest that the police had not sought to access the Mental Health professionals in dealing with A.C. Expert input in this situation would have been of great benefit, given that A.C. had a medical history of previous admissions and treatment. A number of recommendations addressed to both the Police and Health Ministers sought to address these concerns.

Finding:

That A. C. died at 2.41am on 30 April,1997, whilst being conveyed to the Orange Base Hospital, of a gun shot wound to the chest, inflicted at 2.30am at Larella Circuit, Orange, by a (named) member of the New South Wales Police Service in the execution of his duty, such killing being a justifiable homicide.

Recommendations

1. Regional SPSU centres be allocated access to a designated vehicle with tow bar/ball - via a 24 hour roster system so as to ensure availability of suitable vehicle for use by SPSU operatives/teams to convey equipment/trailer to sites on a 24 hour basis.

2. Local field supervisors of SPSU have available immediate access to local council and topographic maps for relevant local area command.

3. SPSU operatives be issued with telephone pagers for use when they are "on call" as to facilitate urgent contact and deployment. Such recommendations be given priority in respect of country regions of nsw.

4. Representations be made by the deputy state coroner to the nsw attorney-general that consideration be given to an extension of the parameters of a certificate under s33aa(4) to extend to "any tribunal including the industrial commissioner of nsw".

5. Officers stationed within the Orange local command receive immediate training in relation to;

(a) dealing with and responding to the needs of intellectually disabled and mental health patients;

(b) the facilities available at and protocols applying to Bloomfield hospital and Cadia house, Orange;

(c) the operation of the 24 hour 1 800 mhiss system;

Such training to be provided to;

* all officers within 3 months of their arrival at any station within the Orange local command; and

* all officers within the Orange local command on an annual basis.

It is noted that consequent to the inquest into the death of Roni Levi, a recommendation was made that there was a need for NSW police training in dealing with mentally ill persons be reviewed and constantly updated and re-enforced with police officers.

6. Police service of NSW report to the deputy state coroner within 28 days:

* full details as to the present status of the local memorandum of undertaking in respect of all local area commands within NSW;

* full details as to the ongoing implementation of the "Levi" recommendation referred to in paragraph 5 above.

7. I urge all parties to the local memorandum of understanding to implement the agreement forthwith.

8. All parties affected by recommendations 5 and 7 report their progress to the deputy state coroner by 31 December, 2001.

2217 OF 1998 Female aged 46 years died on 1 November 1998 at Grafton Correctional Centre. Finding handed down on 31 May 2001 at Glebe by John Abernethy, State Coroner.

C.N., a female Caucasian remand prisoner had been addicted to Heroin for many years. Just prior to her death she had commenced a home detoxification program under the supervision of her GP, though she probably continued to take drugs whilst detoxifying. She had at least twice in the past been on Methadone programs. She had also undergone previous home detoxification programs. Characteristically she had also been a supplier of prohibited drugs.

On 31 October, 1998 the deceased was arrested at Nimbin in relation to two First Instance Warrants which were outstanding at the time. No issue arose at inquest in relation to the arrest of the deceased or her processing by officers of the New South Wales Police Service. She did not appear to any of the police involved in her processing, to be affected by drugs or alcohol. She did not complain of illness or pain and denied intent to self-harm. The deceased appeared calm and

did not appear agitated or aggressive.. Police noted that she was taking 1x5 mg Valium every four hours and 2x Normison each evening and 1x Clonidine every four hours.

Whilst in the custody of the police the deceased asked to see a medical practitioner. She was seen by the Government Medical Officer who was informed of her detoxification regime. The GMO examined the deceased in her cell at Lismore Police Station. She told him that she had been using Heroin and was suffering abdominal cramps. The GMO was of the view that her symptoms were consistent with narcotic withdrawal. He dispensed Valium and advised police to contact him if there were any problems. According to police she spent most of her time sleeping or watching television. She was given her medication and Valium as requested.

At 9.10 am on 1 November the deceased appeared very agitated. Her custody officer felt she was withdrawing from drugs. She appeared to be unsteady with slurred speech. At 9.30 am the deceased appeared before a bail court. Bail was refused and she was returned to her cell. At 11.25 am the deceased and her property were transferred to the Grafton Correctional Centre.

The State Coroner was satisfied that all officers of the NSW Police Service who were responsible for the custody of the deceased carried out their duties with diligence and competence.

On arrival at the prison the deceased underwent the usual reception assessment by a Registered Nurse of the Corrections Health Service. She told the nurse that she was withdrawing from Heroin and had not used prohibited drugs for two days. She also told the nurse that she was on a home detoxification program, using Valium, Normison and Catapres (Clonidine). The nurse was of the opinion that the prisoner was suffering "mild opiates withdrawal" and prescribed Valium 15 mg, 3 times daily reducing 5 mg daily, Buscopan 20 mg, 4 times daily, and Maxolon 10 mg, 3 times daily. She was also issued with Immodium for diarrhoea. Following her assessment the prisoner was taken to the June Baker Centre. At about 7.30 pm the same nurse was contacted by staff at the Centre and told of the prisoner vomiting. She attended the centre and gave the deceased an injection of Maxolon. The prisoner only complained of vomiting. The nurse remained at the centre for 30 minutes in order to administer Valium. She did not want the prisoner to vomit up the Valium. This done she left the Centre and completed her shift at 9 pm.

The Corrections Officers' shift change occurred at 10.30 pm. The incoming officer was briefed as to the condition of the deceased. Shortly after the hand-over an experienced male nurse of the Corrections Health Service saw the prisoner. He had not been summoned to the Centre. The officer and nurse went to the prisoner's room and found her in the bath. She was found to be unsteady on her feet and appeared to be withdrawing from drugs. Once in bed she complained of headache. She was examined and blood and pulse were taken. She begged for help for her headache. The nurse gave her an injection to calm her and stop her vomiting. He remained in the room with the prisoner and regularly checked her blood pressure. The prisoner continued to complain of headache. She was told that she could not be given more medication until the injected medication took effect. Upon finding the prisoner's blood pressure to be quite high the nurse telephoned a medical practitioner of the Corrections Health Service in Sydney. The prisoner was left in her room and told to "try and relax". She responded with "thank you for helping me". The nurse returned about 10 minutes later and found the deceased to be sitting up. Drugs, including Panadiene Forte and Clonidine were then administered to the prisoner. The

nurse again sat with the prisoner for some time. He and the corrections officer left her when she appeared to be sleeping. After about 15 minutes, and before leaving the Centre the nurse again checked the prisoner and found her to be lying in the same position and breathing normally.

At about 5.15 am the prisoner was found to be deceased. Thereafter appropriate death in custody protocols were carried out.

A Post Mortem Examination was carried out and the deceased was found to have died of coronary artery atheroma with multiple drug toxicity contributing to her death.

Statements were taken from staff and prisoners. A number of prisoners gave evidence at inquest.

The Nurse took part in an ERISP Record of Interview and also gave evidence. He was frank with the police and with the Court.

Issues:

Should the prisoner have been in prison at all?

This matter was dealt with shortly by the State Coroner who was of the firm view that the prisoner was lawfully in custody.

Methadone in the deceased's System.

The State Coroner found it probable that the deceased was given Methadone by one of the other inmates, probably distressed at her illness. There was no evidence before the Coroner that she had brought the drug into the prison though that was possible. He also found it unlikely that a person other than a prisoner gave her the drug. Significantly those treating the prisoner had no knowledge that the prisoner had ingested this most dangerous drug. An expert medical witness confirmed that the process of treating a person with Methadone in the context of poly drug abuse was complex. The clear weight of evidence was to the effect that had it not been for the heart disease the prisoner would not have died of a drug overdose.

Use of Clonidine for drug withdrawal.

Some medical witnesses felt that with the high blood pressure readings the deceased ought to have been taken to hospital. The nurse felt that at the time he left the deceased, hospital was unwarranted. The State Coroner accepted the evidence of an experienced specialist pathologist who was of the opinion that the matter was "line ball". He noted that the head of the Corrections Health Service, and experienced medical practitioner took the same view as the nurse. It was noted that the drug Clonidine may have been most appropriate because of its propensity to lower blood pressure. The Coroner noted that whilst it did not appear to have worked, it did not appear to have caused harm either.

The State Coroner accepted the evidence that the withdrawing with Methadone, in the context of a pre-existing cardiovascular problem made the job of the nurse extremely difficult. He noted that the prisoner had indicated to the nurse that her headache was receding, and that she was resting peacefully. Most medical

witnesses were of the view that the prisoner would not have died but for her severely occluded coronary artery.

Assault one week earlier.

The prisoner had suffered a minor assault approximately one week prior to her death. Neither the forensic pathologist nor the forensic neuropathologist were of the opinion that swelling of the brain was a significant factor in the case. The pathologist felt that small clots in the brain may have accounted for the headaches and raised intracranial pressure just prior to death. He did not feel that the drugs dispensed were sufficient to cause death with the caveat that the combination may have contributed to it, and that the raised intracranial pressure may have led everybody treating the prisoner to believe that the symptoms were simply related to drug withdrawal, whereas some of the symptoms may have been related to the other problem which matched the drug withdrawal symptoms.

Conclusion.

The NSW State Coroner found the issues of manner and cause of death to be complex. He noted that the specialist pathologist felt that the toxicology findings were likely to be incidental to the death, whereas the pharmacologist was of the view that the coronary artery atheroma was more likely to be incidental.

He noted however, that the forensic pathologist had the benefit of a close physical examination at post mortem, of the cardiovascular system of the deceased, and framed his finding after so doing. He accepted his evidence.

The Coroner noted that the program to place detoxification units in Reception prisons throughout the State was continuing. He said:-

"….. I am concerned though that there are nowhere near enough beds. The evidence of Dr. M (which I have heard before) whereby at the MRRC, prisoners have to be severely triaged in order to award beds to only the 9 worst cases is disturbing, though I acknowledge the substantial cost of increasing the size of such units.

Formal Finding.

That C. N. died on 2 November, 1998, in Room 2, June Baker Centre, Grafton Correctional Centre, Grafton, of coronary artery atheroma, with multiple drug toxicity contributing to the death.

Recommendation.

That the New South Wales Government considers the application of further funds in order to provide more beds in Detoxification Units in New South Wales Reception Correctional Centres.

963 OF 1999 Male aged 75 years died on 18 August 1999 at Metropolitan Remand and Reception Centre, Silverwater. Finding handed down on 28 March 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.

The deceased (M.S.) who was 75 years of age and a citizen of Lebanon had recently arrived in Australia. He was arrested by Federal Police a few days after his arrival in Australia when found in possession of a large quantity of heroin. After bail was refused at Court Mr S was conveyed to MRRC, Silverwater on the 14th June, 1999.

M. S. was inducted in the usual fashion and indicated under 'needs/alerts' was the notation that an interpreter was required.

Correctional Health Staff assessed M. S. as having a 'blood circulation problem' and required daily aspirin. M. S. indicated 'no' to the question as to whether he had a heart or other condition.

M. S. was seen the next day by medical staff and, with the aid of another inmate who was interpreting, indicated he had 'dry blood'.
It was unable to be ascertained what medication M. S. was taking prior to his incarceration and the daily aspirin was continued.

M. S. made calls to acquaintances in Australia seeking assistance but made no complaint as to medical condition or treatment.

M. S. was assessed by correctional staff to be placed two out with a person who spoke Arabic but this did not occur and he was placed with a Lebanese prisoner who did not speak Arabic.

On the 7th July M. S. was examined by a medical practitioner who ordered a baseline cardiograph which did not indicate any cardiac symptoms.

M. S. again attended court on 20th July where bail was refused and he was to appear at the Sydney District Court on the 27th August.

On the 18th August M. S. was locked down with his cell mate. He made no complaint about his health to any person but at about 4.30pm M. S. was heard by his cell-mate to groan and was seen to slump to one side. The knock-up button was sounded and prison officers attended the cell. M. S. was unconscious but breathing.

Nursing staff were summonsed and upon M. S. being moved to facilitate CPR he stopped breathing. Ambulance service was called and an ambulance attended. A further Intensive Care ambulance arrived at 5.23pm and although personnel continued to support M. S. he was pronounced life extinct upon arrival at Auburn Hospital at 6.22

A Post Mortem was carried out where it was found M. S. died of Coronary Artery Atherosclerosis.

Issues:

Lack of use of Arabic speaking interpreter when prisoner examined by Corrections Health.

Corrections Health Documents to clearly note the name of personnel who have added information to inmates forms.

Inquest:

An Inquest was held on the 28th March, 2001.
It was clear an interpreter should have been used by Corrections Health Personnel to obtain information from M. S. which related to his health. There was nothing to indicate any person contributed directly to M. S.'s death and M. S. himself did not indicate he was in ill health.

Formal Finding:

M. S. died on the 18th August, 1999 at Silverwater Metropolitan Remand and Reception Centre of Coronary Artery Atherosclerosis.

Recommendations:

Recommend to the Minister for Health that:

1. Corrections Health Prison Assessment Forms clearly indicate the personnel who have added any information to that official Health document; and

2. Corrections Health personnel use an official Health Department interpreter at all times when dealing with persons who have limited English Language Skills.

981 OF 1999 **Male aged 28 years died on 23 August 1999 at the Metropolitan Remand and Reception Centre at Silverwater. Finding handed down on 5 April 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.**

S. B. was a 28 year old man sentenced on the 18th August, 199 at Hornsby Local Court to one month's imprisonment backdated to the 11th August. The completion date for the sentence was the 10th September.

He mad a history of mental illness/mental conditions. He was an illicit drug user and had prior unintentional overdoses. He previously had drug induced psychosis and had spent time in a mental institution. He was noted to be agitated and anxious. He also appeared to have symptoms of a serious mental illness.

He said he felt confused had no hope for the future, no one to talk to but also said he was not suicidal but answered 'maybe' to questions:

'Was he likely to attempt suicide in gaol?; If he was feeling suicidal would he tell gaol staff?'

S. B. was referred to the Risk Intervention Team for nursing assessment and detoxification within the following 24 hours. He was to be placed in a 'safe cell' which had camera surveillance and place on Valium.

On the 12th August he was seen by the Risk Assessment Team and drug and alcohol specialist. He was assessed as suffering from a drug induced psychosis and had done so intermittently for three years. He again told staff he was not suicidal.
As a result of this assessment S. B. was deemed no longer to need the urgent assistance of the Risk Assessment Team. He was to be placed in a normal cell with other prisoners but with a protection regime. S. B. was to be referred to a Psychiatrist and to be reviewed on the 16th August.

On the 18th August S. B. again attended court and it was at this time he was formally sentenced to the one month gaol.

On the 19th August S. B. again was assessed and again indicated to nursing staff he was not suicidal.

On the 21st of August prisoners approached Corrective Service personnel and indicated there would be trouble that evening unless S. B. was removed from their cell. He was too difficult for the prisoners to co-habit with him as they were concerned about his mental state. (S. B. had told a psychiatrist this day he was having auditory hallucinations and that this had been occurring for the past five weeks. He was placed on nightly doses of anti-psychotic medication.) S. B. was placed in a one out cell in Darcy Pod.

He was seen by nursing staff and was not responsive to questions- the plan was for him to be followed up within the week or when requested by S. B.

S. B. was let out of his cell at 10.30am and returned without incident at 2pm.
At 6.30pm S. B. used the knock up button and was spoken to in his cell by Correctional staff. S. B. was seeking information about his 'buy-ups'. S. B. did not appear to be behaving unusually and did not complain of any illness.

At 7.08pm S. B.'s cell was unlocked by Correctional Staff in order that a nurse give S. B. his prescribed medication. S. B. was seen to be slumped against a wall with a noose made from a bed sheet around his neck. CPR was commenced and an ambulance called. At 7.55pm life was pronounced extinct.
A Post Mortem was carried out and a finding of hanging was made.

Issues:

Why was a mentally ill prisoner placed alone in a cell.

At Inquest:

The Inquest was commenced, and with the ready concurrence of S. B.'s family, quickly adjourned until 5th April to enable discussion to take place with senior Correctional staff and senior Corrections Health staff. It became obvious that in relation to S. B. there was no where available for staff to place him at MRRC although he was obviously mentally ill. Following discussions and upon resumption of the Inquest the following information became available:

There are now more people in gaol taking up psychiatric beds than there are out of gaol. Within the gaol system there are only 168 beds for this usage and approximately 20 prisoners at any time throughout the State seeking such beds.

It is obvious that we have moved many of our former psychiatric population from community hospital accommodation to prison accommodation. Apparently 50 per cent of all women prisoners and 33 per cent of all male prisoners have been through the mental health system prior to their incarceration. This surely is totally and absolutely unacceptable to any civilised community.

Formal finding:

S. B. died on the 21st August, 1999 at MRRC, Silverwater of Hanging, such hanging being non-accidental and with the intention of taking his own life.

Recommendations:

I recommend to the Attorney General, Minister for Corrective Services and Minister for Health:

1. As an interim measure the establishment of a separate pod within the MRRC as a mental health assessment and support unit with appropriate trained staff in forensic psychiatric care.

2. A purpose built mental health assessment unit at the MRRC as well as a stand alone psychiatric hospital for the care of forensic patients and this be established as a matter of urgency.

3. Full support be provided for the Local Court Mental Health Court Diversion System with adequate and appropriate community facilities being made available as an alternative to gaol.

4. A transfer mechanism be available to clinicians within Corrections Health Service to alter of their own volition the status of minor forensic patients, that is, those with a resiled drug induced psychosis to be transferred to the general prison population.

2096 OF 1999 **Male aged 29 years died on 10 October 1999 at Goulburn Correctional Centre. Finding handed down on 18 January 2001 at Goulburn by Jacqueline Milledge, Deputy State Coroner.**

A.M. was an inmate at the Goulburn Correctional Centre serving seven years for Armed Hold Up offences and Demand Money with Menaces.

On 9 October, the deceased was moved 'one out' and, as his possessions were placed in the new cell, AM spent time in the yard until 'lock up' at 3pm. About 8:15am on 10 October he was found hanging from the top bunk by a torn bed sheet. The deceased had committed suicide. There was no other person involved in his death.

Concerns raised by the family included the amount of medication their son was on at the time of his death, how he managed to have a torn sheet in his possession, and why some prison records were missing.

Correctional Officer's gave evidence that inmates often fashion torn sheets into clothes lines to enable them to have control over the drying of their washing to safeguard against theft. The officers stated that as soon as the lines are confiscated, another appears within half an hour.

At inquest, the Coroner was satisfied that the prisoner's medication was appropriate for his circumstances.

Another matter that was considered at inquest was his move from Junee prison, where his parents believed he was doing well, to Goulburn. This move took place on the 17th of September. Evidence was given that he was moved for security reasons as white powder was discovered in his cell. There was also prison 'intelligence' to suggest he was arranging the movement of monies to different accounts. The initial 'NARCO' system of drug testing indicated the powder was 'speed', however, subsequent forensic analysis proved negative. The Coroner was satisfied that the transfer of the prisoner was appropriate.

Throughout his period of incarceration the prisoner had accessed the health and counselling services regularly. His medical record clearly shows Corrective Services responded to his requests for assistance timely and often. From the records it appears his depression had many sources. He disliked the facility at Goulburn, he was drug dependant, he was disappointed that his request for transfer was taking so long and he had not had a visit from his family for eleven months. These issues, amongst other things, compounded and on 10 October 1999 he hanged himself

Finding:

That A. M. died as a result of hanging on the 10th of October, 1999, Between 3pm and 8.30am, in Cell 38, a wing of the Goulburn Correctional Facility.

Recommendations:

To the Commissioner for Corrective Services:

1. That the Commissioner for Corrective Services re-enforce the existing protocols to ensure all files and records relating to the deceased remain complete and intact until the Coronial process is at an end.

2. That all activities relating to the removal of items from any deceased's cell be recorded indicating the officers name, date and time and activity.

3. That all inmates under police investigation for drug use/possession, be interviewed by police at the time of referral or as soon as possible thereafter.

4. That the form accompanying any substance sent by police for analysis be endorsed to ensure a copy of the analysis certificate is forwarded to the Governor of the Correctional Centre involved immediately after analysis.

5. That the use of the current 'NARCO' system of presumptive drug identification be reconsidered as it appears to be unreliable.

6. That the existing protocols be re-enforced to ensure that the deceased's property in the cell remains undisturbed until the next of kin have been notified and afforded reasonable time to view the cell.

7. That the personal property of each inmate be searched when transferred from wing to wing.

8. That a record be kept when the officer in charge of the investigation directs that the crime scene is no longer to be preserved. Details should include the time, date, direction and who was directed. This record is to be kept by both the police and the Governor of the Correctional Centre.

Recommendations 3, 4 & 8 where also made to the Minister for Police.

222 OF 2000

Male aged 65 years died on 1 February 2000 at Prince of Wales Hospital, Randwick. Finding handed down on 21 March 2001 at Glebe by Jacqueline Milledge, Deputy State Coroner.

The deceased was an inmate at the Kirkconnell Work Farm. He had been incarcerated since 17 June 1999. His formal release date was 16 December 2003, but with parole it was possible for him to have left the facility on 16 December 2000.

Prior to going to gaol, the deceased had a medical history, including stomach cancer. Corrections staff arranged for the deceased to be seen by a specialist urologist on 20 October 1999. Following that appointment further arrangements were made for a prostate biopsy to be carried out at Long Bay hospital.

On 28 December 1999 he was returned to Kirkconnell where his condition gradually deteriorated until he was admitted to Bathurst Base Hospital on 4 January 2000 before being transferred to Prince of Wales Hospital on 5 January 2000.

There have been no issues raised by the deceased's family with regard to his treatment whilst an inmate at any of the facilities within the prison system. The coroner was satisfied that the medical treatment the deceased received was appropriate and timely.

Finding:
EJ died on 1 February 2000 at the Prince of Wales Hospital, Randwick whilst he was an inmate with the Department of Corrective Services. His cause of death was the complications of the biliary obstruction due to the recurrent gastric carcinoma.

233 OF 2000 **Male aged 30 years died between 24 and 25 February 2000 at the Metropolitan Remand and Reception Centre, Silverwater. Finding handed down on 20 February 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.**

B. H. was married with three young children. He had arrived in New South Wales from Tasmania along with his family, approximately eight weeks prior to his death.

He was arrested and charged on the 23rd of February with aggravated armed robbery and remanded until the 8th of March, 2000.

He was assessed upon entry to the prison as having a drug addiction to heroin and alcohol and was 'withdrawing' from both. He was placed on a drug and alcohol withdraw regime and prescribed Valium.

B. H. indicated he was 'sick tired, stressed and not coping'. He was placed 'two-out' in a cell with another inmate.

At this time the wife of B. H. was in St Vincent's Hospital suffering an unknown illness and the children were in the care of the Department of Community Services.

On the 24th of February B. H. telephoned his wife at Hospital and later at 3.30pm that day was with other inmates 'locked down' for the night.

B. H.'s cell mate indicated at Inquest there was a general though limited conversation with him with an indication that B. H.'s wife was going to visit him the next day. There was no indication from B. H. that there was any problem that was concerning him.

At 7.30pm nursing staff attended B. H. in relation to an injured finger. Nothing of concern was noted by nursing staff at this time.

Later that evening both men lay on their beds and watched television prior to falling asleep.

At 7.45am on the 25th February the cell mate woke and noted B. H. half seated on his own bed with one leg on the floor.

The cell-mate did not note anything wrong and left the cell to obtain his methadone at about 7.50am.

When he returned to the cell the cell-mate looked closer at B. H. and noted his tongue protruding. He advised prison officers who attended spoke to B. H. did not obtain a response and on closer inspection noted a strip of sheeting tied around his throat and attached to the top bar which covers the window from outside.
(The reason the 'noose' was not noted earlier was that B. H. at the time of his death was sporting a large bushy beard.)

Although CPR was attempted B. H. was not able to be revived.

Issues:

1. Difficulty of observing prisoners who are housed in corner cells.

2. Was B. H.'s death suicide or 'attention seeking' behaviour.

There are coroner cells in all PODS at the gaol and these are not used for persons at risk. Information known to Corrective Services did not indicate B. H. at risk.

The information concerning the wife of B. H. being in hospital and the children in the care of DOCS which would both be indicators of risk were not known to Corrective Services until after B. H.'s death.

The evidence at Inquest left some doubt as to whether the deceased fully intend to take his own life.

Finding:

B. H. died between the 24th and the 25th of February, 2000 at Silverwater (Metropolitan Remand and Reception Centre) of non-accidental Hanging.

280 0F 2000 Male aged 16 years died on 26 February 2000 at Bega. Finding handed down on 16 January 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.

J.B. was a passenger in a motor vehicle that was being driven by L.M.[4]. Their vehicle came into collision with a second vehicle which was being pursued by police. The driver of the second vehicle has been charged by police with an indictable offence. In those circumstances the inquest was terminated under the provisions of section 19 of the Coroners Act 1980.

414 of 2000 Male aged 21 years died on 18 April 2000 at the Metropolitan Remand and Reception Centre, Silverwater. Finding handed down on 26 September 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.

ST was a young man of twenty one years who had been dabbling in drugs for quite a period of time, certainly since about Year 9 when he started with marijuana at school and unfortunately had progressed onto harder drugs. He had had a number of brushes with the law which had previously resulted in a period of incarceration.

In January 1998 he overdosed on heroin and spent some days at Cumberland Hospital. Between April and October, 1999 he was in gaol and during that time was stabbed by another inmate, apparently following an argument over non-payment for drugs. In early February, 2000 ST attempted to take his own life by overdose but was located in time. On 15th April, 2000 he was arrested by police in Sydney and charged with false pretences. He appeared before Parramatta Local Court on 16th April (before a bail justice) and was granted conditional bail (security to be lodged) but the bail could not be raised. He was returned in custody on that day to the Silverwater Reception Centre.

On admission to Silverwater he was assessed by a nurse and a drug and alcohol worker. Whilst being assessed by the nurse he did give some information but not all in relation to his current drug usage and his most recent attempt at self harm. He was assisted to locate a friend (by phone) who indicated she would post bail for him when he returned to Court the following day. Prison staff said he appeared quite positive and confident that he would only get a short sentence even if he didn't get bail. He returned to Parramatta Court on the 17th and bail was then refused. He spoke to prison officers and other prisoners on the way back to prison but did not give any indication to anyone of an intent to cause self harm.

On the evening of the 17th a security check found nothing untoward however when prison officers attended at 6.30am the following morning, ST was found hanging in his cell. When nurses attended they found him to be deceased and it appeared that he had been for some time. A post mortem examination did not provide any evidence to suggest that any other person was involved in ST's death. A toxicological analysis of a blood sample showed morphine to be present and higher levels in the urine, rather than in the blood and bile, indicated fairly recent usage. It is not known how ST got access to heroin, however it appears to have been orally ingested as there was foil and matches found in his cell, but no syringes located.

[4] See case 554 of 2000

A number of prison officers and those making assessments of ST gave evidence at this Inquest. The coroner found these witnesses to be impressive and well aware of their duties in relation to the prisoner. An unfortunate thing about Corrective Services is that in many ways, we have shut down our mental institutions and forced corrective service officers to take on new role of being the gaolers for people who have mental conditions or mental illnesses. A Senior Officer in the Corrective Services hierarchy (Mr. Grant) has given evidence and put forward a number of recommendations which the coroner proposes to support.

Finding: That ST died on 18th April, 2000 at Silverwater Reception Centre of hanging and that such hanging was carried out with the intention of taking his own life.

Recommendations.
To the Minister for Corrective Services that:

1. All correctional centres discharging inmates be reminded of the current requirements to complete a discharge summary.

2. That the Minister give consideration to establishing a process whereby a prisoner returning from Court, whose circumstance has changed, be routinely interviewed on return to the correctional centre in an attempt to prevent this from happening in the future.

441 OF 2000 Aboriginal male aged 39 years died on 26 April 2001 at the Metropolitan Remand and Reception Centre, Silverwater. Finding handed down on 21 February 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.

A.D. was a 39 year old Aboriginal man who had not come under the notice of police until he was about 18 years of age.

At that time A.D. began to use alcohol and marijuana to excess. Later he became addicted to amphetamines which caused him to experience episodes of psychosis. This brought him under notice of the police.

He was arrested and placed on remand at the MRRC for a number of serious offences since May of 1999. He was due to return to court at Penrith on the 3rd of May, 2000. Due to the lengthy remand period and his good behaviour A.D. held a position of 'sweeper' on his wing.

A.D. had one prior incident of self harm in 1996 which he indicated had occurred when he wanted to be moved from police cells to the mainstream prison population.

On the 28th of June 1999, A.D. was examined by a psychiatrist as he was behaving in an aggressive fashion. This appeared to relate to him withdrawing from drugs. However during this interview he advised the psychiatrist he was also using 3-6 grams of heroin per day. A.D. was also using lawfully prescribed medications to treat depression.

A.D. sought that he be placed 'one-out' in a cell following his examination as he suffered from severe asthma and could not tolerate cigarette smoke.

On the 26th April at about 7.15, A.D. and another 'sweeper' were let go from their cells to perform their duties. At the same time those inmates who were on the methadone program were also released from their cells to obtain their medication.

Once this had taken placed all inmates other than the two sweepers were returned to their cells.

Both A.D. and the other sweeper made coffee in the kitchen, then they separated with the second sweeper returning to seek a cigarette. It was indicated these were in A.D.'s cell.

After attending the cell the second sweeper was called away by another inmate then returned to A.D.'s cell where he sought a further cigarette. A.D. was on his bed lying down and did not respond to the sweeper's request.

In response to another inmate seeking his assistance the sweeper left, assisted the inmate then went to his own cell for a short period. He then returned to A.D.'s cell and found him in the same position he had left him. Again A.D. did not respond to his questions, and at this time the sweeper saw a piece of foil near the foot of A.D.s bed. He picked it up asked A.D. what it was but did not receive a reply. He shook A.D. and noted no breath or heartbeat.

The sweeper alerted Correctional officers who performed CPR and called for medical assistance.

A.D. did not regain consciousness. It was noted at the time Correctional officers attended A.D. was found to be lying on his bed in a very 'neat' fashion.

The cell of the deceased was searched. No illegal substances or drug paraphernalia were found. The silver foil that the second sweeper stated he removed from the deceased's cell was located on him when he was searched. The sweeper indicated that he took the foil from A.D.'s cell in an attempt to prevent A.D. getting into trouble. The foil showed it contained 'rock' heroin.

The cell of Asian inmates which was nearby was searched and part of a syringe was located but no drugs.

At post mortem the cause of death was shown to be Acute Narcotism.

Issues:

1. Deceased was lying in 'too neat' a fashion on his bed.

2. Was the deceased a victim of foul play on the part of Asian inmates who had on an earlier occasion caused the deceased some problems?

Findings:

Concerns had been raised early that the neatness of A.D.'s bed and room was not as would be expected. That the neatness showed another person may have moved A.D. prior to or shortly after death. Although the position of A.D.'s body remained of interest throughout the Inquest.

There was nothing at Inquest to indicate any other person was implicated in the death of A.D.. A.D.'s body did not indicate any signs where he had been held in order heroin be forcibly administered. There was nothing to indicate he would

not have been a willing user of the drug. There was no evidence of any kind that could infer A.D.'s death was an act of suicide.

A.D. died on the 26th of April, 2000 at Silverwater (Metropolitan Remand and Reception Centre) of Acute Narcotism.

554 OF 2000 Female aged 18 years died on 22 March 2000 at Canberra. Finding handed down on 16 January 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.

L.M. was the driver of a motor vehicle in which J.B.[5] was a passenger. Their vehicle came into collision with a second vehicle which was being pursued by police. The driver of the second vehicle has been charged by police with an indictable offence. In those circumstances the inquest was terminated under the provisions of section 19 of the Coroners Act 1980.

884 OF 2000 Male aged 25 years died on 5 August 2000 at Parramatta. Finding handed down on 31 October 2000 at Westmead by Janet Stevenson, Senior Deputy State Coroner.

The deceased (M. M.) died whilst a passenger in the front seat of a motor vehicle being driven in Pitt Street, Merrylands. A known person has been charged with an indictable offence in respect of the death.

1068 of 2000 Male aged 28 years died on 18 September 2000 at Lithgow Correction Centre. Finding handed down on 30 August 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.

J.S. was a 28 year old man without history of mental illness of suicidal ideation. He had a history of drug and alcohol abuse from the age of about 22 years. He was a user of amphetamine and heroin. He had been previously served periods of incarceration prior to his death.

He came into the care of Corrective Services on the 31st of May and indicated a usage of intravenous drugs - heroin and amphetamine.

On the 1st of October J.S. received a 6 month sentence at Wollongong Local Court for assault, breach of AVO and other matters, his earliest release date being the 25th of November, 2000.

On the 20th of October he was to return to Gosford District Court for sentencing in relation to outstanding charges of Break enter and steal.

J.S. remained at Silverwater until he became a sentenced prisoner and on the 9th of September he was transferred to Lithgow Correctional Centre.

Mr Simpson appeared settled upon his admission and was considered to integrate well with other inmates and was not classified as 'difficult'.

[5] see case 422 of 2000

Mr Simpson was in a relationship and had a child from a previous relationship. He maintained good relations with the mother of his child. His present girlfriend visited him in custody the day prior to his death.

A fellow inmate who was a friend of the deceased had been with J.S. the afternoon prior to death. He was not aware of J.S. having a drug habit. He advised that other than himself Simpson only spoke to another inmate, W. When last spoken to J.S. was in good spirits.

At about 8.15, J.S. was spoken to by Correctional staff when they commenced 'head checks'. He appeared well and did not have any complaint.

W, who was an inmate receiving methadone that morning attended the clinic at about 9.10am. In doing so he was seen to speak to J.S. through the flap of the door on the way to and from the clinic.

At 11.50am J.S.'s cell was opened to permit him to have his lunch. At this time he was found face down on the bed and was non-responsive. Upon him being checked there were no signs of life.

Upon police attending the deceased was found to have one empty plastic bag in his hand and 6 foils of heroin were found in a plastic bag between the buttocks. No other drug paraphernalia was found.

A homemade syringe was later found in W's cell but this was not tied to usage by the deceased.

A Post Mortem found the deceased died as a result of Acute Narcotism through the usage of heroin. A recent injection site was located in the right upper arm.

There was no evidence to suggest the deceased deliberately took his own life nor that any other person was involved in his death.

Issues:

Who supplied the heroin to the deceased; was the syringe found in Wardell's cell the same one used by the deceased.

Inquest:

At Inquest the issues posed were unable to be resolved.

Suspicion rests as to supply of the drug with the deceased's girlfriend who visited him the day before his death. The syringe found in Wardell's cell may well have come from the deceased, being passed through the cell flap. This could not be confirmed.

Finding:

J.S. died on the 18th September, 2000 at Lithgow Correction Centre of the Acute Narcotism.

1174 OF 2000 Male aged 48 years died on 16 October 2000 at Prospect. Finding handed down on 25 September 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.

H.R. was serving a six months period of home detention commencing on the 12th of October, 2000. The offences were for High Range PCA and Drive whilst disqualified. He was living in a house that was divided into two flats.

H.R. was alcoholic and diabetic. At the time of his death he was prescribed Valium and Minidiab for the control of cravings for alcohol. He was apparently non compliant in relation to his diabetes. The Probation and Parole Service did not know H.R. was diabetic.

As a Apprehended Violence Order, although expired, had been made within five years of the Home Detention, H.R. was not permitted to have contact with his wife

On the day prior to his death H.R. was seen and breath tested by a Probation Officer in accord with Home Detention Protocols. H.R. showed no signs of alcohol or ill health. He did not complain of any illness.

At 6pm he spoke to the tenant of the second flat but not indicate any signs of illness.

At some time between 8pm and 9pm the tenant of the second flat heard a loud thump as if someone had fallen over. He did not investigate.

On the 16th of October H.R.'s wife rang him and did not receive a response. With the assistance of her son and the second tenant they gained entry to H.R.'s flat and found him deceased. A Post Mortem was conducted and H.R. was found to have died from the Complications of diabetes.

Issues:

1. Should persons potentially subject to Home Detention be subject to a medical assessment prior to determining their suitability.

2. Should section 77(1)(e) Crime (Sentencing Procedures) Act be subject to amendment.

Inquest:

At Inquest it was established the Probation Service had complied with the law and well established guidelines for Home Detention.
The Probation Service has no discretion under present legislation to permit a detainee to co-habit with a spouse where an AVO had been in force within the five year period prior to Home Detention.

Formal Finding:

H.R. died at 440B Blacktown Road, Prospect from the Complications of Diabetes.

Recommendations:

1. The prior medical history of a prisoner be provided to the Probation Service by the prisoner's usual medical practitioner prior to that person being assessed for home detention.

2. The Attorney General be requested to consider amendments to Section 77(1)(e) of the Crimes (Sentencing Procedures) Act, to enable the Probation and Parole Service to permit a discretion to officers of the Service, to allow persons to reside together, even though an AVO which has expired, had been made against one by the other within a five year period.

1282 of 2000 Male aged 30 years died on 15 November 2000 at Lapstone. Finding handed down on 28 August 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.

AS was a 30 year old man who resided with his wife & three children at Emu Plains. He had a criminal history and was awaiting sentence on matters for which he was expecting to receive a gaol sentence. He had decided to steal some vehicles, strip them, and sell the parts to support his family while he was in gaol.

On the evening of 14th November, 2000 AS recruited an accomplice and then drove his wife's car to the North Richmond area where they stole a Ford table top truck. They then drove both vehicles to Cambridge Park where AS's vehicle was parked and another white utility stolen. Both stolen vehicles were then driven towards the Blue Mountains.

The owner of the white utility heard her vehicle being driven away and alerted police to the theft. Information of the stolen utility was broadcast over the police radio. A security guard heard the broadcast and a short time later saw the two vehicles at Penrith and followed them onto the F4 Freeway. He telephoned police on his mobile phone and police were able to stop the accomplice in the stolen utility near Emu Plains.

The security guard continued to follow the stolen truck and kept police informed of the position of the vehicle. When in Darwin Drive at Lapstone, an officer of the Police State Protection Dog Squad arrived on the scene and began to follow the stolen truck. He activated the warning devices on his vehicle but AS did not stop and indeed increased his speed, albeit to 40kph. AS drove the truck onto Governor's drive to a point where it comes to a dead end. There was vacant bushland past the end of the road closed to the public by a cyclone wire fence and gates. AS drove the truck over the gutter, through the locked gates, and then about 50 metres along a bush track until he collided with a tree.

The officer got out of his police vehicle in Governor's Drive and went into the bush to where the stolen truck had stopped. The truck was empty and although he had a torch with him, he could not locate AS. He returned to his truck and got his dog and then continued to search for AS. It was a dark, foggy & windy evening with poor visibility, and the dog appeared to have trouble finding a scent.

Other police arrived at the scene and assisted in the search. A short time later police went down to a gully area and there located AS's body. From the time the truck stopped to when AS's body was found was a maximum of ten minutes.

A subsequent postmortem examination found nothing untoward in relation to AS's body other than a head injury which was consistent with him falling from a height and causing injury to himself.

As AS's death was occasioned during a police operation the relevant procedures came into play. Police were interviewed and were drug and alcohol tested with negative results. There was nothing to indicate that the police had done anything untoward or incorrect in this matter.

Formal finding:

That the deceased died on the 15th November, 2000 in Bushland off Governer's Drive, Lapstone of head injuries occasioned when he fell into a gully whilst fleeing police who were acting in the course of their duty.

1751 of 2000 Male aged 49 years died on 28 August 2000 at Brewarrina. Finding handed down on 31 October 2001 at Bourke by John Abernethy, State Coroner.

The deceased (W.D.) was a 49 year old single Caucasian male normally resident in Cooroy, Queensland. After the failure of his second marriage in 1998 he was employed casually, often as a butcher.

He regularly "locumed" for a Brewarrina butcher. The deceased had lengthy ties with the town and regularly went there for recreational shooting. He had been involved with firearms most of his life and at the time of his death was the registered owner of nine (9) firearms (rifles and hand guns). He also possessed a large quantity of ammunition and a device for making bullets and cartridges. Significantly the deceased also possessed firearms for which he had no licence. In his vehicle after his death, for example, police located secreted one M1 Sub Machine Gun, the property of the Commonwealth. In the recent past he had spoken to his ex wife of taking his own life.

The State Coroner accepted the evidence of the ex wife. Her opinion was that the deceased was capable of taking his own life, or the life of others, should he be at risk of going to gaol or losing his firearms which were very important to him.

In early August 2000 the deceased came to work at the butchery. On 19 August, 2000, at about 2 pm, he went to the Royal Hotel and began drinking "Jack Daniels" and diet coke. During the afternoon and evening he appeared happy but later became heavily intoxicated.

At about 9 pm the deceased grabbed a patron by the hand. She objected. A table was upset and drinks spilt. Arguments broke out between the deceased and a number of patrons. He left the hotel, causing minor damage to a rear door. The publican intervened and took the deceased to his home - premises adjacent to the butchery. He left the deceased there at about 9.22 pm.

The deceased then armed himself with a .22 calibre semi-automatic pistol and promptly returned to the hotel. A patron attempted to wrestle the pistol off him. He said words to the effect: "I'm going to blow them away.". He was then spoken to by the publican and after a struggle, was disarmed. The publican then ran from the scene with the pistol and threw it into a yard containing his dogs - a safe place. A patron called the police. After chasing the publican a short distance, the deceased left the area of the hotel saying: "I've had enough - I'm going to get them.".

At about 9.50 pm a Senior Constable (W) and Constable (C) of police received a radio message to attend the hotel in relation to the incident and were told there was a man with a shotgun. They were not told by the publican or patrons about the pistol - only that there had been an incident, damage caused, the deceased taken home and no action required. (The publican told the court that he did not tell police about the pistol for fear of inflaming the situation.)

Shortly before 10 pm the deceased made his way to the butchery residence and forced entry by breaking glass in the main entry door. He then probably remained in the premises. As a result of the forced entry a "back to base" alarm was activated and the police notified at 10.17 pm. As a result, whilst patrolling the same officers went to the premises, noted the forced entry and the deactivated alarm. They failed to locate the deceased who had either secreted himself inside or again left the premises. They returned to the hotel. This time the licensee told them what had actually occurred earlier and handed the pistol to them. The officers returned to the Police Station at about 10.43 pm.

On their return they commenced computer enquires in relation to the deceased, ascertaining that he held a shooter's licence and a number of firearms. Bourke police were contacted (the Head Station, Darling River Command - in the absence of the Sector Commander, Brewarrina). One officer (W) spoke to a Sergeant at Bourke (M) in order that the Duty Officer might be advised of the occurrence at the hotel; to advise of the data that had been assembled; and to seek advice. The Sergeant told him that he would notify the Duty Officer (G) and asked for a situation report in writing. He called back and directed the officers to commence a Search Warrant application. At that stage the officers at Brewarrina did not feel it was a "high risk" matter. The more senior officer did ascertain that it was alleged that the deceased was trafficking in illegal firearms and suggested that Sergeant M look at the CNI Reference as the matter was "getting very serious now."

The court heard conflicting evidence as to whether one of the officers telephoned the Duty Officer (G). Sergeant (M) briefed another Sergeant (S) who was coming on duty. The Sergeants at Bourke did not believe it to be a "high risk incident" at that stage. With regard to the conflicting evidence the State Coroner said:-

"There is obviously some conflict in the versions and real conflict between (Constable W) and (Duty Officer G). Further (Sergeant M) denies speaking to G until the situation had escalated following entry to the premises. His stance is that he contacted G at about 3 am, 20 August, 2000. M insists that he instructed W to contact G but W denies this on the basis that M said that he would do so."

Sergeant S thought that more ought to have been being done. He contacted the Duty Officer and informed him of the proposed action. Police were recalled to duty and Sergeant S was to become the independent officer with respect to the execution of a Search Warrant.

Execution of the Search Warrant.

On the evidence, no police officer, except Senior Constable W acknowledged to each other or to superiors that the situation had developed to become "high risk".

Shortly before 2.30 am Sergeant S with Constables W and C and two others (H and S) attempted to execute the Warrant. Constable H appears to have been in charge though Sergeant S (the independent observer) acknowledged that he was

by virtue of his rank. Bullet resistant vests were worn and Constables W and S dispatched to watch the premises.

No operational orders were prepared in respect of the execution of the Warrant. Significantly no risk assessment appears to have been done. The actual execution was discussed but no risk analysis was referred to in any of the Records of Interview. Sergeant S still did not believe that the operation was "high risk".

At about 2.10 am Constables C and H entered the house and on entry were confronted by the deceased standing in the bedroom doorway. He was holding a rifle to his shoulder, pointing it at Constable C. On Constable H announcing his office and informing the deceased of the Warrant, the deceased told Police to "back off". They did and a perimeter was set. At 2.34 VKG was informed that police had been confronted by a man armed with a rifle.

The Siege.

The police set a perimeter as best they could, with Constable H returning to the Police Station, arriving at about 3 am. He sought assistance from Bourke, acknowledging that the situation was now "high risk". Sergeant S at Bourke contacted Duty Officer G. G telephoned Brewarrina and was fully briefed. Again there was conflict between G and H as to whether G instructed H to call out all available police. H denied that he was so instructed.

Duty Officer G, saw the situation as "high risk" and at 3.07 am contacted the Local Area Commander to arrange for the deployment of the State Protection Support Unit (SPSU) and negotiators. The LAC directed his Duty Officer to go to Brewarrina. He then attempted to contact his Operations Manager, Inspector W to have the SPSU deployed. On being unsuccessful he contacted the Regional Commander (G) who managed to do so. Inspector W authorised deployment of SPSU personnel to Brewarrina.

Shortly after 3.47 am Inspector W contacted Inspector R of the State Protection Group (SPG) in Sydney. After some time a decision was made not to deploy the SPG at that stage.

Because many police officers were in the Broken Hill - Cobar area for the Olympic "Torch Relay" it took almost an hour to make contact with the various SPSU operatives.

The Duty Officer (G) left his home at 4.19 am. He and others, including a negotiator arrived at Brewarrina at about 4.50 am. The police around the premises largely remained where they were.

The police vehicle at the rear of the premises was driven away at 5.50 am and moments later the deceased left the premises by the rear door. He walked towards Constable S holding a firearm vertically. Sergeant S challenged the deceased, as did Constable S. He was told to drop the gun. When challenged the deceased said "back off, back off" and pointed the weapon - a rifle at Constable S who was in great fear of his life. The police took cover and he walked out into the rear lane, turning to his right. He was not seen alive again.

After leaving the Wilson Street premises.

The State Coroner found it likely that the deceased walked down the lane, across vacant land and onto the Coolabah Road. He took his life by shooting himself in the head a short distance out of town. He was not found until 29 August.

Shortly afterwards the Duty Officer, negotiator and other police arrived at Brewarrina. Senior police were contacted and briefed. More SPSU police were directed to be deployed and finally, and after intervention by the Local Area Commander and the Regional Commander, the SPG were deployed from Sydney at about 7 am.

SPSU police continued to arrive throughout the day and the SPG at about 11 am. The premises were cleared. Despite a wide search of the area and known haunts the deceased was not located until 29 August, 2000.

Issues.

General policing of the complaint at the hotel by Constables W and C.

The State Coroner was satisfied that the two young officers appropriately handled the incident at the Royal Hotel, Brewarrina. The more junior of the two was given the task of "case officer" as a form of "on the job" training. The Coroner saw that as an effective method of ensuring that newer officers quickly learn to handle a wide variety of work.

Some 45 minutes was lost when they were not given vital intelligence by either the licensee or patron. On the second trip to the hotel the publican handled the pistol he had thrown to safety to the officers. The coroner criticised the publican for keeping vital intelligence from police. In his defence the publican was concerned that patrons would become inflamed once they learnt of the pistol.

Once the officers learnt of the firearm they checked the antecedents of the deceased and then informed a Sergeant of Police at a nearby town.

Further Senior Constable W gave a reasonably thorough briefing to Sergeant M at Bourke and followed that up with a "sitrep" to his Duty Officer. The Search Warrant was appropriately applied for.

The sitrep contained data which ought to have put the Sergeants at Bourke on notice that a serious matter may have been unfolding at nearby Brewarrina.

Conflict in the evidence - various police.

The State Coroner resolved various conflicts in the evidence as best he could but was hampered when some nine officers declined to give evidence on the ground of self-incrimination.

The self-incrimination was from possible disciplinary proceedings for their roles in the operation. He heard argument in relation to *Section 33AA, Coroners Act 1980*, a section only recently enacted and came to the view that the police would not be protected by a Certificate (akin to a Certificate pursuant to *Section 128, Evidence Act 1995*) as it does not apply to proceedings other than in a "Court". On a proper construction of the Evidence Act and its Dictionary Administrative Tribunals and the Industrial Commission (unless in "Court Session") would not amount to a "Court". The protection of the Section is not therefore available to a

wide range of witnesses - apart from police officers - nurses, medical practitioners, physiotherapists, pharmacists and the like.

Accordingly the State Coroner forwarded a transcript of the proceedings (his decision and the legal argument) to the Attorney General for consideration of appropriate amendments to the Coroners Act.

He did find that Duty Officer G had been properly briefed by Sergeant S by 11.45 pm in terms "this bloke has been running around with a pistol and had threatened to go back and get a shotgun and that I thought it appropriate that we get a Search Warrant." There is no record of any type of action by Duty Officer G until after the attempted execution of the Search Warrant.

The Police Operation - Execution of the Search Warrant - Was it "high risk"?

The Regional Commander was of the opinion that the SPSU should have been activated prior to execution of the Search Warrant. The State Coroner agreed with the opinion of this senior police officer.

The coroner found the operational guidelines for the deployment of both the SPSU and the SPG to be a reflection of the common sense approach to risk assessment and to the resolution of matters where risk is a factor. He found that the threat of weapons or their use to be a predominant determinant in assessing the degree of risk. He gave detailed reasons supporting his opinion in his judgment. In essence he found that there were reasonable grounds for police to believe that the deceased may use lethal force, so as to cause death or injury to others. He had already issued threats to that effect.
Accordingly the State Coroner found that at the time police applied for the Search Warrant, a high risk situation existed and police should have sought the specialist assistance at that point of time. Execution of the Search Warrant should not have been attempted until that issue was identified to appropriate police and resolved tactically.

He said:

"A fortiori, it follows that whatever occurred after the granting of the Search Warrant was also high risk. In reality the risk simply escalated as events unfolded that morning. It is my strong view that police placed themselves into a situation that could have resulted in a very different outcome to the one the subject of this inquest."

Significantly when the police searched the vehicle of the deceased they found, secreted, a sub-machine gun, property of the Commonwealth.

The State Coroner was concerned that a number of police failed to recognise that execution of the Warrant involved a high risk. Perhaps of more concern was the fact that a number of officers may have felt that they could resolve the matter without specialist assistance.

He found from the Records of Interview taken by investigators that a number of police appear to have only rudimentary knowledge of the Standard Operating Procedures relating to response to high risk situations.

Significantly, those officers tasked with the execution of the Search Warrant did not follow the Standard Operating Procedures in relation to Warrants as they did not perform a risk assessment.

After the deceased confronted police.

Regardless of the situation at the time police learnt of the hotel confrontation, at the time the Search Warrant was applied for this had become a high risk incident. Yet all available police were not called out and no consideration was given to the bringing in of specialist police. Had the SPSU been activated at that time they may well have arrived at Brewarrina before the deceased came out of the premises.

Further the police at the house failed to ensure a proper means of escape at the time of execution of the Warrant.

The call out of the SPSU and the SPG.

Notwithstanding the tyranny of distance in Western NSW and notwithstanding the drain on police resources of the "Torch Relay" which meant that SPSU personnel had to come from Cobar, the call out of operatives took far too long. None had made Brewarrina by the time the deceased threatened police for the second time. No thought was given to utilising operatives from nearer Walgett.

Further, the State Coroner said:-

"I appreciate the problems local police have in towns like Brewarrina ..... , where many incidents they are required to investigate are accompanied by threats or acts of violence. Doubtless in this case the local police thought they could deal with the situation. This was not so. In fact I am of the view that there was a very real possibility that police could have been seriously injured or killed."

In relation to the delay the Coroner went on:-

"..... I am most concerned about the apparent delay from the time police were confronted by the deceased until any decision was made to deploy the SPSU. It was 2:34 am when VKG was advised that the deceased had confronted police with a rifle, yet SPSU operatives were not deployed until 3:47 am. At 2:35 am, staff from the (back to base) alarm company spoke with (the deceased) when he told them that there were three persons in his yard and he would shoot them. This information was relayed to the police at Bourke and it is apparent from the evidence that this information was either not passed on, or if it was, not acted on.

In that intervening period, traumatised police, threatened by an armed man, were virtually left to fend for themselves. The matter is even more disturbing when one considers that deployment is but the first step in activating SPSU personnel. When finally activated, only four were selected to be deployed at the scene."

Concerns about the siege itself.

The coroner's main concern was that all available local police officers were not recalled to duty. Again there was a conflict in the evidence on this issue between the Duty Officer (who said he ordered a call-out) and Constable H (who denied that he was told to call off duty officers out. This conflict could not be adequately resolved, except to say that police were not called out.

Concerns about the manner of deployment of the SPSU.

On the evidence before the Coroner the Duty Officer appraised the Local Area Commander of the situation at 3:07 am. It was not until 3:47 am that the Regional Commander authorised the deployment of SPSU personnel.

Accordingly he was of the opinion that the NSW Police Service ought to consider the issue of delay.

Concerns about deployment of the State Protection Group.

The issue about prompt deployment of the SPG was clouded by the fact that once intelligence had reached the appropriate SPG leaders the facts had been distorted through a number of tellings from primary source to final receipt. In essence the SPG leader, Inspector R was told, not of the offering of a weapon at police on two occasions, but rather "armed with a rifle sitting inside premises; indicated intention to commit suicide". In fact, the coroner found that there was never intelligence to the effect that the deceased was liable to take his own life - only that he would harm others - hotel patrons and police.

The State Coroner said:-

"The very important point to be made is that stories lose accuracy in the repeated telling. The NSW Police Service has to address this if there is likely to be an endemic problem in their procedures relating to call-outs. ..... ."

Whilst the State Coroner was of the view that the SPG should have been called out earlier he acknowledged that deployment was an operational issue for a high ranking, specialist police officer, who must be seized with the salient facts of the case at hand.

The State Coroner also dealt with a number of ancillary issues in this wide-ranging inquest. These were mandatory police training; accountability and note-taking; concerns about VKG; communications in the field.

Conclusion.

In conclusion the NSW State Coroner urged the NSW Police Service to analyse the facts of the case from an operational policing perspective and implement change wherever it is considered appropriate to do so. He felt that the detail of this particular police operation might serve as a useful tool for the training of police officers; or the advanced training of police officers of all ranks. He refrained from making a number of Statutory Recommendations pursuant to *Section 22A, Coroners Act 1980* on the basis that he knew that the Service would be considering the issues raised.

Formal Finding.

That the deceased died on 20 August, 2000, near Brewarrina of a gunshot wound to the head, self-inflicted with the intention of taking his own life.

Recommendation.

That the NSW Police Service critically appraises the dissemination to police of mandatory training programs in respect of High Risk Incidents; that in so doing it considers frequency of delivery of programs to operational police and to actual retention of materials by police officers.

1879 of 2000 **Male aged 20 years died on 18 September 2000 at Goulburn Correctional Centre. Finding handed down on 13 November 2001 at Goulburn by John Abernethy, State Coroner.**

The deceased (K.D.), a 20 year old single, Caucasian male died on the morning of 18 September, 2000 of Methadone Toxicity. He died in Cell 76, Unit 2 and was "two out" at the time of his death.

The deceased had been using prohibited drugs prior to entry into the prison system.

He had been on parole when charged with assault, and was remanded in custody from Goulburn Local Court on the 13th of September, 2000 (Wednesday). On the 15th of September he was sentenced to three months with hard labour.

The deceased had been in both juvenile and adult institutions. Whilst at Bathurst Correctional Centre he met up with a long term prisoner. The two began communicating by letter once the deceased was released. This prisoner had been charged with the sexual assault of a cell mate. The matter was ultimately dismissed in 1999, or withdrawn for want of a complainant.

In any event the deceased was received into the Goulburn Correctional Centre on 13 September, 2000. He was interviewed by a Corrections Officer and importantly, by a Registered Nurse of the Corrections Health Service. He told the nurse of his Heroin habit, and he appeared to that nurse that he was coming off drugs. He also recited a history of self-harm. He was placed in an observation or safe cell overnight and appropriately medicated. He was also to see the Alcohol and Drugs nurse and programs manager. He indicated at reception that he wished to be placed on the Methadone program.

On 14 September he was seen by the Programs Manager. A Welfare Officer also saw him. At 11 am he was assessed by the Risk Assessment Team made up of an Assistant Superintendent, a CHS Nurse and a Psychologist. According to the documentation he was:-

"To remain in OBS cell overnight. To be given exercise in 3 Yard. When inmate returns from court on 15.9.00 he will be put on Strict/Protection and two out at all times.

Management Plan review date 16.9.00."

Despite the clarity of the plan the Team did not meet again on 16.9.00, the day after the deceased was sentenced. He did also remain in the OBS cell on the night of 14 September - as per the plan. But upon his return from court on 15 September, 2000 he was again placed in an OBS cell instead as "two out" as per the plan.

On 16 September, 2000 he was finally placed "two out" with the prisoner with whom he had struck up a friendship prior to coming into the prison. This occurred at the request of both prisoners.

He was not on a Methadone program.

On 17 September the two were released from their cell. The deceased played a vigorous game of touch rugby, appearing well to both prisoners and staff. The two were locked in their cell at 3.30 pm and had their evening meal. At 6.30 pm the Nurse attended to give the deceased his medication, not noting anything unusual. He had been sleeping since dinner. After dinner the prisoners watched television. The prisoner cleaned and tidied the cell in a compulsive fashion. Both went to sleep. The cell mate awoke at about 3.30. He shook the deceased and managed to stop him snoring. When he awoke at 5.30 am the prisoner was dead. Staff were roused and appropriate protocols applied. CPR was attempted. The deceased had died of Methadone toxicity.

Issues.

Signing off on a Risk Intervention by RI Teams.

Though the deceased would probably have been placed as he was, and although there were discussions prior to placement, by phone, by two members of the RI Team, the Team should have met as arranged on 16 September. Younger prisoners especially can become most depressed after being sentenced.

The cell mate and the need to know of his history before placement.

The cell mate was charged with a sexual assault on a cell mate at another time and prison. In the pursuit of safe custody of inmates, especially young inmates, the State Coroner came to the view that the Department of Corrective Services should consider placing a “flag” in its computerised system, flagging such cases so as to more effectively consider whether a particular prisoner ought to be placed, in all the circumstances with certain types of prisoners. This sort of intelligence goes to the issue of safe custody.

The Methadone and how the deceased obtained it.

Despite a thorough police investigation the inquest could not establish how or when Methadone came into the possession of the deceased. It is certainly likely it was not ingested until quite late in the evening. It could have come from another prisoner and it could have been obtained by the cell mate and given to the deceased for a favour. There are certainly other possibilities.

The age old problem of contraband in prisons - particularly drugs is being vigorously addressed at prisons throughout the State.

Formal Finding.

That K.D. died on 18 September, 2000 in Cell 76, Unit 2, Goulburn Correctional Centre, Goulburn of Methadone Toxicity, the prisoner ingesting that substance voluntarily and whilst not on a methadone program.

Recommendations.

1. That the Department of Corrective Services reviews its Risk Intervention Team procedures to ensure that there are in place processes which ensure that Risk Intervention follow-up and "sign off" meetings always take place where it is intended by the original Team.

2. That the Department of Corrective Services considers making it mandatory that RIT Management Plans and RIT Interim Management Plans are placed on all relevant files including Case Management Files, Psychological Files and Corrections Health Centre Medical Files.

3. That the Department of Corrective Services considers the feasibility of implementing system whereby the files of prisoners who may be a risk to the safe custody of other prisoners if placed "two out" with other prisoners, are flagged accordingly so that those responsible for such placements can more effectively consider the safe custody issues involved in "two out" placements.

2028 of 2000 **Male aged 25 years died on 12 October 2000 at Royal Prince Alfred Hospital, Camperdown. Finding handed down on 11 October 2001 at Glebe by John Abernethy, State Coroner.**

On 11 October, 2000 two police constables of the New South Wales Police Service, (one a probationary constable who had experience in the Queensland Police Service) were performing plain clothes duty in the vicinity of Elizabeth Street, Foveaux Street and Central Railway Station as part of City East Target Action Group (CETAG). Their brief was "pro active" policing during the period of the Olympic Games. Whilst they were to look particularly for matters of robbery, steal from the person or steal, in such an area drug offences would be looked for as a matter of course.

At about 1 pm both were near the South Eastern entrance to the concourse, an area of frequent criminal activity. They saw the deceased looking about, walking and turning quickly. He appeared agitated and was near the stairs to the street. They then saw him go into the entrance, down a flight of stairs and re-emerge shortly afterwards. He appeared to be with another man and the two officers thought they saw the two men exchange an item before again disappearing downstairs. They believed that a drug transaction had taken place and began to follow the two. The other man (unknown to the police, a local shopkeeper) disappeared into his shop. Police then followed the deceased who appeared to pass through turnstiles without putting a ticket into them. Though no ticket was found on his property, he may well have had a ticket.

Police lost sight of him but then saw him on Platform 19, towards the Northern end and about 100 metres away. They saw him purchase items at a kiosk. As the deceased walked from the kiosk police produced identification and indicated that they wished to speak to him about suspicious activity at the top of the Devonshire Street Stairs. He was taken a short distance but in full view of those using the platform and spoken to about his bona-fides. He made no admission about engaging in criminal activity. The State Coroner was satisfied, on the evidence, that the deceased did not, in fact engage in criminal activity (purchasing prohibited substance). One of the officers asked the deceased whether he had drugs in his possession. He was also asked to remove the contents of his pockets. He complied with this direction and police found, inter

alia, a modest quantity of money. Police also allege that he was carrying alcohol swabs and cotton wool. The deceased was then asked to sit on the platform with legs crossed. Police noted "track" marks on his inside left arm. A partial address was provided and the deceased indicated, untruthfully, that he was required to report daily to Surry Hills Police as a bail condition.

One police officer attempted to obtain a Central Names Index (CNI) search via VKG. He was informed that the COPS system was down. He told his partner, who then contacted Surry Hills Police by mobile phone. He was told by an officer there that the deceased was not currently required to report on bail and that he was recorded on COPS as being "wanted" by police at The Rocks for a stealing offence. No further information was offered. Significantly no COPS System "Warnings" were conveyed to the officers who had the deceased in their custody.

In the meantime the other officer was speaking to the deceased who told him he had not used drugs for a long time. In a jacket pocket police found a Size 10 grey T-Shirt with the anti-theft device still in place. The deceased could not give a reasonable explanation for that possession.

He was placed under arrest by one constable, for the larceny of the shirt. He was cautioned. One officer was standing to the right of the deceased with the other to his left. A suburban train had commenced to enter Platform 18, travelling South. The deceased was asked to stand up. As an officer reached for his handcuffs, the deceased sprang to his feet and pushed the officer in the chest with both hands, forcing him off balance. He then sprinted towards the end of the platform. At this time a train was entering Platform 19 at approximately 35 kph. The officers chased the deceased, separated by 4 - 5 metres. The deceased disappeared from sight at or near a glassed barrier at the end of the platform. Moments later he was located lying in the cess area beside the tracks. He had either fallen between carriage and platform, or more likely, between carriages. Video footage and evidence of an SRA official vividly corroborated the versions of the police officers.

The deceased was found to be conscious but very badly injured. The officers attended to him as best they could until the arrival of medical assistance. On arrival of other police the two were, after awhile, separated and taken to the Transit Police Office where they separately made notebook entries, statements and Records of Interview by ERISP.

Issues.

Death in Custody Protocols.

These protocols, entered into between police and this office were generally applied so that the investigation was carried out by officers of another Local Area Command. There was an independent Reviewing Officer and oversighting by the Region's Internal Affairs Consultant. The officers were separated reasonably early so that they really had little time to "get their heads together" to concoct the scenario they gave, separately to investigating police. They were not, however, separated immediately by the original investigating officer, and should have been. **That is an issue for the NSW Police Service to address.** That protocol, said the State Coroner, is a very important one as it minimises any chance of police officers fabricating evidence. Equally importantly, to those many honest police it is a viable form of protection from false allegation. The State Coroner was satisfied on this occasion that the officers involved did not

contrive to fabricate evidence. The very differences in their versions militates against that proposition.

The Coroner noted that the two officers made statements and Records of Interview involuntarily and that had they not done so they could have been dealt with internally. To that extent, he said, police, in many cases, do not have the same fundamental right to silence as civilians. In addition he noted that they gave evidence and subjected themselves to strong cross-examination by competent Counsel.

The train and its personnel.

The State Coroner was satisfied that there was no issue involving those responsible for the management or running of the trains. Those at Central Station promptly called for assistance. In particular neither the driver or the guard were in any way responsible for the injuries sustained by the deceased.

The video.

Some videos at and around the railway station were not functioning. The viewing of them would have enabled the witness to see the deceased outside the station entrance. The video that was functioning at least corroborated the version of the police officers and the SRA official - that the deceased ran from police who chased and lost sight of him very quickly.

Reasonable suspicion to stop and search. The arrest.

The State Coroner found that there was some form of "connection" between the deceased and the shopkeeper, though the versions of police and the shopkeeper vary somewhat. On the evidence before him the Coroner preferred the shopkeeper's version. He also found that it was highly unlikely that an illegal supply of prohibited drugs took place - none were located on the deceased. Finally he found that the police officers took the action they did in the reasonable belief that an offence may have been committed

On the finding of goods reasonably suspected of being stolen the police effected a valid arrest.

The incomplete details given to police by the officer at Surry Hills.

An inexperienced officer did not relay important COPS System "warnings" to the police in the field.

Significantly the System warning section posted the following flag:-

"MAY BE AN ILLICIT DRUG USER ….. **MAY TRY TO ESCAPE FROM CUSTODY. WILL RUN TO AVOID APPREHENSION."**

The State Coroner found that had police received the first warning it would have further fuelled their already held suspicion. The latter warning, as it turned out was vital intelligence and would have greatly lessened the prospect of the deceased successfully fleeing police.

The State Coroner found that the initial detention was lawful and whilst under that detention a valid arrest was effected. The deceased chose to run from police.

Finding.

That F.I. died on 12 October, 2000 at Royal Prince Alfred Hospital, Camperdown, of injuries received on the 11th of October, 2000 at Platform 19, Central Railway Station, Central, when he was struck by an electric train whilst fleeing from police officers of the NSW Police Service after he had been placed under arrest, such officers being in pursuit of him in the execution of their duty.

Recommendations.

Need to read and communicate COPS System warnings to police in the field.

1. That recommendation Number 3, inquest 502 of 2000 be again implemented in respect of all NSW police officers, and civilians who may have the need to utilise the COPS System at the request of officers in the field.

2. That those responsible for the initial training of police officers in the use of the COPS System review their courses to ensure that adequate instruction is given in relation to communicating COPS System warnings to police in the field.

   Need to separate police when they are involved in an incident involving a death in police custody or during a police operation within the meaning of Section 13A, Coroners Act 1980.

3. That all police who may be tasked to investigate deaths pursuant to Section 13A, Coroners Act 1980 (deaths in police custody or during police operations) be reminded of the need to promptly separate officers involved in such deaths.

2286 OF 2000 Male aged 33 years died on or about 27 November 2000 at Long Bay Complex of Prisons, Malabar. Finding handed down on 3 May 2001 at Glebe by John Abernethy, State Coroner.

Circumstances of Death.

This 33 year-old Caucasian male sentenced prisoner was serving a period of 18 years penal servitude for murder. At the time of his death he had served four and one half years. The deceased was in the C. Wing, Special Purpose Centre, away from the mainstream of prisoners. He and given evidence for the prosecution in a matter for which he had sought protection.

The deceased was located by Corrective Services staff when the cells were opened at about 6:30 AM on the morning of 27 November 2000. He was observed to be hanging by a piece of cloth which was attached to an iron bar across the window above the toilet area of the cell. He was cut down by officers and it was obvious that he had been dead for some hours.

The State Coroner was satisfied that all "Deaths in Custody" protocols had been carried out.

The deceased had left a number of suicide notes which were identified as being in his handwriting. They were found the cell, addressed to members of his family and to his friends. The notes clearly indicated that he was intending to take his life over the fact that a woman of whom he was fond had told him that she was intending to marry another person. He also stated in his letters that his actions could not be prevented as he hid his intention from both family and prison staff.

In one note he said :-

> "I also want to assure you that there would have been nothing you or anyone else could have done to stop this as everyone around me had no idea what I was planning. As far as everyone knew, I was my normal happy self. Even though the love of my life has just told me her news, I wasn't about to show them my feelings."

He appeared to his family, his psychologist, his drug and alcohol counsellor and to his education officer to be motivated, stable, future oriented and managing his situation well. There had been no previous attempt at self harm, nor had there been previous suicide ideation.

In a note, he apologised to the prison officer who was to find him.

The State Coroner was of the opinion that the prison welfare services to the prisoner were generally adequate, and that even the mundane issues of the deceased's life were being attended to promptly..

The Coroner was satisfied that the deceased fully intended to end his life and actually hid his intention from those around him.

The investigating officer raised a concern about hanging points within the cell. The State Coroner acknowledged the issue, indicating that the same issue had been canvassed in many previous inquests. He was satisfied that the Department of Corrective Services was making strenuous efforts in various ways to minimise the risk of prisoners taking their own lives by hanging.

Finding.

That ….. died on or about 27 November, 2000, in Cell 42, Special Purpose Centre, Long Bay Complex of Prisons, Malabar, by hanging, self-inflicted with the intention of taking his own life.

182 OF 2001 Male aged 24 years died on 29 April 2000 at Fishing Point. Finding handed down on 11 April 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.

The deceased S.E. was a 24 year old man who was living with his father and step mother having recently returned from Wagga.

S.E. had been a poly drug used for some time however had reached the stage where he wanted to enter a rehabilitation clinic.

S.E.'s father was a musician with his own band. A 'reward' on offer to him should he no longer use drugs and remain drug free was for him to be allowed to play in his father's band. This was a much cherished desire of S.E.'s.

An appointment was arranged by S.E at the Toronto Health Clinic during the early part of the week of the 24th of April. S.E. had prepared himself and his family for this to be the time he was to enter rehabilitation. Upon attending the clinic it was discovered he was not entered into the diary for that day although he was spoken to for some time by the drug and alcohol counsellor. (The counsellor gave evidence at Inquest that he had not previously seen S.E. until that day. Further it was not the procedure to enter a rehabilitation scheme on the first attendance at the clinic nor to do so while still a drug user.)

Upon S.E. returning home from the clinic he was angry and depressed which caused him to binge on alcohol over the next few days. On the morning of the 29th of April S.E. went with his father to collect money owing to S.E. and later S.E. apparently used this money to obtain illegal drugs (heroin?)

The binge drinking and drug taking caused an argument with S.E.'s father and Mr M left the premises in order that no further trouble be caused.

Later that day a tenant of the house in S Street telephoned S.E.'s step-mother Mrs G to advise S.E. had a gun and was threatening to kill his parents.

Mrs G spoke to S.E. and then telephoned the police. She advised police a gun was in the house but did not believe S.E. knew where it was located.

A number of Police attended the house but initially did not believe the house was occupied although some of the police did believe they saw some movement at the window of the house.

Police donned vests and returned to further investigate. During this time S.E. again telephoned his step-mother saying he had the gun and was going to kill himself.

Shortly after two shots were fired in quick succession, one striking a constable in the shoulder area the other ricocheted to a building across the road. The constable was dragged to safety by another officer and was assisted from the scene

A few moments later S.E. shot himself in the mouth dieing instantly.

Issues:

1. Was an error made by the Toronto Health Clinic in not admitting S.E. to rehabilitation.

2. The highlighting of the efficacy of police utilising protective vests.

Inquest:

There was no finding of any impropriety on the part of the Health Clinic. There appeared to be an error in S.E. name not being noted in the clinic's diary as having an appointment for the day stated on his appointment card. It appeared S.E. had misunderstood the procedures pertaining to rehabilitation. The drug and alcohol counsellor acted in an appropriate fashion in spending time with S.E. advising him of procedures and directing him to suitable assistance when he attended the clinic early in the week.

The police who attended the premises on the day acted professionally and appropriately. The situation which confronted them was unexpected and contrary to the expectations of those who believed they knew the deceased well, his family. This incident has brought home to police that they must satisfy themselves of the danger of the situation without relying on the information which is supplied by family members.

A number of the police who attended S Street that day have not returned to duties. One of these officers gave evidence as the first witness of the Inquest and it was apparent this incident has extracted a high toll.

Findings:

That S.E. died on the 29th of April, 2000 at Fishing Point in the State of NSW of a gunshot wound to the head self inflicted with the intention of taking his own life.

No formal recommendations made.

191 of 2001 **Male aged 23 years died on 27 January 2001 at Sydney Harbour Bridge, Miller's Point. Finding handed down on 21 November 2001 at Glebe by John Abernethy, State Coroner.**

The deceased, a young Asian Australian (C.H.), was killed on the 27th of January, 2001 at about 5:21 am on the roadway of the Sydney Harbour Bridge. He had been walking on the Bridge in an extremely drugged state. At autopsy he was found to have 0.3 mg/l meth-amphetamine (speed) and 2.1 mg/l MDMA (ecstasy). The MDMA level in particular was spectacularly high. Police had been called to the scene and were attempting to place the deceased in a police wagon after they had seen him walking South in Lane 4 against Northbound traffic. There was a struggle during which time a motor vehicle travelling South in Lane 5 hit the deceased killing him. He died from the multiple injuries sustained. The police officers were fortunate to escape injury themselves.

On the 26th of January 2001, Australia Day, the deceased attended the "Big Day Out" (BDO) concert at the Homebush Bay Olympic Complex. The State Coroner was satisfied that many patrons, including the deceased obtained and consumed drugs at the BDO. He was also satisfied that the supplying of drugs amongst friends and acquaintances was prevalent. In general terms the drugs of choice, apart from Cannabis, were amphetamine and MDMA - "dance" or "party" drugs.

The deceased met up with a group of friends at about 1 pm at Homebush. One friend supplied him with a quantity of meth-amphetamine. The coroner was unable to determine just how the deceased came to have or obtain a significant

further quantity of the drugs he clearly ingested. Between 9 and 10 pm a number of witnesses were of the opinion that the deceased was well affected by drugs.

The deceased left the BDO with a group of 4 friends and travelled by motor vehicle to Neutral Bay. One friend, the supplier, wanted him to sleep the night there and go home the next morning. During the journey he stated that he felt "trippy". On arrival at Neutral Bay the deceased and two female friends entered a flat whilst two male friends attended a convenience store.

At about 1.30 am the deceased made a perfectly rational message call to his girlfriend, indicating where he was and at what time he would return to her home.

Probably between 2.30 and 3.30 am the deceased stood up abruptly and left the flat. He refused a lift to Milson's Point Station and appeared angry and upset with his friends.

Between that time and his being seen by various motorists on the Sydney Harbour Bridge the deceased made a number of message calls to various people. Many of them were difficult to understand, some impossible to understand. All are contained in the brief of evidence before the State Coroner.

His movements between leaving the flat and 5am are not clear but at about that time he was seen by a number of motorists on the roadway of the Bridge, walking against the traffic. A number of motorists, concerned, dialled 000.

At 5.15 am VKG broadcast a job for police to attend the Bridge roadway. The job was classified "Category 3" (Occurring now). A probationary constable and a constable from The Rocks Police Station attended the bridge promptly in a marked truck. They saw the deceased coming towards them in Lane 4 between the Southern Pylons and the toll plaza. They also noticed a Northbound taxi slow and drive carefully around the deceased. The police vehicle was stopped about 5 metres from the deceased, with red and blue lights flashing. The headlights were left on as it was still dark. The deceased was told to "get off the bridge". He went towards lanes 5 and 6. The officers got out and took the deceased's arm, urging him to come with them. He resisted and lashed out, grabbing and ripping one policeman's shirt. Police managed to get him to a point near the side of the van but he kicked out at the side of the van, forcing himself and the police off balance and into Lane 5. OC Capsicum Spray was used by one officer to no effect. The other officer then noticed a motor vehicle bearing down on the three men. The police jumped away from the lane to safety but could not assist the deceased who was run over, suffering fatal injuries.

Issues.

The Police Operation.

Death in custody protocols were promptly put in place. The police officers were separated and later that morning cooperated with investigators by separately engaging in a "video walk through". They later, separately, underwent ERISP Records of Interview. They gave evidence at inquest and subjected themselves to competent examination, thus totally cooperating with investigators and the coroner.

The NSW State Coroner was satisfied that the officers had neither the time nor opportunity to collaborate and provide a "sanitised version". The differences in

their versions were the normal differences of perception and recollection one would expect from witnesses of truth. Their versions were corroborated by the Chief Traffic Operations Officer, RTA, who watched events on a video monitor.

The State Coroner found that the operation took place over a very short period of time. The time between police arrival on the bridge and impact was perhaps marginally less than 50 seconds, between 5.21.20 am and 5.22.10 am.

The officers had to make split second decisions and in the view of the Coroner took the only viable options. They did their best to make the deceased safe. The Coroner expressly found that there was no time to close the Bridge down. He also found that closing off several lanes would have been ineffectual; and to have left the deceased to continue to wander may have invited criticism. The use of OC spray was appropriate in all the circumstances.

The NSW State Coroner commended the two police constables for their attempt to make the deceased safe. He found that they nearly lost their lives by doing so.

The Driver.

The driver of the vehicle which knocked the deceased down also cooperated with police and gave evidence at inquest. The State Coroner was satisfied that there was no prospect that she had committed an indictable offence and that police, in not proceeding against her for a summary offence were not acting inappropriately.

The State Coroner said this:

"In essence, against her not seeing C.H. at all, or the police earlier than she did I can say that one does not expect pedestrians in the middle lanes of the Sydney Harbour Bridge. The carriageway is a freeway with no parking or stopping. There is a posted speed limit of 70 kph and she was doing no more than that speed. I am satisfied that she decelerated once she saw the flashing blue and red lights. The headlights of the police vehicle were on and that must have affected her vision. H.C. at least was wearing dark clothing. There may well be other factors in her favour. I have not necessarily been exhaustive."

The Friends.

The young people the deceased was with that night also gave evidence and the State Coroner could not say that they were not telling the truth. He found, on the evidence that many young people use "party" drugs and know little about their side effects and dangers. He also found little evidence that they will necessarily "look after" each other as does a "designated driver" where alcohol is concerned.

The Drugs Ingested and their Effect.

Significantly, expert evidence was to the effect that the deceased had ingested potentially lethal quantities of both meth-amphetamine and MDMA.

Two experts alluded to the bizarre behaviour exhibited by the deceased on the bridge, earlier on leaving the flat, and through a series of telephone messages as consistent with both or either meth-amphetamine or MDMA intoxication. Both

spoke of the hallucinogenic effect the drugs can have if taken in sufficient quantities, and also of side effects such as delusions and paranoia.

Formal Finding.

That C.H. died on 27 January, 2001 at the Southern end of the Sydney Harbour Bridge, Miller's Point, of multiple injuries received then and there when he was struck by a motor vehicle driven by …..

461 of 2001 **Male aged 19 years died on 10 May 2001 at Minto. Finding handed down on 16 November 2001 at Westmead by Janet Stevenson, Senior Deputy State Coroner.**

T.M. was a 19 year old man living in the Macquarie Fields ares. He was a diagnosed with schizophrenia from the age of 16 years. He had received his last intravenous injection of medication on the 30th of April, 2001, administered by staff at the Macarthur Mental Health Service.

T.M. had a history of auditory hallucinations, referential thoughts and visual images. He had not expressed recently to any health professionals an intention to self harm, although he had attempted to hang himself a few months prior to his death.

On the 18th of April,2001 T.M. received a 3 months and 28 days period of Home Detention after a conviction of Revocation of Parole. (Larceny and Take and Drive Motor vehicle). The Order commenced on the 18th of April and was due to expire on the 14th of February. He was due for parole on the 15th of August.

He was being supervised by the Probation and Parole Service and was subject to the usual random visits wore an electronic anklet.

He was last seen by the Probation and Parole Service on the 8th of May, 2001 and did not appear to have any concerns. He was reminded on that day to attend for his next planned medication injection on the 14th of May. He had attended a Drug and Alcohol rehabilitation programme on the 9th of May after he had completed his employment for the day. This rehabilitation was part of his Home Detention programme.

At about 4pm on the 10th of May T.M. was seen on the northern end of the north bound platform of the Minto Railway Station. He was seen to lie down on the platform at the northern end of Platform One (City Bound). He appeared to glance at the trains which were arriving.

At about 4.02pm he stood up and was looking in a southerly direction at the Country Link train as it approached the platform.

The train was travelling at 108k/ph as it passed through the station. The permitted speed for the area is 120k/ph.

As it approached the northern end of the platform T.M. jumped in front of the train against the driver's windscreen. His body was located in grass about 2 metres from the track. This was captured on a CCTV tape which was being used by State Rail.

A Post Mortem was not carried out on T.M. although blood samples were taken for toxicology.

Police identified T.M. through the number on the anklet he was wearing.

It appeared T.M. was upset by a mobile telephone bill for $1,000 that he had received the night before.

Finding:

T.M. died on the 10th May 2001 at the Minto Railway Station Minto of multiple Injuries when he jumped from the north-bound platform into the path of a train with the intention of taking his own life.

Appendix 1:

Summary of inquests heard or terminated in 2001

File No.	Date of Death	Place of Death	Date Completed	Age	Manner of Death	Death in Custody/ Police Op	Place of Hearing
778/97	30/4/97	Orange	24/8/2001	20	Gunshot	Police Op	Glebe
2217/98	2/11/1998	Grafton	31/5/2001	46	Natural Causes (Drug toxicity contributing)	In Custody	Glebe
963/99	18/8/1999	Silverwater	28/3/2001	75	Natural Causes	In Custody	Westmead
981/99	21/8/1999	Silverwater	5/4/2001	28	Hanging	In Custody	Westmead
2096/99	10/10/1999	Goulburn	18/1/2001	29	Hanging	In Custody	Glebe
222/00	1/2/2000	Randwick	21/3/2001	65	Natural causes	In Custody	Glebe
233/00	24-25/2/2000	Silverwater	20/2/2001	30	Hanging	In Custody	Westmead
414/00	18/4/2000	Silverwater	26/9/2001	21	Hanging	In Custody	Westmead
280/00	26/2/2000	Bega	16/1/01	16	Motor Accident	Police Op	Westmead
441/00	26/4/2000	Silverwater	21/2/2001	39	Drug Overdose	In Custody	Westmead
554/00	22/3/2000	Canberra	16/1/2001	18	Motor Accident	Police Op	Westmead
884/00	5/8/2000	Parramatta	31/10/2000	25	Motor Accident	Police Op	Westmead
1068/00	10/9/2000	Lithgow	30/8/2001	28	Drug Overdose	In Custody	Westmead
1174/00	15-16/10/2000	Prospect	26/9/2001	48	Natural Causes	In Custody	Westmead
1751/00	20/8/2000	Brewarrina	31/10/2001	49	Gunshot	Police Op	Glebe
1879/00	18/9/2000	Goulburn	13/11/2001	20	Drug Overdose	In Custody	Glebe
2028/00	12/10/2000	Camperdown	11/10/2001	25	Hit by Train	Police Op	Glebe
1282/00	15/11/2000	Lapstone	28/8/2001	30	Police Pursuit	Police Op	Westmead
2286/00	26-27/11/2000	Long Bay	3/5/2001	33	Hanging	In Custody	Glebe
182/01	29/4/2000	Fishing Point	10/4/2001	24	Gunshot	Police Op	Westmead
191/01	27/1/2001	Sydney	22/11/2001	23	Motor Accident	Police Op	Glebe
461/01	10/5/2001	Minto	16/11/01	19	Hit by Train	In Custody	Westmead

Appendix 2:

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed.

File No.	Date of Death	Place of Death	Age	Circumstances
948/95	22/5/95	Long Bay	24	In Custody-
1265/98	23/6/98	Long Bay	44	In Custody
1328/98	5/7/98	Long Bay	36	In Custody
1757/98	29/8/98	Silverwater	39	In Custody
2217/99	26/10/99	Bathurst	53	In Custody
1304/99	12/11/99	Glossodia	24	Police Op
1317/99	19/11/99	Silverwater	23	In Custody
2491/99	3/12/99	Long Bay	25	In Custody
2565/99	18/12/99	Queanbeyan	28	Police Op
180/00	27/1/00	Tamworth	37	In Custody
258/00	7/2/00	Bondi	25	Police Op
280/00	26/2/00	Bega	16	Police Op
612/00	27/3/00	Bathurst	51	In Custody
257/00	16/4/00	Thornton	33	Home Detention
1100/00	5/6/00	Randwick	29	Police Op
1830/00	28/8/00	Cessnock	33	In Custody
2177/00	8/11/00	Tamworth	18	In Custody
2181/00	10/11/00	Goulburn	29	In Custody
2092/00	23/10/00	Oberon	27	Police Op
2093/00	23/10/00	Oberon	38	Police Op
2274/00	26/11/00	Long Bay	64	In Custody
2363/00	13/12/00	St Peters	18	Police Op
2385/00	15/12/00	Loftus	46	Police Op
36/01	08/12/2000	Kempsey	40	Police Op
61/01	09/01/01	Sydney	57	Police Op
107/01	07/01/01	Gosford	14	In Custody
110/01	29/01/01	Penrith	33	Police Op
129/01	17/01/01	Tamworth	42	In Custody
131/01	21/12/00	Sandgate	28	In Custody
154/01	21/01/01	Grafton	26	In Custody
185/01	19/02/01	Silverwater	33	In Custody
237/01	02/03/01	Campbelltown	19	police op
275/01	07/02/01	Manly	36	police op
337/01	18/02/01	Stotts Isle.	18	Police Op
342/01	05/04/01	Parramatta	33	In Custody
382/01	24/02/01	Tumut	57	Police Op
461/01	10/05/01	Minto	19	In Custody
545/01	23/03/01	Long Bay	75	In Custody
555/01	31/05/01	Liverpool	59	Police Op
583/01	29/03/01	Randwick	31	In Custody
626/01	16/06/01	Silverwater	19	In Custody
764/01	16/03/01	San Remo	38	In Custody
773/01	30/04/01	Randwick	79	In Custody
774/01	24/07/01	Kogarah	20	In Custody
779/01	26/07/01	Villawood Mig	31	In Custody
792/01	03/05/01	Goulburn	44	In Custody
825/01	08/05/01	Bathurst	39	In Custody
858/01	16/08/01	Silverwater	47	In Custody
935/01	07/09/01	Westmead	26	In Custody
975/01	01/06/01	Berrima	34	In Custody
1005/01	25/01/01	Pheasants Nest	33	Police Op
1009/01	26/10/01	Cabramatta	53	Police Op
1203/01	21/11/01	Pheasants Nest	30	Police Op
1249/01	06/12/01	Windsor	43	In Custody
1259/01	09/12/01	Liverpool	25	In Custody
1879/01	29/08/01	Arding. Armidale	48	In Custody
1931/01	25/10/01	Orange	21	Police Op

2043/01	14/11/01	Lismore	20	In Custody
2090/01	09/11/01	Newcastle	42	Police Op