Report by the NSW State Coroner

into deaths in

custody/police operations

for the year 2020.

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

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

Dear Attorney General,

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

I attach a hard copy and an electronic copy of the 2020 report.

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

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

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

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

Yours faithfully,

Magistrate Teresa O'Sullivan
(NSW State Coroner)

Summary of Data in the Report

- **A total of 48 deaths subject to *Section 23 of the Coroners Act* were reported to the NSW State Coroner in the calendar year, 2020.**

- **The figure of 48 deaths recorded in 2020 represents a decrease of 10 deaths from the previous Annual Report for the year 2019 in which 58 deaths were reported.**

- **20 of the overall 48 deaths were as a result of natural causes. Natural causes remains as the highest manner of death (41.6%) of all deaths. Followed by hanging (22.9%) of which 11 deaths were recorded in 2020.**

- **4 Aboriginal deaths were recorded in 2020 (8.03%) this figure represents a reduction of 3 deaths from that recorded in 2019.**

- **The 4 aboriginal deaths all occurred in correctional custody and were all as a result of natural causes.**

- **In 2020, the State and Deputy State Coroners completed a total of 45 Section 23 inquests.**

- **Of the 45 inquests conducted, there were 37 findings made by the Coroner, 4 further matters were referred to the Director of Public Prosecutions following the inquest and 4 matters were suspended by the Coroner after receiving advice that a person had been charged with the death.**

- **2 further s.23 deaths reported prior to 2020 (2014 and 2018) were identified by the Coroner as not being a S. 23 reportable death following receipt and careful consideration of the coronial brief in those two cases, the inquests for both these matters were dispensed by the Coroner.**

- **44 of the 48 deaths in 2020 were male.**

- **4 of the 48 deaths were female, 3 occurring within a police operation and 1 occurring in custody.**

- **35 deaths occurred in custody compared to 47 in custody recorded in 2019.**

- **34 of the 35 custody deaths were in NSW Correctional facility custody.**

- **1 of the 35 deaths in custody occurred in an Immigration Detention Centre at the Villawood Immigration Detention Centre.**

- **The 1 death at Villawood Detention Centre was a probable suicide.**

- **1 of the deaths in custody in a Correctional facility was as a result of an alleged homicide by another inmate, this matter was suspended by the Coroner.**

- **Of the 34 deaths in a correctional facility, 18 were serving a fulltime sentence and 16 were on remand at the time.**

- **Of the 18 serving a full time sentence, 16 died as a result of natural causes, 2 as a result of probable suicide.**

- **Of the 16 deaths of inmates on remand, 5 were as a result of natural causes, 9 as a result of probable suicide, 1 was the result of an alleged stabbing by another inmate and one is unknown at this stage.**

- **Of the 34 deaths in a correctional facility, 21 were over the age of 50 with 12 being over the age of 70. The oldest inmate to die in 2020 was 88 years of age.**

- **13 S. 23 deaths occurred within or as a result of a police operation compared to 11 in 2019.**

- **In 2020 the State and Deputy State Coroner made a total of 36 Coronial recommendations pursuant to *Section 82 of the Coroners Act 2009*.**

- **The Coronial recommendations are contained within this report at the conclusion of the relevant finding by the Coroner.**

STATUTORY APPOINTMENTS

Pursuant to Section 22(2) of the *Coroners Act 2009*, only the State Coroner or a Deputy State Coroner can preside at an inquest into a death in custody or a death in the course of police operations. The inquests detailed in this report were conducted before the following Senior Coroners:

NSW State and Deputy Coroners 2020 who undertook Section 23 Inquests

Her Honour Magistrate TERESA O'SULLIVAN NSW State Coroner

1987	Admitted as solicitor of Supreme Court of QLD
1987-89	Solicitor, Legal Aid QLD
1989-90	Solicitor, Child Protection, Haringey Borough, London
1990	Admitted as solicitor Supreme Court of NSW
1990-97	Solicitor, Marrickville Legal Centre, Children's Legal Service
1998-03	Solicitor, Central Australian Aboriginal Legal Aid Service, Alice Springs
2003-08	Solicitor, Legal Aid NSW, Children's Legal Service
2008-09	Solicitor, Legal Aid NSW, Coronial Inquest Unit
2009	Appointed Magistrate Local Court NSW
2015	Appointed NSW Deputy State Coroner
2019	Appointed NSW State Coroner

Her Honour Magistrate HARRIET GRAHAME

Deputy State Coroner

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

His Honour Magistrate Derek Lee

Deputy State Coroner

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

Her Honour Magistrate Elizabeth Ryan

Deputy State Coroner

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

Her Honour Magistrate Carmel Forbes

Deputy State Coroner

1983	Admitted as Solicitor of the Supreme Court of NSW
1986-87	Solicitor for Department of Motor Transport.
1987-92	Solicitor in private practice.
1992-98	Solicitor for Legal Aid Commission.
1998-2001	Solicitor in private practice.
2001	Appointed a Magistrate.
2011	Appointed a Deputy State Coroner.

Her Honour Magistrate Elaine Truscott

Deputy State Coroner

1984-1986	Barrister & Solicitor, Grey Lynn Community Legal Centre, Auckland NZ
1986-1987	Project Officer, Civil Rehabilitation Committee, Sydney
1987-1993	Solicitor, Legal Aid Commission, NSW
1993-2000	Barrister
2000	Appointed Magistrate Local Court, NSW
2010	Deputy State Coroner whilst Local Court Magistrate Newcastle
2014	Appointed NSW Deputy State Coroner.

His Honour Magistrate Stone

Deputy State Coroner Newcastle

1977	Admitted as a solicitor of the Supreme Court of NSW.
1977-1979	Solicitor, Greaves Wannan and Williams of Sydney
1981	Solicitor, Conway McCallum & Co of Sydney
1982-1984	Solicitor, Mortimer Hendriks Griffin & Erratt of Wagga Wagga
1984-2012	Partner and from 2006 Chairman of Commins Hendriks Pty Ltd of Wagga Wagga. Accredited Specialist- Criminal Law and Personal Injury Law (from 1983). Accredited mediator. Extensive experience in litigation in a range of jurisdictions.
2012.	Appointed a Magistrate, NSW Local Court
2016.	Appointed a NSW Deputy State Coroner

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Introduction by the New South Wales State Coroner

What is a death in custody?

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

- the death, wherever occurring, of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the Migration *Act 1958* (Cth);

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

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

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

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

- while temporarily absent from a detention centre, a prison or a lock-up; and

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

It is important to note that in relation to those cases where an inquest has yet to be heard and completed, no conclusion can be drawn that the death necessarily occurred in custody or during the course of police operations.

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

Intensive Correction Orders

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

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

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

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

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

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

any police operation calculated to apprehend a person(s)

a police siege or a police shooting

a high speed police motor vehicle pursuit

an operation to contain or restrain persons

an evacuation

a traffic control/enforcement

a road block

execution of a writ/service of process

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

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

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

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

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

In this regard, I agree with the answer given to that question by former New South Wales Coroner, Mr Kevin Waller which remains still relevant today:

> *"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".*

I also agree with Mr Waller that:

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

Coronial investigations into deaths in custody are an important tool for monitoring standards of custodial care and provide a window for the making and implementation of carefully considered recommendations to prevent deaths that should not have occurred.

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

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

The DOI is required to notify immediately the State Coroner or a Deputy State Coroner, who are on call twenty-four hours a day, seven days a week.

The Coroner so informed, and with jurisdiction, will assume responsibility for the initial investigation into that death, although another Coroner may ultimately finalise the matter. The Coroner's supervisory role of the investigations is a critical part of any coronial inquiry.

Upon notification by the DOI, the State Coroner or a Deputy State Coroner will give directions for experienced detectives and other relevant police to attend the scene of the death.

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

Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit. The Coroner, if warranted, may inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during the inquest. Death scene visits by Coroners is rarely undertaken, a Coroner is more likely to visit the scene just prior to the inquest being conducted to familiarise the Coroner with the scene.

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

In cases involving the NSW Police

When informed of a death involving the NSW Police, as in the case of a death in police custody or a death in the course of police operations, the State Coroner or the Deputy State Coroner's will in most cases request the Crown Solicitor of New South Wales to instruct independent Counsel to assist the Coroner with the investigation into the death.

This course of action is considered necessary to ensure that justice is done and seen to be done. In these situations Counsel (in consultation with the Coroner having jurisdiction) will give attention to the investigation being carried out, oversee the preparation of the brief of evidence, review the conduct of the investigation, confer with relatives of the deceased and witnesses and, in due course, appear at the mandatory inquest as Counsel assisting the Coroner.

Counsel will ensure that all relevant evidence is brought to the attention of the Coroner and is appropriately tested so as to enable the Coroner to make a proper finding and appropriate recommendations. Prior to the inquest hearing, conferences and direction hearings will often take place between the Coroners, Counsel assisting, legal representatives for any interested party and relatives so as to ensure that all relevant issues have been identified and addressed. In respect of all identified Section 23 deaths, post mortem experienced Forensic Pathologists at Lidcombe, Newcastle or Wollongong forensic facilities conduct the post mortem examinations.

Responsibility of the Coroner

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

> **81 Findings of Coroner or jury verdict to be recorded**
>
> (1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so:

(a) the person's identity, and

(b) the date and place of the person's death, and

(c) in the case of an inquest that is being concluded the manner and cause of the person's death.

(3) Any record made under subsection (1) or (2) must not indicate or in any way suggest that an offence has been committed by any person.

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

78 Procedure at inquest or inquiry involving indictable offence

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Role of the Inquest

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

Deaths in custody and Police Operations are personal tragedies and have attracted much public attention in recent years.

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

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

Similarly in relation to police operations and other forms of detention the Coroner will investigate the appropriateness of actions of police and officers from other agencies and review standard operating procedures. In other words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist and, if so, ensure, as far as possible, that remedial action is taken.

Recommendations

The common-law practice of Coroners (and their juries) adding riders to their verdicts has been given statutory authorisation pursuant to Section 82 of the *Coroners Act 2009*. This section indicates that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations.

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

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

Unavoidable delays in hearing Inquests

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

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

It is settled coronial practice in New South Wales that the brief of evidence be as comprehensive as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case.

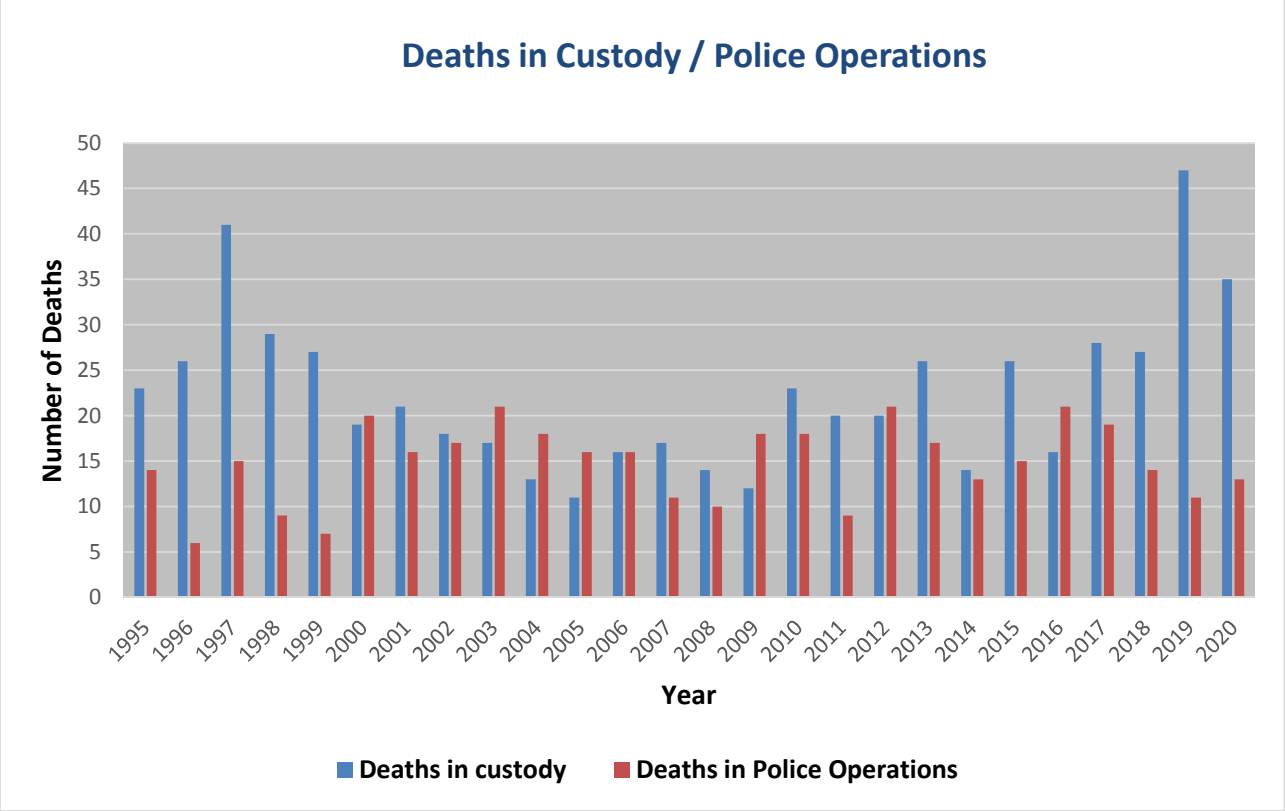
It has been found that an initially comprehensive investigation will lead to a substantial saving of court time in the conduct of the actual inquest.

In some cases there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services.

The results of those investigations may have to be considered by the Coroner prior to the inquest as they could raise further matters for consideration and perhaps investigation.

Table 1: **Deaths in Custody/Police Operations, for the period to 2020.**

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32
2007	17	11	28
2008	14	10	24
2009	12	18	30
2010	23	18	41
2011	20	9	29
2012	20	21	41
2013	26	17	43
2014	14	13	27
2015	26	15	41
2016	16	21	37
2017	28	19	47
2018	27	14	41
2019	47	11	58
2020	35	13	48

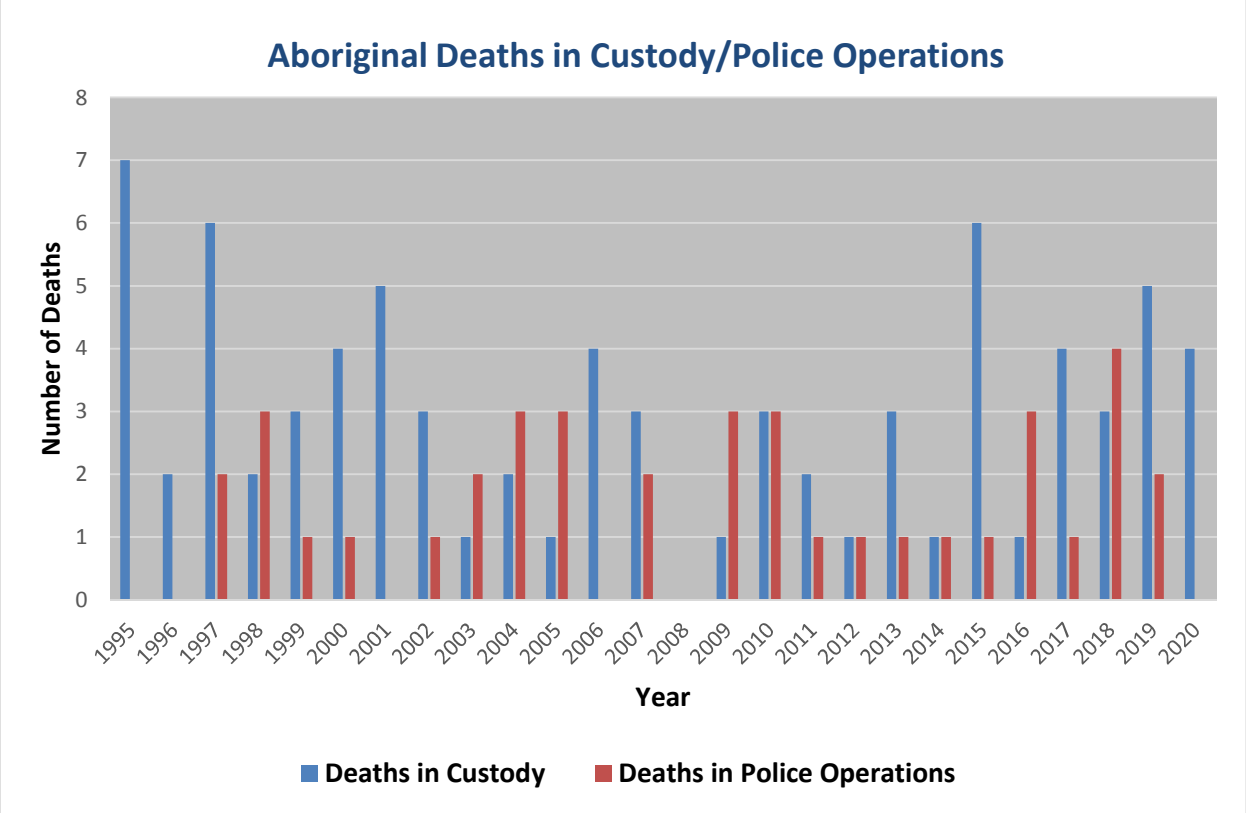


** 34 of 35 the deaths in custody were persons in the custody of Corrective Services. The one further death recorded in custody occurred at the Villawood Detention Centre in the custody of the Commonwealth immigration authority.

Table 2: **Aboriginal deaths in custody/police operations 2020***

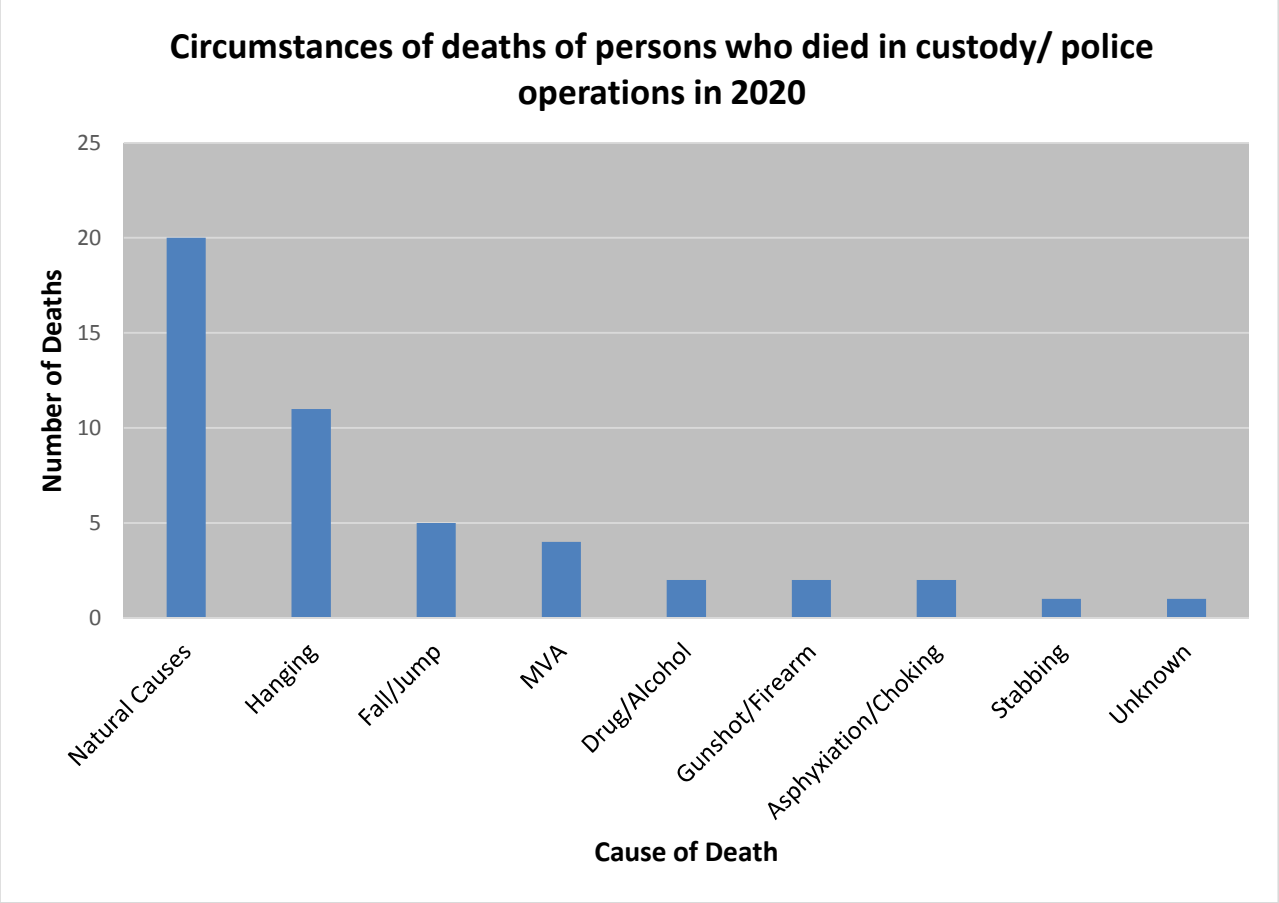
Year	Deaths in Custody	Deaths in Police Operation	Total
1995	7	0	7
1996	2	0	2
1997	6	2	8
1998	2	3	5
1999	3	1	4
2000	4	1	5
2001	5	0	5
2002	3	1	4
2003	1	2	3
2004	2	3	5
2005	1	3	4
2006	4	0	4
2007	3	2	5
2008	0	0	0
2009	1	3	4
2010	3	3	6
2011	2	1	3
2012	1	1	2
2013	3	1	4
2014	1	1	2
2015	6	1	7
2016	1	3	4
2017	4	1	5
2018	3	4	7
2019	5	2	7
2020	4	0	4

*** Known at the time to be Aboriginal or Torres Strait Islander of this report being compiled.**


Aboriginal Deaths in Custody/Police Operations
Number of Deaths
0
1
2
3
4
5
6
7
8
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
Year
Deaths in Custody
Deaths in Police Operations

Circumstances of deaths of persons who died in Custody/Police Operations in 2020

20 - Natural Causes	**41.6%**
11 – Hanging	**22.9%**
5 - Fall/Jump	**10.4%**
4 – MVA	**8.4%**
2 - Drugs/Alcohol	**4.1%**
2 - Gunshot/Firearm	**4.1%**
2 - Asphyxiation/Choking	**4.1%**
1 – Stabbing	**2.0%**
1 – Unknown	**2.0%**



SECTION 23 INQUESTS UNDERTAKEN IN 2020

Following are the written findings of each of the cases of deaths in custody/police operations that were heard by the NSW State Coroner or a Deputy State Coroner in 2020.

These findings include a description of the circumstances surrounding the death and any recommendations that were made.

Please note: Pursuant to Section 75(1) & (5) of the *Coroner's Act 2009* the publication of the names of persons in certain inquests has been removed where the finding of the inquest is that their death was self-inflicted, unless the Coroner has directed otherwise.

The deceased names in those cases will be referred to as a pseudonym.

	Case No	Year	Name	Coroner
1	141693	2015	**John Pocklington**	DSC Truscott
2	208086	2015	**Brooke Carroll**	DSC Grahame
3	323840	2015	**Robert Howlett**	SC O'Sullivan
4	323811	2015	**Ivan Mikic**	DSC Lee
5	373099	2015	**John Cartwright**	DSC Grahame
6	18089	2016	**Tristan Naudi**	SC O'Sullivan
7	19119	2016	**DP**	SC O'Sullivan
8	56536	2016	**Beanika Goak**	DSC Lee
9	56558	2016	**Roza Mawin**	DSC Lee
10	56518	2016	**Adut Mathang**	DSC Lee
11	186812	2016	**Mahmoud Allam**	DSC Lee
12	39421	2017	**Yi Chiu** (*pseudonym)*	DSC Truscott
13	100899	2017	**SB**	SC O'Sullivan
14	136779	2017	**MW**	DSC Truscott
15	202885	2017	**Eric Whittaker**	SC O'Sullivan
16	256693	2017	**Christopher McGrail**	SC O'Sullivan
17	275511	2017	**George Cameron**	SC O'Sullivan
18	288854	2017	**Tane Chatfield**	DSC Grahame
19	297414	2017	**LP**	DSC Lee
20	311913	2017	**Francis McCann**	DSC Lee
21	373943	2017	**Andrew Ngo**	DSC Ryan
22	37983	2018	**Jonathon Hogan**	DSC Grahame
23	80723	2018	**LS**	DSC Truscott
24	194750	2018	**Richard Willett**	DSC Truscott
25	199143	2018	**Neville Towner**	DSC Truscott
26	206773	2018	**William Laird**	SC O'Sullivan
27	283647	2018	**Peter Simpson**	DSC Forbes
28	334938	2018	**Kerry Curtis**	SC O'Sullivan

29	369349	2018	**CD**	DSC Stone
30	372498	2018	**Lawrence Hausia**	DSC Grahame
31	391439	2018	**Grace Herington**	SC O'Sullivan
32	20200	2019	**A**	DSC Ryan
33	49616	2019	**Francis Sawle**	DSC Grahame
34	53379	2019	**Thomas Kedwell**	DSC Forbes
35	59022	2019	**Michael Murphy**	SC O'Sullivan
36	69926	2019	**Dat Nhieu Ha**	DSC Forbes
37	85457	2019	**Dwayne Johnston**	SC O'Sullivan
38	106322	2019	**Edward Carter**	DSC Grahame
39	114274	2019	**XY**	DSC Grahame
40	182081	2019	**Geoffrey Fardell**	DSC Lee
41	184669	2019	**Ho Pan Chan**	DSC Grahame
42	221339	2019	**Cemil Guler**	DSC Lee
43	248603	2019	**Peter Glen**	DSC Ryan
44	261510	2019	**Stephen Pitty**	DSC Truscott
45	121160	2020	**Michael Black**	DSC Grahame

1. 141693 of 2015

Inquest into the death of John Pocklington. Finding delivered by DSC Truscott at Lidcombe on the 27 July 2020.

John Pocklington was born on 31 July 1983 and was 31 years of age at the date of his death. John was one of six children to Vicki and Greg Pocklington. Vicki and Greg met during their teenage years and were married at the age of 18. They had four sons and two daughters and John was their fourth child.

The family initially lived in Revesby then moved to Padstow. Vicki and Greg separated in about 2000. After the separation, Vicki remained in the then family home in Padstow which remained John's home address up to the time of his death. John was very close to his family particularly his mother who imagined that he would be living with her always. His early death has taken a terrible toll on Vicki and all of John's family members.

John started his schooling at Revesby South Public School. However, his mother identifies a violent incident which occurred at the school when John was about 7 years of age. Vicki said John was left highly traumatised and since that time he would refuse to attend school. Although John enrolled at other schools Vicki indicates that nothing either she or the schools could do would assist to ensure John's attendance and consequently, John did not complete primary school.

Vicki describes that John taught himself to read sufficiently. She said that John was very skilful and had intuitive skills with his hands. He learned mechanics from his father and was adept at most tasks involving mechanics and building. He built his own motorised scooter when he was a teenager and could fix almost anything. John loved music, loved riding his bike and found freedom being alone. He was always very well groomed and very tidy. He was strong-willed, pushed boundaries and was a non-conformist. He was tremendously loyal to his family and friends and he is of course much missed.

Vicki indicates that when John was about 15 years of age, he began associating with various boys who were involved in juvenile crime, which led to John going down a similar path.

Offending

On 31 May 2001, when John was 17, he was charged with multiple drug-related and firearm offences. In July he was charged with goods in custody offence and in March 2003 he was placed on an 18 month supervised bond and to undergo urinalysis. In June 2002 the drug and firearm matters were finalised with John being convicted and placed on similar bonds. On 11 March 2004, John was charged with drug offences for which he was sentenced in December of that year to community service and a suspended sentence supervised bond to attend drug and alcohol rehabilitation and education.

When John was about 21 he began a relationship with a girl who lived with John at his mother's house but the relationship ended in October 2005 in an incident where John committed offences including detaining her in his car. In August 2007 John was sentenced to imprisonment. He served 15 months in prison and was released in June 2008.

Vicki Pocklington indicates that this period of imprisonment was a turning point in John's life. She indicates that because the girl was under 18 years of age, John was placed on the Child Protection Register offender's register, which disturbed him considerably. Vicki states that it was during that sentence when John was first diagnosed as suffering from schizophrenia and paranoia. At the end of 2008 John was charged with failing to comply with the CPR obligations and remanded in custody and in June 2009 he received a concurrent sentence with offences of intimidate police. He was released on 13 September 2009. In 2011, John was placed on supervised suspended sentence bonds for intimidate police and assault. In 2013, he was sentenced to Intensive Correction Orders for assaults. Those orders were called up by the parole board in May 2014 and John re-entered custody until his release on 3 January 2015. John continued living with his mum in Revesby. On 14 April 2014, he was charged with further assault offences, damage property and offensive behaviour offences arising out of an incident at the Wood Chop Bar at the Easter Show. He was granted conditional bail with a restriction that he not be in a public place whilst affected by alcohol.

A few days later John was charged with intimidate police after saying something to a police officer when he attended the station to report on bail. He was granted bail in Parramatta Court but on 25 April 2014, whilst playing "two-up" at a pub, he became intoxicated and involved in an incident from which he was charged and refused bail. He was also apparently in breach of his parole. It was whilst on remand for those matters that John died in custody.

Mental Health and Drug Use

On 31 May 2004, when John was 20 years of age, his Probation and Parole Officer Anne McCarthy conveyed him to Bankstown Mental Health Service because as she was interviewing John to prepare a pre-sentence report for John for a conviction of cultivation and possession of cannabis she became concerned about his welfare and mental state. The records indicate that John had been depressed and had thoughts of suicide. The attending mental health nurse recorded that John appeared angry and agitated at times, with "*vague suicide threats*".

The mental health nurse arranged a review which was performed by Dr Ali, a psychiatric registrar. From Dr Ali's notes of the afternoon of 31 May 2004, it appears that he obtained a history of John having some suicidal ideas in the past, though he had not made any clear attempt. Apparently Dr Ali found no evidence of psychosis or any perceptual disturbance. He raised a diagnosis of a personality disorder or some form of situational reactive depression. Dr Ali offered to admit John to Bankstown Hospital which John declined. John also refused a prescription of antidepressants. Dr Ali was of the opinion that there were insufficient grounds to admit John as an involuntary patient.

However, about two weeks later John was admitted to Bankstown/Lidcombe Hospital for three days after being brought in by Police and scheduled as a mentally disordered person on 15 June 2004. The hospital notes indicate that the admission followed an incident where John, whilst intoxicated, assaulted his mother and possibly his sister and threatened to kill himself. The hospital records include a history of recent substance use, including three to four cans of beer per day, regular cannabis use and ecstasy use. On 22 July 2004, John was referred to the Bankstown Mental Health Service for an assessment under s. 32 of the *Mental Health (Forensic Provisions) Act* 1990. The records refer to an admission to Bankstown Hospital five months previously for a drug induced psychosis. According to the records, John had reported a four-year history of amphetamine, cannabis and ecstasy use, though he apparently stated that he'd stopped cannabis use about five weeks ago.

The report created on 22 July 2004 indicates that John was high functioning, had a supportive family, was pleasant, cooperative and appropriate during the assessment and had a reactive affect. He was assessed as being at no risk for suicide, harm to self or harm to others and he was not diagnosed with any condition under DSM-IV. On 26 September 2005, John attended the Padstow Parade Clinic, where he saw a Dr T Quach. Mr Pocklington presented with anxiety, major depression and a history of drug abuse and in that regard, he told Dr Quach he was a heavy smoker of cannabis and occasional user of amphetamine. Three days later John was admitted to Bankstown/Lidcombe Hospital after being brought in by Police for a mental health assessment under s. 22 *Mental Health Act* 2007 because of threats to kill himself on 29 September 2005. The Emergency Department record refers to John having a background four-year history of polysubstance abuse, with cannabis, amphetamine and ecstasy.

During 2006, John was admitted to Bankstown/Lidcombe Hospital as an involuntary patient 24 -26 May 2006, due to experiencing an acute psychosis. At the time, John described urges to harm him-self and others. He had a further one-day admission on 31 May 2006 with feelings of irritation, racing thoughts and urges to harm himself and others. John's mental health condition may then reasonably have been well controlled for a period, before another series of hospital admissions commencing in early 2011. He was admitted as an involuntary patient between 1- 2 March 2011 suffering acute psychosis.

John remained under the treatment of the community team of Bankstown Mental Health Service from 2011 – 2015, where he came under the care of Dr Casimir Liber, psychiatrist. Dr Liber notes that when she first saw John in May 2011, he had already been diagnosed with chronic schizophrenia and paranoia. Dr Liber has indicated that John required high doses of medication to help him sleep and calm his levels of distress and paranoia. She treated him with high doses of Seroquel and Zyprexa (both antipsychotics). Dr Liber has indicated that over the period she saw him, John was a difficult patient, who was frequently non-compliant with his medication which would result in a deterioration of his mental health marked by increased paranoia and distress. Vicki says in her statement that John was introduced to methamphetamine or "ice" when he was about 28 years old. This would be about 2011 and may account for some of the presentations of psychosis.

On 26 February 2012, John presented to the Emergency Department (ED) at Bankstown/Lidcombe hospital complaining that he had shortness of breath following taking amphetamine that night and claiming someone had spiked his drinks.

Handwritten notes record that a drug screen showed presence of amphetamines, benzodiazepine and cocaine. On 24 May 2012, John again presented to the ED at Bankstown/Lidcombe Hospital stating that he had body aches all over, numb fingers and complained of vomiting and stiffness in his arms and legs and that he had been taking speed/ice for 2 days and had no sleep. An ECG was performed and it was queried whether "patient was contracting arms and queried a spasm". Another ECG was performed on 3 June 2012 when John attended the same hospital complaining that when he sat on his bed his heart was racing o/e febrile and this time he denied taking illicit medication but John discharged himself rather than wait for medical review.

On 13 October 2012, John was taken by police to Bankstown/Lidcombe Hospital under s. 22 of the *Mental Health Act* after becoming involved in a fight with three people at an engagement party, apparently after someone said something derogatory about his sister. John was not admitted as the medical review determined that John was neither mentally ill nor mentally disordered presenting a serious risk of harm to himself or others. The records indicate that Mr Pocklington was under the care of Dr Liber at the time and as part of the discharge plan, he agreed to remain under Dr Liber's follow up care. Also recorded as part of the drug and alcohol history, is that John had a history of polysubstance abuse and that he was positive for THC on the urine drug screen done in the ED. He was noted to be taking Seroquel, but with "*spasmodic compliance*".

On 13 March 2014 John was again taken by police to Bankstown/Lidcombe Hospital under s. 22 of the *Mental Health Act* to Bankstown/Lidcombe Hospital following an argument with staff and patrons at a hotel and making a threat to drive his utility through the front door. He was admitted as he was found to be aggressive and intoxicated and scheduled as a mentally disordered person. He was discharged the following day. From reading the notes written by various Probation and Parole personnel who supervised John it is apparent that when in the community John disclosed that he would binge drink but denied illicit drug use sometimes saying that if he disclosed such they would only want him to stop or change which he was not interested in doing. He appeared selective in what he would disclose to Corrections staff and was only slightly more forthcoming when speaking to health professionals in a custodial setting.

Final Period of Incarceration

On 25 April 2015, John was arrested at a hotel after he apparently approached other patrons threatening to kill them and their families and blow up the pub. The police took John to the Redfern Police Station but shortly thereafter they called for an ambulance and John was conveyed to Royal Prince Alfred Hospital for a mental health assessment. The ambulance record indicates that when paramedics arrived at Redfern Police Station, John was naked in the police cells. The records note that though John was able to initially respond to questions in an ordered fashion, his thoughts quickly changed to irrational and disordered and he expressed suicidal ideations and homicidal thoughts. John told ambulance officers that he had been non-compliant with his medications. The ambulance officers completed a request for a mental health assessment under s. 20 of the *Mental Health Act*.

At Royal Prince Alfred Hospital, John was found to be heavily intoxicated and/or sedated and incapable of engaging in a full mental health assessment. The psychiatric registrar telephoned John's mother on the morning of 26 April 2015. Vicki informed him that John had gone to the pub to play two up and that as far as she was aware he was compliant with Olanzapine and was seeing Dr Liber at the Bankstown Community Health Centre. Vicki expressed no concern about John being at risk of serious harm to himself or others. John was discharged from Royal Prince Alfred Hospital on 26 April 2015 back into police custody who then returned to Redfern station at 7.00 am where he was charged with offences arising from the pub incident. John was then conveyed to the Surry Hills Police Cells which is a transit corrections centre pending transfer to and placement in a reception prison. It is run by Corrections NSW and the Justice Health and Forensic Mental Health Network (the Network) provide medical services. He remained there for 2 nights.

The "New Inmate Lodgement & Special Instruction Sheet" and the "Inmate Identification & Observation Form" (IIO) were completed at 07:45 am on that day. Section 2 of the IIO contains questions about health and each box is ticked *"No"* relating to whether John used non-prescribed drugs, whether he had consumed alcohol in the last 24 hours and whether he had received any psychological or psychiatric treatment. Presumably either John responded to the officer's questions in that way or the officer took any refusal to answer as a "no". Whatever, the case the answers recorded for those matters are not correct.

On 27 April John appeared by video-link before the Local Court and he was bail refused and he was remanded in custody to 11 May 2015. Whilst John was at the Surry Hills police cells on 28 April 2015 he was attended to by a Registered Nurse McCann who was the Nurse Unit Manager. A statement has not been obtained from Ms McCann as she has left Australia and returned to live in Ireland. However, Ms McCann's Progress Notes records *"Pt (patient) knocking up stating "heart pain" – called up for triage. Allergic to Fish/prawns – throat swelling. States has been having this pain for a few months especially after taking drugs; he rates this pain 4/10 – nil travelling down arms etc. (sic). States he hx (history) of schizophrenia on Zyprexa 30 mg nocte last taken 3/7 (days) ago. Nil TOSH (Threats of Self Harm) guarantees safety. ROI (release of information) signed and sent to records. Pt states drinks socially & uses drugs fortnightly, anything barr (sic) heroin"*.

Ms McCann performed standard observations and recorded John's Blood Pressure as 121/80, Oxygen Saturations at 99% respiratory rate as 16 breaths per minute and heart rates at 74 beats per minute. Ms McCann wrote *"Pt advised to rest & knock up if pain worsens. reassurance given".* RN McCann arranged for Dr Liber to release information to the Network. John's medication was then recommenced and he continued to take the Olanzapine each evening while in custody. Later that day John was transferred to the Metropolitan Reception and Remand Centre, (MRRC) in Silverwater. John was interviewed in what is called a "Reception Intake and Screening Process" which involves a prisoner being separately and respectively interviewed by a nurse from Justice Health and a corrections officer from the DCSNSW. They would have had the forms that had been completed on intake at the Surry Hills cells. Presumably the progress note completed by RN McCann also was available.

RN Anna Grigore completed the Justice Health "Reception Screening Assessment" commencing at 4:11 pm concluding at 4.23 pm on 28 April 2015. She sought a detailed history of recent alcohol and drug use. John told her that he used alcohol less than weekly and had last used it 5 days ago. He said that in the last four weeks prior to his incarceration he had used methamphetamine and that he had used it once a month and he had last used it a week ago. He said he smokes it. He denied using cannabis in the last 4 weeks. It is unclear whether the Progress Note completed by RN McCann was forwarded to MRRC for the Reception Screening. Though John disclosed a history of drug use and schizophrenia there is no reference to any cardiac issues other than RN Grigore recording "No" under the heading of Cardiovascular Condition(s). There is no reference to any cardiac issues during the remainder of John's incarceration.

Likewise, there is no entry in any Corrective Services records to suggest that John reported any heart or chest pain or dissatisfaction about the review by RN McCann at the Surry Hills cells on 28 April 2015. John was interviewed by the corrections officer for his Intake Screening commencing 5.15 pm and concluded 5.45 pm. While at the MRRC, John was reviewed by the Risk Intervention Team (RIT) on 29 April and 1 May 2015.

The CSNSW records for 1 May 2015 indicate that John "acknowledged that he had used ice about once a month and denied any other illicit drug use". His main concern at the time was to not share a cell with any inmate who smoked. On 28 April 2015, John was placed in the Darcy Wing, Pod 2, in a one out cell number 92. In classification terms, John was a special management area placement (SMAP) prisoner in light of his history and on his request. On 3 May 2015, John refused to sign Child Protection documents and on 8 May 2015, he declined a psychology referral. Throughout his two weeks at the MRRC, John telephoned his mother but he apparently did not mention to her that he had experienced or was experiencing any heart problems.

On 11 May 2015, John appeared via AVL in the Central Local Court and pleaded guilty to the charges and was adjourned to 18 May 2015 for sentence. That day he was also reviewed by Clinical Nurse Consultation (CNC) Marco Rec. CNC Rec completed a Health Problem Notification Form which stated that John "*must be one out cell. Holding Darcy until R/V by psychiatrist*". That day he moved from Cell 92 to Cell 81 still on his own.

Clinical notes made by CNC Rec on 11 May 2015 contain a useful history John gave about his alcohol and drug intake with notes as follows: *"ETOH (alcohol) : Binge – 1-x2/week, THC (cannabis) last several weeks ago : as much as I can get". Amphetamine: last (used) "months ago". If it's there I will use it – both speed/ice "smoke" or eat it", XTC (ecstasy) x10/day "occasionally cocaine but it's too expensive. Inhalants: not used. Hallucinogens "when I was young it was good stuff it's hard to get. Benzo (benzodiazepine) Rx (review) in past but refuses it'.*

12 May 2015

The events of 12 May 2015 are captured in large part by footage on a Darcy Pod 2 CCTV camera and later in addition by a hand-held camera operated by Corrective Services Officer Brent Samyia.

Corrective Services Officer Medhurst was tasked to conduct a head count of prisoners in the pod. At 6.18 am he came to John's cell, he unlocked the door, opened it and briefly looked inside then closed and relocked it moving on to the next cell to do the same. Though Officer Medhurst stated in his Incident Report written on that day, that John responded to him, he had not recorded what response John had given.

In his statement dated 21 December 2018, Officer Medhurst stated that it was his practice that he would never leave a cell door unless he received a response. In his evidence before the Inquest he said such a response might be verbal or a physical one. Around this time breakfast is left at each prisoner cell. At 6.23 am, John's breakfast was left outside the door to his cell. At 8.27 am, Senior Correctional Officer (SCO) Peter Dally unlocked the door to John's cell and with his leg pushed the breakfast inside. SCO Dally has confirmed in his statement that as he did so, John approached the cell door, bent down and collected his breakfast. This is captured on the CCTV footage. SCO Dally then relocked the cell door and left. It is unknown what, if any of the breakfast John consumed.

At 9.13 SCO Dally returned to John's cell and unlocked the door. The CCTV footage shows that no-one approached John's door during the period 8.27 - 9.13. The CCTV footage shows some movement of prisoners through the cell window but there is no such movement evident through the limited window view into John's cell after the time he collected his breakfast. After SCO Dally unlocked the cell door at 9.13 am John did not appear.

SCO Dally gave evidence and said that when he unlocked the door he called out "let go" to indicate that the occupant was free to leave the cell. He said that it is not his practice to check the inmate at "let go" as the head count has already been completed and he does not interrupt what a prisoner is doing in their cell or disturb their privacy.

A viewing of the Darcy Pod 2 CCTV footage confirms that through the course of the morning, inmates were let out of their cells and a number of them exercised in the large area in front of cell 81. Relevantly about a dozen inmates, including an inmate who I will refer to as "TS" and his cellmate, were exercising. No-one approached John's cell other than an inmate who had been at the door of the next door cell and when he walks away he appears to look into John's cell through the door window at about 9:19:26. Nothing about his demeanour or later demeanour raises any suggestion that what he saw gave him cause for concern.

At 10.08 am, inmate TS walked up to John's cell and looked inside the door. TS knew John as they had shared a cell at a previous time. TS saw that John was lying in bed and appeared unresponsive. He closed the door and walked to the Corrective Services Officers' station in D2 block.

He told SCO Dally that John did not look too good. SCO Dally requested Senior Assistant Superintendent (SAS) Sampson Mariner, who was at the time the Acting Manager of Security for the entire centre, to accompany him to cell 81. At 10.10 am, SCO Dally and SAS Mariner walked to the cell and opened the door. They saw that John was lying supine in bed. They both described him as pale and unresponsive. In his initial statement, SCO Dally stated that: "*I could tell straight away the inmate was deceased as he was pale in colour, his eyes were wide open and he was non-responsive*". SAS Mariner directed SCO Dally to call for medical services and SCO Dally immediately did so by radio.

Neither officer entered John's cell at that time. SAS Mariner left the cell and directed that the area be secured and he walked away from the cell directing the same as he walked. Inmates who had been in the open area quickly complied with the direction. A third officer, CO Carlsson, had followed SCO Dally and SAS Mariner to the cell and he assisted by following prisoners returning to their cells and locking the cell doors. It is evident from CCTV footage that at least ten inmates who had been in the area, quickly complied with the direction to vacate the area. One inmate can be seen to remain in the area which apparently did not give any concern to the officers. I think it likely that he was the "head sweeper" and positioned himself visibly to assist in the orderly compliance.

SCO Dally remained at John's cell door. After SAS Mariner left the area and inmates were vacating the area, SCO Daly entered the cell and touched John's neck very briefly. The time was 10:10:42. He left the cell again, leaving the door opened and unattended at 10:10:52. At 10:11:05 Nurse Fagaloa entered the pod area and she is then joined by Assistant Superintendent Ms Witt. They walk to John's cell and enter it and at 10:11:30. Nurse Fagaloa checked John's neck for a pulse and pulled the covers down to feel his chest and she commenced CPR at 10:11:30. Ms Witt says in her statement that she was at her desk in Darcy 2 when she heard someone say *"He appears to be in a very bad way".* Nurse Fagaloa happened to be in the area as she was a mental health nurse carrying out other duties and Ms Witt asked her to accompany her to John's cell. It would appear that neither attended in answer to the radio call transmitted by SCO Dally. Neither had with them any medical equipment such as a defibrillator or oxygen.

Ms Witt says in her statement that when she entered John's cell she saw that he was *"lying straight on top of the bed with the covers up to his chin. His face was very pale, his eyes and mouth were open".* The Pocklington family are concerned that SCO Dally did not commence CPR either as soon as he discovered John or once he had called for medical assistance on his radio. About 1 ½ minutes had elapsed between the Corrective Services Officers seeing John and Nurse Fagaloa commencing CPR. It is the family position that Corrective Services should not wait for medical staff.

Both SCO Dally and SAS Mariner wrote in their respective Incident Reports that day that SCO Dally on arriving at the cell entered it and after finding John pale and unresponsive, checked for signs of life and called a medical response. However, having viewed the CCTV footage they later made statements correcting that. Each was questioned in the inquest about why CPR was not commenced immediately. Registered Nurse Lauren Lennon and Enrolled Nurse Debbie Wood responded to SCO Dally's radio call of 10:10:04.

They arrived at the cell door at 10.12.18, bringing with them a trolley on which was the emergency bag, which contained an automatic defibrillator, oxygen and other airway management and emergency equipment.

Nurses Lennon and Wood prepared the defibrillator and placed the defibrillator pads on John's chest however John's heart was asystole and the defibrillator at no time picked up a shockable rhythm at any point. Shortly prior to the arrival of Nurses Lennon and Wood, Corrective Officer Samyia attended and began filming events with a hand-held video camera. At about 10.20 am, one of the attending nurses asked why the doctor working in the MRRC that day, Dr Annette Bemand, had not attended in response to the medical call made by SCO Dally. It appears that a Corrective Services Officer then yelled out for someone to fetch Dr Bemand. At about 10:22, Corrective Service officers carried John from the cell and placed him on the floor in the open area of the pod to allow for more medical access as the first ambulance crew of 2 paramedics had arrived as had Dr Bemand. She took over the airway management with bag and mask.

The paramedics asked how long John had been unresponsive and RN Lennon says words to the effect of "*he was still warm*", presumably meaning that John was still warm when CPR commenced. At approximately 10.24, a second ambulance crew arrived, with two further paramedics. They assisted with the CPR and relieved the Justice Health nurses of some tasks. At about 10:27 am one of the paramedics suctioned vomitus from John's airway. At 10:30 a third ambulance crew arrived with a further two paramedics. CPR continued and the defibrillator indicated continued absence of any shockable rhythm. At approximately 10.39, John is intubated to further assist with management of his airways beyond the valve bag mask. Unfortunately, despite the prolonged efforts of the Justice Health staff and paramedics, John could not be revived. At approximately 10.45, the paramedics ceased CPR and declared John deceased. Dr Bemand prepared a Life Extinct Form at 10.50.

The initial officer in charge of the Coronial investigation was Detective Inspector Garry James. He arrived at Darcy 2 at about 11.29 am. He inspected the scene, both outside and inside cell 81. He also viewed the CCTV and requested that it be retained and spoke to a number of Correctional Officers. Vicki Pocklington was informed of John's sad death at approximately 13.40 on 12 May 2015.

Autopsy

Dr Jennifer Pokorny, forensic pathologist, conducted an autopsy at the Glebe Morgue on 13 May 2015 and provided a Post Mortem Examination Report. Relevantly, she concluded that the direct cause of death was Acute Myocardial Infarction and she did not identify any antecedent causes. She did however identify the following:- a vague blue bruise in the upper left thigh/groin surround by three possible puncture marks; areas of scarring, pallor, mottling and softening in the interventricular septum and free wall of the left ventricle of the heart, in keeping with recent and remote ischemic injury, varying in age from hours to at least several weeks; the presence of cannabinoids on toxicological examination of the blood, in keeping with recent cannabis use, as well as Olanzapine at therapeutic levels.

Dr Pokorny indicated that narrowing of the coronary arteries was normally present in severe ischemic heart disease, but was not present in John. She raised an issue as to whether John's long history of methamphetamine use may be associated with this and previous myocardial infarction. She described that no methamphetamine was detected in the blood toxicology analysis.

Issues for Consideration

The following matters were raised in the inquest:

- the cause of death and in particular, whether the use of methamphetamine and/or Olanzapine may have contributed to Mr. Pocklington's death;
- the manner of Mr. Pocklington's death, including:
- the adequacy of the response to the report of "heart pain" on 28 April 2015;
- the adequacy of medical care provided to Mr. Pocklington from 28 April to 12 May 2015;
- observations made of Mr. Pocklington on 12 May 2015;
- any recommendations considered necessary or desirable pursuant to Section 82 of the *Coroners Act* 2009.

Cause of Death

In light of Dr Pokorny' s comments in her report, an expert report from Associate Professor Mark Adams, consultant cardiologist and head of cardiology at Royal Prince Alfred Hospital, has been obtained. Associate Professor Adams described that the post mortem examination findings demonstrate that John had experienced multiple small myocardial infarctions, likely brought about by coronary artery spasm arising secondary to methamphetamine or cocaine ingestion. In his evidence, Associate Professor Adams provided helpful explanations consistent with his report and Dr Pokorny's findings. He described that John had suffered myocardial infarction/s in the week to days prior to and/or leading up to 12 May 2015 and that this in turn led to John suffering a fatal arrhythmia on 12 May 2015 (either a ventricular tachycardia or ventricular fibrillation).

Associate Professor Adams considered it likely that the "*heart pains*" John complained about to RN McCann on 28 April 2015 were likely the result of coronary artery spasm caused possibly from the recent use of methamphetamine or from having suffered previous damage to his heart. He also explained that methamphetamine use can cause cardiac damage regardless of dose and frequency of use. It is not clear when John last consumed methamphetamine because of the variance in the history he gave different people - on 28 April 2015 he told RN Grigore that he had used methamphetamine *"a week ago",* but on 11 May 2015 he told CNC Rec that it was "*months ago"*.

In terms of frequency, on 28 April 2015 he told RN McCann that he had been having heart pains for a few months especially after taking drugs and on 1 May 2015 he told the Risk Intervention Team he had used ice once per month.

The possible puncture marks in John's upper thigh/groin raises the possibility of him having injected some form of illicit drug but in the absence of any such drug being detected on post mortem toxicological assessment, the relevance of it is unclear, particularly in light of John claiming to ingest or smoke methamphetamine rather than inject it. Associate Professor Adams' evidence explains that John's fatal heart attack, in the absence of clear evidence of recent methamphetamine use, was likely due to cardiac damage from earlier and smaller infarcts. Associate Professor Adams' gave evidence that John's use of methamphetamine would have led to recurrent coronary artery spasm and consequently, multiple myocardial infarctions (over months, if not years). He said that methamphetamine caused a vaso- constriction and cardiovascular spasms which would create scar tissue.

He said that each small cardiac infarction would leave further scarring or damage on the heart and each would have cumulative effects causing repeated cardiac infarctions leading to the fatal arrhythmia which occurred on 12 May 2015. Associate Professor Adams thought that this one was more likely to have been caused by an earlier infarction, occurring in the week to days prior to 12 May 2015. In the absence of John having any methamphetamine in his blood at autopsy it seems clear that John did not use methamphetamine within 48 hours of his death.

Associate Professor Adams explained that John did not have coronary artery disease nor a spontaneous artery dissection and there was no evidence of embolization so it is clear that methamphetamine usage over time was the precipitating factor. Associate Professor Adams explained that fatal arrhythmias, whether due to ventricular tachycardia or ventricular fibrillation, typically occur without warning or other symptoms such as chest pain and instead present with loss of consciousness and sudden death. Given that Associate Professor Adams explained methamphetamine use can cause cardiac damage regardless of dose and frequency of use and that it is not possible to accurately determine John's use of methamphetamine given the inconsistent accounts contained in the medical records, Ms Finlay submits that there are insufficient findings that John was a chronic methamphetamine user. Whether John used methamphetamine once a month or sporadically, he identified that his binge drinking was more problematic though he was sufficiently aware to tell RN McCann that he had begun experiencing heart pain after he used drugs over the recent few months.

Manner of death

The manner of John's death involves a consideration of the way or circumstances in which it occurred and involves a focus on more than just the medical cause of death.

The adequacy of the response of the report of "heart pain" on 28 April 2015

Associate Professor Adams was asked to comment on RN McCann's review and response to John's complaint of "heart pains" on 28 April 2015 taking into account the clinical context in which it occurred.

Namely, being that of a nurse working in a Justice Health Clinic in a correctional facility. Though he was not critical of RN McCann not organising an immediate medical review other evidence suggests that an ECG should have been considered.

Associate Professor Adams' acknowledged in his evidence that had John presented to a hospital or had been in the community a medical review could have been organised on the basis of the "heart pain" complaint however in John's circumstances he points to a number of important pieces of clinical information which mitigate against urgent or even prompt referral for medical review being necessary at the time. In particular, the observations RN McCann recorded were all within normal limits. A pain of 4/10 is not severe and RN McCann appeared cognisant that John was complaining of heart pain rather than chest pain because she noted that it did not radiate to the arm. EN Woods gave evidence that had an inmate complained to her that he was experiencing heart pain she would have organised and performed an ECG. She said that it is a readily available test and that is a very simple procedure. She said she would also have considered whether to organise a medical review.

Associate Professor Adams said that a medical review could include an ECG and a blood test to examine Troponin levels which can indicate, depending on the timing of the test to the pain or cardiac event, whether there has likely been a release of a protein registering an elevated level consistent with demonstrating a cardiac event. However, Associate Professor Adams commented that had a medical review been undertaken on 28 April 2015 or shortly thereafter, it is unclear as to whether any therapeutic response would have ensured that would have averted John's death. Associate Professor Adams has suggested that an ECG might have shown some changes consistent with myocardial infarction, such as ST elevation of depression and that blood troponin levels would likely have been elevated due to the myocardial infarctions (identified on autopsy) but the previous infarctions were likely very small and even on a coronary angiogram being performed may not have been indicated and likewise an echocardiogram may have been within normal limits.

Associate Professor Adams indicated that had John undergone a urine/blood drug screen that he would have been likely advised to avoid using drugs, particularly amphetamines because of the high risk of causing further myocardial damage. He also suggested that a medical review could also have resulted in John being given aspirin and monitored for 48 hours. However, he noted in his evidence that many people would not have prescribed Aspirin and even if they had it would not have prevented the arrhythmia suffered on 12 May 2015.

RN McCann should have organised an ECG and a medical review if that was possible. However given that she saw John at 11 am and he was transferred from that location to the MRRC that day such an arrangement may have not been possible. Associate Professor Adams said that if John had been in a tertiary hospital setting and reported that he was experiencing heart pain within a 4/10 range he would have been referred for a medical review. However, Associate Professor Adams said that the fact that John was in custody, had a psychiatric, criminal and drug history and was young would make a decision to refer him for a medical review not an "easy decision to make".

RN McCann could have completed a Health Problem Notification form advising the need for John to have an ECG and medical review which could have been followed up by the Justice Health staff at the MRRC. This would have been consistent with ensuring a continuity of care from one correction's facility to another. We do not know whether RN McCann considered doing so as she is not available. However, it should be noted that at the time John was screened at MRRC he did not apparently mention the pains to RN Grigore which suggests that they had either ceased or were significantly less than he reported five hours previously.

In the absence of evidence from RN McCann, Justice Health provided a document from the Adult Emergency Response Guidelines (2009) titled "Cardiac Pain Algorithm" which provides a pathway to medical service personnel for treatment where a prisoner is experiencing Chest Pain/Angina/Possible Acute Myocardial Ischaemic/Infarction, which indicates that if systolic Blood Pressure is greater than 90 mmHG then *half to one table of Glyceryl Trinitrate (GTN) and if the pain is relieved provided 300 mg Aspirin (oral). If possible perform an ECG, discuss with medical officer. If the ECG is abnormal or unclear then the prisoner should be transferred to hospital for further assessment if ECG changes are apparent.* John's systolic reading was 121 so had RN McCann approached his knocking up on his cell button and complaining of heart pain as an emergency those guidelines should have prevailed.

In the circumstances RN McCann should have indicated that John required both an ECG and a medical review so that bloods could be taken to measure his Troponin level. If she was unable to do this because John was about to transit to MRRC, then a Health Problem Notification Form should have been completed and highlighted so that John could receive this care. Though John had an ECG on 25 April at the hospital which was normal and there was a possibility that the ECG if performed on 28 or 29 April may have also been normal, if blood had been taken there was a good chance that a rise in John's Troponin level would have been detected and further investigations could have followed. However, had a medical review been arranged I accept that any follow up from investigations over the next 14 days would have not likely progressed to any effective treatment to prevent the acute myocardial infarction causing his death on 12 May 2015. That is likely to have been the case regardless of whether John was in custody or living in the community. In the circumstances John's family feel aggrieved that John did not have the opportunity to have his heart pain further investigated after reporting it to RN McCann. I agree that a person's access to adequate health care should not be jeopardised because they are in a custodial setting.

The adequacy of the medical care provided to Mr Pocklington from 28 April - 12 May 2015

No criticism has been made of the medical/nursing care provided to John from 28 April 2015 through to him being found unresponsive on 12 May 2015. No cardiac condition was identified at the MRRC Reception Screening and there is no record of John raising the issue again with any member of Justice Health. His medical and nursing management was routine and largely focused on his mental health issues. Associate Professor Adams is clear that the Olanzapine John had recommenced had no role in his experiencing a heart attack. In respect of 12 May 2015, expert opinion has been sought from an Accident and Emergency Physician,

Professor Anthony Brown, a Senior Staff Specialist in Emergency Medicine at Royal Brisbane and Women's Hospital and a Professor of Emergency Medicine at the University of Queensland, as to the adequacy of the medical response to Mr Pocklington being found unresponsive on 12 May 2015. Professor Brown has provided a detailed report based on his review of relevant statements and in particular, the CCTV and hand-held camera footage.

Professor Brown was not critical of any aspect of the care and engagement of resuscitation procedures and timeliness. He described the CPR as being of a high standard, with appropriate use of a bag valve mask to provide breaths interspersed with 30 external cardiac compressions. He also noted that the person providing cardiac compressions was rotated at appropriate intervals. Professor Brown identified some small areas in which the CPR may not have been textbook, though he was not overtly critical and did not suggest that any variations in technique would have influenced the overall outcome of the CPR.

Professor Brown did not express any concerns regarding the initial performance of CPR on the cell bed and he had no criticism of the equipment used during CPR. He considered that the resuscitation attempts were ceased at an appropriate time. Professor Brown was not of the view that any earlier attendance by Dr Bemand was required or would have changed the course of events as he was satisfied that those who were performing the CPR (Justice Health staff and then paramedics) possessed and performed the necessary skills. Both Associate Professor Adams and Professor Brown agreed that in order to have some chance of survival from an acute heart attack that emergency first aid needs to be commenced within about four minutes of the patient's collapse. The Polkington family have viewed the CCTV footage and are concerned about the response of the Corrective Services Officers towards finding John unresponsive. Whilst it is clear that SCO Dally immediately called for medical assistance, the time between that radio call and when that assistance arrived was a particularly difficult period for them to see because there was no checking of vital signs, urgency or provision of CPR.

SCO Dally and SAS Mariner both gave evidence that a priority in attending a medical emergency in a prison environment is to ensure the safety of the environment. They said it was not safe to enter the cell until the pod was secure from all the prisoners who had been 'at large' in the pod. Whilst I accept that position, I do appreciate that from the Polkington family's perspective a viewing of the CCTV footage may not give the impression that John's situation was treated as "medical emergency" until after the nurses started CPR. Inmate TS who first discovered John did not run to the officer's station and the officers did not run to John's cell carrying any medical apparatus. The officers stayed outside John's cell but for the briefest of moments when SCO Dally entered it and touched John's neck for a second and then went back outside. The first two nurses attended without running and without medical equipment and it was not until the other nurses arrived with the emergency trolley that any equipment, particularly the defibrillator was available.

Two minutes elapsed between TS discovering John, fetching and bringing the officers back to the cell. Another one and half minutes elapsed before RN Fagaloa commenced CPR.

For the family that is a long time to watch the CCTV particularly after hearing evidence from Associate Professor Adam and Professor Brown that time is of the essence.

Both experts agreed that given the descriptions of John having blue lips and cold extremities, very pale pallor, eyes and mouth open and non-responsive with cardiac asystole, that he was likely to have suffered collapse at least 30 minutes prior to TS discovering him. RN Lennon's report that he was warm is more likely due to the fact that John was in bed under covers rather than an indication that his collapse was more recent. Professor Brown said that the outcome of an unwitnessed cardiac arrest where the patient is found to be in asystole is almost universally fatal and even in witnessed events with full tertiary hospital facilities the survival rate is as little as 7%.

John's family acknowledges that given John's collapse was unwitnessed there was no opportunity for the resuscitation attempt to engage the defibrillator or CPR. The Corrective Services Operations Policy (13.2.1.1) sets out what a First Responding Officer (FRO) should do upon discovering a death in custody: - 1. Determine and assess the situation for any risks or hazards including *"Prior to entering a scene to provide assistance, the FRO and all subsequent staff must make sure it is safe to do so…protecting people and providing the injured with first aid and medical care is the first priority.* 2 Establish and notify Communications – *call for assistance from other officers...it is the responsibility of all staff to provide first aid to injured people if in a position to do so and provided it can be administered safely. It is imperative that this is done as soon as possible to protect life. Once the FRO has determined it is safe to enter the scene the FRO must immediately check for signs of life and commence resuscitation….*

Though SCO Dally entered the cell after calling for assistance on the radio and he briefly checked for signs of life he did not commence resuscitation. His explanation was that it was not safe to do because the pod was still being made secure. SAS Mariner said that he would not have expected SCO Dally to enter the cell because there was no officer providing security for him. I do not accept that it was not safe for SCO Dally to have commenced CPR after he entered the cell and felt John's neck. If it was unsafe he would not have re-entered the cell in any event. The CCTV shows that the immediate area was sufficiently vacated by prisoners who were compliant. I accept the evidence from the officers that safety is particularly poignant in a remand wing because prisoners are not as settled as those who are sentenced and many prisoners on remand are not necessarily known by the officers and some have difficult behavioural concerns due to substance withdrawals, mental illness or gang affiliations. However the CCTV footage would suggest that it was sufficiently safe for a corrections officer to have entered the cell and commenced CPR while the area was being secured and rather than wait for a complete lock down or for the medical staff to arrive.

Had RN Fagaloa not been in the pod at the time, CPR would not have been commenced as soon as it was as the corrections officers were waiting for medical staff to arrive rather than engaging in first aid as was required under the policy. The nurses arrived with the medical equipment a little over 4 minutes after TS discovered John but within 45 seconds of RN Fagaloa commencing CPR. CSNSW has confirmed that every pod now has a defibrillator housed in it. This means that Corrections Officers are able to commence using that apparatus immediately rather than waiting for medical staff to bring the equipment into the pod from the clinic.

In regard to whether the response to John was treated as an emergency, I acknowledge the custodial setting is a relevant context and that due to the inmate population, particular in a remand wing, it was important for TS and the Corrections Officers and Health staff not to react or act in a way which could cause alarm, panic or unwanted involvement of other prisoners. SCO Dally's said that he did not check for John's vital signs and commence CPR was due to security and believing that medical assistance was readily available. I think that this explanation is more given in hindsight because at the time SCO Dally genuinely thought John was deceased because he saw John had his eyes open and he was unresponsive and he was pale.

However, the policy relating to a Death in Custody makes it clear that *even if an officer finds an absence of signs of life in a person it does not necessarily man that a person had died and accordingly the FRO **must** check for the following signs of life: breathing, pulse, heartbeat and or pupil/contraction on exposure to light.* SCO Dally did not do those things.

The policy goes on *"If the inmate is not breathing or a heartbeat cannot be detected resuscitation **must** be started and first aid applied where necessary. Resuscitation attempts **must** continue until medical personnel arrive and take over…once health staff arrive CSNSW staff may withdraw unless they are requested by medical staff to assist in treating the inmate".* In relation to SCO Dally not checking for signs of life (as set out in the policy) or providing CPR once he had called for medical assistance, Professor Brown indicated that it would have made no difference. He explained that he agreed with Associate Professor Adams' view that for John to have had some chance of survival, he would have needed to have been found within four minutes of his collapse.

Though there is no evidence of when it was during the period 8.27 to 10.08 am that John had become unconscious and unresponsive it is likely to have been at least 30 minutes prior to inmate TS seeing him. Given the descriptions of his skin pallor and extremities having a blue tinge that it is likely that John had collapsed at least half an hour prior to inmate TS seeing him. Associate Professor Adams explained that the blue tinge of lips and hands is as a result of a lack of circulation of oxygenated blood. Professor Brown took into account that RN Lennon suggested that John was still warm when CPR began, noting that he was clothed and in bed and that it takes some time for a deceased's body to cool.

Recommendations

A Coroner has a statutory power to make recommendations under Section 82 of the *Coroners Act*. Counsel Assisting has put forward two recommendations for consideration. The first relates to clarifying to the CSNSW officers that providing emergency first aid should not be compromised by an emphasis of dealing with risks and hazards over checking for signs of life and commencing first aid. Mr Downing queried whether the Operations Policy Manual which then applied or the Custodial Operations Policy and Procedures which now apply make it clear that security of the centre is the highest priority and everything else is secondary. Counsel Assisting suggests that if it is the intent of the policy that corrections officers identify prisoners at large in the environment as a "risk and hazard" that must be dealt with prior to checking for signs of life then the policy should say so.

Without such, he queries whether the steps a corrections officer should take and what those priorities are unclear. Counsel Assisting points out prompt steps are required when time is of the essence and if a prisoner is in tachycardia (rather than asystole) the quick use of a defibrillator is essential. Ms Finlay agrees that an attempt to preserve life should be the primary focus though acknowledges the need to ensure security so that responders are safe to be able to respond to a medical emergency. Ms de Castro Lopo does not support a change to the Operations Policy and Procedure because even if there is explicit reference to a hazard and risk being that of inmates being at large in the vicinity, it cannot always be predicted what the situation will be in a serious incident. For example, what might be done in a remand wing might be different to that done in a sentenced prisoner wing.

I accept that both SCO Dally and SAS Mariner were appropriately trained and experienced officers who were aware of their responsibilities as First Responding Officers. The first instruction from SAS Mariner was appropriate "radio for help" and his second response was to clear the area of inmates and enlist the assistance of other officers. That response was not essentially at the exclusion of SCO Dally being able to enter the cell and check for signs of life. Indeed both officers wrote in their respective Incident Reports filed that day that this had been done. It hadn't because they were both of the view that John was deceased.

While SAS Mariner was organising other officers, Officer Carlsson had the security of the pod in hand leaving SCO Dally sufficiently safe to enter the cell. He in fact did enter the cell. The fact he did not properly check for signs of life and commence CPR was not because the area was not secured. It was because he believed the medical team were soon to arrive and in any event John was deceased. It was not because there was a confusion or misunderstanding about prioritising security with first aid.

Mr Kellaway pointed out that SAS Mariner said that to render it safe to enter John's cell that the officers had to contain and isolate the area and he would not have directed SCO Dally to go into the cell alone because there was a need to maintain sight and sound of another officer. I note that SAS Mariner did not direct SCO Dally to go into the cell but SCO Dally did go in so he must have felt safe enough to do so. The CCTV footage indicates that the area appeared safe enough for him to have done so. In any event, there was nothing to stop one officer guarding the cell door while the other officer entered, checked for signs of life and commence CPR whilst medical support arrived. Accordingly I do not propose to make a recommendation about identifying whether the presence of prisoners may present a specific hazard or risk when assessing an emergency situation.

Further, I note that there are many everyday tasks, not just emergency situations, requiring corrections staff to always maintain an assessment of the hazard and risk prisoners provide to themselves and to each other and to the operation of the centre generally and given this explicit requirement there seems little to advance by making it implicit in an emergency environment. The second recommendation Counsel Assisting suggested for consideration is put forward by Professor Brown's report that Justice Health and Corrective Services adopt a team structure and role delineation for cardiopulmonary arrests and the type of life support training that might be given to Correctional Officers might be appropriate. The first aid support which was provided to John was performed by Justice Health personnel and the attending paramedics who did not call on CSNSW officers to assist.

The policy in the CSNSW "Custodial Operations Policy & Procedures" for medical emergencies is at 13.2 and clearly sets out that: *"Correctional officers must provide first aid to inmates until medical personnel respond and commence treatment. Correctional officers must assist medical personnel if requested".*

The policy clearly sets out the role of the First Responding Officer (or officers and that the role can be shared) and other correctional officers. I am satisfied that policy adequately identifies and communicates the CSNSW officer's roles and I do not think the circumstances of this case warrant any recommendations in that regard. Ms Finlay submitted that I consider a recommendation that Correctional Officers wear body video cameras citing that if SCO Dally or SAS Mariner had worn one, what they saw would be recorded. Whilst that issue is of interest, it was not ventilated with any of the witnesses and was not an issue about which I inquired so I am not now in a position to consider such a recommendation but I do note that most of what occurred is captured on the CCTV and shortly thereafter by the hand held camera so in this matter very little further evidence, if any would have been gained in any event. The Polkington's grief for the loss of their beloved John is amplified by not only the fact that he died suddenly and so young but because he was in custody, away from those with whom he was extremely close, particularly Vicki who had always given him unwavering love and support. John told Corrections officers repeatedly that his family was his protection and on his reception he was upset about how his incarceration would upset Vicki.

The family have been extremely patient and have pursued and ensured that John's death be properly investigated and understood and so over 5 years later and just 2 days before John's birthday which would have been his 37th, they can truly say that they have done everything they could to make sure that John's coronial process has been properly completed. I again pass on my sincere condolences to them.

Formal Findings:

Identity: John Pocklington

Date: 12 May 2015

Place: Metropolitan Reception and Remand Centre, Silverwater NSW 2128

Cause: Acute Myocardial Infarction

Manner: Natural

2. 208086 of 2015

Inquest into the death of Brooke Carroll. Finding deivered by DSC Grahame at Lidcombe on the 22 May 2020.

This inquest concerns the tragic death of Brooke Carroll. Brooke died by the side of the Mitchell Highway after the vehicle she was travelling in hit a power pole. At the time of the collision, the vehicle was being followed by a police car. Brooke was in the passenger seat. The driver was speeding and affected by methylamphetamine.

Brooke was only 18 years of age at the time of her death. She was one of four sisters and also had two half-brothers. She had strong bonds with her parents and also with her uncle and aunt. Her sister shared with the court a little of Brooke's personality. "To know Brooke was to love her. She had a personality like no other. Brooke had so many hopes, dreams and aspirations. She was never afraid to set the bar high. As kind and gentle as she was, Brooke was equally mischievous and was always ready to play jokes and bring humour …she was a larrikin."

The profound grief felt by all family members was evident in court four and a half years after her death. I acknowledge the pain of losing this wonderful young woman so young.

The role of the coroner

The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of death. The coroner is also to address issues concerning the manner and cause of the person's death. A coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future. In this case, there is no dispute in relation to the identity of Brooke, or to the date, place or medical cause of her death. For this reason the inquest focused on the manner and circumstances of Brooke's death and on questions about whether her death could have been prevented.

At the time Brooke died, she was a passenger in a vehicle being followed by a NSW Police Force vehicle. Her death clearly occurred "in the course" of police operations. In these circumstances, pursuant to the relevant legislation, the conduct of an inquest, by a senior coroner, was mandatory. The purpose of these provisions is to ensure that a death of this nature is thoroughly and carefully reviewed. The public must have confidence that all deaths which occur during police operations are scrutinised carefully and independently and that any opportunities for improving police practice are quickly identified.

I am satisfied that after Brooke's death, an investigation of the events surrounding the collision took place pursuant to the relevant NSW Police Force Critical Incident Guidelines and that the necessary information was gathered by non-involved officers so that these matters were able to be properly and fully examined at the inquest in an impartial manner.

The inquest could not be commenced until after the relevant criminal proceedings had concluded. I acknowledge this delay is likely to have caused further distress to Brooke's family members.

The evidence

The court took evidence over three hearing days. The court also received extensive documentary material, compiled in a two volume brief of evidence. This material included witness statements, medical records, photographs and video recordings, as well as court records. While I do not intend to refer to all of the material in detail in these findings, it has been comprehensively reviewed and assessed.

A list of issues was prepared before the proceedings commenced and circulated to the parties. The issues explored at the inquest included:

- Was Senior Constable Trudgett's attempt to follow Mr. Thompson's vehicle a "police pursuit", such as to enliven the pursuit policy within NSW Police Force Safe Driving Policy ("the SDP")?

- If the conduct of Senior Constable Trudgett amounted to a "pursuit" for the purposes of the SDP, whether the conduct of Senior Constable Trudgett prior to and during the pursuit was appropriate.

- If Senior Constable Trudgett' s conduct did not amount to a "pursuit" for the purposes of the SDP, whether his conduct was appropriate in the circumstances, in light of the other provisions of the SDP.

- Whether, if the conduct of Senior Constable Trudgett did not amount to a "pursuit" for the purposes of the SDP, it should have done so, so that the safeguards contained in the SDP apply to these circumstances.

- Regardless of the applicability of the SDP, was Senior Constable Trudgett's contact with VKG adequate?

These questions directed the focus of the evidence presented in court. However as is often the case, a hearing can crystallise the issues which are really at stake.

In addition to brief oral evidence from the officer in charge, Sergeant Yonneka Hill, two witnesses were called to give oral evidence. The court heard from Senior Constable Luke Trudgett, who was the involved officer, and also Acting Senior Sergeant Nicholas Hrymak, who provided a report for the purposes of assessing whether or not Senior Constable Trudgett' s conduct on the night was in compliance with the SDP. Throughout the inquest, it became clear that aspects of the SDP are poorly understood by the officers tasked to implement it. Police are often called upon to make difficult decisions quickly. More training and clearer guidance is needed to ensure these decisions are based on an adequate assessment of the risk involved.

While I have some criticism of Acting Senior Sergeant Hrymak's review of the incident that led to Brooke's death, I am satisfied that Senior Constable Trudgett approached these proceedings with honesty and a genuine willingness to learn. It is important to note that the driver of the vehicle involved in the accident, Scott Thompson, has already been dealt with in a criminal court. He was charged and convicted for aggravated dangerous driving causing death, and failure to stop in a police pursuit, amongst other offences. Documents relating to these proceedings were before the court and those matters were not revisited in any detail.

Mr Thompson gave various early inconsistent accounts of what happened. What is clear is that he knew police were signalling him to stop and he continued to drive at speed. His eventual plea reflects this fact.

Background

Little is known about Brooke's decision to travel in the car with Scott Thompson that evening. The court is informed that Mr Thompson was Brooke's boyfriend, but knows little about the nature of their relationship. The car they were travelling in had been purchased on the day of the incident from Mr Thompson's friend Gregory Knight. It appears the car belonged to Ms Maddison Emery, who at some point was in a volatile relationship with Mr Knight.

During the investigation, the car was examined by Senior Constable Anthony Pellicane. The only pre-existing defect discovered was that the nearside rear tyre was found to be worn, with no tread present on the inner edge of the tyre. This may have contributed to the driver losing control at speed, in poor weather.

The events prior to the critical incident

Senior Constable Trudgett had been a police officer for around eight and a half years at the time of Brooke's death. He had spent three of those as a highway patrol officer. He had undergone a highway patrol education course, which included full time study at Goulburn and on the job training in the western region. By July 2015 he estimated that he had been involved in 2000 – 3000 traffic stops and a small number of pursuits.

On Wednesday 15 July 2015, Senior Constable Trudgett was rostered on at Dubbo Police Station and was tasked to conduct Highway Patrol duties within the Orana Local Area Command between 4pm and 2am. Senior Constable Trudgett was the driver of Western 219 ("WTN 219"), a green, fully marked Highway Patrol Holden SS Commodore sedan, NSW registration CB 59 DR. He was in full police uniform and operating as a single unit. WTN 219 had a Mobile Data Terminal ("MDT") attached to the vehicle and Mobile Automated Number Plate Recognition ("MANPR") capabilities, as well as In Car Video ("ICV").

At the commencement of his shift, Senior Constable Trudgett conducted a number of routine checks and procedures relating to his vehicle and equipment.

Senior Constable Trudgett noticed that on attempting to log onto the MDT, there was no power running to it, or to the ICV, which was obvious as the mirror did not illuminate. He noted that the radar appeared to be working appropriately. Senior Constable Trudgett subsequently attended the police "radio techs" and was assisted by Senior Constable Goodman, who replaced a fuse in the rear of the vehicle. This resulted in the ICV and MDT being operational. Senior Constable Trudgett stated that throughout his shift that evening, the ICV was functioning correctly with the exception of the microphone, which appeared to be faulty. Senior Constable Trudgett stated that he commenced his duties on the road and conducted three vehicle stops prior to the fatal accident, without incident. The ICV appeared to be functioning, aside from the issue with the microphone.

At approximately 8.15pm, Senior Constable Trudgett was driving WTN 219 in a "general west direction" on the Mitchell Highway. He said the road "appeared to be in a reasonable condition." The highway at that point is a single lane dual carriageway and the area has a sign post indicating a speed limit of 110km/h.

The weather conditions

The court heard various accounts of the weather conditions at around that time. Senior Constable Trudgett noted that prior to and at the time of the incident it had been raining. Independent civilian witnesses were more descriptive. Justin Beavis described the weather just before the accident as "terrible" … "it was pouring rain and there was rain all over the road that [his] car was, sort of, tracking off on the road". Angela Coker, who was travelling from Sydney to Dubbo, stated that "it was raining all the way". She described the conditions as "raining very heavily'. They were, yeah, horrendous". She was familiar with the road, but the weather was such that she was travelling at a speed lower than she would normally. Robert Thomson said it was "raining horribly" and that the weather was "probably the worst [he had] driven on those roads…" he had his high beams, driver lights and spotlights on his vehicle on and "visibility was very poor". He was driving a lot slower and had engaged the four wheel drive on his vehicle, because he thought the conditions were "very dangerous".

I accept that the road was wet and the driving conditions were dangerous with diminished visibility. The ICV shows that Senior Constable Trudgett had his wipers on and that rain was falling. It was dark.

The course of driving

Senior Constable Trudgett told the court that as he approached Tarwong Lane, an oncoming vehicle "popped over the rise and appeared to have their main beam headlights on". The headlights remained on as the vehicle continued to travel in an easterly direction towards Wellington. Approximately 50 metres from the oncoming vehicle, Senior Constable Trudgett activated WTN 219's primary warning lights. In the recorded interview he conducted the day after Brooke's death, Senior Constable Trudgett stated "I activated the police warning lights to conduct a u turn." However in his later police statement, provided five days after the incident, he stated "I activated the Police vehicle's primary warning lights to signal the driver to stop."

In oral evidence, Senior Constable Trudgett clarified his thinking at the time he made the decision to activate his lights, agreeing that in terms of his state of mind, he put the warning lights on, "namely the lights on top of the police vehicle above, to indicate to [Thompson] with the high beams to stop". He further explained:

"I was conducting a U-turn in order to … when I activated my lights it was the intention to stop. I've conducted the U-turn safely and then when Mr Thompson was nowhere to be in sight, I've had to catch up."

Senior Constable Trudgett confirmed that the issue he was concerned with was the offence of using high beam lights on an oncoming vehicle. Senior Constable Trudgett conducted his U-turn just near a roadside memorial on the southern side of the roadway. It was dark but he was able to identify that the car with the high beams was white in colour. He accelerated to "catch up to the vehicle", rounding a slight left hand bend in the roadway, and then he saw the brake light on the white vehicle activate as it navigated a slight right hand bend leading onto the Maryvale Straight.

Shortly after this, Senior Constable Trudgett saw a "white flash" or "glow" in the area he believed the white vehicle was travelling. Senior Constable Trudgett accelerated further reaching an approximate speed of 170 km/h before slowing slightly to take a right hand bend. The court was able to view the ICV, which records a highest speed at 170 km/h.

Justin Beavis was travelling from Dubbo towards Wellington at the time of the incident and told police that the white car had followed his 4WD at a very close distance after leaving the town of Geurie, until both vehicles entered the 110 km/h zone sign posted area of the road. Mr Beavis states that the white car then overtook him and "flew past", "leaving him for dead". He described the speed as "unbelievable" in light of the rain. Mr Beavis states that he "noticed the police car", WTN 219, first seeing "his lights" and then noticing the police car turn "around in pursuit of the speeding car".

After making it through the right hand bend, Senior Constable Trudgett observed a white vehicle (BFN-49J) in a paddock on the northern side of the Mitchell Highway. He stated "my eyes were on the vehicle and as I looked back in front of me there was a cable or wire across the roadway appearing to be falling. The sounds of glass exploding inside the Police vehicle and something hitting it rang out." Senior Constable Trudgett stopped his vehicle at what he estimated to be about 60-70 metres past the white vehicle. He realised that his police vehicle had no power and that the ICV was not recording. He had no headlights or light bar. Senior Constable Trudgett used his police radio to call for urgent assistance.

He walked back towards the white vehicle in the paddock, flagging down two civilian vehicles to slow down and stop on his way to the white sedan. When he got to the white car, the first person he saw was a female in the front passenger seat. He believed that she was already dead. He was unable to find a pulse.

This person was Brooke Carroll. Senior Constable Trudgett then noticed a male he recognised as Scott Thompson trying to exit the vehicle. He was wearing a seatbelt and had a brown and white bag draped over his shoulder. He appeared to be momentarily trapped by compression and confinement.

Senior Constable Trudgett called out to the two civilian vehicles that had stopped. One male, Adrian Whitehead, called '000' and another male, Robert Thomson, came into the paddock to assist him. In his recorded interview, Senior Constable Trudgett stated that Mr Thompson had some apparent injuries including a head laceration. He appeared to have scattered speech and train of thought, and overall he appeared vague. Senior Constable Trudgett then attempted to free Mr Thompson by cutting his seatbelt with his Leatherman. He also cut the brown and white bag draped over Mr Thompson's shoulder, which felt heavy.

Senior Constable Trudgett stated that he then questioned Mr Thompson about the other passengers in the vehicle. He was told that there was an additional male passenger in the vehicle called "Stephen". This was evidently a lie. Senior Constable Trudgett briefly spoke to the '000' operator before asking Robert Thomson to conduct "a line search for a body or a further injured person". Robert Thomson attempted to locate the third person. He walked back up to the road following the marks through the field and to the foot of the telegraph pole. Nothing of interest was located.

Senior Constable Trudgett then asked Mr Thompson "Why did you try and fuck off from me? I just wanted to talk to you about the high beams". Mr Thompson denied he had taken off and enquired about the other car that was in front of him. Senior Constable Trudgett told Mr Thompson that there was no other car.

He also reconfirmed with Mr Thompson who the other passengers in the vehicle were. Mr Thompson still stated there had been a male and female passenger in the car. It was later confirmed that there were only two people in the car. Robert Thomson states that while he was assisting with Mr Thompson, he asked him questions about the incident. He stated that Mr Thompson told him that his car had been travelling approximately 120 km per hour and that he had "just hit a pole". Approximately 15 minutes later, assistance arrived including police vehicles Wellington 20 and Western 222 and ambulance paramedics. Mr Thompson was taken to Dubbo Base Hospital. It was subsequently confirmed that his bag contained methamphetamine and cannabis.

Senior Constable Trudgett immediately observed significant damage to the roof of the white vehicle and to the offside part of the vehicle near the "B pillar" (behind the driver's seat). Senior Constable Trudgett described the car as "almost folded in half." He also described the "telephone pole/post" as broken in two pieces – one piece with cable rolled on itself on the southern side of the roadway and the bigger piece located on the northern side of the roadway". Senior Constable Trudgett also noted the damage to WTN 219, the vehicle he had been driving. Both ICV cameras were off the windscreens, the near side and rear windscreens had "exploded" and there was "damage to the front and the offside of the vehicle for the whole length of the vehicle".

He stated he did not "think there was a panel that wasn't dinted."

Sergeant Kelly Wixx was the Supervisor at Dubbo Police Station on the evening of the accident and was utilising fully marked police vehicle Dubbo 14. She acknowledged the broadcast relating to the collision at about 8:30pm and proceeded to the scene of the accident. When she arrived at the scene, she observed that Senior Constable Trudgett' s vehicle was approximately 100 metres from the white vehicle and that there was a broken piece of telegraph pole in the drainage ditch on the right hand side of the road, with steel cabling wrapped around it. Sergeant Wixx stated that a short distance from this, a police light bar system was lying on the road, which Senior Constable Trudgett identified as belonging to WTN 219.

In all the circumstances, it appears that Mr Thompson lost control of his vehicle and collided with a telegraph pole. Damage to the pole caused wires to fall on the roadway. These have impacted with WTN 219 and dislodged the police light bar and caused other damage. Sergeant Brett Samuel and Senior Constable Gudgeon of the Crash Investigation Unit attended the incident at approximately 1.45am on 16 July 2015. They confirmed the significant damage to the white vehicle was caused by the white vehicle colliding with a timber telegraph pole. The court has had an opportunity to review their evidence and view the photographs of the collision scene. I accept that Brooke's terrible injuries were caused by this collision and that there was no contact between the white vehicle and the police car. This is corroborated by viewing the ICV.

Post mortem examination and Brooke's cause of death

Tragically Brooke was confirmed deceased at the scene and was subsequently transferred to Dubbo Base Hospital. A post mortem examination was performed by forensic pathologist Dr Leah Clifton on 17 July 2015. In her report dated 22 September 2015, Dr Clifton stated that the cause of Brooke's death was multiple injuries to the head, thorax and limbs, including fractures to the skull, left clavicle, pelvis, right femur, left tibia and fibula and right scapula. There were also multiple superficial lacerations, bruises and contusions on her body. Dr Clifton concluded these injuries were consistent with blunt force trauma in a high speed motor collision.

Proceedings against Scott Thompson

Scott Thompson was charged, convicted and sentenced in relation to Brooke's death and other related matters. He received a sentence of four years and nine months (with a non-parole period of three years and seven months) for "dangerous driving occasioning death in circumstances of aggravation". The aggravating circumstance was that his driving was impaired by methylamphetamine. A number of other offences were also finalised, including a failure to stop in a police pursuit, driving under the influence of methylamphetamine, driving with illicit drug in blood and drive while disqualified. He was also convicted of a drug supply charge. Forensic pharmacologist Dr Judith Perl provided an expert report in this matter. In her view, the concentration of methylamphetamine detected in Mr Thompson's blood was "very significant" and would have "very substantially" impaired his driving ability at the time of the collision.

It should be emphasised that Mr Thompson pleaded guilty to failing to stop in a police pursuit. The plea was taken on an agreed set of facts and Mr Thompson received a custodial sentence for the offence. Both Senior Constable Trudgett and Acting Senior Sergeant Hrymak told the court that they were unaware of this outcome. It is difficult to understand why this important information was not available to Acting Senior Sergeant Hrymak when he was tasked to review the incident. It is difficult to understand how the Assistant Commissioner who signed off on the report or someone on the Critical Incident Team did not at least question Acting Senior Sergeant Hrymak's characterisation of the course of driving, given the criminal charge which had been preferred.

Notwithstanding the fact that neither Acting Senior Sergeant Hrymak nor Senior Constable Trudgett had knowledge of the fact that Mr Thompson had pleaded guilty to failing to stop in a police pursuit, I am deeply troubled by the apparent inconsistent approach across the agency as a whole, regarding the categorisation of the driving of Senior Constable Trudgett on the tragic evening in question. At the conclusion of these coronial proceedings, those appearing for the Commissioner of Police ("Commissioner") urged me to accept that no pursuit had occurred. However during the criminal prosecution of Mr Thompson, other officers, also working for the Commissioner, appear to have thought it appropriate to pursue a conviction for the offence of failing to stop in a police pursuit. Indeed Mr Thompson was convicted and sentenced for this very offence. Acting Senior Sergeant Hrymak was adamant to the end that no pursuit took place. Why then was a plea accepted to the charge? Why was Mr Thompson imprisoned for the offence?

The Safe Driving Policy

In recent times, the complex issues surrounding police pursuits have been widely debated in public and have been the subject of significant research and investigation throughout many parts of the world. A number of the issues as they relate to NSW have previously been examined by this Court. The issues clearly have a wide public intere**st.** The question of whether and in what circumstances police should pursue a vehicle is a complex one and one that is currently approached differently in various jurisdictions. There are no obvious or easy answers and reasonable people may differ on the correct approach to take. Ultimately, it involves a careful balance between interests that at times conflict.

Providing police with sound and accessible guidance on the operation of their discretion to pursue becomes a difficult but necessary task, particularly when decisions to pursue are so often made quickly and in stressful circumstances. Over the years many in the community have been rightly concerned at the number of deaths arising from or in the course of police pursuits. The SDP is a NSW Police Force internal policy document which guides police driving practice and strategies, including the conduct of police pursuits. There have been numerous iterations of the policy. The court had access to the policy in force at the time of Brooke's death ("SDP version 7.2"), and the current policy ("SDP version 9.2"). While much of the policy is identical across versions, there have been some significant changes.

The previous Commissioner Scipione APM notes in the foreword of the SDP version 7.2 that the NSW Police Force has a major responsibility to improve road safety and in doing that, "we must lead by example".

Right from the start, the policy makes it clear that oversight of pursuits is essential and the Duty Operations Inspector ("DOI") is especially charged with the role of determining whether a pursuit shall terminate or continue. Individual officers no longer have an unfettered discretion in this matter. A clear head, away from the stressful operational environment, must be involved if a pursuit is to continue.

Part 6 of the SDP version 7.2 deals specifically with urgent duty and pursuits, providing definitions and guidelines to support officers in making their decisions to initiate and/or continue pursuits. It is clear that a pursuit commences at the time a decision is made to pursue a vehicle that has ignored a direction to stop. The pursuit continues if the police vehicle follows the offending vehicle in an attempt to remain in contact, whether or not warning lights or sirens are activated.

Police are given guidelines to consider prior to making a decision to pursue, which involve weighing up the danger to themselves, other road users and the subject of the pursuit. Police are reminded that the driver and the vehicle must be appropriately classified. The Pursuit Guidelines in SDP version 7.2 did not specifically guide officers to consider weather conditions, traffic density, and road conditions. However, later versions of the policy have added this guidance. Importantly, in the factual circumstances of this case, the SDP Version 7.2 contained a clear direction that when a vehicle engages in a pursuit, the DOI or VKG shift operator must be informed and certain information must be communicated immediately, including the reason for the pursuit and the conditions at hand. If communication cannot be made with VKG, police must not pursue. This policy is aimed at giving proper independent oversight to each and every police pursuit which occurs in NSW. If police in pursuit are told to terminate, they must do so. It is an essential and important part of the current policy.

A critical issue arising in this case was whether officers are adequately trained to quickly and accurately recognise when they are "in pursuit". Is there a grey area between following a vehicle after a traffic stop and being "in pursuit"? Only the latter will provide the officer and the general public with the protection of contemporaneous oversight and independent risk assessment. This court has previously grappled with the question – was this course of driving a "pursuit"? Are there ways to clarify and improve police understanding of policy in this area?

- **Was there compliance with the Safe Driving Policy?**

The evidence of Senior Constable Trudgett

Senior Constable Trudgett impressed the court as a genuine and honest witness who did all he could to grapple with the issues before the court. I accept that he has been severely and sincerely traumatised by Brooke's death and has given the matter considerable thought. His willingness to review his original assessment of the circumstances in which he found himself does him enormous credit. Senior Constable Trudgett initially told the court that he had not been "in pursuit" of Mr Thompson. He explained: "I was conducting a U-turn in order to…when I activated my lights it was the intention to stop. I've conducted the U-Turn safely and then when Mr Thompson was nowhere to be in sight, I've had to catch up. And if I had gotten behind him earlier enough and he still hadn't stopped, that's when I would have been looking at going with the sirens, adding the flashing of the lights and horn in order to stop, if he hadn't have stopped then, then it would be in pursuit."

The thrust of his evidence was that the brief period where he followed the white vehicle was not a pursuit but rather an attempt to "close the gap" after an attempt at a traffic stop. In his mind, pursuant to the policy, there was no obligation to call VKG until it became "a pursuit."

I accept that Senior Constable Trudgett genuinely believed he was conducting a traffic stop. He explained

"I felt that at the time it wasn't a pursuit because I was in the correct…vehicle… I needed to catch up to him for, safety of police and others, and I also took in the, the conditions at the time, being night, rainy and being a rural road. I felt that catching up and well stopping him about the, the offence of using his high beam on an oncoming vehicle required my, my attention." Senior Constable Trudgett told the court he had conducted traffic stops before where he had just activated lights and the person had just pulled over. Senior Constable Trudgett was taken to the relevant definition of pursuit in SDP version 7.2.

He was advised that at the time of Brooke's death, a pursuit included circumstances where an officer has attempted to stop a vehicle and the driver of the vehicle is attempting to avoid apprehension or appears to be ignoring police attempts to stop them and the officer continues to follow them, whether or not their vehicle is displaying warning lights or sounding a siren. On reflection, Senior Constable Trudgett agreed that on the evening of 15 July 2015 he had signalled to the driver to stop, the driver appeared to be ignoring the request to stop, he made a decision to follow him and that this constituted a "pursuit".

Senior Constable Trudgett also stated that he now believed there was "ambiguity" with respect to the correct interpretation of the policy. He had already stated that while he had some education about the SDP and had read it two or three times, he had not been specifically trained in its interpretation. He was aware that there were discussions and differences of opinion between highway patrol officers about "what constitutes a pursuit and what doesn't" under the SDP and, for example, at what point "trying to keep in contact", becomes a "pursuit".

At the time Senior Constable Trudgett' s car made contact with the wires from the power pole, he was chasing the white vehicle at up to 170 km/h. His light was activated. Some of his first words to the driver were "Why did you try and fuck off from me?", so it is clear he believed that the vehicle was trying to avoid apprehension. I am well satisfied that Senior Constable Trudgett was "in pursuit" within the meaning of the policy and that his conduct should have been subject to the oversight and guidance of an independent officer. In other words VKG should have been contacted.

I accept that the period of time between the U-turn and the point where the collision occurred was relatively short, just 47 seconds. Nevertheless in my view a pursuit had clearly commenced. While we are now aware that the driver was affected by drugs and had been speeding shortly prior to the accident, it is important to remember that at the time the pursuit commenced, it did so because a motorist did not dip his high beams on a dark and rainy night.

It became evident that Senior Constable Trudgett was not particularly troubled by the speed at which he was travelling, nor did he think it inappropriate for a traffic stop. He was focussed on "closing the gap". He stated "I needed to close the gap. I, I don't think about the speed as much. I'm not going to try and pull max speed in order to catch it". When questioned about his speed of 170 km/h, he explained that he "didn't believe its high speed" on a highway. In my view the circumstances of this case make it very clear that Senior Constable Trudgett, operating as a single officer, would have been assisted by calling in a pursuit so that he had the immediate guidance of a senior independent officer.

The evidence of Acting Senior Sergeant Hrymak

The brief contained a report prepared by Acting Senior Sergeant Hrymak, of the Traffic Policy Section, Traffic & Highway Patrol Command. Acting Senior Sergeant Hrymak had been attached to the Traffic Policy Unit since 2013 and had previously worked in general duties and as a highway patrol officer. He conducted a review of the incident "based on the contents of the information stored on Eagle. I". However he was unable to identify which documents he had actually reviewed. I was concerned, for example, when statements from independent eye-witnesses about the road and weather conditions were put to him in court and he had no recollection of seeing them. Nor did he apparently have any way of checking whether or not he had reviewed those statements.

He was an unhelpful witness in a number of respects. Firstly, his report contained reference to the incorrect version of the policy. Secondly, he had no direct experience in drafting and reviewing the policy and limited involvement in training with respect to the relevant sections. Thirdly, he appeared to have limited knowledge of police involvement in the specific incident or any awareness of the criminal proceedings. His review was, in my view, superficial. Acting Senior Sergeant Hrymak had been asked to provide a report for the purposes of assessing whether or not Senior Constable Trudgett' s conduct on the night was in compliance with the SDP. His report concluded that "S/C Trudgett did not give the offending vehicle a direction to stop. S/C Trudgett was undertaking a traffic stop and was attempting to reduce the distance to the offending vehicle". His opinion was that Senior Constable Trudgett' s conduct was in compliance with the SDP guidelines in relation to traffic stops.

Acting Senior Sergeant Hrymak had the opportunity to hear Senior Constable Trudgett' s evidence. By the time he gave his oral evidence, he was well aware that Senior Constable Trudgett had clarified any possible ambiguity about the reason he activated his lights. It was a signal to stop. He was aware that Senior Constable Trudgett decided to follow the vehicle and drove in wet conditions at a speed of 170 km/h. He was aware that some of the first words Senior Constable Trudgett exchanged with the driver after the collision indicated that the officer believed the driver had "tried to fuck off." He was aware that Mr Thompson was convicted and gaoled for not stopping in a police pursuit. He was aware that the involved officer had agreed, in hindsight, that a pursuit had been triggered.

Notwithstanding all of this, Acting Senior Sergeant Hrymak remained firm in his view that no pursuit had occurred. He said "…in this actual incident had the officer closed the distance on the vehicle, and there was a clear intention of him to stop that vehicle by way of warning devices, and the vehicle doesn't stop, at that point that's when a pursuit is engaged."

I found his explanation and lack of reflection unimpressive. In my view, he is incorrect and his evidence does nothing but further muddy the distinction between traffic stop and pursuit.

Changes to the policy since Brooke's death

It was well beyond the scope of this inquest to conduct a full scale review of the SDP or assess all the changes made in the last iteration of the policy. However, the court accepts that there have been some small improvements to the SDP since Brooke's death. In the 2019 policy, SDP version 9.2, officers are given more specific guidance in relation to factors they should consider when conducting traffic stops (Part 6), pursuits (Part 7) and in urgent duty (Part 8). For example in relation to pursuits, police must now take into account specified factors such as danger to police and other road users, weather and road conditions, traffic density, and time of day.

SDP version 9.2 also elaborates on one further relevant factor. Prior to engaging in a pursuit, Part 7-2-2 states that an officer should consider "the distance between the police and offending vehicle *and* the speed required to close that distance". However, it is troubling that Part 6-4, which relates to traffic stops and the factors that must be taken into consideration when conducting a traffic stop, a police officer need only consider "the distance required to be covered to reduce the distance to the offending vehicle". "The speed required to close that distance", a factor to be considered in relation to pursuits, is not given as a specific factor to be considered in traffic stops. Considering the particular circumstances of this case, it is hard to understand why speed should only be specifically referred to in relation to pursuits. I accept Senior Constable Trudgett honestly (but incorrectly) believed he was conducting a traffic stop at the time he drove after the white vehicle reaching a speed of 170 km/h in the rain. Clearly whatever he was doing – traffic stop or pursuit – he needed to carefully consider the danger of the speed he needed to reach to "close the gap."

The need for recommendations

Police Officers failing to properly understand or be able to implement the Safe Driving Policy in the field are not a new or isolated issue. The *Inquest into the Death of Corey Kramer* for example, dealt with a non-compliant pursuit of a 14 year old boy on a mini motorbike in October 2016, which occurred more than a year after Brooke's death. Officers following Corey had failed to understand that they were in pursuit and as a result there was no contemporaneous oversight of their decision to follow the boy in extremely risky circumstances. In that case, the court heard some evidence about the nature of training that occurs during initial training at Goulburn Police Academy. It was also referred to the Mandatory Education Program delivered in 2016/17 across NSW.

During the inquest into Corey's death, the Commissioner accepted that there had been a breach of the relevant SDP and that the officers involved had a flawed understanding of the requirements of the policy. Nevertheless, counsel for the Commissioner resisted a recommendation aimed at improving officer training, expressing confidence that sufficient training was already in existence.

Despite that resistance, I made a recommendation in April 2018 that the Commissioner "implement further training and educational initiatives aimed at developing a better understanding of the requirements of the Safe Driving Policy regarding pursuits amongst employees of the NSW Police Force to whom the Safe Driving Policy applies and furthermore, undertakes a full audit regarding the effectiveness of these training and educational initiatives".

Disappointingly, the recommendation was ultimately rejected. Following the proceedings, the Commissioner, M J Fuller APM, informed the court that he

"…consider[ed] there are adequate training and education initiatives in place to educate police on the SDP and pursuits. Following amendments to the SDP, a Mandatory Continuing Education ("MCPE") module was implemented for the 2016/17 training year. The policy puts measures in place to address deficiencies or policy compliance issues. The MCPE remains available as an optional training module for the current training year. These training elements supplement the training courses provided by Police Driver Training".

"*Effectiveness measures are gauged through ongoing assessment and review of policy compliance. This is done at a local level by Safe Driving Panels formed at individual Commands in accordance with the SDP. The Traffic and Highway Patrol Command reviews, on a daily basis, every pursuit in the State. Any compliance issues or other matters of concern arising from them are referred to the State Pursuit Management Committee (SPMC). This Committee is responsible for monitoring the functioning of the SDP and recommending to the Commissioner any changes to policy that may be required. The findings arising from the Kramer Inquest are being considered by the SPMC as part of the SDP review currently underway."*

I note that Brooke's death predates Corey's death. I am confident that should I have been minded to make a similar broad recommendation in these proceedings, it would again be rejected. However, in my view the issues remain. The SDP, particularly as it relates to pursuits, is poorly understood by those tasked to implement it. The issue goes beyond those working in general duties and relates also to those in Highway Patrol Units. At the very least, further training for Highway Patrol Officers is called for. The Highway Patrol Officer who was involved in this tragic incident, Senior Constable Trudgett, himself spoke of ambiguity and ongoing discussion between officers about what being "in pursuit" entailed. When asked about how he thought this ambiguity could be corrected, he asked the court "how much time have you got"?

Two other draft recommendations also arose directly from the evidence.

It appeared evident that there needs to be further work done in explaining the difference between urgent duty, traffic stops and pursuits in a form that is easily accessible to all officers in the field.
The evidence of Acting Senior Sergeant Hrymak indicates to me that the difference is not well understood, even at a senior level. Health workers have benefitted greatly in recent years by the thoughtful design of one page flowcharts which consolidate complicated policy into easy-to-read formats.

In my view, if a chart which would assist officers to understand and interpret Parts 6, 7 and 8 of the SDP cannot be easily produced, then there is a problem with the policy itself, and the grey areas between the categories, which must then exist, need further attention and clarification. Finally there is also a need to add "consideration of speed" as a specific factor to the current policy in relation to traffic stops (Part 6-4).

Response from the Commissioner to draft recommendations

Draft recommendations in those terms were circulated at the end of the proceedings to allow for comment prior to finalisation. In a response from counsel, on the Commissioner's behalf, the need for any further training in relation to the SDP was rejected outright. In relation to the development of a flowchart, the Commissioner stated "the current education of the SDP v 9.2 parts 6, 7 and 8 are sufficiently satisfactory in quality and quantity to delineate the requirements and obligations of officers with respect to each part" and therefore a flowchart is not required. The recommendation suggesting an amendment to SDP version 9.2 (Part 6-4) regarding the inclusion of a specific factor requiring police to consider the speed they would need to travel at in order to reduce distance to an offending vehicle when conducting a traffic stop, will apparently be considered. However it was also submitted that a paragraph in the SDP foreword advising police that their actions must be reasonable in all the circumstances and that all reasonable care must be taken, already serves to "reinforce that all aspects of using a police vehicle are to be taken into account not just speed, and the actions of police must be reasonable, and police must be able to justify their actions."

The response of the Commissioner is disappointing. In my view, there is sufficient evidence to establish that police officers need further assistance in understanding and properly implementing sections of the SDP, particularly in relation to traffic stops and pursuit. After considerable reflection, I believe the Commissioner ought consider carefully the issues raised in these proceedings and implement changes to reduce the risk of road deaths in the future.

Formal Findings

Identity: The person who died was Brooke Carroll.

Date of death: 15 July 2015.

Place of death: By the side of the Mitchell Highway, near Maryvale NSW.

Cause of death: Multiple injuries. Her injuries were consistent with blunt force trauma sustained in a high speed motor vehicle collision.

Manner of death: Brooke was the passenger in a motor vehicle driven at speed by a drug affected driver who was attempting to evade police. The car she was in collided with a pole during a police operation.

I make the following recommendations,

To the Commissioner of Police

1. To give consideration to enhancing the training provided to all Highway Patrol Officers to include a yearly refresher course on Parts 6, 7 and 8 of the SDP and that training be developed and delivered with the assistance and involvement of the Traffic Highway Patrol Command.

2. To give consideration of developing and implementing a flow chart to assist officers in their implementation/interpretation of Parts 6, 7 and 8 of the SDP.

3. To give consideration to amending Part 6-4 of the SDP to include a specific factor requiring police to consider the speed they would need to travel at in order to reduce the distance to an offending vehicle when conducting a traffic stop.

3. 323840 of 2015

Inquest into the death of Robert Howlett. Finding delivered by State Coroner O'Sullivan at Lidcombe on the 22 April 2020.

Mr Robert Howlett was born on the 30 December 1940. At the time of his death on the 3 November 2015, he was serving a custodial sentence at Long Bay Correctional Centre. On the advice of pathologist Dr Ansford, a coronial certificate was issued for the cause of death, which was determined to be ischaemic heart disease with an antecedent cause of coronary atherosclerosis. An identification statement was completed by Sandra Williams, a Correctives Officer who had known Mr Howlett for four years.

Mr Howlett had a long custodial history and was on parole for a life sentence for serious charges. Mr Howlett's initial sentence commenced on 23 March 1984 and he was released on parole on 20 November 2011, whereupon he resided in Community Offender Support Programs residence (COSP) until his parole was breached and he was returned to custody on 15 September 2015. At the time of his death he was housed in cell 7, Wing 15, Area 3 at Long Bay Correctional Centre. Mr Howlett's sister expressed concerns in her statement to the police that Mr Howlett was not receiving his full medications whilst in custody.

The discharge summary from Campbelltown Hospital following an admission on 23 May 2015 indicates that Mr Howlett had been prescribed nifedipine 20 mg daily, and although this was withheld during admission, it could be restarted. General Practitioner records also list nifedipine as one of Mr Howlett's medications. Mr Howlett was not prescribed nifedipine during his last custodial sentence from 15 September 2015.

The Inquest:

The *Coroner's Act 2009 (***the Act***)* provides that where a person dies in lawful custody, an inquest into their death is mandatory and must be presided over by a senior Coroner (ss. 23 and 27). Section 81 of the Act requires me to make a finding as to the identity of the individual who died the date and place of death, and the cause and manner of death. "Cause of death" refers to the physical cause and "manner" refers to the circumstances leading up to and surrounding the death.

A secondary but equally important function of the Coroner is governed by s. 82 of the Act, which empowers me to make any recommendations that are considered "necessary or desirable" in relation to Mr Howlett's death. Having a public inquest is particularly important when a person dies while in custody because prisoners are a vulnerable group within our community.

Their vulnerability is three-fold. Firstly, it is well accepted that many prisoners suffer from some form of physical or mental illness, including those relating to illicit drug use. Secondly, the loneliness and distress of custody may well exacerbate any mental distress.

Thirdly, prisoners do not have the agency to make their own decisions about the type of medical care that they can access and are away from family and friends who might otherwise care for them. They are completely dependent on the authorities who detain them; in this case the employees of a State correctional centre. A hearing for the inquest into Mr Howlett's death was held before me at the State Coroner's Court in Lidcombe on the 22 April 2020. The inquest did not hear oral evidence from any witnesses.

The Evidence:

Background:

In 2015, Mr Howlett was a seventy-four-year-old man with an extensive medical history. He was an ex-smoker with previous heavy tobacco use. He had severe lung disease, with smoking related emphysema as well as previous bronchiectasis. He had had multiple exacerbations of this lung disease with lower respiratory tract infections requiring anti-biotic treatment. Baseline therapy for his respiratory issues included Seretide and Spiriva.

From an early age Mr Howlett suffered from a profound hearing disability that was unresponsive to hearing aids. He was on a waiting list for a cochlear implant. Communication with Mr Howlett was difficult, although he could lip read to a degree. Written notes were often used as an aid to communication. He had a history of gastro-oesophageal reflux treated with omeprazole. He had long term back problems including lumbar compression fractures and spinal stenosis. These caused an unsteady gait and necessitated him using a walking frame for mobilization and a chair for showering.

Long standing problems due to benign prostatic hypertrophy with repeated urinary tract infections were noted. He had a recent fracture of the wrist and iron deficiency of unknown cause. He had a history of hypertension and had been taking the anti-hypertensive nifedipine. Apart from two brief episodes of atrial fibrillation in the context of lower respiratory infections, he was not known to have any heart disease. During 2015 Mr Howlett had a number of exacerbations of his lung disease. In January 2015 he was seen at Campbelltown Hospital where he was found to have an infective exacerbation of his emphysema. Mr Howlett was treated with antibiotics as an outpatient.

In May 2015 he had a further infective exacerbation of his emphysema, complicated by sepsis and atrial fibrillation. The sepsis led to low blood pressure. The sepsis was treated with antibiotics and Mr Howlett was admitted to Campbelltown Hospital for 3 days for intravenous antibiotics. His anti-hypertensive nifedipine was ceased so as not to exacerbate his low blood pressure. According to medical opinion within the brief of evidence, in the setting of rapid atrial fibrillation nifedipine may not only lower blood pressure but potentially cause further reflex tachycardia making the atrial fibrillation harder to control.

On discharge from this admission it is mentioned within the discharge summary that "nifedipine 20 mg daily withheld during admission, however, can be restarted."

On 25 October 2015, Mr Howlett attended the Long Bay clinic with shortness of breath. An irregular pulse was detected and he was transferred to Prince of Wales Hospital for further investigation and management. He was diagnosed with atrial fibrillation and a lower respiratory infection. The respiratory infection settled with antibiotics and the atrial fibrillation resolved spontaneously.

On the 27 October 2015 Mr Howlett returned to a normal wing at Long Bay Correctional Centre with a course of Augmentin duo forte (a broad spectrum antibiotic).

The Fatal Incident:

Witness accounts of the death

Mr Howlett's cell mate, Sidney Manning, states that on the night of the 1 November 2015, Mr Howlett was coughing and struggling to get his breath. On 2 November 2015, Mr Howlett was seen in the clinic for a dressing of a boil. His vital signs were attended; all were satisfactory with no abnormalities detected. Manning states that Mr Howlett had improved on the 2 November 2015, but he was still coughing during the night. As a result of the coughing, Manning asked Mr Howlett if he wanted him to hit the buzzer to alert Correctives staff, but Mr Howlett indicated he was okay. About 6:30 a.m. on 3 November 2015, Manning was released from cell 7 to go to work for the day. About 7:10 a.m. Senior Correctional Officer Manjeet Rana observed Mr Howlett sitting on the edge of the bed. He appeared fine. About 9:30 a.m. Senior Correctional Officer Rana opened Mr Howlett's cell door and saw him sitting on a chair inside his cell. Again, Mr Howlett appeared fine. Senior Correctional Officer Rana left the cell door unlocked. About 10:30 a.m., inmate David Ledgard walked past Mr Howlett's cell. As he walked past, he saw Mr Howlett lying on his bed, face up, with his arm lying off the bed. Ledgard went to the neighbouring cell and then accompanied another inmate, Alastair Paterson, back to Howlett's cell. They then went to the wing office and informed Senior Correctional Officer Rana that Mr Howlett did not look well. Senior Correctional Officer Rana attended Mr Howlett's cell and could not get a response from him.

Inmates Paterson and Ledgard then carried Mr Howlett from his cell and onto the ground outside the cell. They commenced CPR with the assistance of a third inmate, George Warlow, and continued CPR until Justice Health nurses arrived at 10:35 a.m. The nurses took over CPR and administered oxygen therapy. About 11:00 a.m. NSW Ambulance officers arrived. NSW Ambulance Officer Quigg pronounced Mr Howlett deceased at 11:02 a.m. At 12:13 p.m. Mr Howlett was examined by Dr Stephen Hampton, who issued a life extinct certificate.

Nifedipine Medication

To better assess how Mr Howlett's medications were administered while he was in Corrective Services custody, a statement was sought from Bernadette Hollis, Regional Nurse Manager Women's and Metropolitan North within Justice Health and Forensic Mental Health Network.

She was asked to detail how details of an inmate's prescribed medications are obtained upon arrival to custody and why nifedipine did not appear on Mr Howlett's list of prescribed medications during his most recent period of custody. She responded that upon arrival into custody a nurse conducts a Reception Screening Assessment (RSA) with the incoming patient. The patient is asked to provide details of their medications and medical history. If they are taking medications, the patient is asked to sign a release of information form and then this form is forwarded via fax to the community health provider. In Mr Howlett's case he did not disclose nifedipine as a regular medication during the initial RSA or when subsequently interviewed on the 17 September 2015 by the General Practitioner.

When the release of information form signed by Mr Howlett was sent on the 19 September 2015 to his nominated community health provider, Campbelltown Medical Centre, they did not return any information, stating that they had last seen Mr Howlett on the 24 August 2012.

However, Mr Howlett's community health provider appears to have been Campbelltown Mall Medical Centre, which is a different entity to Campbelltown Medical Centre. Records subsequently obtained under a section 53 order for production from Campbelltown Mall Medical Centre disclose records for Mr Howlett up to September 2015, which is shortly before Mr Howlett entered custody. Nifedipine is listed in their records as a long term medication under the name Adalat Oros. Given Mr Howlett's communication and hearing difficulties it may be that a miscommunication occurred concerning the details of his community health provider. On the 29 October 2015 a Network physiotherapist made a request for information from Campbelltown Hospital regarding a wrist fracture. This request for information noted that Mr Howlett had been prescribed nifedipine, but as the request was requested by the physiotherapist there was no appointment made for GP review.

The Expert Report of Professor Adams

Given the concerns expressed by Mr Howlett's sister and the information from Campbelltown Hospital and Campbelltown Mall Medical Centre about Mr Howlett's current medications, an expert report was sought from A/Professor Mark Adams, the head of the Department of Cardiology at Royal Prince Alfred Hospital, as to whether the non-administration of nifedipine during Mr Howlett's custodial sentence commencing 15 September 2015 would have impacted on his death. Professor Adams details the effects of nifedipine in his report, describing it as a calcium channel blocker that relaxes blood vessels and thereby lowers vascular resistance and blood pressure. Adams says that unlike certain other hypertensive medications, nifedipine does not confer other survival benefits apart from the lowering of blood pressure. The exception is in relatively rare cases of a syndrome of coronary artery spasm that does not apply in Mr Howlett's case. The sole apparent reason that nifedipine was prescribed to Mr Howlett was to control his blood pressure.

During the period from 15 September and 3 November, Mr Howlett had his blood pressure measured on numerous occasions. On 17 September 2015 his blood pressure was 116/68, on 25 October it was 101/64, and on 2 November 2015 it was 109/59. Professor Adams notes that these measurements are quite low and prescribing an anti-hypertensive might lower the blood pressure to unsafe levels. Professor Adam's opinion is that it was appropriate not to prescribe nifedipine.

Professor Adam's says that if it had been known that nifedipine was a usual medication for Mr Howlett, it most likely would have been withheld for safety reasons. Professor Adams states: "I do not think that the failure to prescribe nifedipine when the deceased began his last custodial sentence in 15 September 2015 made any contribution to the deceased's death on 3 November 2015."

Autopsy Report

On the advice of pathologist Dr Ansford, a coronial certificate was issued for the cause of death, which was determined to be ischaemic heart disease with an antecedent cause of coronary atherosclerosis.

Formal Finding:

The identity of the deceased: Robert Howlett

Date of death: 3 November 2015

Place of death: Long Bay Correctional Centre

Cause of death: Ischaemic heart disease and coronary atherosclerosis

Manner of death: Natural causes whilst serving a custodial sentence

4. 323811 of 2015

Inquest into the death of Ivan Mikic. Finding delivered by DSC Lee at Lidcombe on the 4 September 2020.

At the time of his death, Mr Ivan Mikic was being held in lawful custody at Wellington Correctional Centre. He was serving a custodial sentence which had been imposed in February 2007. On the morning of 3 November 2015 Ivan was found unresponsive in his cell with no signs of life. Emergency services were called but despite immediate attempts to revive Ivan he was later pronounced deceased. The subsequent post-mortem examination revealed that Ivan died from the toxic effects of methadone. As Ivan had not been prescribed methadone at the time of his death, this raised questions as to how and where Ivan had obtained the methadone, and the circumstances leading up to his death.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died when and where they died, and what was the cause and the manner of that person's death. When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. Further, in Ivan's case questions were raised as to observations made of him by Corrective Services New South Wales (**CSNSW**) staff several hours before he was found unresponsive, and as to how the toxic amount of methadone came to be in Ivan's system.

Ivan's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore, it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

Ivan's father, Peter, and his mother, Olga, were born in Croatia and Germany, respectively. They both came to Australia at a young age and later met and formed a relationship. They had three children together: Debbie, Martin and Ivan, who was born in 1981. Ivan was initially raised in the suburbs of Western Sydney before the family moved to the New South Wales Hunter region. Ivan attended primary school but only had a limited education at secondary school level. Regrettably, due to Ivan's interaction with the criminal justice system, he was unable to sustain any meaningful periods of education or employment. Ivan met his eventual de facto partner, Melissa Bailey, when they were teenagers. They later formed a relationship and had a son, Jake, together.

Although Ivan had frequent interactions with the criminal justice system his brother Martin said that he acknowledged his past wrongdoings and accepted penalties imposed by the courts, including the most recent sentence that he was serving at the time of his death. According to Martin, Ivan was attempting to make productive use of his time in custody by looking after his health, seeking assignment to work programs and learning to become a better person. Ivan reportedly had aspirations of starting his own business and building his own home upon his eventual release from custody.

Ivan was known to have a loud personality and to be what Martin described as a show off. There is no doubt that Ivan was, and still is, dearly loved by his family. There is equally no doubt that Ivan loved his son enormously and that the experience of being in custody while Jake was growing up was extremely difficult for Ivan. Notwithstanding, Ivan maintained regular contact with Jake and the rest of his family, and did his best to be a good father to Jake even though he was separated from him. It is distressing to know that Ivan's life ended in sudden and tragic circumstances, at a time when he was looking and working towards a better future for himself and his son.

Ivan's custodial history

Ivan had previously been convicted of a range of criminal offences as an adult, dating back to 1999. Some of these convictions resulted in sentences of imprisonment. On 28 August 2004 Ivan was charged with a number of offences, including an offence of murder. He was received into the custody of CSNSW at Newcastle Court and later bail refused. On 7 April 2006, at the Supreme Court in Sydney, Ivan was convicted of the offences that he had been charged with. Ivan was subsequently sentenced to partially concurrent terms of imprisonment, with the overall effective sentence being one of 24 years imprisonment, commencing on 29 August 2004 and concluding on 28 August 2028, with an overall effective non-parole period of 20 years, concluding on 27 August 2022.

Following sentencing Ivan was classified as an A2 maximum security inmate. This classification remained in place following reviews conducted in July and October 2015. In about February 2012, Ivan was placed on an active Special Management Area for Protection (**SMAP**) order at his own request. This is a form of protective custody where inmates only mix with other inmates of the same categorisation. Ivan was initially detained at Goulburn Correctional Centre from 2006 to 2013 and was later transferred to Wellington Correctional Centre on 24 March 2014. Upon his arrival at Wellington, Ivan was continuously managed as a SMAP inmate. Due to his classification, Ivan was housed in Cell 71 within the B2 Block (or Pod) along with other SMAP inmates.

The events of 2 November 2015

On 2 November 2015 Wellington Correctional Centre was partially locked down between 11:30am and 3:00pm in order to facilitate a monthly CSNSW staff meeting. This resulted in the B2 inmates, including Ivan, being locked their cells at 11:30am.

Geoff Mason was one of the inmates in B2 Pod, in cell 69, two cells from Ivan's cell. After being locked in his cell Mr Mason sent Ivan what is known, in the correctional environment, as a "string line". This is a line connected between cells which inmates use to pass small items (such as coffee, sugar, and makeshift wicks to light cigarettes) between themselves. At about 12:30pm Mr Mason sent a string line to Ivan's cell and when he retrieved the line he saw that it had some coffee and sugar attached to it, along with a lighted wick. Mr Mason yelled out to Ivan that he had received the items and sent a cigarette, via the string line, to Ivan. Another one of the inmates in B2 Pod, Malone Tuakeu, was working as a sweeper in the Pod whose role was to maintain the general cleanliness of the pod. Available CCTV footage shows that shortly before dinner was served to the B2 inmates, Mr Tuakeu stood on the handle of Ivan's cell door so that he could verbally communicate with Ivan through a vent at the top of the door. This occurred on at least seven occasions over a period of around 20 minutes.

At around 2:30pm Mr Tuakeu was asked by one of the CSNSW officers to take Ivan's dinner to him. Whilst standing at the cell door a CSNSW officer, who accompanied Mr Tuakeu to Ivan's cell, called out three times for Ivan to get up out of his bed but Ivan did not do so. Mr Tuakeu placed Ivan's dinner on a table in his cell and shook Ivan. At the time Ivan was lying on his back with his left leg hanging off the bed. When Mr Tuakeu shook Ivan, he heard Ivan moan and noticed that he looked a bit pale. It appeared to Mr Tuakeu that Ivan was snoring and he believed that Ivan was asleep. At about 3:30pm Mr Mason attempted to attract Ivan's attention by calling out to him a number of times. Mr Mason received no answer from Ivan, which Mr Mason thought to be unusual. At around 4:30pm Mr Mason called out to Ivan again number of further times, and continued to do so intermittently up until 6:50pm. On each occasion, Mr Mason did not receive an answer.

At 10:54pm available CCTV footage indicates that the light in Ivan's cell was turned on, with the sound of a shower running heard from the cell a short time later. At 12:19am on 3 November 2015 the light in the cell was turned off, with no further activity recorded on CCTV footage from this point forward.

The events of 3 November 2015

As at November 2015 it was usual procedure for a head check to be conducted in B2 Pod every morning at around 6:20am. This involves correctional officers checking on inmates in their cells to ensure that they are alive and well, ahead of the daily Let-Go procedure, when inmates are let out of their cells, later in the morning. Both the head check and Let-Go procedures will be discussed in greater detail later in these findings. On 3 November 2015 Casual Correctional Officer Jeduam Wykamp and First Class Correctional Officer Dianne Williams attended Ivan cell at about 6:24am to perform a head check. CCTV footage recorded Officer Wykamp opening the flap on Ivan's cell door and remaining at the door for about 19 seconds before moving onto the next cell.

The Let-Go procedure for B2 Pod was performed later that morning. At about 8:10am Casual Correctional Officer Shaun Leggett, who was assisting with the Let-Go in B2 Pod, opened Cell 71 and saw Ivan who appeared to be asleep. Officer Leggett called out to Ivan, "*Hey, wake up*". When Ivan did not move or respond, Officer Leggett called out to Casual Correctional Officer Simon Kennedy and told him that Ivan was "*sound asleep*". Officers Leggett and Kennedy continued opening other cells as part of the Let-Go procedure and once that was completed, they returned to Cell 71 at about 8:12am.

From the doorway of the cell Officer Kennedy called out to Ivan and told him to get up. When Ivan did not respond Officer Kennedy entered the cell, stood next to Ivan's bunk and again told Ivan to get up. Officer Kennedy touched the back of Ivan's leg twice but Ivan remained unresponsive. Officer Kennedy placed his fingers on the left side of Ivan's neck to feel for a pulse and found none. Officer Kennedy then noticed that Ivan was unconscious, not breathing and saw Ivan's "*skin to be of a blue colour and his eyes glazed and milky*". Officer Kennedy immediately left the cell and went to the landing to call for assistance.

First Class Correctional Officer Trevor Mackander arrived at Cell 71 a short time later and also attempted to gain a response from Ivan, without success. As this was occurring, other correctional officers also arrived at Cell 71. Senior Correctional Officer Daniel Drury made a radio call to the monitor room to call for an ambulance and medical assistance whilst other officers initiated cardiopulmonary resuscitation (**CPR**) whilst Ivan was still on his bunk. Ivan was subsequently moved to the ground where CPR continued. A number of Justice Health & Forensic Mental Health Network (**Justice Health**) nurses arrived on scene a short time later. Registered Nurse (**RN**) Louise Ashton and RN Clair Avery arrived on scene at about 8:15am and began preparing a defibrillator. RN Melinda Pascoe arrived on scene about two minutes later and saw that CPR was already underway. RN Pascoe noted that Ivan had no spontaneous respirations, pulse or heart sounds, and that his pupils were non-responsive.

RN Soby Uthup arrived at the scene with RN Pascoe and saw that RN Ashton was already assessing Ivan whilst CSNSW officers were performing cardiac compressions. When she arrived, RN Uthup saw that Ivan was not displaying any signs of life. Paramedics arrived on scene at 8:28am. Electronic records from the NSW Ambulance case description noted the following:

"*[On examination] [patient] unresponsive, pulseless, not breathing. [Patient] face and arms dark blue, peripherally cold, pupils fixed and dilated, [patient] in extremis/unable to open/inspect airway, [patient's] trachea felt stiff/hard…Correctional center [sic] staff started CPR at 0813. Upon gaining this information we realised [patient] was unwitnessed arrest, had been down for >20 mins, potentially longer*".

With the assistance of correctional officers and Justice Health nurses, the attending paramedics continued CPR until 8:38am. However, despite these efforts, Ivan could not be revived and was subsequently pronounced life extinct.

What was the cause of Ivan's death?

Ivan was subsequently taken to the Department of Forensic Medicine at Newcastle where a post-mortem examination was performed by Dr Leah Clifton on 6 November 2015.

Toxicological examination detected a blood concentration of methadone at 0.43mg/L which Dr Clifton described as being a potentially lethal level. It was also noted that Ivan had moderately severe coronary artery disease in a single major coronary vessel, but that this pathology alone was unlikely to have resulted in sudden death. Ultimately, Dr Clifton concluded that the cause of Ivan's death was methadone toxicity.

What issues did the inquest examine?

Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the matters to be considered. That list identified the following issues:

- ***What were the circumstances leading to the finding of a potentially lethal concentration of methadone in the postmortem toxicological analysis?***

- ***As at November 2015 what measures did CSNSW have in place to prevent the unauthorised diversion of methadone by persons who were administered methadone whilst in custody at Wellington Correctional Centre?***

- ***As at November 2015 what measures did Justice Health have in place to prevent the unauthorised diversion of methadone by persons who were administered methadone whilst in custody at Wellington Correctional Centre?***

These issues are considered in more detail below, together with aspects of the manner of Ivan's death.

What were the circumstances leading to the finding of a potentially lethal concentration of methadone?

Methadone diversion

At the time of his death Ivan was not prescribed methadone as part of any Opioid Substitution Treatment (**OST**) program. This therefore meant that the methadone self-administered by Ivan prior to his death had been obtained from a third party source. It is most likely that the methadone was either covertly brought into Wellington Correctional Centre, without authorisation, from an external source, or diverted by another inmate who was prescribed methadone as part of an OST program.

Whilst the possibility that the methadone administered by Ivan had been covertly brought into Wellington cannot be entirely excluded, the available evidence suggests that it is most likely that the methadone had been diverted.

On the afternoon of 3 November 2015, after Ivan had been pronounced deceased, another inmate (Jeffrey Sherring) informed Senior Correctional Officer Aaron Edwards that, "*The coroner will just have to do a tox screen to see that [Ivan] overdosed on methadone*". When Officer Edwards asked Mr Sherring where Ivan obtained the methadone from, Mr Sherring replied, "*He gets it from the other boys, its putrid drinking other people's vomit*". Investing police later obtained a statement from Mr Sherring in which he explained his general knowledge of the use of methadone whilst in custody. Mr Sherring said that it was common knowledge that methadone is the main form of currency in B2 Pod, and that it is sold by some inmates to other inmates for money, cigarettes or other personal goods and items which an inmate may purchase as part of their "buy up".

Mr Sherring explained that the process of obtaining methadone involved an inmate, who was on the OST program, being given their dose and then keeping it in their mouth (and not swallowing it) or then regurgitating the methadone into a small bucket. The swallowed methadone is then passed through a t-shirt, with the fabric acting as a filter, so that the collected methadone can then be sold to other inmates. Mr Sherring said that he had previously seen Ivan use methadone "*on many occasions*" and said that he was aware that Ivan had a shortened syringe (described as a "fit") which he kept secreted inside his anus. Indeed, the autopsy identified a 50 millimetre long syringe with attached sheathed needle encased in tissue paper and rubber in Ivan's distal descending colon lumen.

Conclusions: The available evidence establishes that it is most likely the methadone which Ivan self-administered had been obtained by him after being diverted by another inmate who was on an OST program. However, it is not possible to identify exactly when and how the methadone was obtained.

Rigor mortis

One aspect of the manner of Ivan's death that was of particular focus during the inquest was the head check performed by Officers Wykamp and Williams at around 6:24am on 3 November 2015. This is because during the emergency response to Ivan being found unresponsive on the morning of 3 November 2015 it was noted by some of the responders that Ivan may have been displaying signs of rigor mortis, suggesting that he had died sometime earlier. Therefore, a question arose as to whether Ivan may have been in extremis or already deceased, by the time of the head check.

In her statement RN Pascoe expressed the view that, in her experience as a nurse since 1990 and having seen expired bodies, it is likely that Ivan "*expired a couple hours earlier, perhaps longer*" prior to the emergency response. RN Pascoe explained that she came to this view "*as the jaw was set hard, and the look of the face was set, and [Ivan] had some kind of rigor stiffness that happens after some time of death*". RN Pascoe went on to explain that the stiffness surprised her as she "*was expecting to attend someone that had just expired*" and that Ivan, in her opinion, was deceased "*for a longer time than anyone could have been resuscitated successfully*".

In evidence, RN Pascoe explained that because Ivan's pupils were fixed and dilated with no response to light, there was some stiffness in Ivan's face, and his face was cold with a slight mottling to the back of his face it appeared that Ivan "*had been expired for a total while*".

Further, RN Pascoe was unable to open Ivan's mouth or move his jaw in order to insert a Guedel (oropharyngeal) airway. In a statement, Dr Clifton expressed the view that the description by RN Pascoe of Ivan's jaw as being "*set hard*" is suggestive that rigor mortis was establishing, or had established, in the jaw. Dr Clifton explained that rigor mortis is known as the stiffening of muscles after death and develops due to depletion of adenosine triphosphate (**ATP**), which usually acts to relax myosin complexes in muscle fibres. ATP depletion therefore leads to prevention of muscle fibres from relaxing and results in stiffening of muscles.

Dr Clifton explained that rigor mortis typically begins to develop within two hours after death, beginning in smaller muscles of the body such as the face and jaw, followed by the neck, wrists and ankles, and then the knees, elbows and hips. Dr Clifton explained that it usually takes between six and twelve hours to develop full rigor mortis.

It can be accelerated in certain conditions, such as where there has been a high body temperature or warm environment prior to or at death, and its onset can be delayed when the body is in cooler temperatures.

When asked to provide an opinion as to the length of the post mortem interval, Dr Clifton said this: "*It is difficult to be accurate in the assessment of time since death in any situation. There are many variables and it is acknowledged in the forensic literature that rigor mortis is the most uncertain and most unreliable post mortem event, and caution must be exercised when estimating time since death based solely on rigor mortis. Assuming the assessment of rigor mortis in the jaw is correct, that the ambient temperature in the cell wasn't extremely high and that [Ivan] didn't have an elevated core temperature, and hadn't been engaging in strenuous activity at the time of his death, in my opinion, [Ivan] had likely been deceased for upwards of 2 hours (potentially more)*".

In evidence, Dr Clifton reaffirmed the opinion expressed above and emphasised that there is no way to scientifically and ethically study this process and therefore make a determination as to how long a person has been deceased based solely on rigor mortis. Dr Clifton explained that even if information regarding the variables referred to above was available it would still be difficult to make any accurate determination of the time of Ivan's death based solely on the degree to which rigor mortis had occurred.

Ultimately, Dr Clifton indicated that the information provided by RN Pascoe that she had difficulty manipulating Ivan's jaw indicated that rigor mortis was establishing in the jaw at the time that Ivan was examined. To Dr Clifton this finding meant that it was not at the commencement of rigor mortis but, rather, well into the process. Ultimately, Dr Clifton opined that it was highly unlikely that Ivan had been deceased for about 15 to 20 minutes, that it was possible he had been deceased for around an hour but that this was probably not the case, and that it was most likely that Ivan was deceased for at least two hours and probably more.

Conclusions: Given the limitations associated with attempting to determine the time of a person's death based purely on rigor mortis, it is not possible to reach any precise conclusion as to when Ivan died. However, the evidence of Dr Clifton indicates that by the time that RN Pascoe noted some

stiffness in Ivan's face and was unable to open his jaw to insert a Guedel airway at 8:29am, it is most likely that Ivan had been deceased for upwards of two hours, and potentially longer. It is not possible to reach any conclusion about the extent to which (if any) the post mortem interval exceeded two hours.

Head check

Dr Clifton explained in evidence that death due to methadone toxicity usually occurs following a period of drowsiness, somnolence or unconsciousness in a person over some hours, although it can also result in instances of cardiac arrhythmia causing a sudden collapse. This in turn raised a question as to whether Ivan was displaying signs of methadone overdose at the time that the head check was performed on the morning of 3 November 2015. Section 12.1.9.2 of the CSNSW Operations Procedures Manual (**OPM**), which was in operation as at November 2015, deals with inmate Let-Go procedures.

It provides that after a correctional officer identifies the name of an inmate in a cell (by verifying the cell card against the Muster Book) the correctional officer will open the cell door and call the inmate by name. Section 12.1.9.2 goes on to provide: "*If the inmate does not respond the correctional officer will attempt to wake the inmate and satisfy themselves that the inmate is in good health. If an inmate does not readily respond, the correctional officer will assume that some harm has come to the inmate and immediately implement the discovering officer procedures for inmates who self-harm*".

These steps are mirrored in the Standard Operating Procedure (**SOP**) for Wellington Correctional Centre relating to Inmate Let-Go Procedures, issued in January 2015. Section 5.6 of the SOP provides: "*A minimum of two officers will conduct Let-Go on each landing. The first officer will un-lock the cell door, the second officer will open the cell door, and call the inmate(s) by name(s). If an inmate does not respond (both a verbal and physical response is required) the correctional officer will attempt to wake the inmate and satisfy themselves that the inmate is in good health*".

Section 5.7 also provides for the discovering officer procedure to be implemented if an inmate does not respond after an officer has made repeated attempts to rouse them. Section 5.8 further provides: "*Officers performing Let-Go procedures will ensure they can physically attest to the fact that all inmates are accounted for and are alive and well prior to moving onto the next cell and continuing with Let-Go*".

Whilst it is apparent that in November 2015 Wellington Correctional Centre had a SOP in relation to inmate Let-Go procedures, there was no equivalent SOP, or formal procedure document, for the performance of head checks. Craig Smith, the Governor of Wellington Correctional Centre at the time, explained that whilst head checks were not mandated, they were often performed at some correctional centres (including Wellington) as an extra precaution. Governor Smith went on to explain that the purpose of the head check was, consistent with relevant sections of the OPM, to ensure that inmates are alive and well, and that if the check identified a serious incident (such as a security breach) it could be managed prior to the Let-Go procedure. Governor Smith explained that in practice the head check streamlined the morning Let-Go procedure and allowed inmates to be released from their cells in a more timely and efficient manner.

Senior Correctional Officer David Onions, the Night Senior for B2 Pod, explained that the head check was also performed as it facilitated the transfer of inmates who were required to be escorted from the correctional centre to attend court. Officer Onions described a head check in this way: "'*Head check' is a physical check through the door flap. Officers get a response from the inmate, either verbal or a movement, for example the inmate will shout out, poke his arm or leg out to show he is alive and well*".

Upon conducting the head check of Cell 71 at approximately 6:24am, Officer Wykamp noted the following in his incident report dated 3 November 2015: "*I asked for a response – as I always do for each cell that I am conducting a head check for. I waited for a few seconds, until I received a response – after receiving a response I then moved onto the next cell. I can't recall the exact nature of the response I received from Cell 71, inmate Mikic, due to having checked a large amount of cells. However, I am aware that I received a response due to always following the same procedure asking for a response from the inmate (or inmates) with the cell, waiting for a response and then when I receive a response I move onto the next cell*".

In evidence, Officer Wykamp explained that when performing head checks it was his usual practice to open the flap in the cell door and call out to the inmate words to the effect of, "*I just need a response. I just need you to move for me, mate*". Officer Wykamp went on to explain that following this an inmate would usually provide a verbal response (by spoken word, rather than a groan or snoring), or move their arm or leg, and that most inmates were aware of the nature of a head check and the time it was usually performed. Officer Wykamp indicated that if he did not receive a verbal or physical response at first instance he would usually bang on the flap of the cell door which then usually elicited a response from an inmate. In the absence of receiving a response following this further enquiry, Officer Wykamp explained that he would seek the assistance of another correctional officer in order to perform first responder duties by opening the cell door in order to assess the situation and the reason for the absence of any response.

Officer Wykamp said that whilst he could not recall the exact nature of the response given by Ivan on the morning of 3 November 2015 he was certain that he did receive a response. Officer Wykamp explained: "*I know I received a response because if I didn't, I would have done, as I said before, the first responding officer duties. So I always make sure I receive a response. If I didn't get a response, I would have done that, so I wouldn't have moved along*".

Officer Williams explained in her statement that her usual practice when performing a head check was to open the window flap of each cell door, obtain a clear view of the inmate (turning on the cell light if necessary), call out "*head check*" and expect to hear a verbal response, look for any movement by the inmate and if none was observed, request the inmate to move. Officer Williams said that once she was satisfied that she had heard a response from an inmate, and observed the inmate move, she would move onto the next cell. In evidence, Officer Williams confirmed that it was her usual practice to not move on from a cell until she had received both a verbal response from an inmate and some type of physical movement. In relation to the morning of 3 November 2015, Officer Williams agreed that she performed a head check of B Pod with Officer Wykamp at approximately 6:20am. Officer Williams provided this account:

"*I did not hear a response from Ivan Mikic. I did not do the head check on his cell. I only heard responses from cells that I attended to on that morning*". In evidence, Officer Williams indicated that she was performing a head check at cell 70 at the same time that Officer Williams was performing a head check in the adjacent cell where Ivan was housed. Officer Williams said that she did not have a particular recollection of the nature of the head check performed by Officer Wykamp, and whether he experienced any difficulty in obtaining a response from Ivan. However, Officer Williams said she did not notice anything about the head check performed by Officer Wykamp that made her believe it had not been performed correctly.

Conclusions: There is no evidence to suggest that Officer Wykamp did not perform a head check at Ivan's cell on the morning of 3 November 2015 in accordance with his usual practice, and the practice that had been adopted at a local level at Wellington Correctional Centre. Whilst Officer Wykamp could not recall the response that Ivan gave when the head check was performed, the available evidence indicates that the response was sufficient to allow Officer Wykamp to continue with the head check of other cells. Having regard to this evidence, and the conclusions already reached above regarding the limitations associated with determining time of death based purely on the onset of rigor mortis, it is most likely that Ivan was not deceased at the time that the head check was performed.
Notwithstanding, this does not exclude the possibility that Ivan was in the terminal phase of methadone overdose and experiencing drowsiness or somnolence as described by Dr Clifton. Depending on the extent of this presentation, Ivan may still have been able to provide an adequate response to the head check. However, as this remains only a possibility on the available evidence, it cannot be said with any certainty that there was a missed opportunity to identify a serious medical event at the time of the head check and, accordingly, intervene to provide medical assistance.

What measures did CSNSW have in place to prevent the unauthorised diversion of methadone at Wellington?

Section 12.1.11.2 of the OPM dealt with the dispensing of restricted drugs at a Health Centre within a correctional centre. It relevantly provided for a correctional officer to act as a witness to the administration of a restricted drug, which included watching an inmate consumed the drug as directed by a Justice Health nurse, and searching the inmate to ensure that the drug had not been diverted.

Section 12.1.11.3 of the OPM set out a number of additional controls when dispensing, relevantly, methadone. It noted that whilst Justice Health had its own policy and procedures to follow concerning the dispensation of methadone and controls to minimise the risk of diversion, operational support would be provided by correctional officers to assist in minimising such risk. It relevantly provided that a supervising correctional officer would:

Ensure that the inmate to whom methadone is dispensed is not carrying anything in their hands or in their pockets, except their identification card; Visually check the inmate's mouth to ensure that it is empty (including ensuring that dental prostheses are removed); Pat searching the inmate with particular checks of collars, sleeves, pockets and hands.

During the course of the coronial investigation it became apparent that following Ivan's death, Wellington Correctional Centre adopted a practice whereby inmates who had received their methadone as part of OST were placed in what was described as a holding yard for observation to mitigate the risk of methadone diversion. Governor Smith explained that the procedure was introduced a short time after Ivan's death (in an attempt by CSNSW to be proactive, as he described it) although he could not say how long it remained in place for. Governor Smith explained that under the procedure inmates from each wing would be brought to have their methadone dispensed to them as a group, with each group subsequently kept in a room (described as a holding yard) whilst the following group had their methadone dispensed to them in turn. Whilst in the holding yard, inmates would be monitored by correctional officers outside of the holding yard, as well as by CCTV cameras within the holding yard. The footage from the holding yard would be displayed on monitors for review by other correctional officers, in addition to reviewing footage from cameras in other parts of the correctional centre.

Despite these measures, Governor Smith explained that instances of diversion still occurred. Two obvious difficulties associated with this procedure are that inmates could simply turn away from the CCTV cameras in order to conceal any diverted methadone, or inmates could simply divert to other inmates in the same holding yard. Governor Smith went on to explain that this procedure continued for a number of months, but was later discontinued because, as he described it, became a "*logistical nightmare*".

This is because, Governor Smith explained, the holding of groups of inmates in the holding yard resulted in delaying or preventing the necessary administrative movement of inmates within the correctional centre and out of the centre (to attend court, for example). As Governor Smith described it, the procedure caused other operations within the correctional centre "*to ground to a halt*".

In evidence, Governor Smith agreed that it was routine procedure for inmates to be locked in their cells for more than 16 hours in pods where there were a high percentage of inmates on methadone (for example, 13 out of 29 inmates in the B2 Pod were receiving methadone). Governor Smith said that the possibility of more frequent checks being conducted of inmates to ensure that they are alive and well had previously been raised at a number of correctional centres, without any change in procedure. However, Governor Smith acknowledged that he could see the benefit in more frequent checks being conducted at correctional centres where methadone diversion is a known problem and where there is a high percentage of inmates receiving methadone and housed in a one-out cell by themselves.

Counsel for Ivan's family submitted that Ivan was at particular risk of methadone overdose given the following factors:

- whilst not receiving methadone as part of an OST program he had a history of opiate addiction
- he was housed in a Pod where there was a high percentage of inmates receiving methadone as part of an OST program;
- there was a known problem with methadone diversion at Wellington Correctional Centre at the time of his death; and

- he was housed in a one-out cell.

On this basis, counsel for Ivan's family submitted that a recommendation ought to be made to CSNSW that it develop a welfare check policy targeted at inmates known to be vulnerable to the risk of methadone overdose and who may be left unchecked for long periods of time. Counsel for Ivan's family further submitted that recommendations ought to be made to CSNSW that it conduct refresher training in relation to the proper conduct of welfare checks to ensure that correctional officers understand the potential signs of methadone overdose, and that CSNSW conduct an audit of the implementation of its policies in relation to preventing methadone diversion.

Officers Wykamp and Williams both gave evidence that as part of initial training provided to correctional officers they had received training in relation to identifying signs of potential drug overdose by an inmate. However, both officers indicated that they had not received specific training in relation to identifying signs of methadone overdose. Further, Officer Wykamp indicated that as at November 2015 he was unaware of the signs of methadone overdose.

Conclusions: Counsel for Ivan's family submitted that Ivan was at particular risk of methadone overdose. However caution must be exercised when the assessment of any such risk is considered retrospectively and with the benefit of hindsight. In this regard, the inquest did not receive any empirical evidence that Ivan's past history and the circumstances in which he was housed placed him at any greater risk of a fatal methadone overdose over and above any other inmate.

Indeed, although the evidence established that methadone diversion was a known problem at Wellington Correctional Centre, Governor Smith gave evidence that as far as he was aware Ivan's death was the first instance of a fatality related to methadone overdose (although there had been other instances of non-fatal overdose).

In this regard, it could not be said that an evidentiary basis has been demonstrated in order to recommend that CSNSW implement a welfare check policy for vulnerable inmates at Wellington. No evidence was given at inquest as to how such a policy might be implemented and the type of assessment of inmates that would be required to identify those with particular vulnerabilities. Similarly, the evidence did not establish any systemic shortcoming or non-compliance with relevant CSNSW policies regarding the dispensing of methadone. No witness from CSNSW was asked about this issue at inquest.

The issue of minimising methadone diversion, where it is frequently used as currency in correctional centres, is a complex and challenging one. Governor Smith acknowledged, on the one hand, the potential benefit associated with increasing the frequency of when inmates are checked on in correctional centres where methadone diversion is a known problem. However, on the other hand, Governor Smith also explained that inmates being locked in their cells for extended periods overnight was routine procedure and that checks which would disturb inmates, particularly when inmates are sleeping, would be likely to cause disharmony, if not open hostility, between inmates and correctional officers.

It should be noted that the inquest primarily received evidence regarding methadone diversion only in relation to Wellington Correctional Centre. No evidence was received as to the prevalence of methadone diversion at other correctional centres, apart from Governor Smith noting (as the current Governor of the Metropolitan Remand and Reception Centre (**MRRC**)), that instances of diversion at the MRRC were fewer in comparison to at Wellington due to, according to Governor Smith, the nature of the inmate population.

It would seem then that the most practical way to address the potential risk of inmates becoming susceptible to methadone overdose at Wellington Correctional Centre is to increase the effectiveness of existing routine checks. This could be accomplished by providing correctional officers with refresher and/or increased training to better recognise the potential signs of methadone overdose. The evidence of officers Wykamp and Williams suggests that specific training in relation to identifying the signs of methadone overdose in an inmate has not been provided to correctional officers, or at least has not been provided since correctional officers undertake their initial training. Whilst the solicitor for CSNSW submitted that such training is already provided to correctional officers as part of their initial training, it was acknowledged that CSNSW would not be opposed to a recommendation being made in this regard. Therefore, I consider that it is desirable to make the following recommendation.

Recommendation: I recommend to the Governor of Wellington Correctional Centre that consideration be given to providing correctional officers with refresher and/or increased education and training to assist officers with recognising the signs of methadone overdose in an inmate, and the circumstances in which interventional action may need to be taken to ensure that the inmate is alive and well.

What measures did Justice Health have in place to prevent the unauthorised diversion of methadone at Wellington?

At the time of Ivan's death Justice Health had in place a number of procedures specifically related to OST which were set out in the Justice Health Drug & Alcohol Procedure Manual (**the Manual**). These procedures were developed for use across the Justice Health Network and were not site specific to Wellington or any other correctional centre. In November 2015, there were 106 patients on the methadone OST program at Wellington.

OST No. 15 of the Manual deals with *Management of Non-Compliance With/Diversion of OST Medication.* It defines diversion as "*the act of supplying a controlled drug or regulated medication to someone other than whom it was prescribed to, and supply to illicit drug markets. This includes the selling, trading, sharing or giving away of prescription medications to a third party. Diversion may be voluntary or involuntary*".

OST No. 5 of the Manual sets out a number of procedural steps to be followed by Justice Health staff regarding the dosing of methadone to inmate patients as part of OST. It relevantly provides that when a patient attends a correctional centre health centre for their methadone dose, a correctional officer supervising the dosing will ensure that the patient:

- Has their sleeves rolled up;
- Is not holding anything in their hands, other than their identification card;
- Is pat searched for containers;
- Opens all clothing around the neck to ensure that no plastic bags or containers are secreted; and
- Has no absorbent material (such as cotton wool) secreted in their mouth.

OST No. 5 also provides that there must be only one patient to be dosed at the dispensary window at any time and that the patient must be easily visible and facing the nursing staff during the entire dosing procedure. Further, methadone is to be administered by a registered nurse and the administration of the dose is to be witnessed and checked by a second staff member. Finally, OST No. 5 provides that "*it is the responsibility of the registered nurse to ensure that the dose administered has been swallowed (in the case of methadone)" and "to watch the patient as she/he drinks the methadone*".

Further, the Justice Health *Guide to Management of Diversion & Non-Compliance with Opioid Substitution Treatment* provides a list describing various incidents of actual and attempted diversion so that they may be more readily identified by Justice Health staff, together with action to be taken by staff in response to such incidents. As already noted above, several witnesses, including Governor Smith, gave evidence that preventing methadone diversion has historically been, and remains, a challenge at least at Wellington, if not at other correctional centres. It would therefore be unrealistic to consider that the procedures put in place by Justice Health and CSNSW could successfully prevent any diversion of methadone at all.

Notwithstanding, the inquest did not receive any evidence to indicate that in November 2015 there was some systemic deficiency regarding the application of procedures set out in the Manual pertaining to the management of diversion of methadone.

Further, as it is only possible to speculate about how the methadone administered by Ivan might have been obtained, there is also no evidence specifically relating to a possible instance of diversion in this regard (noting that the possibility of the methadone having been introduced into Wellington from an external source cannot be entirely excluded).

To the contrary, in their evidence both RN Ashton and RN Pascoe were asked about their experience in dispensing methadone to inmate patients. Whilst RN Pascoe had only been involved in such dispensation on approximately eight occasions, RN Ashton was considerably more experienced in dispensing methadone. In their evidence both RN Ashton and RN Pascoe demonstrated a familiarity with the procedures set out in the Manual in relation to preventing diversion. In particular, RN Ashton explained that she was well known for requesting correctional officers to check the mouth of an inmate again if she suspected that the inmate had attempted to divert methadone, and that inmates suspected of diverting were placed in a management cell with minimal furnishings that could be used to conceal diverted methadone.

Finally, it should be noted that the inquest received evidence from Stephen Ward, the Acting Service Director Drug & Alcohol, Clinical Operations at Justice Health. Mr Ward gave evidence that in January 2020; following completion of a two-year clinical trial, Justice Health commenced providing inmate patients with a new treatment in relation to OST. This new treatment involves inmates commencing an OST program routinely being given a buprenorphine depot injection which lasts for one month. The depot is a subcutaneous injection which dissolves under the skin, and is used as part of OST instead of dispensing methadone.

In evidence, Mr Ward explained that new inmates entering custody who require OST are commenced on depot injections unless there are clinical contraindications, or the inmate is already receiving methadone. This has resulted in a reduction in the percentage of inmates receiving methadone as part of OST from approximately 90 percent down to approximately 52 percent. Further, as the depot is a subcutaneous injection, Mr Ward gave evidence that it is not possible to divert it and that during its clinical trial Justice Health found no evidence of any instances of diversion. It should be noted that whilst the depot injection is available to inmates entering custody, it is not available to inmates already receiving methadone as part of an OST program. This is because there is currently no medical literature or clinical guidelines in relation to safely transitioning a patient receiving methadone to a buprenorphine depot injection. Mr Ward explained that any such transition could only be conducted with inmates in custody for a significant period of time so that the transition could be closely monitored and clinical contraindications identified.

Conclusions: The evidence establishes that as at November 2015 Justice Health (in conjunction with CSNSW) had in place at Wellington (and other correctional centres) a number of procedures designed to minimise the risk of methadone diversion. There is no direct evidence to suggest that the practice of Justice Health staff was inconsistent with these procedures. Notwithstanding, it is evident that despite these procedures (and similar procedures put in place by CSNSW) instances of diversion still occurred, most likely sometime after and away from the point of dispensing, and most likely by a process of an inmate regurgitating methadone. Whilst it is acknowledged that such practices are difficult to monitor and impossible to prevent, there is no evidentiary basis to make any recommendation that the relevant procedures within the Manual be amended in any way.

The new treatment introduced recently by Justice Health for administration of buprenorphine depot injections for new inmates entering custody who require OST has resulted in a reduction in the percentage of inmates receiving methadone. This reduction, and the nature of the depot injection itself, has in turn produced the likelihood of instances of methadone diversion. It is hoped that there will be an increased uptake in the number of inmate patients able to receive the depot injection over time.

In the course of submissions counsel for Ivan's family made reference to OST No. 1 of the Manual which deals with the assessment of inmates for OST. It relevantly provides that its call is "*to ensure that any patient who was commenced on a OST program whilst in custody is clinically appropriate for treatment as per the NSW clinical guidelines*". Counsel for Ivan's family also referred to one aspect of RN Ashton's evidence in which she indicated that it was her understanding that inmates who were stable on OST would be reassessed every 12 months by a medical practitioner.

From these two pieces of evidence, counsel for Ivan's family submitted that because diversion was a persistent issue, and because methadone was known to be used as a form of currency within Wellington, this suggested that a number of inmates were receiving methadone for non-therapeutic reasons. On this basis, counsel for Ivan's family submitted that a recommendation ought to be made to Justice Health to conduct an audit of the implementation and operation of its OST program at Wellington Correctional Centre.

Clause 1 of OST No. 1 provides that "*all patients entering the correctional system on an Opioid Substitution Treatment (OST) program are maintained on that treatment unless clinically indicated otherwise*". It further provides that any patient requesting to commence on OST Program is to have an initial risk assessment, followed by a drug and alcohol nursing assessment and a drug and alcohol medical assessment which is to be documented in the patient's current health record. OST No. 2 sets out a number of procedures relevant to commencing an inmate on OST. Neither OST No. 1 nor OST No. 2 was the subject of any direct evidence during the inquest.

Conclusions: It has already been indicated that there is insufficient evidence to allow for a conclusion to be reached that the methadone administered by Ivan originated from a particular source. Whilst it is most likely that the methadone was sourced from an incident of diversion, it is not possible to reach any definitive conclusion on this issue. This alone means that it is difficult to make the recommendation sought by counsel for Ivan's family. Further, even if it could be definitively established that the methadone administered by Ivan was sourced from an incident of diversion, there is no evidence to suggest that an inmate who was receiving methadone was not clinically indicated to be on the OST Program. This issue was not canvassed during the course of the inquest and no witness was called to address this issue. Therefore, there is no evidentiary basis to make the recommendation sought by counsel for Ivan's family.

Formal Finding:

Identity: Ivan Mikic.

Date of death: 3 November 2015.

Place of death: Wellington Correctional Centre, Wellington NSW 2820

Cause of death: Methadone toxicity, with coronary artery atherosclerosis being a significant condition contributing to death.

Manner of death: Unintentional drug overdose following self-administration of methadone that had been acquired in circumstances unknown, most likely following an incident of diversion. At the time of his death Ivan was in lawful custody serving a sentence of imprisonment.

5. 373099 of 2015

Inquest into the death of John Cartwright. Finding delivered by DSC Grahame at Lidcombe on the 14 February 2020.

Mr Cartwright was 54 years of age at the time of his death on 19 December 2015. He had been sentenced to imprisonment at Windsor Local Court on 17 December 2015 and entered custody at Amber Laurel Correctional Centre ("Amber Laurel") later that evening. Mr Cartwright's sentence warrant was endorsed with a recommendation that he should be detoxed on entry into custody and receives treatment for alcoholism. Despite that recommendation, he received no assessment or treatment for alcohol withdrawal on reception at Amber Laurel.

Mr Cartwright fell when trying to get out of his prison bed on the morning of 18 December 2015. He died from an intracranial haemorrhage the following day.

The role of the coroner

The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the coroner may make recommendations in relation to matters that may have the capacity to improve public health and safety in the future. In this case there is no dispute in relation to the identity of Mr Cartwright, or to the date or place of his death. The court heard evidence relating to his cause of death and the circumstances surrounding his fall.

When a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is detained in custody the state is responsible for his or her safety and medical treatment. It is important to review all inmate deaths, including those which appear to have been naturally or accidentally caused so that we have confidence that each prisoner has received adequate and appropriate medical care. This is particularly so for prisoners like Mr Cartwright who have no family or friends able to advocate on their behalf. Section 81(1) of the *Coroners Act 2009* (NSW) requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Mr Cartwright.

Scope of the inquest

The inquest took place on 10 - 11 August 2020. A three volume brief was tendered including police statements, photographs and CCTV footage, prison and medical records. The officer in charge of the investigation, Inspector Ben Johnson was called to give brief oral evidence, as were a number of involved correctional officers.

Associate Professor Michael Besser, consultant neurologist and Dr Van Vuuren, forensic pathologist assisted the court, giving concurrent oral evidence in relation to the cause of death.

An issues list was distributed before the inquest commenced to focus the pertinent questions for consideration. It comprised the following;

- *The circumstances that brought Mr. Cartwright to Amber Laurel CC.*
- *The reception process at Amber Laurel CC on 17 September 2015, including:*
- *The information recorded about Mr. Cartwright;*
- *The action taken in response to that information;*
- *The reason why no Justice Health staff were present at Aber Laurel CC and the alternatives available;*
- *The decision to place Mr. Cartwright in cell Bass 2.*
- *The circumstances of Mr. Cartwright's brain injury.*
- *The response by Corrective Services NSW staff to reports that Mr. Cartwright was unwell.*
- *Changes to policy and practice at Amber Laurel CC since 2015.*
- *Whether any recommendations are necessary or desirable.*

Background

Mr Cartwright was born on 27 September 1961. He formed a relationship and had two children, the first in 1987 and another in 1988. That relationship ended in 1993 and he was estranged from his wife and sons at the time of his death. From about 1995 he lived with Frances Halpin, a former school friend, in a caravan park at Wilberforce. He appears to have been in a relationship with her at one stage. She has died in the years since Mr Cartwright's death. During his working life Mr Cartwright was a roof tiler. He had not worked regularly since about 1999 (aged 38) when he began to receive the Disability Support Pension. Mr Cartwright was a chronic alcoholic.

He had experienced problems with substance abuse throughout his life. He committed a Mid-Range PCA offence in 1979 (aged 18) and a further five PCA offences, four of them High-Range, are recorded against him, in 1982, 1990, 1999, 2007, and finally 2015 for which he was serving a sentence at the time of his death. He had undergone detoxification and rehabilitation in the past but had relapsed. His alcoholism led to serious health problems, in particular cirrhosis of the liver.

Events leading to imprisonment

On 10 February 2015, members of the public found Mr. Cartwright in a vehicle that was partly hanging off the edge of a retaining wall at Colo Heights. He appeared to be trying to get the car back onto the roadway.

Witnesses approached the vehicle, removed the ignition keys and called police, who attended and administered a breath test, finding him to have a BAC of 0.264, 5 times the limit. Mr. Cartwright was charged with a High-Range PCA offence. Mr. Cartwright admitted this offence and was sentenced to imprisonment.

The Court ordered a home detention assessment. He was bailed with conditions that he should not consume alcohol. He reported to Community Corrections for an assessment but presented intoxicated on the day of his interview. He was therefore told to detox before he could be assessed.

On 24 November 2015, Mr. Cartwright was admitted to the Nepean Hospital Detox Unit. The court had access to the medical notes of that admission. He told doctors he had a 40-year alcohol problem, and at its peak had been drinking 20 schooners of beer plus half a bottle of Jack Daniels a day. He said he had been cutting back since December, but had consumed a bottle of wine and a vodka mixer the night before. He appeared intoxicated at the time of admission.

He reported getting tremors and sweats in the past, but no seizures, which may be another symptom of alcohol withdrawal. Mr. Cartwright's progress at Nepean Hospital was positive. He was given Campral (acamprosate) and oxazepam for management of the symptoms of withdrawal. The notes state that he did not experience any seizures or other serious symptoms of withdrawal during the admission. He scored zero or 1 on the Alcohol Withdrawal Scale at all times, indicating no significant issue. On the third day, 27 November 2015, he was discharged. He said he wanted to return to care for Ms. Halpin. He said he intended to arrange alcohol counselling through probation and parole.

At the time of discharge, Mr Cartwright was given his normal medication including Campral, although it is not known if he took it. He did not have his medication with him when he was admitted to custody.

On 30 November 2015, Mr Cartwright had a CT scan which showed a large mass on his liver, consistent with Hepatocellular Carcinoma, a form of liver cancer. He attended his GP and was referred for management of that condition.

On 4 December 2015, he again attended Community Corrections for the home detention assessment. This time, he provided a breath sample which read BAC 0.082. The assessment was completed on 15 December 2015. It did not recommend that he was suitable for home detention.

On 17 December 2015, Mr Cartwright was sentenced by Magistrate Toose at Windsor Local Court for the High-Range PCA offence. Her Honour imposed 12 months' custody with a 9-month non-parole period. Significantly, her Honour recorded the following recommendation on the sentence warrant:

"*Defendant is to be detoxed for alcohol on entry into custody and also receive treatment for alcoholism.*"

Her Honour also told Mr Cartwright that he was to receive detoxification in open Court at the time she pronounced the sentence.

Entry into custody

At about 2.30pm that afternoon, Mr Cartwright entered the cells at Windsor Courthouse, and about an hour later he was taken to Windsor Police Station. No action was taken at that stage regarding her Honour's comments about detoxification. At 3.20pm, a New Inmate Lodgement and Special Instruction form was completed, which ticked a box to show he was withdrawing from alcohol. That was forwarded to Corrective Services NSW Placements section of Court Escort and Security Unit ("CESU"), to determine where he was to be placed. At some stage that afternoon, a decision was made to place Mr Cartwright at Amber Laurel. It appears this was primarily because the Windsor Police Station was in the catchment area for Amber Laurel, and there were beds available there.

Although placements did have the information on the lodgement form that Mr Cartwright was withdrawing from alcohol, they did not have access to information about whether Justice Health staff were present at Amber Laurel. Amber Laurel is referred to as a "custody centre", an "intake centre" or a "24-hour cell complex". Although it is a gazetted Correctional Centre, it appears that it is intended to be used for short-term accommodation, before inmates are transferred to other correctional centres on the basis of priority. One consequence is that some services and staff are not available at the same level as in other correctional centres. In 2015, Justice Health normally allocated one nurse to Amber Laurel to undertake assessments between the hours of 2pm and 10pm on weekdays. On 17 December 2015, a Thursday, the rostered staff member was sick and a replacement worked until 4.30pm only. Accordingly, there was no Justice Health person present at the time Mr Cartwright was placed or received at Amber Laurel.

In 2015, the relevant Corrective Services NSW policy relating to inmates who were detoxing from alcohol included the following. The Operations Procedures Manual ("OPM") (2015 version) at 10.1.11 required, "*JH* [Justice Health] *to be notified immediately and consulted*" where "*[a]ny inmate held at a court/police cell complex, managed by department officers… is identified or is believed to be detoxing from drugs or alcohol*." The same policy at 10.1.9.2 required Justice Health to be advised immediately upon arrival of any inmate "*with a specific court/parole board request for psychiatric and/or medical attention*".

Although there were no Justice Health present at the time of Mr Cartwright's admission to Amber Laurel, Justice Health also operated a Remote / Offsite / Afterhours Medical Service ("ROAMS"). Through that service, an after-hours nursing manager was available to be contacted by telephone, to advise correctional officers where there was no Justice Health staff member physically present at a correctional centre. The ROAMS service operated in 2015 and continues to operate today. However, while Justice Health policy referred to ROAMS in 2015, the OPM sections quoted above did not explicitly refer to, or provide a contact number for, that service. Mr Cartwright left Windsor police station at 5.41pm and arrived at Amber Laurel at 6.35pm.

At about 7pm, Mr Cartwright was interviewed by Casual Correctives Officer Rami Khaleel as part of the reception process. Officer Khaleel spent about 20 minutes with Mr Cartwright, and completed an Inmate Identification and Observation form including another New Inmate Lodgement and Special Instruction form. On that latter form, Officer Khaleel again ticked the box recording that Mr Cartwright was "withdrawing from alcohol"; he also noted Mr Cartwright's need for alcohol treatment elsewhere on the forms. Although Mr Cartwright's alcohol issue was noted, no referral was made for a medical assessment, and he did not receive any medication. Instead, Acting Senior Correctives Officer Dean Baker, the senior officer on duty at the time, decided to place Mr Cartwright two-out in a camera cell.

Officer Baker was later asked about this decision. He said he believed that placing Mr Cartwright in the camera cell was "*the best [he] could do*". He told the court that he recalled seeing the endorsement on the warrant, but without a nurse to commence some sort of withdrawal regime, there was little he could do. He explained that the "*best thing I could do was keep withdrawing the alcohol; put them in a camera cell to be reviewed by Justice Health the next day when they were on duty*." He appeared to understand that withdrawing from alcohol could involve seizures. In his mind Mr Cartwright was afforded some protection because if that occurred "*the control room officer was able to observe that*." In normal circumstances he would have informed Justice Health, but there was nobody on duty.

He told the court that, back in 2015, he was unaware of the ROAMS service that Justice Health operated. He did not know he could have called for medical advice or management. In 2020 at the time of giving evidence he remained unaware of this service. The options as he understood them were to call an ambulance or manage the situation through cell placement.

He also said he had asked if unscreened inmates, namely those not assessed by Justice Health, could be taken to Surry Hills Police Centre, and screened inmates could be received at Amber Laurel instead. It was not clear when this request was made, or to whom. Officer Baker had in fact refused to accept another inmate on the same truck as Mr Cartwright on medical grounds. That inmate had more obvious medical issues, namely insulin-dependent diabetes and he required a CPAP machine. That inmate was put back on the truck and transported to the Metropolitan Remand and Reception Centre ("MRRC"). Mr Cartwright was placed in Baker Cell 2. Another inmate, "B" was also placed in that cell, partly as a protective measure for Mr Cartwright. Nothing of significance happened until the following morning.

18 December 2015

The next morning, 18 December 2015, the CCTV footage shows that Mr Cartwright woke at about 7.20am. He had breakfast at about 7.40am. He then appeared to vomit and went back to bed. The footage is somewhat grainy while the cell is dark. Records show that a total of five cell alarms were activated from the cell that morning. The cell alarm, when pressed, alerts officers in the control room, who may then start a two-way conversation with the inmate. In 2015, the calls were not recorded. It is pleasing that this is no longer the case.

The first two alarms, at 8.11am and 8.47am, were made by Mr Cartwright's cellmate, "B" who asked for methadone. The officers in the control room seem to have formed a view that the cellmate was being a nuisance.

Those officers were Peter Colin-Thome, the Control officer, and Raymond Hoole, the Risk Intervention Team officer.

At 8.58am, the footage shows that Mr Cartwright attempted to get out of bed. It appears that he was somewhat unsteady. At 9am, the footage shows he got his leg trapped in the bed sheets, and fell over, striking his chest on a fixed stool which was positioned near the bedside. In my view the footage shows that he also struck his head, possibly on more than one occasion, on a desk opposite the bed. He then continued falling to the floor. "B" helped him back into bed.

At 9.02am, "B" again pressed the cell alarm. He repeated his request for methadone, and then said that Mr Cartwright had fallen over, and that he had either broken his shoulder or collarbone, or "*nearly hit his head on the stool*". When questioned about this interaction during the inquest, Officer Colin-Thome was inclined to think that "B" had reported that Mr Cartwright had broken his collar bone.

Response by Correctional Officers

Officers Colin-Thome and Hoole enlarged the relevant CCTV footage and saw Mr Cartwright sitting up in bed. They formed the view that nothing was wrong. This was partly due to the fact that he appeared to be sitting up "on his elbows", and partly because Mr Cartwright did not make any complaint himself. They did not summon any medical help or report the fall to officers in the relevant area. During the inquest Mr Colin-Thome stated, "*I wasn't really in a position to do much about it. As I said there's no nurse around, the only person who could attend to a medical problem was a qualified nurse.*

There was no-one else able to do that and we were led to believe that the nurse would be in before long." He agreed that it was a possibility that Mr Cartwright had fallen and broken his collar bone or shoulder, "*but I didn't take that too seriously because ["B"] was doing all the talking and I felt he was just trying to garner more attention for his needs*." The fact that Mr Cartwright didn't say anything and his "body language" apparently indicated to Mr Colin-Thome that he did not need to take immediate action. Mr Colin-Thome stated, "*[*h*]e didn't scream, didn't say anything, I need something to go on, to be suitably alerted to a serious situation, I got none*."

In other words he believed that "B" was exaggerating the situation to get more attention himself. During his oral evidence Mr Colin-Thome stated that he noted the information about Mr Cartwright on a "scrap of paper" which he intended to give the nurse on arrival. He stated that he did not know he had the capacity to contact an afterhours nurse. He had never heard of a service called ROAMS. He told the court that he became aware that officers attended the cell but he was not entirely clear whether he had notified them "*or maybe they attracted attention by knocking on the door*." I had the opportunity to watch Officer Colin-Thome give evidence. I was unimpressed. Even with hindsight he appeared to lack curiosity or concern.

Mr Hoole was acting as the Risk Intervention Team ("RIT") officer at the time of Mr Cartwright's fall. The RIT officer is responsible for observing live camera footage with a particular focus on inmates identified to be at risk of self-harm and ensure that they remained alive and well. Generally, inmates who are in a camera cell but not identified to be a RIT inmate are not required to be observed by the RIT officer.

Mr Hoole gave evidence that there were 12 RIT inmates that day, that neither Mr Cartwright nor his cellmate "B" had been identified as a RIT inmate and that he had not been given any particular instruction about Mr Cartwright. He went on to say that he did not see Mr Cartwright's fall as he was observing the twelve other RIT cameras and he first became aware of the issue after he overhead "B" state that Mr Cartwright "*had a fall and… had broken his collarbone or something*". Mr Hoole recalled that Mr Cartwright was sitting up, didn't appear to have broken any bones and didn't seem to be in any distress.

From this evidence, it appears to me that neither officer in the control room took any step to alert officers in the section where Mr Cartwright was housed about the report that he had been injured. It appears to me that Mr Colin-Thome, as the Control Officer, ought to have done so. However, as I have noted, he stated he became aware that an officer had entered the cell shortly afterwards; this is consistent with the CCTV footage. Also, given the events that followed, the failure to ask officers to attend the cell did not contribute to Mr Cartwright's death.

At 9.05am, Officer Mark Harper was performing shower duties in the Bass section. He opened the cell door and let "B" out to have a shower. There may have been some conversation with Mr Cartwright, although it is unclear what. "B" returned to the cell at 9.11am.

At 9.18am, Officer Harper was again walking past the cell. He became aware that "B" was yelling or tapping on the door of the cell trying to attract attention. He told the court he had not been aware of an issue but when "B" told him that there was something wrong with his cellmate he thought he should find out what was going on. Officer Harper opened the door. Mr Cartwright was conscious and did not appear to have obvious injuries. Officer Harper told the court that he was immediately aware that Mr Cartwright was an alcoholic.

He asked Mr Cartwright if he needed an ambulance, which he declined, saying he would wait to see the nurse. Officer Harper called the Assistant Superintendent, Jason Thorpe. He explained that he did this because he knew Mr Cartwright was an alcoholic and he "*had an inkling that something wasn't right*."

Assistant Superintendent Thorpe attended the cell shortly afterwards. Officer Harper asked Mr Cartwright again if he needed an ambulance, explaining that Justice Health were not due to start until 10am. Mr Cartwright said he wanted to see the nurse. The officers left and secured the cell.

Assistant Superintendent Thorpe instructed the control room to keep an eye on the cell, and for the Justice Health nurse to attend Mr Cartwright as a priority when available. Officer Harper told the court that he also spoke to the nurse himself. He "*went to the clinic and I had a quick look at his file and you know, I didn't know what kind of alcoholic he was or if he was on a withdrawal regime or anything like that, so I went to Sue-Ellen 'There's a guy up in his cell we just need to go and take a look.'*"

Attendance of Justice Health and Mr. Cartwright's death

At 10am, Justice Health Nurse Sue-Ellen Robinson commenced duty. She attended the cell promptly at 10.02am. She found Mr Cartwright to be unresponsive and bleeding from the mouth. He was stiff and possibly fitting. Officer Harper was also present, and he saw foam coming from Mr Cartwright's mouth.

Photographs taken at the scene later suggest that Mr Cartwright may have urinated on the bed at some point. The nurse provided oxygen, administered Midazolam and asked for an ambulance.

The ambulance arrived at 10.25am. Mr Cartwright was taken to Nepean Hospital. His transfer to hospital was pursuant to an order made under s. 24 of the *Crimes (Administration of Sentences) Act 1999* (NSW), and accordingly he remained in lawful custody while at hospital. A CT scan undertaken at hospital revealed a significant brain injury. Mr Cartwright died the following morning, 19 December 2015 at 5.20am. No problems were identified with the treatment given after the arrival of Nurse Robinson.

Autopsy

A limited autopsy was performed by Dr Van Vuuren on 22 December 2015. No internal autopsy was performed and Mr Cartwright's brain was not examined. Radiology showed a large right cerebral parenchymal haemorrhage, with marked mass effect and shift of the midline in keeping with subfalcine herniation. There was no evidence of fracture. Radiology also showed coronary artery calcification and consolidation of the left lung, and extensive liver cirrhosis with lesions suggesting possible liver cancer.

Toxicology detected alcohol at 0.007g/100mL (possibly post-mortem production) and administered medication (ibuprofen, midazolam and tramadol).

The manner and cause of death

The court was particularly concerned to discover whether Mr Cartwright's fall was a consequence of, or a cause of, his brain injury. Further, the court was keen to understand if the fall or the injury was related to the effects of alcohol withdrawal. The cause of death is to be determined by the application of common sense and experience: *Saraf v Johns* [2008] SASC 166 at [18] per Debelle J. There is authority that that the court is required to make a finding not only of the "terminal" cause of death, but also the "real" cause of death, namely the definable event from which the terminal cause arose: *Ex Parte Minister of Justice; re Malcolm; re Inglis* [1965] NSWR 1598 at 1601 per McClemens J.

The inquest received a report from an independent expert neurologist, Dr Michael Besser. In his opinion Mr Cartwright's intracranial haemorrhage was caused by trauma, sustained during the fall, and helped in by an underlying coagulopathy, caused by liver disease. In oral evidence he stated that the experts were somewhat disadvantaged because no internal autopsy had been performed and there was no neuropathology, however "*going on my…30 years of clinical experience…I feel that the cause of this haemorrhage was traumatic*." Later he told the court that "*to my mind it doesn't have the appearance of a spontaneous intracerebral haemorrhage and there's no video footage that suggests that that may have occurred because he remained conscious for a period of time after his fall*.

He agreed that Mr Cartwright's other co-morbidities including coagulopathy from his liver disease, hypertension, atherosclerotic vascular disease and alcoholism could have contributed to the extension of the haemorrhagic contusion. Dr Besser explained the basis of his view in oral evidence. He stated that if the injury was spontaneous in origin and involving the central structures of the brain he would have expected Mr Cartwright to have been rendered immediately unconscious.

Dr Besser watched the CCTV footage and confirmed that "*any one of the impacts*" he saw could have caused a traumatic brain injury and a haemorrhagic contusion, especially considering the known co-morbidities. He stated *"[i]t can progress rapidly if there were these additional co-morbidities such as coagulopathy, hypertension and his … atherosclerotic small vessel disease*." In his view the most likely mechanism of the intracerebral haemorrhage was trauma resulting from a fall.

Dr Mohamed Nasreddine, a Forensic Radiologist, provided a report for the court. He was not clear such a conclusion could be reached, stating "*it would be very difficult to infer/state that the trauma or a primary cerebral haemorrhage was the initial or contributing event*."

Dr Van Vuuren, the Forensic Pathologist who conducted the post mortem examination had a similar view. Her initial Autopsy Report did not specifically address the likely cause of the intracranial haemorrhage, however in a later report she stated that "*the initial event, either trauma or a natural cause, leading to haemorrhage in the brain would be difficult to determine*." She outlined the factors which could have contributed, together or alone, to the haemorrhage including coagulopathy from his liver cirrhosis, hypertension and chronic alcoholism. She also noted that in rare circumstances liver carcinoma can metastasise in the brain and cause haemorrhage. In oral evidence she confirmed her view that it was not possible to say with certainty that the haemorrhage was the result of traumatic impact.

Dr Van Vuuren stated that "*if he has fallen that hard to get an intracranial contusion I would have expected some injury on the skin that's quite pronounced*." She also stated that Mr Cartwright's injury involved the right basal ganglia, which she said was one of the areas that can be involved in a spontaneous intracerebral haemorrhage. Dr Besser and Dr Van Vuuren gave concurrent evidence. Dr Van Vuuren agreed with Dr Besser that trauma was the *most likely* cause of the injury seen at autopsy. However, she was not shaken in her view that a spontaneous cause could not be ruled out.

Having reviewed the expert evidence, I am satisfied, on the balance of probabilities, that the mechanism of injury was traumatic. I understand and accept Dr Van Vuuren's view that *certainty* is not possible. However, on the material before me I am comfortable to the requisite standard. Professor Besser gave firm evidence based on 30 years' experience that the apparent extension of the injury throughout the brain was consistent with the trauma he identified on the CCTV footage. I accept his view that it is highly likely the injury was caused by the fall.

Issues arising from the evidence

Justice health

Roslyn Pavey, Regional Nurse Manager for the Women's and Metro North Region at Justice Health gave evidence before me. She explained that ROAMS was operating at the time of Mr Cartwright's death.

She gave evidence that since July 2016 there has been some extension to the hours of Justice Health coverage at Amber Laurel. Since the combination of Amber Laurel and the Emu Plains Correctional Centre into one cost centre in August 2017, there have been further opportunities to provide assistance to Amber Laurel when required, resulting in extended nursing coverage.

Ms Pavey outlined the way in which ROAMS works. She told the court "*there's a number that they can dial up and contact the after-hours nurse manager for advice [and] support. They're the nurse that isn't there - they will advise when to send to hospital; advise on medications … They generally consult in the absence of a nurse on site*." She explained that the existence of the service and how to contact it was communicated to staff at correctional centres in a variety of ways.

She expressed surprise when she was informed that correctional officers who gave evidence in this inquest had stated that they were unaware of ROAMS back in 2015 and remained unaware today. She agreed it may demonstrate a need for renewed training or publicity for correctional officers. Ms Pavey was also asked about what her advice might have been had she been in the role of giving after-hours advice to a correctional officer in relation to a patient such as Mr Cartwright. While it was difficult to say for sure, given the variables, she would certainly have seriously considered advising that he be sent to hospital for assessment.

Corrective Services

The court heard from Craig Osland, the General Manager for the CESU within Corrective Services NSW. He explained to the court that it can be difficult if unscreened inmates arrive when there is no Justice Health coverage. After hours there is no option of sending the inmate to a Centre such as the MRRC. An officer could seek advice from ROAMS or send the inmate to Hospital. In exceptional situations where NSW Police bring an inmate and there is "*a clear blatant and obvious, observable injuries or the person is grossly intoxicated or under the influence of drugs*" the inmate can be refused and the police referred to the local hospital to obtain medical clearance before the person can be entered into custody.

Mr Osland found it "*difficult to comprehend*" that in 2020 officers would have no understanding of ROAMS. Mr Osland gave evidence that the process of contacting ROAMS is "*well established and in place in all of my custody locations*" and that it is used "*quite regularly*". He further stated that one of the obligations of his managerial supervision includes ensuring that there is access to training modules, and as the Custodial Operations Policy and Procedures ("COPP") were introduced in 2017 there was COPP compulsory training. In that respect, he stated that has ensured that all Corrective Services NSW staff have access to training and information as to the use of ROAMS, and agreed that training is the best method to ensure compliance with the COPP. Chapter 1.1 of the current version of the COPP substantially repeats OPM 10.1.11 and 10.1.9.2 at par 4.7 and 4.8, respectively. In particular, par 4.8 relevantly states: "*JH&FMHN [Justice Health and Forensic Mental Health Network] will provide advice on managing inmates identified as detoxing from drugs or alcohol.*

JH&FMHN staff must be immediately notified and consulted in relation to the care of these inmates." Chapter 6.1 of the current version of the COPP provides the contact number for ROAMS and the procedures for doing so.

Mr Osland was taken to the issue of Mr Cartwright's sentencing warrant, which was endorsed by Magistrate Toose as set out above at [0] and agreed that the recommendation was not put into effect.

Mr Osland gave evidence that he would expect to be notified of any inability to put a judicial officer's recommendation into effect, particularly if it were to occur during business hours. He further supported the proposition that there be a process to notify the General Manager or to contact Sentence Administration if a recommendation by a judicial officer cannot be carried out.

The need for recommendations

Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keep in mind the limited nature of the evidence that is presented and focusses on the specific lessons that may be learnt from the circumstances of each death.

Draft recommendations were suggested by counsel assisting at the conclusion of evidence. In general terms they related to three policy areas. Firstly, that policy should be changed to ensure that unscreened inmates are not sent to a centre unless Justice Health staff are present. Secondly, that staff involved in the reception and screening of inmates should receive training in relation to the ROAMS service and in relation to mandatory contact with that service if Justice Health staff are not present and an inmate is detoxing from alcohol or drugs. Thirdly, that policy require that any recommendation endorsed on a warrant by a Judge or Magistrate receive proper attention.

I note that the first of the draft recommendations was resisted by counsel for the Commissioner of Corrective Services NSW. The court was asked to consider the number of unscreened inmates that come into the system on a daily basis. While most may arrive during hours where a Justice Health staff member is rostered, this will not always be the case. In NSW people may enter custody at many locations throughout the state and it would be extremely difficult logistically to ensure they were taken to a Centre where a Justice Health staff member was available. The evidence before me indicated that in 2015 there was "*no 24 hour provision of medical staff at… any other court cell, Police cell or custody centre*" in NSW.

I understand this remains the case. The ROAMS service when properly used should ensure immediate advice is available 24 hours a day throughout NSW. On reflection, having considered the matters put to me, I have decided against the recommendation.

I was persuaded that the draft recommendation aimed at training in relation to the ROAMS service for officers involved in reception and screening was appropriate. I was troubled by the fact the at least two officers told the court that they were unaware of the service or their ability to contact it for advice. Given that reception centres do not always have access to on site medical advice; it becomes critical that the availability of ROAMS is well known. It is also critical that correctional staff are advised of the necessity of contacting the service for inmates who may be withdrawing from drugs and alcohol.

I was also persuaded that a new process should be instituted in relation to recommendations endorsed on warrants from judicial officers. Given the evidence in these proceedings, I accept submissions from Corrective Services NSW that this recommendation should be limited to recommendations regarding the medical assessment or treatment of an inmate.

If such a recommendation cannot be carried out, the issue should be escalated to the General Manager of the relevant Centre for his or her consideration and action. In the absence of the General Manager it should be brought to the attention of the next most senior officer. This provides an important check on the system and should ensure that health issues considered important by the court are not lost in the process of admitting inmates into custody. It also ensures that if a junior officer is for some reason unaware of his or her ability to request JH assistance or advice via ROAMS, the matter will necessarily be considered by a more senior officer.

Formal Finding:

Identity: John Charles Cartwright
Date of death: 19 December 2015
Place of death: Nepean Hospital, Penrith NSW
Cause of death: Intracranial Haemorrhage
Manner of death: Mr Cartwright fell in his cell at Amber Laurel Correctional Centre on 18 December 2015. He sustained trauma during the fall that caused a large intracranial haemorrhage, in the context of serious health problems and alcohol withdrawal.

Recommendations pursuant to section 82 *Coroners Act* 2009

To NSW Commissioner for Corrective Services;

To General Manager, Court Escort and Security Unit, Corrective Services NSW;

1. The Court Escort and Security Unit should ensure that all staff involved in the reception and screening of inmates receive training and guidance on the use of the After Hours Nurse Manager within the Remote/Offsite/Afterhours Medical Service ("ROAMS") of Justice Health, and the requirement for that service to be contacted where an unscreened inmate is received into custody detoxing from drugs or alcohol where no Justice Health staff member is physically present, in accordance with the Custodial Operations Policy and Procedures ("COPP") manual, section 1.1 at paragraph 4.7-4.8 and section 6.1 at paragraph 2.1.

2. Corrective Services NSW should consider adopting a practice that, where a recommendation regarding medical assessment or treatment is made by a judicial officer on a warrant, and the recommendation cannot be carried out, that fact should be immediately brought to the attention of the General Manager of the Correctional Centre (or in the absence of the General Manager the next most senior officer) where the inmate is received.

6. 18089 of 2016

Inquest into the death of Tristan Naudi. Finding delivered by State Coroner O'Sullivan at Lidcombe on the 14 February 2020

Tristan Francis Naudi was born on 13 October 1992. He was 23 years old when he died at approximately 11:28pm on 18 January 2016 at Lismore Base Hospital. At approximately 6:30pm on 18 January 2016, Tristan consumed a gummy lolly containing MDMA. As the drug began to take affect Tristan's behaviour began to deteriorate. As the evening progressed he became increasingly unsettled, anxious and eventually aggressive. This behaviour was out of character for Tristan, with his friends describing him as ordinarily calm and laid back.

Several calls were made to 000 by Tristan's friends, neighbours and Tristan himself. Police arrived at Tristan's home at approximately 10:00pm and handcuffed Tristan behind his back and placed him in the cage of their Mitsubishi Pajero. Police transported Tristan to Lismore Base Hospital pursuant to s. 22 of the *Mental Health Act 2007* (NSW) and arrived at approximately 10:41pm. Hospital staff had to clear another patient from the isolation room and prepare the room for Tristan before he could be brought inside. Tristan was brought into the isolation room at approximately 10:57pm.

Tristan died at Lismore Base Hospital at approximately 11:28pm. Prior to his death, medical staff were attempting to sedate Tristan and had administered 10mg of intravenous droperidol and 10mg of intravenous diazepam. An autopsy report dated 28 April 2016 recorded the direct cause of death as "acute cardiac arrhythmia in 3, 4-methylenedioxymethamphetamine (MDMA) intoxication with prone physical restraint".

The nature of an inquest

As Tristan died while he was in police custody, an inquest is mandatory pursuant to ss. 23(1) (a) and 27(1) (b) of the *Coroners Act 2009* (NSW) ("the Act"). The role of a Coroner, as set out in s. 81(1) of the Act, is to make findings as to the identity of the deceased, the date and place of the person's death, and the manner and cause of the person's death. Section 82 of the Act empowers the Coroner to make any recommendations that are considered "necessary or desirable" in relation to any matter connected with Tristan's death. Tristan's identity and the date and place of his death were not in dispute. The focus of the inquest was on the cause and manner of Tristan's death.

An issues list was distributed in advance of the inquest, which provided:

- The inquest will consider the manner and cause of Tristan's death and any relevant contributing circumstances.

- The matters listed below are expected to be the primary focus of this inquest, but are intended as a guide only.

- Other relevant issues may arise during the inquest, which will require examination.

- In particular the inquest will consider:

- Medical evidence relating to cause of death including:

- Stimulant drug intoxication: the possibility of lysergic acid diethylamide (LSD) consumption and, as revealed on toxicology results, presence of:

- 3,4-Methylenedioxymethylamphetamine (MDMA)
- 3, 4 Methylenedioxyamphetamine (MDA, metabolite of MDMA).

- Physiological stress to the body as a result of MDMA toxicity and the later use of prone (face down) restraint.

- Tristan's prior medical history and the likelihood of any underlying medical condition of relevance to cause of death.

- Events at Lismore Base Hospital once Tristan was brought in by Police, including:

- Who made the decision to bring Tristan from the Police Van into the isolation room, what was discussed at that time and what was observed as Tristan was brought in?

- Use of restraint once Tristan was in the isolation room including decisions as to how to restrain him, location of Police Officers when restraining him, communication between Police and Hospital staff and the estimated time that Tristan was restrained in the prone position.

The hearing commenced on 13 May 2019. During that first week of the inquest, an issue emerged in relation to the non-attendance of an ambulance at 16 Sansom Street, Bangalow on the night of Tristan's death.

The matter was adjourned to enable NSW Ambulance to be joined as a party of sufficient interest, and for further evidence to be obtained. The inquest resumed on 30 September 2019, at which time the Court heard further evidence from witnesses including witnesses from NSW Ambulance.

In preparing these findings, I have been greatly assisted by the detailed written submissions of Counsel Assisting as well as the written submissions prepared on behalf of the interested parties.

Background

Counsel Assisting prepared a detailed chronology of the events on 18 January 2016, which I propose to adopt. Tristan was on a day off work. He told Emma, his partner, he wanted to get some acid to take before he went out to the Buddha Bar with Aidan Mulkerrins (flatmate) and another friend, Kyle.

15:03–17:05 Series of SMS messages sent between Tristan (on Emma's phone) and Cheyne Taylor, arranging for Tristan to meet with Cheyne. Tristan was told to bring some "soft lollie things, so we can do them up…just definitely bring some jubes or something…just any sort of soft lollies that will absorb liquid …"

Between 17:05–18:00 approx. Tristan met with Cheyne and brought gummy lollies home.

Between 18:00–18:30 approx. Tristan and Aidan took 1 gummy lolly each. The remaining lollies were stored in an ice cream container in the freezer but on later testing were not found to contain any illicit drugs. Tristan later went into the bedroom where Emma was getting ready for work. Emma observed Tristan was in a really happy mood and excited. He said he had some acid, he got the acid as soft lollies.

20:00 approx. Aidan and Tristan went to the Buddha Bar but later returned home to Bangalow. Aidan called Jared Vanke (friend) because he felt Tristan was taking it harder and thought it was better to have someone sober to come over and keep watch.

According to Aidan: Over the course of the evening Tristan became almost non-coherent. He couldn't register anything and tried to call Emma. When Aidan went to take the phone to call 000 he saw that Tristan had called the number himself.

Jared arrived at the Bangalow house. Aidan was still concerned that Tristan was behaving very erratically. He couldn't sit still. He was naked. Tristan screamed out and called for Candi (another flatmate). Candi came out of her bedroom with her phone. Aidan and Tristan were standing near the front door. Candi went back into her room and Tristan followed. He went up and held onto Candi quite tight in a kind of bear hug. Tristan was screaming at Candi and she screamed too. Aidan managed to pry Tristan off Candi. Tristan continued to pace around and then grabbed Aidan's dog, Diego. Tristan was still screaming. Aidan went to sit across the road and waited for the Police to arrive.

According to Jared, Tristan ran towards Candi and crash tackled her to the ground. It looked like Tristan wanted to get Candi's phone so he could talk on the phone.

Tristan and Candi both screamed. Tristan later became extremely aggressive towards Aidan, swinging punches and collecting him around the ribs and side of his stomach. According to Candi: She was standing in the hallway on the phone to the 000 operator when Tristan came running towards her, grabbed her by the shoulders and forced her into the doorway of her room. She got away from him back into the hallway but Tristan followed and tackled Candi to the ground. She dropped her phone. Candi called to Aidan "help me" and curled into the foetal position on the ground. Tristan was on top of her. He was naked, hitting her around the head and neck with his open hands.

21:31 First call to 000 as noted in Incident Log 817297. The call was terminated requiring several call backs.

21:36 000 call leads to ICEMS message to NSW Ambulance from Police.

ICEMS is the "Inter Cad Emergency Messaging System…that allows for electronic messaging between different computer aided dispatch systems. It allows for collaboration and teamwork between response agencies. Where an emergency call is attended by one agency but another is required, the agencies can communicate electronic messages via ICEMS."

ICEMS notification from NSW Police inviting Ambulance to attend said "From Telstra M req pol and Ambo, stated has had drugs. On connection M said hello, stopped responding. Some movement in background, call terminated. On callback inft said something about girlfriend terminated call. On call back inft said needs pol, phone broke up, terminated call. On callback inft gave Loc terminated call. NFI. CHKS OTW."

21:38 Automated "Will attend" message communicated by Ambulance to Police via ICEMS.

NSW Police also send ICEMS message to Ambulance "Will attend".

21:39 Ambulance ProQA generated priority of 2A emergency response (according to NSW Ambulance guidelines, this means that an ambulance should be with the patient within 30 minutes of the case being booked). Ambulance call taker then rang number recorded in ICEMS message to try and obtain further information on medical condition of patient. Tristan answered the call and when asked what was going on said "I don't know. I've taken some acid…Can you help me?" Additional information available to NSW Ambulance meant that ProQA generated a new dispatch code requiring 1C emergency response (most timely ambulance response attending with lights and sirens).

21:42 Ambulance Duty Operations Centre Officer ("DOCO") subsequently downgraded the incident back to a category 2A. The rationale for the downgrade is not recorded in Ambulance records and the DOCO does not recall this incident.

21:45 Incident Log 817414 recorded that BRU19 (the Pajero that ultimately transported Tristan to hospital) acknowledged the job. Inside BRU19 were Senior Constable Michael Chaffey and Senior Constable Michail Greenhalgh.

21:52 Candi had locked herself in the bathroom and called 000. She was put through to NSW Ambulance. Amongst other things she said Tristan "was tripping…he just attacked me…please get someone here…he's outside yelling and screaming down the street…They're coming back to the house I think. Oh god he keeps yelling zero, zero, zero, he needs help…he shocked me a little bit."

During this call Ambulance NSW told Candi "So the Police are gonna be there to help him and then we'll – the ambulance won't be too long after…The ambulance are on their way." However, no ambulance was on its way. As set out above, the job had been downgraded to a category 2A response and no ambulance had yet begun travelling to Tristan in Bangalow, even under that response category.

As a result of Candi's call to NSW Ambulance, ProQA again generated a new dispatch code (this time also marked with a "V" to signify the potential for danger or violence on site) requiring a 1C emergency response (lights and sirens).

21:55 ICEMS message update from Amb-n setting status to urgent.

The 1C response generated by ProQA was again overridden and downgraded to a 2A response by the DOCO. The reason for the downgrade is not recorded in Ambulance records.

According to Jared: Tristan had moved outside but then ran inside and got the keys to his kombi van. He ran outside with them and fell face first onto the garden area before tripping and falling onto his side on the pavers. Tristan got into the driver's seat and Jared pulled the door open and wrestled with him and got the keys. Jared then closed the door. The window was open and Jared locked the door by pushing the button down. Tristan couldn't work out how to unlock it. Tristan then jumped into the back of the kombi knocking over the surf boards. Tristan seemed to panic when he realised he was locked in and called "get me out of here". Jared got Tristan to move towards the driver's door and unlocked the door. Tristan pushed Jared with his right hand and tried to get out of the Kombi but his foot got caught in the seatbelt and Tristan fell face forward onto the tar road. Tristan landed heavily on the right side of his face and Jared took the opportunity to throw a towel over him and put his knee on Tristan's back.

Tristan seemed to have worn himself out a bit and Jared removed his knee from Tristan's back. Tristan remained lying on the road. He asked "…how far off is help?" and Jared said "It's not long." Police arrived shortly afterwards.

21:57 An entry was inserted into the Incident Log which recorded a call from a neighbour, Hugh Burton. The entry said "Inft can hear multiple M & FM screaming AA – inft can also hear thumping & believes it is physical – can hear people screaming 'Aidan' like they are trying to stop him doing something..."

21:58 Police radio message entered into Incident Log recorded BRU19 having given an estimated time of arrival on scene as "couple of mins."

21:59 Police radio message in Incident Log "BYR81/M/For BRU19 just had a call from AA neighbour escalating number of persons fighting poss smashed a window that is where the inj has come from."

22:00 BRU19 arrived on scene. NSW Ambulance was advised of this via ICEMS shortly thereafter.

22:03 ICEMS message from BRU19 "Have 1 M here subdued and in the back of the truck going off – still need the ambos to attend." Tristan was in the cage at the back of the Pajero with the cage door locked but the back door to the Pajero open.

22:04 ICEMS message from BRU19 into log "NFC [probably meaning 'no further cars'] required – M has taken acid – unsure if the ambos are going to be able to get near him – may have to convey him to the nearest hospital."

Sometime after Tristan was in the back of the Pajero but whilst Greenhalgh was in in the house checking on Candi, Chaffey recorded Tristan on his mobile phone. He did this so that he could show the footage to doctors to demonstrate how disturbed Tristan's behaviour had been.

22:05 Ambulance CADLink Look Back map shows the ambulance that was en route to Byron Bay from Gold Coast Hospital back in vicinity of Byron Bay ambulance station. ICEMS message from Amb-n: "Ambos not on the way as yet are Police going to transport."

This was a message from NSW Ambulance asking if Police were going to transport Tristan after advising NSW Police that an ambulance had not yet commenced travelling to the job (for whatever reason). Although the statement of Tony Gately suggested this was a question posed by NSW Police, the ICEMS log records it as being "from Amb-n". The content of the message suggested it was a question being posed by Ambulance. VKG understood it to be a question being asked by "the ambos" and Gately agreed that his statement was in error in this regard.[46] Finally, Keough's evidence was that he did not send a message "calling off" the Ambulance nor did he say that Ambulance should not attend the Bangalow residence.

22:11 Police [Radio] message entered into Incident Log "NFC – M is in the back of the truck – partner is talking to spvr about poss us conveying this M to the hosp – he is pretty violent."

22:13 ICEMS message from BRU19, update message sent to Amb-n "Don't think the ambos will be able to get near this M – standby – believe it is the spvr on the phone now."

22:14 ICEMS message from BRU19, sent to Amb-n, "Spvr advised us to convey this M to Lis under Section 22."

ICEMS message sent to Amb-n "Ambos not required thanks."[51] ICEMS status update from Amb-n setting status to "Closed"

22:20 Police [Radio] message entered into Incident Log "BRU19/M/OTW [on the way] to Lis Hosp"

Using the timings recorded in the Incident Log, Tristan had been in the cage in the back of the Pajero for about 17 minutes by this point.

Excerpt from VKG recording, BRU19 "I'm just wondering whether it'd be a call just to ring the A & E at Lismore just to let them know we're on our way, ah, with this feller. Just so they're prepared."

VKG response "I think that would be a good idea after what I just heard, no worries." BRU19 "Oh can you hear that?" VKG "Um…it's pretty loud".

22:28 Message in Incident Log, telephonist: "Lis Hosp advised that they have no rooms avail curr – there will most likely be a big delay"

VKG "Ahh Brunswick 19 I think that might have been you, just for your info, I've just been on the phone to Lismore Hospital, they're pretty full and they don't believe they're going to have any room for him so there might be a bit of a wait with, um, the male in the back of the paddywagon at this stage."

22:31 Speed camera at Bangalow Road recorded BRU19 travelling at 86km/h in 50km/h zone. This was en route to Lismore Base Hospital.

22:41 BRU19 arrived at Lismore Base Hospital. The journey took approximately 21 minutes and Tristan had been in the cage of the Pajero for approximately 38 minutes.

22:45 Sergeant Keough made an entry in the Incident Log "For record: Richmond Clinic ACU have no beds available. Tweed Heads ACU also have no beds but advice received from ACU (Sister Karen) that as Bangalow is within the Lismore health area the POI is to be the taken to Lismore A&E and placed at a location there pending vacancy in Richmond Clinic. Brunswick Heads 19 conveying drug affected 22 year old male from Bangalow to Lismore Base Hospital A&E for initial medical treatment & then ACU assessment via a Police issue Section 22. Lismore Police to meet and assist Brunswick Heads 19…this info not for broadcast. RECORD ONLY, created by Sgt J Keough – supervisor, Byron Bay."

22:52 Tristan was triaged by Clinical Nurse Practitioner Xanthe Moss.

According to Dr Murray: "it was clear from speaking to the officers and what I could observe from outside the paddy wagon that this man was very, very disturbed … so I could hear loud banging against the walls…it seemed to me he was bashing his head or body against the walls…and I felt just from hearing that and what I, the reports I had from the Police that we, um , that I did not want him out of the paddy wagon until we were fully prepared to deal with him."

According to Dr Edwards: "I went outside, just to view the patient, just to get an idea of, like, the level of agitation…I saw Tristan in the back of the Police van…I noted he was naked…he had his hands cuffed behind his back…he was kicking up. Like, on the roof of the van. So like, actually kicking his legs right up against the roof…and he was banging his head against the cage door….and sort of shouting, making, not really saying anything coherent. But obviously, visibly, very, like upset and agitated."

CCTV footage from the ambulance bay at Lismore Base Hospital at Tab 72 seems to show the Pajero rocking at certain points.

22:57 BRU19 moved closer to the doors of the vehicle in anticipation of bringing Tristan from the Pajero into the isolation room.

22:58 approx. Tristan was carried from BRU19 into the isolation room at Lismore Base Hospital. By this time he had been waiting in the back of the Pajero for about 17 minutes since arriving at the hospitaland had been in the cage in the back of the Pajero for approximately 54 minutes in total.

Tristan was observed to be sweating profusely as he was taken out of the Pajero and carried into the isolation room (however there was no opportunity to formally measure his temperature before he died).

22:59 approx. Dr Karpa inserted cannula into left forearm…Pt calling out incomprehensible words and moving around.

23:00 approx. Dr Edwards administered droperidol 10mg.

23:02 Dr Edwards administered diazepam 10mg.

Tristan non-verbal and not moving. Staff requested that his handcuffs be removed, which attended to by police. Tristan was then turned around to be near oxygen and other supplies.

According to Dr Murray: "cardiopulmonary resuscitation was commenced with bag-mask ventilation and cardiac compressions with full team in attendance. He was successfully intubated with a cuffed endotracheal tube at first attempt and bag ventilation commenced. Cardiac monitor was attached and he was found to be in asystole. …a total of 7mg of adrenalin was administered over subsequent rounds. The rhythm was always asystole or slow PEA. Further attempts at resuscitation were discontinued after 25 minutes of CPR with no return of spontaneous circulation at any point during that time interval. Extensive bruising to the face was noted during resuscitation attempts (police reported that was present when they arrived) and handcuff injury was also noted."

23:28 Time of death.

Police conduct in placing Tristan in the cage in the back of BRU19

As outlined in the chronology above, prior to police attendance Tristan had been physically aggressive to Aidan, Jared and Candi.

Tristan was presumably motivated by fear and desperation but there is no doubt that his actions were also aggressive to others. His behaviour was unpredictable.

Tristan was also a danger to himself as demonstrated by events after he took the keys to the kombi van. In these circumstances, Jared's actions in taking the keys from Tristan to prevent him from driving off and in restraining Tristan on the ground once he fell from the van, were both brave and caring, driven by an appropriate sense of concern for his friend. As Senior Constables Chaffey and Greenhalgh drove to the scene in BRU19 they had no way of knowing what Tristan was ordinarily like: he was a stranger to them and the scant information available to them prior to arrival suggested they were attending a scene where someone was potentially violent and out of control.

Senior Constable Chaffey described what he saw on approach as follows: *I saw a person laying on the ground with another person on top of them alongside a Volkswagen Combi … he was lashing out … I held onto his arm and tried to talk to him. It was pretty clear that he wasn't, um, comprehending what I was saying he was just randomly yelling out words, random words, um, similar to Triple 0 … tried to stand him up and walk over to the Police truck … then he lashed out, so we grabbed either arm*.

Senior Constable Chaffey went on to describe how he lent Tristan against the Kombi and applied handcuffs. Senior Constable Chaffey said that Tristan "*was naked … very sweaty …starting lashing out with his arms … and legs trying to kick out … so the best way we could restrain him was to put him in the back of the police truck so that he wouldn't hurt himself, or someone else, or us."* Senior Constable Greenhalgh described arriving on the scene to see two males on the ground one on top of the other and yelling profanities. He stood Tristan up and then said "What's going on mate?"

On Senior Constable Greenhalgh's account, Tristan then lashed out so they grabbed him, struggled with him, handcuffed him and got him in the truck.

There was some dispute between Senior Constables Chaffey and Greenhalgh as to the extent that Tristan was resisting as they tried to move him into the Pajero. On Senior Constable Chaffey's version "once he was handcuffed and he wasn't lashing out we were able to walk him to the back of the police vehicle and he actually climbed in to the back of the police vehicle of his own volition." Senior Constable Greenhalgh however said "I remember grabbing him in a full bear hug and having to walk him…I've walked him there." He "wouldn't say it was easy…[n]ot at all" getting Tristan into the Pajero.

It is unnecessary to resolve the inconsistency between their accounts. It is not surprising that their recollections differ given all that went on that night. In any event, a number of other witnesses observed or heard the police interaction with Tristan at the Bangalow address. Aidan said that police: were really good with Tristan from what he could see and hear. I heard the police speaking to Jared and they said they would have to put the cuffs on Tristan and then I could hear Jared sort of explaining that to Tristan … and it was almost like he was letting them but also not letting them. It was kind of hard to explain.

Jared witnessed more of a struggle. He said Tristan: realised they were there, he pushed me off and faced the police officers who were out of their car. He was in his aggressive stance again. He came towards one of the officers and was yelling out them [sic] … I don't remember what he actually said then but it was the same aggressive scrams [sic] he had been doing all night. The police both grabbed him and had him up against the front of the Kombi. Once the police grabbed his left hand and put a handcuff on. They were in a struggle with Tristan, he wouldn't allow his other hand to be brought around and was struggling with the police … It took both of them to hold him there, they managed to get the handcuffs on him.

A neighbour, Carolyn Mortimore, said once the police arrived: I saw the police pick him up off the roadway. The police were very gentle. He wasn't fighting them in any way and they didn't have to force him to do anything. The police walked him to the back of the police car and put him in the back … He got into the car with their assistance. The police communicated with him and provided instructions about lifting his legs. I can remember one saying "Get your legs in mate." … The entire incident surprised me with how well the police handled it all. They were calm and assertive throughout it but not scary. Considering the situation, there was almost gentleness in the way they acted.

Peter Mortimore said when police got to Tristan (Tristan was still on the ground at this stage):

They got either side of him and raised him to his feet quite gently. They were talking to him and trying to calm him down … I couldn't see the male resisting too much and at the same time, the police were not applying any force to him.

The male was extremely agitated but he didn't seem to be fighting the police much … The officers were calmly instructing him to step up into the back of the police car.

They advised him to watch his head as he got in and to lift a leg over into the back. They seemed to have a few problems getting him. He didn't seem to be resisting as such, he was just difficult to handle.

Another neighbour, Pauline Burton, could hear police talking calmly to people in the street whilst her husband Hugh Burton (who had earlier called 000) could hear "continuous yelling and the muttering of voices. I could hear the rational voices of police trying to pull the situation down, not escalate it." Katrina Holt recalled the point where Tristan was in the back of the police van: The policeman said to the guy, "Don't hurt yourself mate." I could see he was kicking and thrashing around in the back … At no time did I see police act inappropriately. I actually thought the officer was quite calm considering how violent the male was.

Perhaps Tristan was compliant at some times and aggressive at others. This was certainly the case earlier in the evening with Jared and Aidan. Once the police were on scene Jared said Tristan's "aggressive behaviour came in waves two minutes on two minutes off at this time. When he was aggressive he would yell out, kick the walls, then seem to take a breather, he would then become aggressive again. I kept trying to calm him through all of this. I couldn't get through to him."

Senior Constable Chaffey gave evidence that Tristan "settled a little bit and then he'd kick out again and he'd settle and he'd kick out again … it was only a matter of like seconds, like 30 seconds or something like that. It was … sort of on a regular basis he'd be kicking out and then yelling…" It was submitted by Mr De Brennan, appearing for Mr Vincent Naudi, that the Court should "not overstate the risk that Tristan presented to other people" as Tristan had, at most, committed what might be described as summary offences rather than strictly indictable offences. Having regard to the evidence summarised above, I am unable to accept this submission.

I accept the submissions advanced by Ms Bennett, for the Commissioner of Police, and Counsel Assisting that assessing Tristan's behaviour through the lens of whether he committed summary or indictable offences is unhelpful and unnecessary. The role of the NSWPF is to protect the public and a police officer is permitted to use force as is reasonably necessary for the protection of persons from injury or death, regardless of whether the need for the use of force arises from any criminal act.

The evidence indicates that Tristan was aggressive to Jared, Aidan and Candi, and also posed a risk to himself. In these circumstances, whether or not Tristan had committed any criminal offences, police had a duty to intervene and to prevent Tristan from harming himself or others. Mr De Brennan submitted that Tristan displayed "moments of lucidity" and that his behaviours were "not so confronting as to be completely unmanageable". Mr De Brennan further submitted that "the need to contain and restrain Tristan should have been subsidiary to his overall welfare".

I accept that there were moments during the evening when Tristan was able to briefly answer questions and speak coherently but these moments were relatively fleeting.

I find his behaviour overall was erratic and dangerous and needed to be managed somehow. I am unable to accept the submission that "the need to contain and restrain Tristan should have been subsidiary to his overall welfare." This submission presents a dichotomy that didn't exist. It was not inconsistent with Tristan's overall welfare to contain and restrain him. Rather, it was a necessary step in trying to get him the help he needed and protect others from his erratic behaviour.

As Mr Evenden pointed out, to the best of knowledge of attending police, placing Tristan in the back of the Pajero was a temporary measure as they expected that an ambulance would attend. In these circumstances, I am satisfied that police acted appropriately in placing Tristan in the back of the Pajero. It is significant to note that the chronology set out above demonstrates that Tristan was in the cage in the back of the Pajero within approximately three minutes of police arriving on scene. This was accomplished without police needing to draw their firearms or batons and without resorting to the use of OC spray or tasers. I accept Counsel Assisting's submission that this was in itself an achievement in the circumstances.

The decision that police would take Tristan to Lismore Base Hospital

The decision to downgrade the incident category

The chronology demonstrates that an ambulance was requested to attend the scene at Bangalow but the category (and therefore the response time priority) given to that request was twice manually downgraded by the Deputy Operations Centre Officer (DOCO) at NSW Ambulance. Unfortunately, this long after the event the DOCO does not recall the reason for downgrading the incident category. Accordingly, given the absence of contemporaneous records to explain the decision, neither the Court, nor Tristan's family, will ever know the reason.

Tony Gately, Director of Control Centres at NSW Ambulance, inferred that the first decision to manually downgrade from category 1C to category 2A was due to the fact that the ambulance call taker had been able to speak to Tristan when the call taker returned a call from Tristan and therefore knew that Tristan was "conscious and breathing."

As the chronology makes clear, Tristan's matter was again scaled up to a category 1C response after Candi's telephone call. It was again manually overridden and downgraded to a category 2A response for reasons unknown. Gately infers, but the Court cannot know that this was due to the suggestion that Tristan was now considered violent and "the DOCO would have been aware that any attending paramedics would need to stand off from the scene until the NSWP had arrived."

Even allowing for the fact that the category had been downgraded to 2A, the 30-minute priority guideline was not met. Here the matter became visible to the dispatcher at 21.39 which required, if the Category 2A timeframe was to be met, an ambulance to be with Tristan by 22:09. I accept that the guideline is just that, a guideline rather than an inflexible rule. However, as at 22:09, an ambulance had not yet been dispatched, much less arrived on scene.

Mr Gately described the decision to manually downgrade as "not supported by NSWA policy or procedure." In terms of the systemic issues arising from the decision to downgrade the priority given to Tristan's matter, Mr Gately gave evidence that an "unauthorised practice existed for a limited time in the Northern Control Centre whereby some supervisors would, for various reasons and in order to manage resources, override the system manually". However, I accept the evidence of Mr Gately that the local practice of manual overrides has ceased because it is not supported by NSW Ambulance policy or procedure.

The delay in dispatching an ambulance

The Court received evidence in the form of CADLink Look Back maps showing the location of NSW Ambulance crews on the night of 18 January 2016. The Bangalow house was in a geographical area typically covered by ambulance vehicles out of Byron Bay and Mullumbimby stations. Ballina was then the next station in the "response order" for Bangalow.

There was no crew on at Mullumbimby on the night of 18 January 2016 although two single units were "on call". As at 21:39 (the time that the Ambulance ProQA system generated the 2A emergency response priority for Tristan) they were estimated to be 22.3km and 24.5km away. Ballina had an ambulance crew at Ballina station at 21:39 and 21:52 but that crew had been dispatched to another job by 22:05. Had the Ballina crew been dispatched to Tristan they would not have been available for this job. The evidence does not however, permit me to make findings about whether that Ballina crew should have been dispatched to Tristan. There are simply too many unknown factors that may have influenced that decision and which the Court, unfortunately, cannot know.

Two ambulance vehicles were operating out of the Byron Bay station.

As at 21:39 one vehicle, Byron Bay 4576, was en route back to Byron from a Gold Coast Hospital. It was estimated to be 41.2km away from Tristan's home.

The second vehicle, Byron Bay 4572 was at the station estimated to be 9.6km from Tristan.

Submissions on behalf of New South Wales Ambulance emphasised, and I accept, had this Ambulance been dispatched, "this would have left a lack of on- duty cover in the Byron Bay region." Mr Gately infers this was the reason the available vehicle was not dispatched to Tristan. I also note, however that there were no competing 1C category matters awaiting ambulance dispatch as at 21.39. The CADLink Look Back map for 21:52 likewise shows an available vehicle at Byron Bay station at that time which suggests no competing 1C category matters were then awaiting dispatch. I accept though, that the information available to this Inquest is provided with the benefit of hindsight. Ambulance staff tasked with decisions to dispatch vehicles on the evening of 18 January 2016 could not have known what competing demands would be placed on the service across that period.

Turning to the CADLink Look Back map for 22.05 it shows Byron Bay 4572 still at Byron Bay station but by this time Byron Bay 4576 had also returned. The time of return is unknown.

There had been a change in status for Byron Bay 4576 in the meantime. By 22.05 it was marked "On Call (Single)" which Mr Gately inferred might have related to end of shift arrangements. Submissions on behalf of New South Wales Ambulance emphasised the information shared between Police and Ambulance immediately prior to 22.05. This is a specific reference, as set out in the chronology above, to the Police entry into ICEMS at 22:03 "Have 1 M here subdued and in the back of truck going off – still need ambos to attend" followed at 22:04 by another entry from Police "NFC Req- M has taken acid – unsure if the ambos are going to be able to get near him – may have to convey him to the nearest hospital."

This information may, or may not, have impacted upon decisions around dispatch to Tristan at 22.05, the evidence is not clear enough to permit me to make a finding either way. It follows, I am not in a position to make any considered findings about whether an ambulance should have been dispatched to Tristan prior to the decision by NSW Police to take him to hospital in a police vehicle. The evidence simply does not permit me to explore the context around particular decisions at anything other than the very general level set out above.

I acknowledge the very real concerns expressed by Tristan's family about the non-attendance of ambulance and the fact that if an ambulance had attended, it might have produced a different result for Tristan. It is regrettable that this Inquest has not been able to consider this further. If an ambulance had attended on the evening of 18 January 2016, it might have produced a different result for Tristan or it might not.

Counsel Assisting submitted, and I accept, that any number of scenarios might have arisen depending upon matters such as: If the ambulance arrived prior to police whether, given Tristan's presentation, paramedics were willing to commence assessment prior to police attendance. Both Scott Deeth, Acting Director of Clinical Practice at NSW Ambulance, and Mr Gately indicated that paramedics may have had to "stand off" until the scene was secured by police. If the ambulance arrived after police but before Tristan was placed in the Pajero whether, given Tristan's presentation, paramedics were able to "assess" him whilst police restrained Tristan outside the Pajero.

If the ambulance arrived after police placed Tristan in the Pajero whether, given Tristan's presentation, paramedics were able to do anything other than conduct a visual assessment. This would depend upon the extent Tristan was willing and able to co-operate in a way that permitted him to be safely removed from the Pajero and assessed. Paramedics would not be expected to get into the back of the Pajero to assess Tristan. Whilst the Court cannot know whether paramedics would have been able to conduct anything other than a visual assessment once Tristan was in the back of the Pajero, it seems unlikely any more detailed assessment would have been possible.

The video footage recorded by Senior Constable Chaffey provides direct evidence of Tristan's behaviour shortly after he was put into the Pajero (Tristan was in the Pajero by about 22:03 and the Pajero departed the scene by about 22:20).

Dr Holdgate said "having seen the footage of Tristan, I've never seen anyone as disturbed as Tristan was both in his inability to connect with the conversation around him [which must go to his capacity to co-operate with paramedics had they attended] and his level of physical distress and agitation [which must go to the ability of paramedics to safely assess him]." If the paramedics who attended were able to conduct a physical assessment, whether Tristan would have co-operated long enough to permit the administration of sedation, followed by a period of monitoring his response and the need for further sedation if required.

On this point, I reject the submission that having Tristan secured in a "small and contained area would have provided ambulance officers with ample opportunity to assess his vital signs and, if deemed appropriate, to potentially jab him with a syringe containing antipsychotic medication so as to calm him down". Associate Professor Holdgate highlighted the difficulties with this scenario in her evidence and concluded:

I think it's a big assumption to know whether that [referring to sedation via intramuscular injection] would have worked or not. It entirely depends on whether those drugs were effective. The initial dose of 10 milligrams in him was probably a relatively low dose so I think there would be no certainty that that would or wouldn't have been effective in an intramuscular dose. We just don't know. What follows from this is that, because intramuscular doses generally take about 15 minutes to "kick in" (if they work), Tristan either would have had to maintain co-operation during that time or be restrained during that time. Even if paramedics were successful in administering intramuscular sedation, their capacity to appropriately monitor Tristan would be limited.

Similarly, Scott Deeth, Acting Director of Clinical Practice at NSW Ambulance, expressed concerns about the ability of paramedics to administer sedation to a patient restrained in the back of a police vehicle: Administering medication to a patient held in the rear of a police vehicle who is still exhibiting violent behaviour is problematic. The patient would need to be removed from the vehicle and likely further physically restrained to ensure the safe administration of chemical restraint.

If the paramedics who actually attended were then authorised to administer droperidol (described by Mr Deeth as "the most effective" sedative). If not, they would have had to use midazolam. It is uncontroversial that it would have been desirable for paramedics to attend the Bangalow residence and to make their best attempts to assess and/or treat Tristan. However, I am cognisant of the resourcing limitations facing NSW Ambulance, and the need to factor in operational matters such as ambulance coverage. In these circumstances, the Court welcomes the recent opening of an ambulance station in Pottsville and the provision of additional services in the region. It is hoped that this will go some way in preventing a similar situation from occurring in the future.

Sergeant Keough's decision that police would take Tristan to Lismore Base Hospital

The decision to have BRU19 take Tristan to Lismore Base Hospital was made by Sergeant Keough. This is clear from the Incident Log, the VKG transcript, and Sergeant Keough's own evidence.

Sergeant Keough explained that he directed BRU19 to transport Tristan for the following reasons:

Tristan's reported violence, drug-affected and non-compliant state meant that it was unlikely that paramedics would be able to get near him;

Tristan was secured in the cage of BRU19 and it was not safe to open the cage if paramedics had attended. As a result, paramedics would not have been able to administer sedation; An ambulance had not yet been dispatched and Sergeant Keough had no information about how long it would take for an ambulance to arrive at Tristan's address; Sergeant Keough thought it was important for Tristan to be transported to hospital as soon as possible so that treatment could be administered. Sergeant Keough did not "call off" the ambulance. It was only once he directed that BRU19 should take Tristan to Lismore Base Hospital that the decision was then communicated to NSW Ambulance via an ICEMS message at 22:14.

Counsel Assisting submitted that:

It would obviously have been preferable for an ambulance to attend and attempt an assessment of Tristan. It is possible that this might have made a difference for Tristan. But the fact there was an option for police to wait for an indeterminate period for an ambulance to arrive (with whatever physiological sequela[e] might flow from Tristan's continued restraint in the interim) and possibly establish rapport with Tristan and possibly sedate Tristan and possibly transport him to Hospital with police assistance, does not mean Sergeant Keough was wrong in making the decision that he did in the circumstances.

In fact, the decision for BRU19 to transport Tristan to Lismore Base Hospital was sensible in the circumstances that existed on 18 January 2016. Tristan was a danger to himself and others. He needed help and as at 22:05 help from NSW Ambulance was not yet on its way. In making that submission, Counsel Assisting relied upon the following factors, most of which expand upon the matters raised at [63] above: Tristan was already safely secured in the back of the Pajero (although this was far from an ideal vehicle for him). Tristan was still agitated and aggressive.

Paramedics may not have been able to establish rapport and assess Tristan safely even if they had attended. Scott Deeth, Acting Director Clinical Practice, NSW Ambulance watched the DVD of Tristan in the back of the Pajero and expressed the view "Conducting an assessment of a patient exhibiting the behaviour of Mr Naudi is difficult. Had paramedics arrived before the NSW Police, I am doubtful that they would have been able to establish rapport and conduct any type of assessment. They may have assessed the situation and determined to 'stand-off' pending NSW Police arrival." When asked about the situation at hand, that is, with Tristan already in the back of the police Pajero and police present, Mr Deeth said he would expect paramedics to communicate and engage with the patient, attempt to de-escalate and try to conduct an informed assessment. He also noted that if they could not establish a line of communication, safety would be a paramount consideration for the patient, paramedics and bystanders. It is far from clear that paramedics would have been able to establish communication with Tristan.

Paramedics would not have been expected to enter the cage for the purpose of assessing Tristan. Mr Deeth said he would not expect paramedics to do so and any decision to remove Tristan from the cage and restrain him whilst administering sedatives and monitoring their effect would require assistance because of the need to handle the patient in a safe manner.

Associate Professor Holdgate gave expert evidence about medical assistance from the time that Tristan was detained in the Pajero until he reached the hospital. She said: It sounds from the description of his agitation and his inability to engage with his surroundings was severe. I don't think it would have been safe for anyone to do anything else. Until he could be contained with some sort of chemical sedation, I don't think it would have been physically possible to actually get close enough to provide any other treatment and certainly not to provide any monitoring or measure of any of his vital signs…it wouldn't have been possible [to cool him down] without containing him first.

In terms of restraining Tristan on a stretcher, Dr Holdgate said "I think it would have been actually very difficult to contain him on a stretcher. I've seen people close to that who have actually caused themselves injury by being restrained on a stretcher and then tipping the whole stretcher over because they're so physically agitated so I think that may or may not have been possible." Dr Holdgate further said "I think the choice has to be made at the time using the resources you've got for the safety of both him and all the people around him…but the alternative of bringing him in an ambulance with – manacled to the sides or strapped to the sides might have been very dangerous for the drivers, for the ambulance staff, for the police and may or may not have been physically actually possible to do, depending on his level of agitation so that also might have carried significant risks."

Droperidol "was only introduced for use in NSWA in November 2015" and whilst staff from the Northern Rivers Zone had been trained in its use by end January 2016, Scott Deeth could not say whether the paramedics who may have attended on 18 January 2016 would have completed training and been authorised to use the droperidol at that time. They may have been restricted to using midazolam. Neither Dr Holdgate nor Dr Murray suggested that midazolam was a more appropriate sedative for Tristan.

Even if sedation had been administered by paramedics this would have likely delayed Tristan's transport to hospital because "you can't then just put him unwarranted [query "unmonitored"] in the back of a police van and he may be too agitated to be put in the back of an ambulance so you would have to wait and see if it works and then that's just prolonging the delay to get to hospital." Further, Dr Holdgate noted that an initial dose of 10 milligrams in a young man of Tristan's size "was probably a relatively low dose so I think there would be no certainty that that would or wouldn't have been effective in an intramuscular dose." However, if sedation had been administered with good effect, the physiological stress Tristan was experiencing would have been reduced.

In circumstances where an ambulance had not been dispatched by 22:05, and for the reasons submitted by Counsel Assisting, I am satisfied that Sergeant Keough's decision that police would transport Tristan to Lismore Base Hospital was reasonable.

That said it is uncontroversial that transporting someone like Tristan, who is suffering from an acute behavioural disturbance, in a police vehicle is far from ideal. It would of course have been preferable for Tristan to be transported in an air-conditioned ambulance and, as outlined above, it is possible that this may have resulted in a different outcome for Tristan.

The decision that police would transport Tristan to hospital was consistent with the July 2007 Memorandum of Understanding for Mental Health Emergency Response ("2007 MOU"), which was expressed to apply to "persons with a known or suspected mental illness or mental disorder, or who exhibit behaviours of community concern."
The 2007 MOU provided:

- Police have obligations to transport, or assist in the transport of, a person to a health care or custodial facility under relevant Acts, legislative orders and warrants.

- Police assistance may be required by Ambulance in the pre hospital emergency setting to safely manage and transport behaviorally disturbed patients. This will be particularly relevant with restrained patients in the care of Ambulance, where Police presence is required to reduce the safety risks to the patient and Ambulance Officers.

- Police's role in other transport of mentally ill persons is limited to situations where there is assessed serious risk to the person or others such that Police presence (as escort or transport) is required.

This remains the position under the NSW Health – NSW Police Force Memorandum of Understanding 2018 ("2018 MOU"), which provides:

Police officers may transport a person detained under the MHA to hospital in a police vehicle. NSWPF policy indicates that such people should be transported in a police caged vehicle. However these vehicles are not designed for such transports and do not offer the ability to effectively monitor persons who have medical issues or serious mental health issues. Police vehicles should therefore be viewed as a last resort for transport.

Police vehicles should only be utilised where the person is at risk of serious harm to themselves or others or where their behaviour presents a threat to public safety, including a risk to paramedics during transport that cannot be safely managed by the paramedics, and the Police vehicle is the safest transport option. It is acknowledged that in remote areas of NSW, other considerations may apply.

The Court received into evidence a USB containing an online training module for police in the 2013–2014 training year on "Excited Delirium/Positional Asphyxia". In that module, the Chief Medical Officer for NSW Police indicated that police should not transport someone who they suspect is experiencing 'excited delirium' until the person has been medically reviewed. Sergeant Watt gave evidence that this remains the "preferred methodology" for dealing with someone with 'excited delirium' but acknowledged that it might not be possible in some circumstances.

The training module appears to dissuade police from transporting, even as a last resort, a person who they believed was experiencing 'excited delirium'. An issue might arise, particularly in rural and regional areas, where someone might wait for an indeterminate period of time for an ambulance to firstly become available and secondly travel to the incident, even whilst police are on scene and able to contain the person and leave immediately to take them for urgent medical review.

In this respect, Sergeant Watt said:

"if I was five minutes away from St Vincent's Hospital, I wouldn't be waiting for an ambulance, because I can have him to medical attention before the ambulance … gets there, … it is a difficult situation, ideally yes they should [wait for an ambulance] but there are circumstances where an alternate methodology designed to get a better result, is acceptable."

The training module is inconsistent with the 2018 MOU and accordingly has the potential to mislead. I accept Ms Bennett's submission that there is no evidence that any of the police officers involved in Tristan's case were actually misled by the training module. However, I consider it desirable that the inconsistency be corrected.

The NSWPF Mitsubishi Pajero

During the course of the inquest, an issue arose as to the appropriateness of restraining and transporting Tristan in the cage of the Pajero. The caged area of the Pajero does not have air-conditioning. There are only two small fans in the caged area. Senior Constable Chaffey indicated that the cabin of the Pajero has air-conditioning and the fans would suck in a small amount of cool air, but this was not equivalent to being in the cabin.

I accept Associate Professor Holdgate's evidence that the poorly ventilated small space in the cage of the Pajero contributed to Tristan's physiological stress, particularly as Tristan had a high body temperature from his response to the MDMA. I also accept that it is likely that Tristan injured himself by struggling and bashing his head and body against the cage in the back of the Pajero. The cage was not padded and Sergeant Watt gave evidence that he was not aware of any NSWPF vehicle having padding in the cage.

In relation to the Pajero, Senior Constable Greenhalgh said: "obviously we're only last resort [for transportation], but you know, it's obviously the worst place for someone suffering from mental illness or drug-affected people". Counsel Assisting submitted that the Pajero was not a suitable vehicle. It was hot and cramped and despite the handcuffs, Tristan most likely inflicted further injury on himself because he was able to move around in the cage. Ideally, even if not taken by Ambulance, Tristan would have been safely secured within a large air-conditioned space, where police could monitor him on the trip and where he could have been restrained in a way to limit further injury to himself. Similarly, Ms Bennett conceded that the Pajero was "not ideal" but noted that it was the only police vehicle available in the area at the time.

Evidence was received from the NSWPF that Pajeros are the predominant first- response vehicle in the Tweed Byron Local Area Command (LAC) (as the Tweed Byron Police District was known at the relevant time). The vehicles are suitable for use in the highly diverse terrain within the LAC, including on beaches, mountainous tracks, flooded areas and other remote areas. The NSWPF indicated that a Pajero was not specifically selected and that the officers who accepted the job over the VKG happened to be in a Pajero. Sergeant Keough indicated that the only vehicles patrolling the Tweed Heads, Murwillumbah, Kingscliff, Brunswick Heads and Byron Bay areas on the evening of 18 January 2016 were Pajeros. There was one other vehicle in the Byron Bay area, described in evidence as the "ice-cream truck". However, that vehicle was not on patrol and was for use by the shift supervisor in the event that they needed to attend an incident or job. A Ford Ranger was available in Mullumbimby but it was not on patrol on the night. Sergeant Keough also indicated that Highway Patrol sedans operated within the LAC but those vehicles are not equipped to transport detained persons.

In these circumstances, I accept that the use of the Pajero for transporting Tristan to Lismore Base Hospital was far from ideal and it undoubtedly contributed to Tristan's physiological stress. However, it was the only available option at the time because at 22:05 an ambulance had yet to be dispatched. In these circumstances, I am not critical of police for transporting Tristan in the cage of the Pajero.

However, in light of the evidence from Associate Professor Holdgate and the concerns expressed by Senior Constable Greenhalgh as well as Tristan's family, the Commissioner of the NSWPF may wish to examine the use of the Pajero and other similar vehicles for transporting mentally ill or drug-affected individuals and may wish to give consideration to how these or other vehicles might be upgraded to ensure that those restrained in the cage are safely transported to hospital.

The delay in bringing Tristan into the isolation room at Lismore Base Hospital

Lismore Base Hospital staff including Dr Murray, RN Culpitt and RN Longmuir was all aware police were on their way with a new patient but they already had another patient in the isolation room. According to the timestamp on the CCTV footage from Lismore Base Hospital, BRU19 arrived at approximately 10:41pm. However, Tristan was not immediately brought into the isolation room.

The CCTV footage shows BRU19 moving closer to the entrance to the isolation room at 10:57pm. Tristan therefore spent approximately 16 minutes in the cage of the Pajero after arriving at hospital and before being carried into the isolation room. This was in addition to the time Tristan spent in the cage whilst decisions were being made at Tristan's house for police to take him to hospital (about 17 minutes) and the time it took for BRU19 to travel to Lismore Base Hospital (about 21 minutes).
Tristan was therefore in the cage in the back of the Pajero for approximately 54 minutes before being transferred into the isolation room.

I accept the submissions of Counsel Assisting and Mr Evenden that this additional period of confinement would have further contributed to Tristan's physiological stress. It follows that the sooner Tristan was safely removed from the cage, the better. In this respect, it is significant to note the opinion of Associate Professor Holdgate that:

Having seen the video footage of Tristan, I've never seen anyone as agitated as he was and I very much doubt the hospital would have any expectation that he was as ill as he was…it's always a struggle to manage the limited physical space and work out how you're going to move people around safely to prepare a room so even though the ideal would be the room would be vacant and all the staff ready when he arrives, I don't think anyone could have predicted he would have been as distressed as he was.

Dr Murray developed a clear plan, which he communicated to Dr Edwards and other staff. The plan involved:

Observing and assessing Tristan while he was in the cage of the Pajero;

- Preparing the isolation room, which included moving the patient that was in the isolation room at the time, removing the bedframe and placing the mattress on the floor;
- Discussing the use of intravenous droperidol and diazepam with Dr Edwards and instructing a nurse to draw up the medication;

- Bringing the patient in once the isolation room was ready. Dr Murray and Dr Edwards both wanted to observe Tristan being brought from the Pajero into the isolation room. Dr Murray said "it would have given me a little bit of feeling how disturbed ... violent, aggressive he was." Dr Murray also wanted to be the person to decide when Tristan would be brought in from the Pajero. He said this was not the usual course but in this case he wanted to "immediately insert an intravenous cannula and sedate him. But I wanted everything ready before it, so we didn't have a long struggle or restraint in the room."

- Administering the intravenous droperidol and diazepam as soon as possible under Dr Murray's supervision;

- Determining further treatment once Tristan was adequately sedated.

In relation to Dr Murray's plan, Associate Professor Holdgate said "I think that's exactly the plan that you would want to enact". In these circumstances, I accept Counsel Assisting's submission that the delay in getting Tristan out of the cage was undesirable but the need to move another patient and prepare the isolation room for Tristan were legitimate considerations for the hospital to take into account. Since Tristan's death, Lismore Base Hospital has moved to a new facility which includes two isolation rooms for use in the Emergency Department, which Dr Murray described as adequate for their needs.

Transferring Tristan from BRU19 into the isolation room

The decision to bring Tristan into the isolation room

When asked how he learnt that the hospital was ready for him to bring Tristan into the isolation room, Senior Constable Chaffey said "I'm not entirely sure but I believe that the, the door to the room that I knew that he will have to go into opened and that, that signalled that we were right to go in there." Senior Constable Chaffey did not recall anyone telling him they were ready for Tristan to be brought in but said that it "could have happened". Senior Constable Greenhalgh assumed that the decision to bring Tristan in "would've been" because hospital staff said they were ready but he had no recollection of the actual direction given.

Of the nurses who provided statements in relation to Tristan's death, they were either not in the room themselves when Tristan was brought in (Donna Jelsma, Kim Sterling, April Cupitt, Wendy Longmuir) or cannot assist in determining who, if anyone, gave the direction to police (Xanthe Moss). Rohit Bhagat, a security guard at Lismore Base Hospital, refers to an unidentified female nurse who, on his account, said to one of the police officers "you restrain him down and we will inject him" shortly before the police positioned themselves at the back of the Pajero and opened the door. The CCTV footage appears to show some discussions between police and nursing staff at various points before the Pajero is reversed closer to the door to the isolation room.

Unfortunately because the camera is focussed upon the main ambulance entrance rather than the entrance to the isolation room the CCTV does not record Tristan being moved from the Pajero. The footage does seem to capture a nurse in conversation with one officer (most likely Senior Constable Chaffey) as he gets out of the Pajero having reversed it into place. If a direction was made by hospital staff to police to bring Tristan in, hospital records do not record who communicated that direction. Based on the evidence, I am unable to determine who made the decision to bring Tristan into the isolation room from the Pajero.

Regardless of who made the decision to have Tristan brought into the isolation room, it is clear that this part of Dr Murray's plan was not properly executed. As a result, Dr Murray and Dr Edwards were denied a valuable opportunity to observe Tristan's behaviour as he was brought into the room. I accept, however, the submission of Mr Jackson that other key aspects of Dr Murray's plan as outlined were in fact implemented. This will be discussed further below. Counsel Assisting submitted, and I accept, that it is difficult to generalise from the specific failure to execute Dr Murray's plan on this occasion, in order to draw a conclusion that this was part of a systemic failure on the part of the hospital.

In any event, the Northern NSW Local Health District has since implemented a policy entitled "Transfer of a patient from a police vehicle into a gazetted emergency department safe assessment room", which makes clear that "[t]he Nurse in Charge is responsible for advising the Police to enter the emergency department with the patient."

The method of transferring Tristan into the isolation room

The evidence differs in relation to how Tristan ended up being placed face down on a mattress in the isolation room with his head facing towards the door.

Senior Constable Chaffey said that he reached into the cage of the Pajero and grabbed Tristan's left leg. Tristan at first kicked out and his toes hit Senior Constable Chaffey's face and his heel connected just above the police shirt pocket. Senior Constable Chaffey then grabbed Tristan's left leg whilst Senior Constable Greenhalgh took his right leg. Senior Constable Ellis then stepped in to help on Tristan's right hand side. On Senior Constable Chaffey's account, Tristan "flipped over" as they grabbed his legs and he ended up face down. Senior Constable Greenhalgh said that as they lifted Tristan out of the Pajero he came out feet first and somehow ended up face down. He indicated that prone restraint was not a deliberate choice and agreed that it resulted from the way in which Tristan was removed from the Pajero.

Senior Constable Greenhalgh also recalled that "one of the staff", he presumed hospital staff, directed them to put Tristan down on his stomach. Senior Constable Griffith recalled a female voice asking that Tristan be "on his stomach to go into the room to make it easier to put the cannula into his arm." Senior Constable Ellis recalled a discussion between police and hospital staff that included police saying, "We'll carry him facedown … with his legs and by his arms so therefore obviously 'cause he had blood and snot and shit down on his face and obviously we don't want to get a) spat on … b) any blood off him onto us … and then the medical staff, I'm not sure if it was before we lifted him out or got him into the room, requested he be placed facedown." The following entry appears in Senior Constable Ellis' notebook: "I said bring him out face down as he had a nose/mouth injury blood and in his ranting was spitting blood for officer safety and infectious diseases".

In cross- examination, Senior Constable Ellis said "it might have just been a mere suggestion, but that's the best way to do it" and maintained that he did not make the decision to bring Tristan into the isolation room face down. Clinical Nurse Specialist Wendy Longmuir was not in the room when Tristan was brought in but gave evidence that patients brought in from a police vehicle are "brought into the room and held down by the shoulders and their thighs and their ankles, if we've got enough people to do that. And that's normally facedown."

Mr Evenden submitted that that the Court should find that there was a direction from hospital staff that Tristan be placed face down. In contrast, Counsel Assisting, Ms Bennett and Mr Bradley submitted that the evidence does not allow for any finding as to who made the decision to bring Tristan into the isolation room, or whether a direction was given that he be placed face down.

I am not persuaded that the evidence permits a finding that Tristan was placed face down because of a direction from hospital staff. I cannot exclude the possibility that, as Mr Bradley submitted; the method ultimately adopted may not have been intentional or planned and may have been the product of a combination of police effort and Tristan's resistance and struggle. Given Tristan's presentation, I am not satisfied that there was anything unreasonable in the manner in which Tristan was brought into the isolation room.

Submissions on behalf of Vincent Naudi were critical of the fact that Tristan was brought in face down with his head the wrong way around (facing towards the door), noting that Dr Murray would have preferred that Tristan's head be at the other end of the room. As a result, once Tristan was found not to be responding, he had to be turned around to face the medical equipment.

Mr De Brennan submitted that, as a result, valuable seconds were lost. I accept that some seconds must have been lost because of this but I am not critical of that fact given the circumstances confronting police and hospital staff at the time. In this respect, I accept the evidence of Associate Professor Holdgate that:

I think he was brought in the only way that was physically possible from the description that I've read ... The description I read was that the only way they could extract him from the van was to get his legs first, he then flipped on his face and they then had to take him out backwards and that's how they entered because they were right backed up [against] the door. My understanding [is] that's why he entered the room in the direction. Whether he came in head first or foot first, I don't think it really mattered.

Dr Murray gave evidence that because Tristan was handcuffed behind his back, he could not have been restrained on his back as this would prevent the insertion of a cannula. Dr Murray indicated that a short period of prone restraint was required to allow for intravenous access. Dr Murray further stated that while it was possible for police to move the handcuffs from the rear to the font, he considered that it would have been "very dangerous" and would have delayed the administration of the sedation.[175] However, Dr Murray indicated that if Tristan had been brought in with his hands cuffed to the front, then he would have been restrained on his back or on his side. Associate Professor Holdgate gave evidence to a similar effect.

I accept this evidence.

As outlined earlier in these findings, it seems to me to have been reasonable for police to handcuff Tristan to the rear when they arrived at Bangalow and when they expected Ambulance to attend. Unfortunately, and as Mr Evenden has submitted, the ramification of that earlier decision was that Tristan came to be restrained face down when he arrived in the Isolation Room.

Restraining Tristan within the isolation room

The evidence demonstrates that Tristan still required restraint when he was placed face down on the mattress in the isolation room. This does not appear to be in issue between the parties. The main issue appears to be the manner in which Tristan was restrained. In any event, it is useful to set out the observations of various witnesses.

Lloyd Marsh was a bystander across the road from the emergency department entrance. He saw four officers carry Tristan from the Pajero into the isolation room. He said:

The male had the strength to move all four Police officers quite easily by thrashing his body about. The Police were struggling to walk forwards with the male into the Emergency Department as they were trying to restrain the male…Once they were inside the doors to the Emergency Service Entrance were shut but I could still hear the male yelling, bellowing and screaming.

Dr Karpa was, unexpectedly, the first doctor in the isolation room. He inserted the cannula that Dr Edwards then used to administer the droperidol and diazepam. Dr Karpa said that when he went in to help he saw "the doors to that room open and the back of the paddy wagon…and I saw the gentleman who was being restrained um, violently thrashing around." According to Dr Karpa, as Tristan was being carried in he was "out of control…he was violent and he was dangerous."

Dr Murray was asked whether, when he entered the isolation room to see Tristan already restrained face down, w e r e t h e r e other restraint options? Because he was extremely disturbed, he was also handcuffed with his forearms behind his back." Dr Murray also said if Tristan had not been restrained at that point "there would be a high risk of him, without being restrained we would be unable to insert the cannula and get him sedated and whilst so agitated there was a risk of ongoing physical damage/injury." Associate Professor Holdgate noted, and Dr Murray agreed, this would also have put Tristan at risk of cardio-respiratory collapse and multi-organ failure.

Dr Murray also said, in relation to the need for continued restraint:

"My priority was to get him, those drugs in and to get him sedated as soon as possible. There was a sweaty forearm; a cannula could be, with a violent movement, could fall out at any moment. If you like there is a window of opportunity to get those drugs in and to sedate this patient before further harm. And that was my focus and then we would look after it, bang, bang, sedated, we'll look after everything else".

Whether there was a knee on Tristan's back

There is a dispute as to whether one or more of the police officers placed their knee or knees on Tristan's back.

In terms of where police were stationed as they restrained Tristan face down on the mattress, most of the witnesses (with the exception of Dr Karpa) recall two officers at the top end and two on Tristan's legs. According to Senior Constable Chaffey, he had his leg on Tristan's left leg to stop him from kicking around and also had his right hand around Tristan's left wrist and left hand on Tristan's left elbow. Senior Constable Greenhalgh had his leg on Tristan's right leg. Senior Constable Griffith had the shoulder on the left hand side. Ellis was on Tristan's right hand shoulder. Senior Constable Chaffey recalled that Tristan was still moving around (at least initially) and that is why he had to put his hands on Tristan's wrist and elbow.

According to Senior Constable Greenhalgh, he initially had Tristan's right leg pulled back "stretching his thigh…I …had my knees down on, I'd say, back of his legs, and hamstring area probably." At this stage Tristan "was still kicking. I was, with my, body weight and my gun belt I'd be over a hundred kilos, and I was getting lifted."

According to Senior Constable Griffith, she had her knees touching Tristan's torso but not on top of him.

At a later point she had her hand very lightly on his head every time he moved in her direction but denied putting pressure on the back of his head so that his face was pressed into the mattress. Senior Constable Griffith described Tristan "thrashing around" when police were trying to hold him on the mattress. According to Senior Constable Ellis, he had Tristan (initially at least) "from the chest up" whilst "the main pressure to stop him from kicking out was down sort of from his hips". At some point Senior Constable Ellis then put his knee near the small of Tristan's back resting up against Tristan but with the downward force of his knee on the mattress. There were also times when Senior Constable Ellis had to apply pressure to Tristan's shoulder.

Dr Murray "didn't observe direct pressure, going down on the chest, [Tristan] was being restrained at the shoulders … and I remember having a very clear view of the back area, and the arms and the placement of the cannula." He did not see police officers with their knees on Tristan's back: instead he said he had "a picture of the knees being sort of against the body with the force of their upper bodies pinning the shoulders." Dr Edwards observed that "two of the officers were, uh, pressing on his upper thigh…and another two of the officers were at the top end, um, pressing, I think with both hands, onto his shoulder, upper chest area." Tristan was being "firmly restrained" or "very firmly held" prompting Dr Edwards to say, prior to administering the IV medication, to the officers at the top end of the mattress, "Can you please make sure the patient can breathe in that position?"

Dr Edwards recalled officers at the top of the mattress kneeling with their knees "probably on the head of the mattress" and she agreed with a question asking whether they had their hands "sort of on the…the shoulder blade, chest area." Whilst none of the officers recalled hearing Dr Edwards say "Can you please make sure the patient can breathe in that position?" this does not mean it was not said. This was a busy and noisy room and people were focussed upon the task at hand such that they may not have heard everything that was beingsaid.

Further, Rohit Bhagat, a hospital security guard, recalls the female doctor saying "We can take a little bit of weight of [sic] him."

Similarly Dr Karpa recalls saying "Get off the chest, get off the chest" although none of the officers recalled hearing this. As for Dr Edwards, this does not mean that Dr Karpa did not say those words. In addition to these warnings, Senior Constable Chaffey said he said words to the effect of "just be mindful of positional asphyxia." All of the other officers reported hearing this from Senior Constable Chaffey and Dr Karpa heard something similar, although not identical.

Other hospital staff observed the restraint. Registered Nurse Longmuir recalls one officer on each shoulder (female officers) and one on each thigh (male officers). She said "I did not observe anything I would consider to be excessive in the restraint and I did not think the police were using any more force than I would have used if I had been involved in the restraint." Clive Guthrie, a hospital wards man, was only in the room for about 30 seconds but remembered seeing two officers holding the shoulders down and two holding the ankles (his vision of these last two police was partly obscured by the officers closer to Tristan's shoulders).

He said "the police at the top part of the male patient had one of their hands on the shoulder blade area and were kneeling on the ground next to the male patient."

Rohit Bhagat recalled there being a female officer on the patient's left shoulder, male officer on the other shoulder and an officer on each leg, with their knees pressed onto a leg each. Further "while the patient was on the ground he was fighting to get up. He was using his head in a head butting type motion. I don't know if he was fighting or trying to breathe … I saw the police woman push his head down at one stage. She didn't hold his head down." Dr Karpa had a different recollection of how Tristan was restrained. He was the only witness to recall that the police had their knees on the back of Tristan's chest.

In his interview with investigating police, Dr Karpa said "they had at least two officers I think, possibly four, with their knees on his chest" and another officer to Dr Karpa's right. Then he said there must have been two officers on the chest, and one on each leg. Dr Karpa recalled that a police officer to his right "who might have been Asian or some dark skinned person" said "careful about something asphyxiation". This corroborates Senior Constable Chaffey's evidence of mentioning something about positional asphyxiation although Dr Karpa said he does not recall the word "positional" being used before "asphyxiation".

Dr Karpa said that the officers who had their knees on Tristan's back had "pretty much all their weight on him. And they needed to put all the weight to stop him from moving. And even with that he was still moving." He recalled "two knees, one each side, and they were big blokes and they were just, all the pressure on his chest." During cross-examination, Dr Karpa said that there was one officer on the left-hand side of Tristan's shoulder who had one knee on the back of Tristan's chest and another officer on the right hand side with one knee on the back of Tristan's chest. He thought that both of these officers were male although he conceded he could be mistaken because what he remembered was the knees.

Later in his evidence Dr Karpa said: "where does it say in my evidence that the police officer who was in charge of the left shoulder of this patient had their knee on the chest? …that doesn't mean that it was the person at the top left hand side of the patient who was putting it on there. The other officers were coming from the bottom right-hand side, and that is where they would've got access to the back from." He said there were two quite large male police officers "both coming from the right hand side, but, they had a knee on each side of the chest."

In an attempt to clarify Dr Karpa's evidence, Counsel Assisting asked a series of questions, limited to the time that he was inserting the cannula into Tristan's left arm. Dr Karpa's evidence was that at that time there was one officer on the left leg. There was another officer on the right-hand side with his left knee on the right side of the back of Tristan's chest, and his leg then "sort of coming down over the patient's backside." A third officer was on the left-hand side on the shoulder, holding down Tristan's shoulder and arm but with no knee on the chest at all. A fourth officer was on Tristan's right-hand side, midsection but more towards the feet probably. Ultimately, Dr Karpa said "what sticks in my head the most, what I can see most vividly is a … police officer on his back with his knee in his back" but it was possible that there was only one knee.

Dr Karpa remained adamant that at least one officer had a knee on the back of Tristan's chest. He said that the "knee being on the chest is something I remember very vividly cause I could see it being a problem".

Mr De Brennan submitted that Dr Karpa's evidence should be accepted. He noted that, as a locum doctor, Dr Karpa bore no allegiance to any of the parties concerned. Mr De Brennan further submitted that, despite Dr Karpa being at cross-purposes at times during his evidence, he was decisive in his conviction that one of the officers had his knee on Tristan's back. Similarly, Mr Evenden submitted that Dr Karpa's evidence was internally consistent and consistent with the evidence from other witnesses which was that Tristan was firmly restrained.

Mr Evenden submitted that aside from a concession that it was possible that there was only one knee on Tristan's back, any confusion in Dr Karpa's evidence arose from incorrect assumptions as to where particular officers must have been. In this respect, Dr Karpa said:

"I'm confused about the way it's been presented to me, yes, cause you're talking about this person on the left hand side being a female, putting her knee on the chest. But that's, that's not how I've recalled it in any of my evidence and it's not something that I remember happening".

As outlined above, Dr Karpa's evidence shifted on a number of occasions. First, in his interview with police, he suggested that there were two or possibly four officers who had their knees on Tristan's back. Later in his interview, he suggested that there were two knees on Tristan's back coming from opposite sides of Tristan. He reiterated this view in cross-examination but later said that there were two knees coming from the right side. Ultimately, Dr Karpa conceded that it was possible that there was only one knee on Tristan's back. This inconsistency detracts from the reliability of Dr Karpa's evidence notwithstanding Mr Evenden's submission that Dr Karpa may have been confused by incorrect assumptions by various counsel during cross- examination. It is significant that no other witness observed any knees on Tristan's back. In this respect, I accept Mr Bradley's submission that Dr Karpa was focussed on inserting the cannula whereas Dr Murray, who was present in the isolation room at this time, was in charge of Tristan's overall management and supervised the administration of droperizol and diazepam. Dr Murray did not raise any concerns as to the manner of Tristan's restraint. Significantly, in response to a question about who is in charge when police are restraining someone in a hospital setting, Dr Murray said:

"Well the doctor in charge is in charge of the medical care and if, if I was that doctor and I was concerned about the way the restraint was being carried out, then I would communicate that concern to the police and ask them to modify the restraint. That is an approach I have always followed."

I accept that if Dr Murray had had concerns about the way in which Tristan was restrained, he would have voiced them. In these circumstances, I prefer the evidence of Dr Murray, other hospital staff members as well as the four police officers to Dr Karpa's. Their evidence was credible and broadly consistent. Accordingly, I am unable to accept the evidence of Dr Karpa that there was a knee or knees on Tristan's back while he was being restrained in the isolation room. Even if one of the officers did have a knee on the back of Tristan's chest for a short period, this was not inconsistent with police policy as set out in the NSW Police Force Handcuffing Manual Version 5.3, February 2014 or the NSW Police Force Weapons & Tactics Policy & Review Close Quarter Control Version 2.2.

The use of prone restraint

Prone restraint increases the risk of respiratory restriction and physiological stress. Other factors may also contribute to an increased risk. In Tristan's case, Associate Professor Holdgate described the risk in the following terms: Face-down restraint has a recognised risk of positional asphyxia and this risk increases with the length of time that the patient is held face-down. Most guidelines recommend no longer than 2-3 minutes in this position. Patients who are drug intoxicated, such as Tristan, may be at greater risk for positional asphyxiation. In addition, Tristan was showing signs of significant physical stress prior to being placed in this position and may have been more susceptible to the effects of lower oxygen levels.

Associate Professor Mark Adams, cardiologist, described the risk involved in physical restraint (not limited to prone restraint) as follows:

… with physical restraint it is likely that there would have been increased physical exertion on the part of Tristan and this may have resulted in increased sympathetic drive, increased blood pressure and temperature leading to increased cardiac demand and increased risk of cardiac arrhythmias. Therefore I think that physical restraint may have indirectly had some contribution to Tristan's death.

In contrast to Associate Professor Holdgate on the topic of positional asphyxia, Dr Clifton, forensic pathologist, said that the issue of positional asphyxia causing respiratory compromise in the setting of prone restraint is contentious. There have been multiple studies exploring respiratory compromise during prone restraint with and without pressure on the back and it has been concluded that the prone position is physiologically neutral and respiratory compromise was never established.

Nonetheless, Dr Clifton agreed that restraint was more broadly a likely factor in Tristan's death because "restraint, especially prolonged and active in the context of acute … MDMA toxicity would produce significant physiological stress to the body." I accept Counsel Assisting's submissions that the risks associated with prone restraint needed to be balanced against the risk that, without effective restraint, doctors would not have been able to administer sedation which, given Tristan's disturbed behaviour, would have posed a serious risk itself. In this respect, I accept Associate Professor Holdgate's evidence that:

There's a risk. At that stage everything is a risk. Leaving him untreated is a huge risk. The actions required to treat him carry a huge risk. Similarly, in her report, Associate Professor Holdgate said:

"Essentially the treating clinicians were faced with the dilemma of leaving Tristan untreated, causing significant injury to himself and a risk to others, and likely to clinically deteriorate with eventual cardiorespiratory collapse and multi organ failure, or actively treating him with immediate sedation but knowing that this required him to be held still in a potentially dangerous position while the drugs are administered".

I accept that prone restraint is a valid choice in circumstances that compel its use, provided that it is only used for as short a period as possible. However, Mr Evenden submitted that no clinical staff took any steps to limit the duration of the restraint, other than their obvious efforts to sedate Tristan as soon as possible. It was also submitted that Tristan's restraint in the isolation room was impacted by the unplanned manner in which he was brought in.

Similarly, Mr De Brennan referred to Associate Professor Holdgate's report, in which she opined:

My main concern regarding Tristan's care was the movement of him from the van to the isolation room and being placed in face-down restraint without appropriate planning and without the senior medical staff aware that this was happening. Because of the high risk associated with placing Tristan in restraint, particularly face-down, this process should have been carefully planned so that Tristan was brought into the isolation room only after all necessary medications had been drawn up, all staff fully briefed regarding their role in restraint and administering medications, and appropriate preparation to place Tristan on cardiorespiratory monitoring as soon as he was sedated.

It appears that the uncoordinated movement of Tristan into the isolation room led to him being restrained for longer than necessary while drugs were still being drawn up and with no preparation for post-sedation care. As senior medical staff entered the room Tristan was already in face-down restraint despite no apparent discussion between police and senior medical staff about how the process of achieving sedation should be managed. The level of restraint required to keep Tristan still enough to receive medications was understandably high, and the use of the brief period of face-down restraint was not unreasonable. But the importance of limiting this restraint to the shortest possible time to minimise the risk of respiratory restriction in a patient who was already demonstrating high levels of sympathetic overdrive was not appreciated. I address the evidence as to any delay in drawing up the medications at [187]ff. I address the evidence as to whether the risk of respiratory restriction was not appreciated at [195]ff.

Dr Murray said the following:

"All I can say is I'm very aware of the danger of prone restraint. But that I thought that it was essential in this situation and everything that I did was to try and minimise the time of prone restraint and the time from being removed from that paddy wagon to being adequately sedated so that we could remove the handcuffs and get him out of the prone position, monitor and look after him. And everything I did was directed from that from the beginning". Dr Murray also said that "we don't like the prone [position] unless there … is no alternative" but in Tristan's case he "felt there was no alternative." In terms of the possibility that once Tristan was in the isolation room, police might have removed the handcuffs so Tristan no longer had his hands behind his back, Dr Murray said:

That was a possibility but I would judge that it would be very dangerous to do so and would've delayed the time for the administration of the sedation, because once the cuffs were removed, given his behaviour, there may have been an ongoing struggle; there was a risk of someone being hurt, and then it could be quite time consuming to get them back on.

Associate Professor Holdgate agreed that it would not have been safe to remove the handcuffs because Tristan was "so difficult to contain because he was so agitated". It is unclear how long Tristan was restrained in the prone position. The CCTV footage suggested that Tristan was removed from the Pajero shortly after it reversed closer to the door at 22:57. This was largely consistent with the Hospital progress note that recorded Tristan being brought into the isolation room at 22:58.

Dr Karpa saw Tristan being carried into the room and moved to insert the cannula once Tristan was restrained on the mattress. The progress notes record Dr Karpa inserting the cannula at 23:59 (presumably a typographical error which should read 22:59). Dr Karpa recalled a delay between the cannula being inserted and the medication being drawn up. In his interview with police, he said that by the time he inserted the cannula, Tristan had probably been in the isolation room for "several minutes". He said that the medication had not been drawn up by the time he inserted the cannula.

However, Clinical Nurse Specialist Wendy Longmuir recorded a nursing progress note that suggested she drew up the medications outside the isolation room (consistent with Dr Murray's explicit plan that the medication be ready before Tristan was brought in) and carried them into the isolation room as Dr Karpa was inserting the cannula. That note also recorded the droperidol being administered by Dr Edwards at 23:00 and the diazepam being administered at 23:02. Clinical Nurse Specialist Longmuir also gave evidence that "the medication was drawn up and ready to go by the time they had the cannula in". She remembered this because she was "standing in the room with it in [her] hands".

Dr Murray did not think there was a delay. Nor did Dr Edwards recall a delay. The evidence indicates that Tristan was restrained face down in the isolation room for approximately four minutes. The cannula was inserted at 22:59. The droperidol was administered at 23:00 and the diazepam was administered at 23:02. The slight delay between the administration of the droperidol and diazepam is explained by the saline flush. Associate Professor Holdgate accepted that this timeframe was reasonable and noted that: It more than likely may have been less than that. The common approach would be to inject, flush and then immediately inject the second drug so I think two minutes would probably be the maximum difference between the two drugs being administered.

The weight of the evidence, which I accept, is that the medication was ready by the time Dr Karpa inserted the cannula. Accordingly, I am satisfied that there was no significant delay in the administration of sedation. Dr Murray could not have known precisely how long Tristan had been restrained in the prone position because he was not present when Tristan was brought into the isolation room. When Dr Murray was asked about the fact that he was missing the vital piece of evidence as to how long Tristan had been restrained, he said: I can't see how if I'd been if someone had told me the number of minutes, it would have changed my actions from the point I entered that room.

Dr Murray's first priority was sedation. Counsel Assisting submitted that Dr Murray was keenly aware of the risks in Tristan's case, including the risk of "sudden death occurring during prone restraint".

Dr Murray was an impressive and thoughtful witness and I accept his evidence that he was aware of the risks associated with prone restraint and that he took steps to minimise the amount of time that Tristan was restrained face down. In these circumstances, I do not find that there was anything unreasonable about the way in which Tristan was restrained while he was in the isolation room.

Policies and Guidelines on the use of prone restraint

Health Guidelines

I accept that the way in which Tristan was restrained was largely consistent with Health guidelines, memorandums and policies at that time including:

Memorandum of Understanding Mental Health Emergency Response, July 2007, NSW Health, Ambulance Service of NSW, NSW Police Force. "Restraint" was addressed at part 7.3. Whilst it did not specifically refer to prone restraint, the memorandum did not prohibit its use provided it was "consistent with the policies and procedures applying to the respective agencies."

Health Policy Directive, Aggression, Seclusion & Restraint in Mental Health Facilities in NSW, PD2012_035, which also applied to the "care of mental health consumers in Emergency Departments that are declared mental health facilities" and specifically addressed restraint and seclusion processes at page 9 and following. This directive specifically provided: "Face down restraint should only be used if it is the safest way to protect the patient or any other person. If face down restraint is used, it will be time limited. The maximum time a person will be held on the ground in face down restraint is approximately 2-3 minutes to allow sufficient time to administer medication and/or remove the person to a safer environment."

Although Mr. Evenden accepted that prone restraint was a valid choice in the circumstances, he submitted that it should have been for no more than two to three minutes, or substantially less given Tristan's risk factors. Obviously this would have been preferable but I accept that Tristan's presentation necessitated prone restraint for a slightly longer period. As referred to above, I accept the evidence of Dr Murray that he was "very aware of the danger of prone restraint" and trying to "minimise the time of prone restraint". Health Policy Directive, Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint, PD2015_04 which contemplated the use of prone restraint but only as a last resort and for the shortest period possible.

The Ministry of Health Guideline Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments GL2015_007 took a different approach. Whilst the Guideline made clear that it "does not replace clinical judgment", it also read: "Avoid restraining patient in a prone position as it places the patient at high risk of respiratory restriction". Counsel Assisting submitted that this appears to be inconsistent with the abovementioned policy directives that permit prone restraint although only where necessary and for a short period of time. However, Mr Bradley submitted that the document makes clear that "this is a Guideline only" and it does "not replace clinical judgment".

Mr Bradley further submitted that the Guidelines are to be read subject to the two health policy directives referred to above, being PD2012_035 and PD2015_004, and in any event the word "avoid" is not prohibitive in effect but is ordinarily read as having a cautionary effect. I accept that the Guideline is only a Guideline however, if it is meant "to guide" then it seems sensible that it guide in a way consistent with the health policy directives. I do not propose however, to make a recommendation relating to this Guideline, particularly in circumstances where the Ministry of Health is not a party of sufficient interest in these proceedings.

Police Guidelines

The NSWPF Handcuffing Manual and the Weapons & Tactics Policy and Review Close Quarter Control policies both permit prone restraint if it is reasonably necessary. Sergeant William Watt, a Senior Operational Safety Instructor, said the following in his statement: … there are very few outright prohibitions on the use of any technique, and even where there are, there is an acceptance organizationally that breaching a policy may be appropriate in specific circumstances in order to prevent a significantly worse outcome.

In response to a question about whether there is a time limit as to how long it is safe for police to restrain someone in the prone position, Sergeant Watt said: To be fair, that's because I am not aware of any safe time limit and it's – and fundamentally the struggle continues as long as the struggle continues, if I haven't got them under control for whatever purpose I need them under control and that takes, five, eight, ten minutes, then it's difficult to put a time limit and say okay after two minutes you can't use the prone restraint technique anymore, it's practically impossible.

The weight of the evidence is that the use of prone restraint by police is permitted if it is reasonably necessary in the circumstances. Having regard to the evidence of Associate Professor Holdgate and Dr Murray about the need for Tristan to be restrained given his level of agitation, I am satisfied that police acted in accordance with the abovementioned policies. The NSWPF Guidelines on the Management of People Affected by Methylamphetamine and Other Stimulant Drugs ("NSWPF Guidelines"), however, advised police to "[a]lways ensure that the person is not in the prone position as this can also increase the risk of positional asphyxia." Although Ms Bennett submitted that this is just a guideline, Sergeant Watt accepted that it reads as an outright prohibition.

The inconsistency between the NSWPF Guidelines and the manuals and training that Sergeant Watt gave evidence about was described by Sergeant Watt as "extremely" undesirable and potentially confusing. I accept Sergeant Watt's evidence in this respect. The NSWPF Guidelines otherwise provide useful information about the way that MDMA use can affect pain tolerance and lead to an increased risk of positional asphyxia. They helpfully identify additional risk factors that might contribute to increased demand for oxygen when an individual is highly stressed.

'Excited delirium'

The 2013-2014 training package focused on 'Excited Delirium' which the Chief Medical Officer described as a "mental condition".

Dr Glen Smith, Consultant Clinical and Forensic Psychiatrist prepared an expert report, in which he observed that excited delirium "is a controversial diagnosis considered to be a sub-category of delirium also known as 'agitated delirium'." Dr Smith indicated that excited delirium is not recognised in either of the "two most widely used classification systems in psychiatry" being the DSM-5 and the ICD-10 although it is recognised as an entity in some literature and by the American College of Emergency Physicians.

Dr Smith further observed: In my opinion, the concept of ExDS does not assist in understanding the manner or cause of Tristan's death more than the recognised diagnosis of substance-intoxication delirium according to the recognised criteria of DSM-5 and ICD-10, the well-established classification system in psychiatry.

Counsel Assisting submitted that police officers tasked to respond to a person like Tristan, with aggressive and disturbed behaviours, are unlikely to have the luxury of time to consider, from their lay perspective, whether or not the person is experiencing the "mental condition" of 'excited delirium'. Their much more immediate concern will be on containing the behaviour in a way that minimises risk to the person involved, the public and the officers themselves. This seemed to be acknowledged in part two of the training module which noted that it is unlikely officers will be able to evaluate a person displaying this behaviour.

In these circumstances, Counsel Assisting queried the utility of a training module on 'excited delirium' which said nothing about whether a person experiencing such symptoms might be at increased risk of serious injury or death if subject to prone restraint. That is, there was no attempt to link the information within the 'excited delirium' module to the risk factors set out in the NSWPF Guidelines.

The 'excited delirium' module included a separate 'positional asphyxiation' module which provided a few short references to potential risk factors such as drug and alcohol use. However, there was nothing within that module that directly linked with the specific risk factors set out in Appendix A of the NSWPF Guidelines. The absence of a link between the information contained in the module and the risk factors in the NSWPF Guidelines is likely because the 'excited delirium' module was produced for the 2013-2014 police training year and therefore pre- dates the Guidelines which were published in February 2014. Accordingly, it appears that the module is outdated.

Counsel Assisting submitted that this seems like a missed opportunity to reinforce a consistent message about risk factors when restraining someone who is experiencing disturbed behaviour (whether experiencing 'excited delirium' or otherwise) and may well be lost on busy officers amongst the "endless" information they are required to familiarise themselves with.

I respectfully agree with Counsel Assisting's submissions.

'Excited delirium' in other jurisdictions

The existence of 'excited delirium' as a syndrome was considered in the *Inquest into the Death of Odisseas Vekiaris* (Coroner Jamieson, Coroners Court of Victoria, 18 December 2015). Her Honour ultimately found that 'excited delirium' and 'excited delirium syndrome' are neither appropriate nor helpful for ascribing a medical cause of death.

Her Honour also recommended that Victoria Police remove from its training materials/literature any reference to "excited delirium" or "excited delirium syndrome" until such time as it is recognised by Australian medical professional bodies. Coroner Jamieson was able to draw upon the resource of the Coroners Prevention Unit (established in Victoria in 2008) to research and provide a background discussion paper on 'excited delirium'. This assisted Coroner Jamieson by providing relevant information from the point of view of those who believe that Excited Delirium exists and is a valid medical cause of death however, the report equally highlighted that some experts do not recognise Excited Delirium as a medical conditions nor is it recognised by most professional medical associations.

The lack of a similar research facility as the Coroners Prevention Unit in this state means that it falls to the Counsel Assisting team to try and source relevant evidence via experts such as Dr Smith. This is, unfortunately, an expensive and ad hoc approach to identifying and researching systemic issues linked to this Court's power pursuant to s. 82 of the *Coroners Act 2009* to make recommendations in the interest of public health and safety.

Cause of death

Dr Clifton, then Forensic Pathology Registrar, recorded Tristan's direct cause of death as "acute cardiac arrhythmia in 3, 4-methylenedioxymethamphetamine (MDMA) intoxication with prone physical restraint" in the autopsy report dated 28 April 2016.

Dr Clifton observed:

"This is a complex and difficult case involving 3, 4- methylenedioxymethamphetamine (MDMA) intoxication causing an acute behavioral emergency necessitating the use of restraint by NSW Police. There are a range of potential causes of death without definite evidence that any of these causes either alone or in combination caused the death".

Stimulant drug intoxication and physiological stress

Tristan believed he had taken LSD but toxicological testing revealed he had consumed MDMA. Tristan's post-mortem blood sample showed 0.16mg/l of MDMA and 0.03mg/l of 3, 4-methylenedioxyamphetamine (MDA), a metabolite of MDMA.

John Farrar, consultant forensic pharmacologist, initially opined that Tristan had ingested a drug consistent with LSD but at a level below the laboratory limit of detection.

He opined that the distribution of LSD in the lollies may have been uneven such that Tristan consumed a full recreational dose but that the quantity of LSD in the remaining lollies was below the laboratory's detection limit. Mr Farrar later conceded that the clinical signs Tristan exhibited were also consistent with the consumption of MDMA. It is theoretically possible that Tristan consumed LSD. However, in circumstances where the remaining lollies did not contain LSD (or any other drug); there is no basis to conclude that Tristan had also consumed LSD.

Tristan was not a first time user of MDMA. Emma said "I also know that Tris has taken MD (MDMA) in crystal form and cocaine. He would use these kinds of drugs probably once a fortnight." Indeed, Tristan had taken "probably a point" of MDMA on the evening of 17 January 2016. According to Aidan, he had "seen Tristan take cocaine and also MDMA on his days off. He would vary his intake to sometimes once a week or fortnight". However, Aidan had seen Tristan take MDMA "each weekend for several weekends in a row when he's in social gatherings more than when he's at home."

Tristan's past history with MDMA use is relevant because Professor Jones, Specialist Physician and Clinical Toxicologist, said in oral evidence:

"It's rather paradoxical situation with MDMA that in many drugs of abuse, more exposure over time leads to tolerance but in the MDMA case, in respect of cardio toxicity, in fact repeated uses of MDMA may increase the susceptibility to toxic effects, in particular the arrhythmogenic effects of the drug so I guess what I'm saying to you is there's a lot of complexity when it comes to MDMA and its toxic effects".

It is possible that Tristan died as a result of MDMA toxicity. In this respect, Professor Jones indicated that "the type and/or severity of stimulant/toxic effects mediated by MDMA are unpredictable … As with every illicit drug, both the dose and purity of the MDMA changes substantially [from dose to dose]. Professor Jones opined that the presence of 0.16mg/l of MDMA and 0.03mg/l of MDA in Tristan's post-mortem blood sample is consistent with ingestion in the order of 50-75mg of MDMA. As the toxicity of MDMA is unpredictable, Professor Jones indicated that this could "represent a recreational, toxic or fatal dose". To this end Professor Jones noted "it remains unclear 'why some people seem to have acute, even fatal, reactions to doses that are commonly tolerated in others'."

In terms of factors that might influence the toxicity of MDMA, Professor Jones referred to "dose, ambient temperature, dancing/other activity, the genetic, physiological and pathophysiological nature of the user and the co-exposure to other substances." Although the evidence does not exclude the possibility that Tristan died as a result of MDMA toxicity, I am not satisfied, on the balance of probabilities, that this was the cause of Tristan's death. In this respect, Professor Jones agreed in cross-examination, Tristan had consumed a relatively low dose to result in death. Similarly, Mr Farrar opined that while MDMA toxicity contributed to Tristan's death, it was not the sole cause.

Counsel Assisting submitted that MDMA was implicated in Tristan's death. At the very least, the drug triggered the following series of cascading events:

Tristan's uncharacteristically disturbed behaviour leading to the physiological stress prior to police attendance; the need for restraint once police attended Tristan's home; the further physiological stress arising from a period of confinement in the cage in the back of BRU19; and a final period of prone restraint whilst sedation was administered at hospital. I respectfully accept Counsel Assisting's submissions. Counsel Assisting's submissions are supported by the evidence of Professor Jones and Associate Professor Adams, which I accept. In her expert report, Professor Jones said "[b]ut for MDMA exposure that night, Mr Naudi would not have been expected to have developed cardiac arrest and die".

Further, in cross-examination, Associate Professor Jones said:

"I can't exclude the cause of death being MDMA cardiovascular toxicity. The mechanism fits. The timing fits and potentially, because of the environmental factors of fear, of adrenalin, of more adrenalin, possibly the restraint, a degree of hypoxia, I still believe that there's enough evidence there that MDMA has played a significant contribution to Mr. Naudi's demise."

Similarly, Associate Professor Adams said:

"MDMA is a powerful sympathetic driver of the heart but so is all of the other things that came subsequent to taking that. Such as the physical efforts and the restraint and all of these things and even without MDMA, it's possible to die just from that level of sympathetic stress … And in this case … it might not have just have been the MDMA but certainly that was a contributor and probably contributed to those psychological effects that then led on to further sympathetic drive from the distress and stress Tristan's prior medical history and the likelihood of any underlying medical condition of relevance to his cause of death". Associate Professor Adams excluded the possibility that an electric shock Tristan sustained in 2014 was in any way relevant to his death in 2016. He also effectively excluded (although this is not definitive) the presence of long QT syndrome.

Dr Clifton, Professor Jones and Associate Professor Holdgate all agreed that it was unlikely that undiagnosed long QT syndrome or an allergic reaction to the sedative medication were factors that contributed to Tristan's death.

I accept the evidence of the experts in this respect.

Respiratory or cardiac arrest

There is a disagreement between the experts as to the precise cause of Tristan's death.

Associate Professor Holdgate opined that "the fact that he was noted to be blue/purple when he was turned over and that his initial cardiac rhythm was asystole is more suggestive of a primary respiratory arrest followed by a secondary cardiac arrest".

In lay terms, Associate Professor Holdgate explained that:

"*When they first monitored his heart there was no sign of any electrical activity, [which] is commonly what you see when a cardiac arrest occurs preceded by respiratory arrest. In other words, breathing stops before the heart stops beating Okay so the term cardiac arrest medically means that the heart has stopped effectively pumping blood around the body so the person won't have a pulse and there's two electrical things that can happen that causes the heart to do that. One is the heart can have no electrical activity. That's what the asystole or more commonly in adults, the heart can have disorganised electrical activity called ventricular fibrillation which is the type of cardiac arrest we mostly see when people have a primary heart problem so asystole in adults are where the heart is not beating and has no electrical activity. It very rarely happens as the first event and normally is the response of the heart to a lack of oxygen to the heart.*

So in adults we mostly see that because the patient has not been able to breathe or has had some reason they haven't had oxygen delivery prior to the heart stopping beating, so the first thing that happens is they don't get enough oxygen because they're not breathing effectively and then the heart is placed under stress because it doesn't get oxygen and actually just stops beating all together. As distinct from a primary heart problem where the heart itself is diseased or problematic or has something wrong with it where it starts fibrillating in a disorganised manner and then the breathing stops secondarily to that because the brain isn't getting enough oxygen to tell the body to breath[e]".

Associate Professor Holdgate thought it was very unlikely that the cardiac arrest came about through ventricular tachycardia and fibrillation progressing to asystole.[301] She noted that, for someone with a young and healthy heart, the deterioration from a ventricular dysrhythmia to asystole usually takes more than four or five minutes. In coming to this conclusion, Associate Professor Holdgate relied upon the observations of Dr Edwards and Dr Karpa of discolouration to Tristan's neck and chest when the handcuffs were removed and he was turned over onto his back.

Dr Edwards said that when Tristan was turned onto his side, she "noted his neck to be [a] blue, purple colour." In her interview with police, Dr Edwards later said "he looked like he'd been, it was like, hypoxic." Dr Karpa said that Tristan's "chest to face [was] purple … in a triangular pattern." He said there was a "definite delineation between that and the rest of his skin." For completeness, I note that Dr Murray did not observe that Tristan had a purple chest. Associate Professor Holdgate conceded that "we can't say for sure which was the primary event". She thought that what Dr Edwards and Dr Karpa described was more suggestive of a primary respiratory arrest followed by secondary cardiac arrest but could not be definitive about it.

Professor Jones and Associate Professor Adams instead favoured a diagnosis of a primary cardiac arrest. For Professor Jones this was because once Tristan was found to be unresponsive the first rhythm that was detected was asystole. Professor Jones was careful in her evidence to say however, that it was not impossible for Tristan's death to have occurred the other way around, being a respiratory arrest followed by cardiac arrest.

In her report, Professor Jones opined that: There seems little doubt that Tristan Naudi died from a sudden cardiac arrhythmia, with a documented asystolic cardiac arrest on cardiac rhythm strip.

This would be an unusual spontaneous occurrence in a young adult with a structurally normal heart. MDMA is known to cause cardiac arrhythmias and is the most likely cause in this case. It is likely that the initial arrhythmia was ventricular fibrillation … which later evolved into asystole … and finally electro-mechanical dissociation.

Similarly, Associate Professor Adams opined that: … the mostly likely cause of Tristan's death on 18 January 2016 was a fatal cardiac arrhythmia and this was most likely a ventricular arrhythmia such as ventricular tachycardia (VT) degenerating to ventricular fibrillation (VF) and then asystole. This is supported firstly by the autopsy findings (or lack of physical pathological changes) which are typical of a death due to cardiac arrhythmia where the problem (electric disorder) is physiological and not visible once death has occurred.

Secondly the clinical scenario where there was sudden unresponsiveness and lack of pulse and breathing efforts is also typical of a death due to a serious arrhythmia such as VT or VF. Lastly the microscopic changes seen in the heart at autopsy are similar to those described previously in cases on cardiac death associated with MDMA intoxication. Associate Professor Adams agreed with Professor Jones that a primary cardiac arrest was more likely because the first rhythm detected was asystole. He said "[Tristan] was a young man and quite fit as well and I wouldn't expect him to be becoming asystole very quickly from hypoxia."

He further said: Usually if it's a primary respiratory arrest, if it's due to physical things such as restraint or choking, it would be usual to observe a period of real respiratory distress, attempts to get your breath rather than just suddenly becoming unresponsive. In terms of the evidence that Tristan was struggling up to a very short time before he became non-responsive Associate Professor Adams said: *"I think there's an issue that when someone stops struggling after they have been struggling, if it's a purely respiratory problem, normally when you turn them over and feel their pulse, they would not be in asystole but rather have a very slow heart rate. Perhaps fast to start with but slow after minutes and this would gradually degenerate*."

Similarly, Associate Professor Adams said, in response to a question about Dr Karpa's evidence that when someone arrests they normally turn white or grey: *"I think the problem is … you can't know when this cardiac arrest happened because he wasn't being – didn't have cardiac monitoring on is my recollection at the time so … if it had just happened and you turned the person over and … say for instance you were monitoring the patient, you noticed that he became asystolic or went into ventricular fibrillation, when you turn the person over and they were already cyanotic, yeah, I totally agree. It would suggest a respiratory cause but if that had been going on for a minute or two without the knowledge of it and unless someone was feeling his pulse the whole time or monitoring his ECG, it's impossible to tell.*

Thus whilst Associate Professor Holdgate favoured a different specific cause of death to Professor Jones and Associate Professor Adams, none were able to be definitive.

Associate Professor Adams gave evidence that the blue or purple discolouration observed by Dr Edwards and Dr Karpa, which Associate Professor Holdgate relied upon in forming her opinion, is not a "particularly reliable technique to judge one thing from the other". He said that people with "a primary cardiac arrest will often be quite dusky and suffused in their upper body" because there is an "impairment of venous return to the heart because … it's not pumping".

Dr Clifton gave evidence that there was nothing at autopsy to indicate that a respiratory arrest was the cause of Tristan's death but she could not exclude it either. In this respect, Associate Professor Holdgate agreed that someone could suffer a respiratory arrest with asystole without having any evidence of that at autopsy and said, "You'd expect in that situation a heart may well have been completely normal". Dr Clifton further acknowledged that if there was something preventing someone from breathing, this could result in a primary respiratory arrest followed by a secondary cardiac arrest. However, Dr Clifton noted that, in the forensic literature, it has not been established whether any sort of prone restraint with pressure on the back is something that compromises respiratory function.

Mr Evenden submitted that the evidence of Associate Professor Holdgate that Tristan suffered a primary respiratory arrest should be accepted. In contrast, Ms Bennett, Mr Bradley and Mr Jackson submitted that the evidence of Professor Jones and Associate Professor Adams that Tristan suffered a primary cardiac arrest should be accepted. Counsel Assisting submitted that the Court is not in a position to determine whether Tristan suffered a primary respiratory or cardiac arrest.

None of the experts were definitive in the views they expressed and they each conceded in cross-examination that it would not be possible to exclude either a primary respiratory arrest or a primary cardiac arrest. In these circumstances, I am unable to determine, on the balance of probabilities, whether Tristan suffered a primary respiratory or cardiac arrest. In lay terms, I am unable to determine whether breathing stopped before the heart stopped beating or whether the heart stopped beating first. As Associate Professor Adams acknowledged, in the absence of cardiac monitoring, it is impossible to definitively establish whether a respiratory or cardiac arrest was the primary cause of Tristan's death.

Prone restraint and positional asphyxia

It was submitted by Ms Bennett that there is no sound evidentiary basis for the Court to find that positional asphyxia or the use of prone restraint was a contributing cause to Tristan's death. It is uncontroversial that the physical restraint experienced by Tristan contributed to his death. For example, Associate Professor Adams said: "*Nevertheless, with physical restraint it is likely that there would have been increased physical exertion on the part of Tristan and this may have resulted in increased sympathetic drive, increased blood pressure and temperature leading to increased cardiac demand and increased risk of cardiac arrhythmias*".

As Ms Bennett submitted, the physical restraint experienced by Tristan included:

- the physical restraint undertaken before police arrived at Tristan's house;
- handcuffing by police;
- transporting Tristan to hospital in the Pajero;
- transferring Tristan from the Pajero into the isolation room; and
- the approximately four minutes of prone physical restraint in the isolation room.

Counsel Assisting correctly submitted that the evidentiary basis for reliance on prone restraint comes from the uncontested evidence that that is how Tristan was being restrained when Dr Edwards and Dr Karpa separately commented upon the weight being applied to him and when he was observed to be unresponsive.

In this respect, Dr Clifton gave evidence that: The reason for that is that this man had an arrhythmic event or a cardiac arrest of whatever mechanism at that time because it was a perfect storm of events and one of those events was prone physical restraint.

You have an agitated, drug-affected person whose heart rate is high, whose [sic] very confused and aggressive at times who has a heightened sense of awareness at that time because of what's going on because of the drugs, because the adrenalin of what's going on and he's being restrained which causes further stress, physiological, emotional, what not. I cannot exclude the prone restraint as having a role in him developing an arrhythmia at that time.

I accept Dr Clifton's evidence notwithstanding that it was based upon clinical information provided to her rather than the findings of her autopsy report. It is evident that Tristan's death was caused by a "perfect storm" of a number of factors, including MDMA intoxication with the attendant pathological process of "stimulant cardiovascular effects including an elevated heart rate and blood pressure, producing an increased physiological strain on the heart" as well as physical restraint, including in the prone position, which produced additional "significant physiological stress to the body." Accordingly, I am satisfied that physical restraint, including prone physical restraint contributed to Tristan's death.

Mr De Brennan submitted that positional asphyxia arises from the evidence of Dr Edwards and Dr Karpa. However, Dr Clifton makes plain that "the issue of positional asphyxia causing respiratory compromise in the setting of prone restraint is contentious". Similarly, Professor Jones noted that the existence of positional asphyxia remains "highly controversial". In these circumstances, I do not propose record positional asphyxia as a direct cause of Tristan's death.

Counsel Assisting submitted that the cause of death should be recorded as "Acute cardiac arrhythmia in 3, 4-methylenedioxymethylamphetamine (MDMA) intoxication with physical restraint (including prone physical restraint)". I accept that this represents a fair summary of the cause of Tristan's death.

The need for recommendations

Counsel Assisting, Mr De Brennan and Mr Evenden submitted that I should make various recommendations addressed in turn below.

The NSWPF Guidelines

Counsel Assisting submitted that I should make the following recommendation to the Commissioner of Police:

That the NSW Police Force Guidelines on the Management of People Affected by Methylamphetamine and Other Stimulant Drugs be reviewed to ensure consistency with other NSW Police Force policies and training permitting the use of prone restraint, but only where reasonably necessary.

Ms Bennett submitted, on behalf of the Commissioner of Police, that a recommendation to this effect is unnecessary given the evidence of Sergeant Watt that he would bring the existence of this inconsistency to the attention of his superiors. Notwithstanding this, there is no evidence before me as to what review process, if any, might occur or what the result of any review process will be. In these circumstances, I consider that it is desirable to make the proposed recommendation.

As Counsel Assisting submitted, this is not to suggest that prone restraint should be encouraged. Rather, police material should consistently emphasise that it is permissible only if it is reasonably necessary in the circumstances.

Training

Counsel Assisting proposed the following recommendation in relation to training for police officers:

To the extent that there is any change to the Guidelines referred to in Recommendation 1 (outlined at above), that consideration be given to providing a training module on the amended Guidelines, including by reference to the risk factors presently included at Appendix A. Similarly, in submissions on behalf of Emma Bell, Mr. Evenden proposed the following recommendation:

That consideration be given to developing and delivering a mandatory training package for all police officers other than commissioned officers, in relation to restraint and the risks of sudden death through positional asphyxia, and including scenario-based training.

I am sympathetic to what Senior Constable Greenhalgh described as the "endless" information that officers are asked to read or consider in training, given the almost endless range of scenarios that they might be asked to respond to in the course of their job.

However, as Counsel Assisting submitted, there is little point in having guidelines if police officers are not aware of the useful information contained with them. Here the directly involved officers were generally unable to identify risk factors that may lead to an increased risk of positional asphyxia. This is significant because as both Counsel Assisting and Mr Evenden submitted, Appendix A to the NSW Police Force Guidelines on the Management of People Affected by Methylamphetamine and Other Stimulant Drugs already provides useful information to officers on risk factors.

The Commissioner similarly opposes the recommendation as unnecessary. I consider that it is desirable to make the recommendation as proposed by Counsel Assisting outlined at above.

Excited Delirium

Counsel Assisting proposed the following recommendation in relation to the 2003-2004 police training module on 'Excited Delirium':

That consideration be given to removing the "Excited Delirium" module from NSW Police training resources given that the 'mental condition' of 'excited delirium' is not recognised in the DSM-V nor ICD-10 and the advice to officers contained therein appears to be inconsistent with the current NSW Health – NSW Police Force Memorandum of Understanding 2018 to the extent that the MOU contemplates that police officers may transport a person detained under the *Mental Health Act 2007* to hospital in a police vehicle as a last resort.

The Commissioner opposes the recommendation on the basis, inter alia; police do not diagnose conditions but rather recognise behavioural symptoms. Accepting that police do not diagnose, it is not clear to me why the module needs use the phrase "excited delirium" at all.

I consider that it is desirable to make the recommendation as proposed by Counsel Assisting outlined at above.

Restraint in a hospital setting and for the purpose of sedation

Mr Evenden submitted that I should make the following recommendations: That consideration be given to developing a specific policy that governs restraint by police officers within a hospital setting. That consideration be given to developing and delivering training for police officers in relation to restraint for the purposes of sedation, including consideration of the need for any interagency training for the purposes of managing persons experiencing a mental health crisis or acute behavioural disturbance.

I do not propose to make the recommendation. Although a worthwhile goal, I accept submissions from Counsel Assisting that "restraint within a hospital setting will depend upon many factors including the resources available in each particular setting and clinical decisions from the doctor in charge" such that "it is difficult to see how a … policy could be flexible enough to cover a broad range of potential scenarios and facilities yet specific enough to be useful."

NSWPF Mitsubishi Pajeros

Mr Evenden proposed the following recommendation in relation to the vehicles used to transport people who are mentally ill or drug-affected: That consideration be given to improving the conditions under which mentally ill or disordered persons might be transported using police vehicles, including through modifications to existing vehicles that may include, but are not limited to: Improved air-conditioning or other ventilation.

Installation of padding in caged vehicles.

A similar recommendation was proposed by Mr De Brennan: That any and all vehicles of a similar make and design to BRU19 be retired by NSW Police and replaced with vehicles that are safe and humane. In particular, it is recommended that NSW Police consider the procurement of vehicles that have: greater space for those in police vehicle custody; improved comfort including the provision of vehicles with cushioning and/or padding for those suffering from an acute behavioural psychosis and/or similar conditions whether relating to their mental health and/or serious drug or alcohol intoxication/affectation.

Counsel Assisting submitted that, assuming that police involvement in transporting mentally ill or disordered persons from place to place is increasing, the need to consider the appropriateness of vehicles used for that purpose is clear. However, Counsel Assisting considered that recommendations should be informed by specific evidence, including why the Pajero was used on this occasion (because it was a multi-purpose vehicle and police expected an ambulance to attend), the total length of time Tristan spent within the vehicle (about 54 minutes, a substantial portion of which involved the door of the Pajero open), the length of the journey between Bangalow and Lismore Base Hospital (about 21 minutes) and the opportunities to observe Tristan whilst in the vehicle.

Having regard to the fact that Tristan survived both the journey to hospital and a further period of confinement whilst waiting to be transferred into the isolation room, Counsel Assisting did not support the making of this recommendation.

Similarly, in submissions on behalf of the Commissioner of Police, Ms Bennett indicated that the Court does not have evidence, including appropriate expert evidence, as to any “ideal” or obtainable police vehicle. Accordingly, it was submitted that the recommendation has no evidentiary basis. I accept the submissions made with regard to any proposed recommendations regarding the use of the Pajero to transport Tristan. Whilst there is insufficient evidence before me to as to the “ideal” vehicle to be used, I consider that it is desirable for a recommendation to be made in the terms proposed by Mr Evenden.

Body cameras

In submissions on behalf of Vincent Naudi, Mr De Brennan submitted that I should make the following recommendation:

That consideration be given to mandating that, where practicable, police deployed to incidents said to be related to alcohol or other drug intoxication wear body worn camera footage. Sergeant Watt gave evidence "from [his] personal point of view" in relation to the use of body cameras. He indicated that he thought that "they're a good idea" and that the footage captured could be used as case studies for training purposes. However, this issue was not considered in detail during the course of the inquest and does not arise on the evidence. Accordingly, I do not propose to make this recommendation.

Pill testing

Mr De Brennan proposed a recommendation in relation to pill testing. As this issue was not explored during the course of the inquest, I do not propose to make this recommendation.

Formal Finding:

Identity: The deceased person was Tristan Francis Naudi

Date of death: Tristan died on 18 January 2016.

Place of death: Tristan died at Lismore Base Hospital.

Cause of death: Tristan died from an acute cardiac arrhythmia in 3, 4-methylenedioxymethylamphetamine (MDMA) intoxication with physical restraint (including prone physical restraint).

Manner of death: Tristan died while being restrained at Lismore Base Hospital as medical staff were attempting to sedate him.

Recommendations pursuant to section 82 *Coroners Act 2009*

For the reasons stated above, I make the following recommendations to the **Commissioner of the NSW Police Force**:

1. That the NSW Police Force Guidelines on the Management of People Affected by Methylamphetamine and Other Stimulant Drugs be reviewed to ensure consistency with other NSW Police Force policies and training regarding the use of prone restraint.

2. To the extent that there is any change to the Guidelines referred to in Recommendation 1 (outlined at [279] above), that consideration be given to providing a training module on the amended Guidelines, including by reference to the risk factors presently included at Appendix A.

3. That consideration be given to removing the "Excited Delirium" module from NSW Police training resources given that the 'mental condition' of 'excited delirium' is not recognised in the DSM-V nor ICD-10 and the advice to officers contained therein appears to be inconsistent with the current NSW Health – NSW Police Force Memorandum of Understanding 2018 regarding the transportation of a person detained under the *Mental Health Act 2007* in a police vehicle.

4. That consideration be given to improving the conditions under which mentally ill or disordered persons might be transported using police vehicles, including through modifications to existing vehicles that may include, but are not limited to: Improved air-conditioning or other ventilation. Installation of padding in caged vehicles.

7. 19119 of 2016

Inquest into the death of DP. Finding delivered by State Coroner O'Sullivan at Lidcombe on the 27 February 2020.

DP was born on 11 October 1970 in Auckland, New Zealand. DP died following a confrontation with police inside the Quakers Hill Police Station on 19 January 2016. He was aged 45 years at the time of his death. Members of DP's family attended each day of the inquest, some travelling from interstate and overseas, which is a testament to their love for him. They spoke of DP as someone who brought joy and laughter to their lives, and of their ongoing grief at his passing.

Role of the Coroner

The role of a Coroner, as set out in s. 81 of the *Coroners Act 2009* (NSW) (**the Act**), is to make findings as to the identity of the person who died, when and where they died, and the manner and cause of their death. The manner of a person's death means the circumstances surrounding their death and the events leading to it.

Under s. 82 of the Act, a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question. As DP died as a result of police operations, an inquest is mandatory pursuant to ss. 23 and 27 of the Act. The coronial investigation into DP's death gathered sufficient evidence to answer the questions about DP's identity, where and when he died, and the medical cause of his death. As a result, the inquest was primarily focused on the manner of DP's death.

It is important for DP's family to know and understand how and why he died. To this end, the inquest examined the circumstances surrounding DP's attendance at Quakers Hill Police Station on 19 January 2016 and the actions of the police officers present at the time, including their use of force. The inquest also examined the management of DP's mental health condition and his substance use in the period leading up to his death.

In preparing my findings, I have been assisted by the oral submissions of counsel assisting, Mr Jason Downing, and the oral submissions made on behalf of the NSW Commissioner of Police ("the Commissioner"), Sergeant Craig Weston, and the Western Sydney Local Health District. At the outset I remind myself that I am considering the conduct of those involved in the events of 19 January 2016, and the events leading up to that day, with the benefit of hindsight. I will endeavour to be realistic when assessing the conduct of those involved; particularly the conduct of the police officers who found themselves in what was no doubt an unexpected, dynamic and confronting situation.

FACTUAL BACKGROUND

DP was born on 11 February 1970 in Auckland. He was the third born of five siblings and spent his childhood in New Zealand. DP's eldest daughter, JM, was born in 1996. Not long after JM's birth, DP moved to Australia.

DP settled in Sydney and initially worked as a labourer, before securing work in scaffolding through his older brother, AP. In about 2002, DP met Ms LH, with whom he formed a relationship that continued through to the time of his death. DP had another daughter, T, born in 2004, with Ms LH. He was also stepfather to T1, who was Ms LH's daughter from a previous relationship.

Substance Use and Mental Health History

When Ms LH first met DP in about 2002, she was aware that he used ecstasy and marijuana recreationally. At that time, and for some years prior, DP had worked in the scaffolding industry. He worked on a number of large industrial sites, including those where he would do "fly in/fly out" work.

In about 2008, DP was working on a site in Bowral NSW. He telephoned Ms LH and told her that he had commenced smoking "Ice" (methylamphetamine) and further, that Ice use was fairly common amongst those he was working with. At that time, Ms LH understood that DP's use of Ice was sporadic and recreational. In 2010, DP and Ms LH moved into in a house in Rooty Hill together. She observed that on occasions, DP would smoke Ice through a pipe.

Employment on Curtis Island

On 31 July 2013, DP began work with Bechtel Construction (Australia) Pty Limited (**Bechtel**), doing scaffolding work at a liquid natural gas construction project located on Curtis Island in Queensland. During his employment, DP was provided with accommodation on site. He worked a rotation of four weeks work, followed by one week break. He returned home to Sydney during his break. DP remained employed by Bechtel and working on Curtis Island until 5 March 2015.

DP indicated on a pre-employment medical screening questionnaire that he had no history of any mental health condition and was not presently (nor had he previously been) addicted to alcohol or drugs. During DP's employment with Bechtel, Ms LH noticed a change in his behaviour and personality, noting that he became more selfish and that he spent more time sleeping. Ms LH also noticed DP was smoking Ice more regularly, including smoking it when he was home. DP informed Ms LH that Ice use was a normal part of socialising amongst his fellow workers, with them smoking it in their cabins.

AP was also aware that DP was using Ice, as well as ecstasy and another drug known as "Datura", while DP was working on Curtis Island. Datura (or more correctly, Datura Wrightii) is a plant also known as Jimson Weed, which is taken orally and has a hallucinogenic effect.

AP recalls DP telling him that he took drugs to combat the loneliness he experienced when away from home, and that Ice use was rife throughout the scaffolding industry. AP also noticed changes in DP's personality. He noticed that DP went from being a happy person to being much quieter. DP's stepdaughter, T, gives a slightly different account of DP's behaviour over this time. She indicated that she did not notice any change in his personality and that DP continued to be a supportive, happy and loving step-father.

Incident at Brisbane Airport

Around late November or early December 2014, DP phoned Ms LH from Curtis Island and reported that he was hearing voices outside his window.

He also claimed that everyone was looking at him and watching him. Ms LH was concerned, as this was out of character for DP. She contacted Lifeline and obtained advice to the effect that DP may be suffering from some form of drug-induced psychosis. Ms LH then contacted DP's nephew, known as "AJ", who worked on a different project on Curtis Island, to see whether he might be able to help. AJ was AP's son. AJ reportedly told Ms LH that he had "*seen it before*" and that he would arrange for DP to come home to Sydney so he could get some help.

On 3 December 2014, DP was travelling back to Sydney with AJ. During a stopover at Brisbane Airport, DP punched a complete stranger, Mr Barry Whitworth, striking him in the jaw, for no apparent reason. After the incident, DP was approached by two Australian Federal Police (**AFP**) officers, Federal Agents Michael Cotton and Greg Cruise, who had been informed of the apparent assault on Mr Whitworth. When they approached DP, he let go of the trolley bag he was pulling, threw his rucksack down on the ground, raised his fists and adopted a boxing pose. As Federal Agent Cotton reached for his capsicum spray and baton, DP called on the officers to use their Taser against him.

The Federal Agents were able to calm DP down. When they sat down and spoke to him, they enquired as to why he was so agitated. DP reportedly failed to explain, but did say that he wanted the police to shoot him in the head. DP was then taken into custody and charged with assault occasioning bodily harm and obstructing a Commonwealth official. On 18 February 2015, the matter was dealt with in the Queensland Magistrates Court and DP pleaded guilty. He was convicted and received a $1,500 fine. According to AP, AJ informed him that DP had an ounce of Ice on him while at Brisbane Airport and when AJ discovered it, he took it and flushed it down the toilet.

Initial Treatment

Following the incident at Brisbane Airport, DP returned to Sydney and was met by Ms LH. DP continued to report hearing voices and expressed a concern that his Rooty Hill house was under surveillance. As a result, Ms LH took DP to the Emergency Department at Blacktown Hospital on 5 December 2014. A Mental Health Assessment was conducted by a clinical nurse consultant. During the assessment, DP reported that he had been hearing noises in the roof and believed people were looking through the windows. He also expressed his belief that there were people in the roof putting cameras in there and that they were talking about him.

DP told the clinical nurse consultant that he had used Ice over the week, and that he had been awake for about four to five days. He stated that had had last used Ice on Wednesday, 3 December 2014. The clinical notes record that DP stated that he had wanted to use a police officer's gun to shoot himself when he had been in the police cells in relation to the Brisbane Airport incident. The assessment made by the clinical nurse consultant at the time was that DP had a number of continuing fixed paranoid delusions and a provisional diagnosis of "drug induced psychosis" was recorded. After discussing DP's care with the on-call psychiatrist, the clinical nurse consultant discharged DP home with a referral to the Acute Mental Health Team (**AMHT**) for follow up. She also recommended that DP refer himself to drug and alcohol services.

Members of the AMHT conducted a home visit with DP on 7 December 2014. DP denied current drug use or psychotic symptoms. As no acute mental health issue was identified during the home visit, DP was discharged from the service.

The Discharge Summary records the resolution of paranoid thoughts and auditory hallucinations. DP was encouraged to seek drug and alcohol counselling to assist him in abstaining from illicit substances, and given the details for Bridges Inc, a drug and alcohol counselling service in Blacktown. It was noted that there was a potential risk of relapse if he continued Ice use. DP attended three appointments with general practitioners at the St Martin's Village Medical Centre in Blacktown in December 2014 to monitor his progress. At his appointment on 29 December 2014, DP was provided with a medical certificate stating that he was fit to return to work.

Between 9 December 2014 and 17 January 2015, DP attended five sessions of drug and alcohol counselling with Cameron Brown, a drug and alcohol counsellor working at Bridges Inc, in Blacktown. During his sessions, Mr Brown sought to teach DP relapse prevention tools and he recorded that, initially, DP appeared motivated to stop using illicit substances. Whilst DP appears to have remained abstinent from Ice for a short time, at his appointment 17 January 2015 he reported using Ice again. He also indicated his intention to return to work on Curtis Island, despite this being a trigger for his Ice use.

On 27 January 2015, DP attended a general practitioner at the Gladstone Valley Medical Centre in Queensland. He requested that a urine drug screen be done and sent to his solicitors (presumably in relation to the charges arising from the Brisbane Airport incident). The drug screen returned a positive result for nicotine only. According to Ms LH, DP's mental health seemed to improve whilst he was in Sydney, during which she understood he was abstinent from Ice.

Return to Curtis Island

Following his court proceedings in February 2015, DP returned to work on Curtis Island. Shortly thereafter, he reported to Ms LH that he was hearing voices again and Ms LH believed he was expressing paranoid thoughts. At Ms LH's request, AJ again assisted DP to return home to Sydney. DP's employment records indicate that he ceased work on 5 March 2015.

Further Treatment

Following DP's return to Sydney, he told AP that he was hearing voices and expressed suicidal thoughts. AP decided to take DP to his home in Moss Vale. DP then lived with his brother in Moss Vale for various periods between about March and August 2015. On 14 March 2015, DP attended Dr Cudmore, general practitioner, at the Eastbrooke Medical Centre in Bowral. DP described having a depressed mood and thoughts of suicide. Dr Cudmore arrived at a diagnosis of a major depression and prescribed DP a daily dose of 50mg of sertraline, an anti-depressant. A follow up appointment was made for 29 March 2015 to review the effectiveness of the medication and to arrange a referral to a psychologist. DP failed to attend this appointment and when followed up, elected not to make a further appointment.

On 12 June 2015, DP attended Dr Kwong, general practitioner, at the Eastbrooke Medical Centre. AP also attended the appointment. On that occasion, Dr Kwong prepared a Mental Health Care Plan for DP and referred him to Bruce Schubert, psychologist. Dr Kwong also provided DP with a referral to Dr Warwick Williams, psychiatrist. Dr Kwong prescribed DP a daily dose of 2.5mg of olanzapine to treat DP's auditory hallucinations and paranoia. DP attended appointments with Mr Schubert on 15 June 2015, 22 June 2015 and 4 August 2015. DP reported a history of heavy use of Ice, delusional thoughts, auditory hallucinations and ongoing paranoia.

Dr Schubert was of the view that DP suffered drug induced psychosis. Appointments focused on cognitive behavioural therapy and relapse prevention. DP attended his first appointment with Dr Williams on 21 July 2015. Dr Williams recorded a history of depressive symptoms and Ice use. Dr Williams noted that DP's psychotic symptoms persisted, despite his reported abstinence from Ice over the last two months. Accordingly, Dr Williams concluded that the appropriate diagnosis was schizophrenia. He prescribed a 40mg dose of ziprasidone, an atypical antipsychotic medication, twice daily. Dr Williams encouraged DP to continue his appointments with Mr Schubert and scheduled a follow up appointment for a fortnight's time. DP attended sessions with Dr Williams 28 July 2015, 4 August 2015 and 11 August 2015.

During these sessions Dr Williams sought to teach DP behaviour therapy techniques to manage his symptoms. Dr Williams recorded that DP was improving and should remain on ziprasidone long term. DP returned to live with Ms LH in Quakers Hill. Ms LH noticed that DP had less energy and slept more. He also appeared depressed and tired. Ms LH believed that this was related to DP's medication. DP also expressed concerns regarding his medication and Ms LH formed the view that he may not have been taking his evening dose.

In August 2015, DP and Ms LH visited DP's daughter, JM, in Melbourne. JM noticed DP to be very tired and not his usual self. DP also indicated to JM that he did not feel like himself. On 14 September 2015, DP began work as a scaffolder for Transfield Services, working at Port Botany in Sydney. DP's supervisor, Mark Credaro, found DP to be very reliable, quiet and easy going. He did not observe any concerning behaviours or signs of mental health or substance use issues. DP concluded his employment with Transfield Services on 16 January 2016.

Ms LH noticed an improvement in DP's condition after he returned to work, which she believed was because DP's mind was occupied. Whilst she did not consider that he was back to his normal self, they began to spend more time together and talk more often.

Deterioration in Mental Health

Over the Christmas period of 2015, Ms LH noticed that DP seemed more depressed. DP mentioned that he wanted to get his finances in order in case anything happened to him, which concerned Ms LH and she wondered whether he might be contemplating suicide. Ms M came to Sydney to visit DP in early January. During the visit, DP began to express paranoid thoughts about his work colleagues watching him and said that he was hearing voices again. DP told Ms LH that he had smoked Ice with his work colleagues and apologised to her. Ms M noticed that DP seemed paranoid and spoke about not being able to trust people.

On 11 January 2016, Ms LH took DP to see Dr Christie, general practitioner, at the St Martins Village Medical Centre in Blacktown. DP reported experiencing suicidal thoughts the night before, stating that he had thought about stabbing himself with a knife or jumping off a cliff. Dr Christie was concerned that DP may be suffering from drug induced paranoid ideation, with features of a major depressive illness. He was concerned about DP's behaviour and demeanour and he referred DP to the Emergency Department at Blacktown Hospital for assessment. DP and Ms LH attended the Emergency Department at Blacktown Hospital that afternoon. DP was seen by a registered nurse in in the Psychiatric Emergency Care Centre and then assessed by Dr Yichao Liang, the psychiatric registrar on call. Dr Liang noted a history of drug induced psychosis and paranoia.

She also noted that DP had self-reduced his medication and had used a larger than normal amount of Ice the previous Tuesday (5 January 2016). DP told Dr Liang that he experienced paranoid thoughts after using Ice. He also told her that he sometimes suspected people were talking about him, and that some of his friends were posting video clips of him onto Facebook, related to his drug use. Dr Liang recorded that DP recognised that his paranoid thoughts were irrational. Dr Liang noted that DP had experienced suicidal thoughts the day before, but had not acted on them. DP denied any ongoing suicidal ideation or thoughts of harming himself or others. Dr Liang diagnosed "*drug induced psychosis (nil acute risk at this stage)*". DP was advised to see his general practitioner to resume his regular dose of ziprasidone and was discharged home with a referral to the AMHT. He was also provided with a number for the Mental Health Hotline.

The AMHT contacted DP by telephone on 12 January 2016. He denied thoughts of self-harm or harming others and indicated that he had recommenced his recommended dose of ziprasidone. A home visit was scheduled for the following evening. Members of the AMHT attended DP at home on 13 and 15 January 2016. According to Registered Nurse (**RN**) Hyde, one of the mental health nurses who attended the home visit on 13 January 2016, DP was pleasant and polite at the time of the review. He acknowledged relapsing into Ice use after a period of abstinence and he also described feelings of regret about his relapse. He further indicated that he was still experiencing auditory hallucinations. DP expressed concern regarding his medication, as it made him drowsy and he needed to work due to financial pressures.

RN Hyde considered that DP had insight into the cause and effect of his drug use on his mental state and encouraged him to seek referral to a psychiatrist and to review his medication. RN Hyde was of the view that DP required ongoing review, but that his presentation did not give rise to immediate concerns of self-harm.

RN Johanna Feeney and RN Michael Gillen conducted another home visit with DP on 15 January 2016. DP reported some improvement in his symptoms, but indicated that he continued to experience some paranoid thoughts. DP reiterated that he was disappointed in himself for using Ice and intended to abstain. He also agreed to see his general practitioner for a referral to a new psychologist and psychiatrist closer to home. DP indicated that he proposed to visit his brother in Moss Vale over the upcoming weekend and a further home visit was scheduled for Wednesday, 20 January 2016.

On 16 January 2016, DP attended work at Port Botany. DP approached Mr Credaro, and informed him that he intended to finish his contract that day. As the project was due for completion the following week, Mr Credaro was aware that other contractors had found work on a new project. Mr Credaro asked DP if he was joining the same project, to which DP replied that he was. Mr Credaro formed the view that DP was excited about his new role. On Sunday, 17 January 2016, Ms LH and TH travelled to Port Macquarie for a planned holiday. Ms LH had invited DP, however he had indicated that he did not want to go. Ms LH observed DP to be agitated and pacing, as though waiting for them to leave. On Monday, 18 January 2016, Ms LH spoke to DP on the phone. He told her that he had finished work earlier than expected and they had general conversation. That was the last time Ms LH spoke to DP.

The Events of 19 January 2016

On the morning of Tuesday, 19 January 2016, DP drove his white Holden Commodore sedan to the Quakers Hill Police Station on Highfield Street in Quakers Hill, arriving at shortly after 10.30am. At that time, Andrew Welsh, a member of the public, was sitting in the foyer waiting for a colleague who was speaking with police. A 12-year-old boy was just outside the front doors of the police station, waiting for his mother. As at 19 January 2016, Quakers Hill Police Station did not have CCTV cameras monitoring the foyer area. Accordingly, I am reliant on witness accounts to determine what occurred that day.

Arrival of DP

At the time DP arrived at Quakers Hill Police Station, Sergeant Jennifer Hilder was working at the station, carrying out duties as the Education Development Officer for the Local Area Command. Sergeant Hilder was in her office (**the EDO Office**), off to the left side of the foyer as one enters the front doors. Sergeant Craig Weston and Senior Constable Natalie Stewart were present with Sergeant Hilder in the EDO Office. Senior Constable Stewart saw the Commodore come to a stop in the "Police Only" parking area through the window of the EDO Office and commented, "*Who is this? That's not an unmarked police car*". Sergeant Hilder saw DP exit the driver's side door and noticed that he had a knife in his right hand.

He paused beside the vehicle for several seconds and appeared to be locking the doors. Sergeant Hilder, Sergeant Weston and Senior Constable Stewart all observed DP to walk from the vehicle towards the front doors of the police station. Sergeant Hilder gave evidence that she yelled, "*He's got a knife*" and moved towards the doorway of the EDO Office. Sergeant Hilder told Senior Constable Stewart to go and alert the other officers in the station that DP had a knife.

Sergeant Hilder was not wearing any appointments as she was on restricted duties. Senior Constable Stewart saw that DP had a large knife, similar to a carving knife. She used her swipe card to access the secure area of the police station and moved towards the station constables' desks. As she did this, she noticed civilians present in the foyer area. Senior Constable Stewart saw Constable Antoinette Holden and Constable Mustafa Amiri, and said to them, "*There's a guy coming in with a knife*". Senior Constable Stewart then alerted her supervisor, Leading Senior Constable Scott Whale. Senior Constable Stewart was also on restricted duties and not wearing any appointments.

Sergeant Weston heard Sergeant Hilder say, "*He's got a knife*" and moved into the foyer. At this point, the front glass doors opened and DP walked into the foyer of the police station. Sergeant Weston gave evidence that DP was holding the knife in his right hand, about waist high, pointing downwards. He observed DP to walk towards the counter. Sergeant Weston gave evidence that DP looked at him, and they made eye contact. At that point, DP was one to two metres inside the front doors. Sergeant Weston called out, "*Drop the knife*" and DP replied, "*No*". Sergeant Weston then drew his firearm and held it in the cover position.

As DP continued to move towards the counter, Sergeant Weston yelled, "*Drop the knife. Police*", and DP replied, "*No, shoot me*". Sergeant Weston also gave evidence that DP said, "*You know me*"; however, Sergeant Weston had never met DP before. Sergeant Weston observed DP to be calm, not yelling or screaming. He did not appear to be jittery or agitated.

He did not appear to Sergeant Weston to be drug-affected. Sergeant Weston heard Leading Senior Constable Whale calling on DP to drop the knife and could see Leading Senior Constable Whale and Constable Holden behind the counter with their firearms drawn. Sergeant Hilder gave evidence that DP was walking in a casual manner and seemed calm. Andrew Welsh described DP's demeanour as "a bit dazed, a bit … glassy-eyed" and recalled that he was moving "fairly slowly".

Senior Constable Stewart heard Sergeant Weston yelling, "*Drop the knife drop the knife*" and saw Leading Senior Constable Whale run from his office to the front counter. She heard him say, "*Just drop it, just drop it*". Senior Constable Stewart then moved backwards, towards the desks and computers. Leading Senior Constable Whale gave evidence that he moved towards the front counter and saw DP in the middle of the foyer with a large knife in his right hand.

He heard Sergeant Weston call out "*Drop the knife*". Leading Senior Constable Whale drew his firearm, pointed it at DP and also yelled "*Drop the knife*". He observed DP to have a blank expression and to continue moving forward towards the counter. Constable Amiri was in the desk area of the station and heard Senior Constable Stewart say "*There's a man coming with a knife. I can't do anything, I'm restricted*".

He looked into the foyer and saw DP holding a knife in his right hand at about waist height. He observed DP to walk towards the front counter and said, "*Mate, drop the knife*". He described DP as having a "blank look, like not paying attention". Constable Amiri was positioned behind a partition. From this position, he could hear noises, but could not see anyone else in the foyer. Constable Holden was walking towards the front counter and heard Senior Constable Stewart say, "*I can't help, I'm restricted*". She saw DP in the foyer and heard a woman say, "*He's got a knife*".

This caused Senior Constable Holden to notice that DP was holding a knife near his hip. Senior Constable Holden gave evidence that DP was stationary when she first saw him. Constable Holden observed Leading Senior Constable Whale come out of his office and move quickly towards the front counter. She heard Leading Senior Constable Whale call out, "*Get out of the station*" and "*Put the knife down*". She also saw him draw his firearm. Constable Holden then drew her firearm, as she knew there were civilians in the foyer and was concerned for their safety.

DP moves towards Sergeant Weston

Sergeant Weston gave evidence that DP paused for a "split second" near the counter before turning to his left to face Sergeant Weston. Sergeant Weston raised his firearm and pointed it towards DP. He aimed for the centre body mass, being the area between the shoulders and abdomen. Sergeant Weston estimated that DP was about three metres away from him at this point. Sergeant Weston continued to call on DP to drop the knife. Sergeant Weston gave evidence that DP continued to move towards him, so he took a step back. DP continued to advance. Sergeant Weston gave evidence that DP then raised the knife up to about shoulder or head height, with the blade pointing downwards. He then stepped forward with his left foot. Sergeant Weston discharged one round from his firearm and saw it hit DP in the upper chest area. Sergeant Weston saw DP fall backwards to the ground, at which point Sergeant Weston moved his firearm to cover DP, in case he got back up.

Sergeant Hilder gave evidence that DP walked in a slow pace towards the counter. About one to two metres from the counter, DP turned in the direction of Sergeant Weston, moving in a continuous arc.

She was standing behind Sergeant Weston, slightly to his right in the doorway to the EDO Office. She heard Sergeant Weston continue to say, "*Put the knife down*". Sergeant Hilder further gave evidence that DP was mumbling and she thought that she heard the words "*shoot*" and, after a brief pause, "*me*". Sergeant Hilder described DP taking another couple of steps towards Sergeant Weston, calmly and slowly, "like he was on a mission to walk somewhere". Sergeant Hilder gave evidence that, without warning, DP lifted his right arm up near the top of his head and started to bring it down towards Sergeant Weston. DP was still holding the knife and was within one to two metres of Sergeant Weston at that point. Sergeant Hilder gave evidence that DP did this quickly, in a rushed motion. Sergeant Hilder then saw Sergeant Weston discharge his weapon.

Leading Senior Constable Whale gave evidence that he saw DP pause for between two and five seconds about a metre from the counter. Leading Senior Constable Whale continued to say "*Put the knife down*". Leading Senior Constable Whale saw DP turn to his left, in the direction of Sergeant Weston, and heard DP say "*Shoot me now*".

DP then moved at a speed that Leading Senior Constable Whale described as "the beginning of hurried" towards Sergeant Weston. Leading Senior Constable Whale gave evidence that he saw DP raise his right arm with the knife protruding from his hand. Leading Senior Constable Whale was about to discharge his firearm when he heard a shot fired. He observed that DP "reeled for a second" and then fell to the floor. Senior Constable Stewart saw DP move towards the front counter and then turn left, in a "fluid motion", towards Sergeant Weston.

Senior Constable Stewart heard Sergeant Weston and Leading Senior Constable Whale call on DP to drop the knife about four times each. She described DP as being "very focused" and "deliberate in his movements". As he moved towards Sergeant Weston, Senior Constable Stewart saw DP start to raise his right hand and bring the knife up to his waist. As DP moved towards Sergeant Weston, Senior Constable Stewart's view of him was blocked by Leading Senior Constable Whale. When she last saw DP, he had raised the knife up to his shoulder and had started to walk a little faster. She couldn't see DP at the time she heard the shot.

Constable Holden gave evidence that, due to her position behind the counter, she couldn't see anyone to the right of DP. She heard a shot fired within seconds of drawing her own firearm. Constable Amiri gave evidence that he moved down the hallway towards the door leading from the secure portion of the station into the foyer. He lost sight of DP at this time. He heard the gunshot before he reached the door. Mr Welsh remained in his chair near the EDO Office during the incident. He gave evidence that Sergeant Weston had his firearm drawn, as did two officers behind the counter. He heard someone ask, "*Are you alright mate?*" and heard numerous officers yelling, "*Put the knife down*". Mr Welsh gave evidence that DP said, "*I'm not putting the knife down*".

Mr Welsh further stated in evidence that DP walked towards the front counter and then turned to his left, facing Sergeant Weston. Mr Welsh saw DP raise the knife above his head, holding the knife in a downwards motion. Mr Welsh described this as a "stabbing sort of motion". Mr Welsh observed DP to be "very agitated". Mr Welsh gave evidence that as DP got within three to four feet of Sergeant Weston, he raised the knife further above his head and "lunged" towards Sergeant Weston. He then heard a gunshot. Mr Welsh further gave evidence that Sergeant Weston "gave every chance for [DP] to put the knife down" and he "couldn't fathom how long [Sergeant Weston] waited" before discharging his weapon.

The evidence given before me establishes that the entire incident occurred very quickly. It appears that the time from when DP entered the foyer of Quakers Hill Police Station until the time Sergeant Weston discharged his firearm was about 20 – 30 seconds.

Aftermath

Constable Amiri, who is also a registered nurse, kicked the knife away from DP and began to render first aid. He applied pressure to DP's wound and encouraged him to keep breathing. When DP stopped breathing, Constable Amiri and Leading Senior Constable Whale, who had previously worked as an ambulance officer, commenced CPR. Other officers assisted with CPR until the ambulance officers arrived.

An ambulance was called at 10:34am and the first ambulance officers arrived on scene at 10:42am. Following their arrival, the ambulance officers took over CPR. A CareFlight helicopter containing two doctors and a further paramedic arrived at the scene at about 11:04am. Despite the considerable efforts of all those who assisted DP, he was pronounced deceased at 11:17am. A critical incident was declared and the relevant protocols enacted.

Post-mortem examination and toxicological analysis

Dr Rianie van Vuuren, forensic pathologist, conducted the post-mortem examination on DP on 20 January 2016. Dr van Vuuren concluded that the direct cause of death was a gunshot wound to the chest, with no antecedent causes identified. Toxicological analysis of DP's femoral blood was performed and it returned a negative result for alcohol, a result of 0.12mg/L for methylamphetamine and less than 0.2mg/L for amphetamine (a metabolite of methylamphetamine). DP's prescribed medication, ziprasidone, was not detected. Testing for olanzapine, which was found in DP's house, was also negative.

Dr van Vuuren assessed the methylamphetamine level detected in DP's blood sample as being in the potentially toxic to lethal range.

Search of DP's home

As part of the critical incident investigation, a warrant was obtained to search DP's home in Quakers Hill. A number of officers from the Critical Incident Investigation Team and officers from the Forensic Services Group attended DP's home in Quakers Hill at around 5:30pm on 19 January 2016 for this purpose. During the search of the premises, officers located a glass ice pipe and a small resealable satchel containing clear crystals. Subsequent testing confirmed the clear crystals to be methylamphetamine. Police also located various medications including Zeldox (ziprasidone), Eleva (sertraline), olanzapine and an antibiotic. During the search of DP's home, it was noticed that there was a knife missing from the Scanpan knife block in the kitchen. Crime scene examinations carried out at Quakers Hill Police Station determined that the knife carried by DP was of the same brand. It appears that DP took the knife from his knife block before attending Quakers Hill Police Station.

ISSUES EXPLORED AT THE INQUEST

Prior to the inquest, a list of issues to be explored was circulated to the interested parties. I turn now to consider each of these issues.

Issue 1: The adequacy of mental health care and treatment received by DP between 11 and 19 January 2016

Issue 1 and its sub-parts involved consideration of the adequacy of the mental health care and treatment received by DP between 11 and 19 January 2016. It was on 11 January 2016 that Ms Huriwai took DP to see Dr Christie, general practitioner, and then on his advice, took DP to the Emergency Department at Blacktown Hospital. This led to DP coming under the care of the AMHT.

As part of the coronial investigation, comprehensive statements were obtained from those involved in the care and treatment of DP over this period. Clinical records for DP from the Blacktown Hospital, the AMHT and St Martin's Village Medical Centre were also obtained. An expert opinion was sought from Dr Kerri Eagle, a forensic psychiatrist with extensive experience working in the public mental health system. She is also a conjoint lecturer in mental health law at the University of New South Wales. Dr Eagle reviewed the available treating records and statements from relevant clinicians and others, and provided a report dated 6 September 2019.

She considered DP's background and prior psychiatric history, but particularly focused on DP's likely psychiatric diagnosis and the care he received from 11 January 2016 onwards. Dr Eagle also gave oral evidence during the inquest.

Mental health diagnosis

Dr Eagle formed the view that DP suffered from either a chronic psychotic illness, such as schizophrenia or a substance induced psychotic disorder. In coming to his view, she acknowledged the limitations of a retrospective psychiatric assessment, including the difficulty in arriving at a firm diagnosis without the benefit of a clinical assessment of DP in person. Dr Eagle expanded on this conclusion in her evidence, noting that it is difficult to distinguish between schizophrenia and a substance induced psychotic disorder when a person is using methylamphetamine. This is because methylamphetamine use can trigger a psychotic illness in a person who does not necessarily have a chronic psychotic disorder. In DP's case, Dr Eagle expressed the view that the fact that DP had only shown psychotic symptoms later in life suggested "he may have had more of a substance induced psychotic disorder".

However, Dr Eagle acknowledged that Dr Williams, who did have the chance to assess DP in person, formed the view that DP had features that were consistent with schizophrenia. She noted that, whilst is unusual for someone to develop a psychotic illness later in life (DP was 44 years old when he saw Dr Williams), methylamphetamine use can trigger the onset of a psychotic illness if the person is psychologically or biologically vulnerable to the onset of that illness. Dr Eagle gave evidence that DP's use of methylamphetamine was "extremely significant" in relation to his mental health condition. She noted that if DP was suffering from a substance induced psychotic disorder, it is likely that his psychotic symptoms were almost entirely the result of his methamphetamine use. Alternatively, if DP was suffering from a chronic psychotic disorder, such as schizophrenia, methylamphetamine is known to precipitate relapse and exacerbate symptoms.

Dr Eagle also identified a possible comorbid depressive illness. However, she gave evidence that it can be difficult to diagnose a mood disorder in a person who is using methylamphetamine, as the substance itself can both cause and mask mood disturbances.

Dr Eagle noted in her report that she considered DP to also have a severe stimulant use disorder, noting his difficulty controlling his methylamphetamine use, and the impact on his functioning, relationships and employment.

Mental health care and treatment

Dr Eagle was not critical in her report of the care and treatment DP received for his mental health condition in the period 11 January 2016 to 19 January 1016. As to DP's management at Blacktown Hospital on 11 January 2016, Dr Eagle concluded that DP was properly assessed and that his risks and treatment needs were identified. Dr Eagle's attention was drawn to concerns raised by Ms Huriwai in relation to her not being included in the assessment of DP and Dr Eagle was specifically asked to consider whether collateral information should have been sought from Ms Huriwai. In this regard, Dr Eagle noted that the treating team were aware that DP had been brought in by Ms Huriwai and would return home with her.

Overall, whilst Dr Eagle indicated that it is recommended that primary care providers are involved in treatment planning, Dr Eagle concluded that there did not appear to be any specific deficiency in DP's care and treatment arising from this concern.

Dr Eagle gave specific consideration to whether DP could have been considered to be a mentally ill person under the *Mental Health Act 2007* (NSW) (**the MH Act**) at the time he was reviewed by Dr Liang on 11 January 2020, so that he might have been involuntarily admitted for inpatient treatment. Dr Eagle concluded that DP could have been considered to be a mentally ill person, as he was describing delusions and hallucinations, and his illness was contributing to a potential risk of self-harm.

However, Dr Eagle referred to the requirement under the MH Act for Dr Liang to consider whether DP could be safely and effectively cared for through a less restrictive form of treatment (as compared to involuntary admission) and concluded that it was reasonable for Dr Liang to discharge DP into the community with follow up care. In coming to this view, Dr Eagle placed emphasis on DP's prior engagement with community-based treatment, his insight into the nature of his illness and his treatment, the availability of support in the form of Ms Huriwai, and the availability of treatment and follow up in the community. Dr Eagle considered that the Blacktown AMHT provided care of a high standard, including assertive follow up in the community. Dr Eagle noted that the AMHT conducted appropriate and timely assessments of DP's mental state and treatment needs, including liaising with Ms Huriwai and encouraging DP to engage in ongoing psychiatric care. Dr Eagle further noted that the AMHT also counselled and educated DP regarding his use of illicit substances.

Dr Eagle gave evidence that it is extremely difficult for clinicians and family members to predict whether a person will attempt or go on to complete suicide, and that expressions of suicidal ideation are an unreliable indicator. Dr Eagle noted that the clinical records of the AMHT appeared to indicate that DP was improving, and that when DP was seen on 15 January 2016, there was an appropriate assessment of relevant risk factors. She accepted that there was not any particular indication on 15 January 2016 (the last time that DP was seen by the AMHT) that he was likely to act as he did some four days later.

In considering this issue, I have been assisted by the submissions of counsel assisting and of Mr Bradley, who appeared for the Western Sydney Local Health District.

Counsel assisting submitted that DP appeared to be engaging with the AMHT and that the observations of the AMHT clinicians that DP was improving reflected observations made by DP's family. Mr Bradley submitted that the discharge plan for DP developed by Dr Liang was followed and highlighted the proactive and assertive follow up that DP received in the community. Mr Bradley submitted that there was evidence of DP's improvement and noted that the AMHT had plans for further follow up on 20 January 2020. Mr Bradley submitted that I would accept the evidence of Dr Eagle, that the care provided to DP was adequate and appropriate, and that the AMHT in particular provided a high standard of care.

Counsel assisting submitted that it would be open to me to find that the care and treatment provided to DP was both adequate and appropriate.

I found Dr Eagle's evidence on this issue to be of great assistance. I find that the care and treatment DP received for his mental health condition in the period 11 January 2016 to 19 January 1016 was adequate and appropriate and commend the AMHT for their assertive follow up of DP in the community.

Issues 2 – 4: The manner of DP's death

Issues 2 to 4 involved a consideration of the manner of DP's death, including the impact of his mental health condition and his use of methylamphetamine on his cognitive function and his conduct and behaviour at Quakers Hill Police Station on 19 January 2020. In considering these issues, I have been assisted by the evidence of Dr Eagle, and also an expert report prepared by Dr Jonathan Brett, clinical toxicologist, addressing the impact of the substances detected in DP's post-mortem blood sample.

Dr Brett concluded that, on the available evidence, DP was experiencing a methamphetamine use disorder as at 19 January 2016. Further, based on a combination of witness observations of DP and the level of methylamphetamine and amphetamine detected in DP's blood, Dr Brett concluded that DP was suffering from methamphetamine intoxication at the time of his death. Dr Brett noted in his report that in a person with a pre-existing psychosis or major depression, such intoxication can cause severe cognitive impairments. Dr Brett noted that it is difficult to determine when DP would last have consumed methylamphetamine, due to the effects of post-mortem redistribution. However, taking into account the methylamphetamine and amphetamine concentrations detected in DP's blood, Dr Brett opined that is likely that DP had used methamphetamine within the hours leading up to his death.

Dr Brett also had regard to the toxicological analysis results, which indicated that ziprasidone was not detected in DP's blood. Dr Brett indicated that this result meant that DP had not taken ziprasidone for a minimum 33 hours prior to his death. Consequently, Dr Brett concluded that it was unlikely that ziprasidone was exerting any anti-psychotic effect at the time of DP's death. Dr Eagle gave evidence that, at the time DP entered Quakers Hill Police Station, his judgment would have been impaired both by symptoms of psychosis and the effects of methylamphetamine. In coming to this view, Dr Eagle noted in her report that psychosis and methylamphetamine intoxication can result in significant disturbance of judgment, reason and mood.

In evidence, Dr Eagle expressed the view that DP was potentially experiencing auditory hallucinations and paranoia, causing an emotional response of distress or fear.

Dr Eagle further gave evidence that the methylamphetamine consumed by DP would have heightened his sensory experiences. She explained that methylamphetamine can cause feeling of euphoria, but also of fear and agitation. In light of the evidence of DP's previous expressions of suicidal ideation (see above at [22], [27], [36] and [37]), Dr Eagle expressed a view that this indicated that, as at 16 January 2016, DP had been struggling with his mental state and experiences and that he had been contemplating suicide, at least intermittently, for a period of time in the lead up to his death. Dr Eagle acknowledged DP's prior references to wanting police to shoot him and wanting to shoot himself with a police gun. She expressed a view that DP had considered that, if he was going to end his life, this would be the way that he would do it.

Dr Eagle concluded that DP most likely took the knife to the Quakers Hill Police Station on 19 January 2016 and lunged at Sergeant Weston with an intention of provoking police into shooting him. Dr Eagle further concluded that DP's judgment was likely significantly impaired by methylamphetamine intoxication and possible psychotic symptoms. Dr Eagle considered that DP, even in his disordered state, had some awareness of his actions and had formed an immediate intention to end his life in this way. She commented that this reflected DP's previous thoughts of ending his life by being shot by police. I have had regard to the totality of the evidence of the eyewitnesses, the toxicological analysis results, and the expert opinions of Dr Eagle and Dr Brett as to DP's actions and mental state on 16 January 2020. I have also been assisted by the submissions of counsel assisting and Mr Haverfield, who appeared for the Commissioner, on this issue, which I summarise below.

Counsel assisting submitted that DP had demonstrated some forethought of ending his life in a way that involved police. Counsel assisting further submitted that, whilst the evidence indicates that DP attended Quakers Hill Police Station with the intention of provoking police to shoot him, this evidence must be considered in light of DP's methylamphetamine intoxication, his symptoms of psychosis and the fact that DP had not taken his prescribed anti-psychotic medication in at least 33 hours. Accordingly, counsel assisting submitted that I would find that DP's thought processes and judgment were significantly impaired.

Mr Haverfield submitted that DP appeared to be aware of police training and was determined to take his life by provoking police to shoot him. In this regard, Mr Haverfield emphasised the evidence of witnesses to the effect that DP said, "*shoot me*" and "*shoot me now*". On the basis of the evidence it is clear that DP attended Quakers Hill Police Station in possession of a knife and lunged at Sergeant Weston with the intention of provoking police into shooting him. I find that DP's judgment was significantly impaired at that time by the effects of methylamphetamine intoxication and possible psychotic symptoms, and that these factors contributed to his behaviour.

Issue 5: Consideration of police actions on 19 January 2016 as a reasonable and proportionate response to the circumstances

Issue 5 involved consideration of the actions of the police officers present at Quakers Hill Police Station on 19 January 2016. In particular, the inquest considered whether Sergeant Weston's discharge of his firearm was a reasonable and proportionate response to the circumstances and DP's actions.

The Court has had the benefit of the transcripts of the directed interviews and statements from the officers present on 16 January 2016, and oral evidence from Sergeant Weston, Sergeant Hilder, Leading Senior Constable Whale, Senior Constable Stewart, Constable Holden and Constable Amiri. Statements were also obtained from civilian witnesses present at Quakers Hill Police Station and Mr Welsh, the member of the public sitting in the foyer at the time of the incident, gave oral evidence.

Additionally, Sergeant Glen Knox, a senior Operational Safety Instructor in the Weapons and Tactics Policy and Review Unit (**WTPR**) of the NSW Police Force, reviewed the circumstances of DP death and the actions of the police officers present on 16 January 2016. Sergeant Knox provided a report and gave evidence in the proceedings.

In preparing his report, Sergeant Knox considered the Tactical Options Model employed by the NSW Police Force, the training provided to officers regarding firearm use and the NSW Police Force policy in respect of discharging firearms (as contained in the Police Handbook).

Sergeant Weston gave evidence that, at the time he discharged his firearm, he was of the view that it was necessary to defend himself and others from the possibility of being killed or seriously injured. He perceived a risk to himself, Sergeant Hilder and the member of the public in the foyer (Mr Welsh). Sergeant Weston gave evidence that, due to the enclosed space and the proximity of DP, who was advancing with a knife, he did not consider that it was appropriate to use a baton, OC spray or a Taser.

Sergeant Weston stated that he aimed for DP's centre body mass, as this was the training he had received and he understood that this was because the centre body mass is the biggest target. Sergeant Weston considered that he did not have the option of disengaging and retreating into the EDO Office as DP posed a threat to Mr Welsh. Sergeant Weston also gave evidence that he would not have locked DP out of the police station, as this would have posed a risk to members of the public outside.

Sergeant Knox considered the various tactical options available to Sergeant Weston at the time he discharged his firearm and concluded that he was justified in discharging his firearm, there being an immediate risk to his life and the life of others present and there being no other way of preventing or neutralising the risk. Sergeant Knox noted that Sergeant Weston used a number of tactical options to attempt to gain control of the situation and have DP put down his knife. These included officer presence and communication. Despite use of these tactical options, DP did not comply with his direction (or those of other officers present) to drop the knife.

Sergeant Knox also noted that, whilst Sergeant Weston did not attempt to use weapon-less control or a baton, these would not have been appropriate tactical options for the situation confronting Sergeant Weston. Sergeant Knox confirmed this in his oral evidence.

In oral evidence, Sergeant Knox was asked whether there may have been some other tactical options that Sergeant Weston could or should have employed, including the use of OC spray, the deployment of a Taser or shooting at a different part of DP's body. Sergeant Knox gave evidence that, in relation to the use of OC spray, officers are trained to "spray, move, assess". Sergeant Weston was in close proximity to the wall of the EDO Office and therefore had little space to move back.

Sergeant Knox also indicated that there was a risk that the use of OC spray would contaminate Sergeant Weston himself and Mr Welsh, and noted that its effects can differ between people (and, as such, may not have irritated or incapacitated DP). Sergeant Knox gave evidence that he would not have used OC spray in the circumstances and that he would not instruct another officer to use OC spray in similar circumstances. Sergeant Knox gave evidence that for a Taser to achieve neuromuscular incapacitation, both probes need to connect and that it is most effective when the probes "split the belt line". Sergeant Knox explained that this can be difficult when a person is moving and/or wearing loose clothing. Sergeant Knox also indicated that, if the Taser did not incapacitate DP, Sergeant Weston was unlikely to have had sufficient time to transition to another tactical option.

Sergeant Knox gave evidence that, at the time DP rushed at Sergeant Weston, DP was likely too close to Sergeant Weston for the Taser to be effective and he did not consider that the use of a Taser would have been a wise choice in the circumstances.

Sergeant Knox gave evidence that officers are trained to shoot at the centre body mass for a number of reasons, including that it is a larger target than a person's extremities (thereby minimising the risk of missing the person and injuring a bystander), the difficulty of taking a well-aimed shot at a person's limb (particularly if they are moving), and because injuring a limb or other part of the body may not have the result of stopping the immediate threat. Acknowledging that it appears to be a common-sense position, counsel assisting asked Sergeant Knox whether he was aware of any studies or research done to support the proposition that that officers were less likely to miss their target when aiming for centre body mass (as opposed to a smaller body part). Sergeant Knox indicated that he was not aware of any literature, but that this was a worldwide practice. Sergeant Knox noted that injuries to a person's arms or legs can still be lethal.

Sergeant Knox was also asked to consider whether it would have been appropriate to lock the doors of the police station when Sergeant Hilder first saw DP with the knife near his vehicle, so as to prevent DP entering the foyer. Sergeant Knox was firmly of the view that it would not have been appropriate to leave DP, armed with the knife, outside with access to the general public. Sergeant Knox concluded that Sergeant Weston discharged his firearm as a last resort at extremely close range to protect himself from serious injury or death. Sergeant Knox further concluded that Sergeant Weston's actions were consistent with NSW Police Force policy, procedure and training practice guidelines.

In relation to this issue, counsel assisting submitted that, considering all the circumstances, the police response was a reasonable and proportionate response to the actions of DP and the threat that he posed. Counsel assisting submitted that, whilst Sergeant Weston had other tactical options available to him, such as the use of OC spray or a Taser, it was not unreasonable for him not to use them, given he was confronted with a person armed with a knife and had limited space to retreat.

Counsel assisting further submitted that, had Sergeant Weston retreated into the EDO Office and closed the door, this would have posed a risk to the member of the public in the foyer.

Mr Haverfield adopted counsel assisting's submission that the police response was a reasonable and proportionate response. In this regard, Mr Haverfield referred to the evidence of Mr Welsh that he "couldn't fathom how long [Sergeant Weston] waited" and that Sergeant Weston have DP every opportunity to put the knife down.

Mr Haverfield submitted that the officers acted in accordance with the tactical options model and their training, noting that Sergeant Weston only fired one shot to stop the threat posed by DP. Mr Haverfield further emphasised that there was an immediate attempt to render medical assistance to DP. Mr Haverfield submitted that I would not have any criticism of the actions of the police officers present on 19 January 2016.

Mr Madden, who appeared on behalf of Sergeant Weston, also adopted counsel assisting's submission that the police response was a reasonable and proportionate response and referred to the evidence of Mr Welsh.

Mr Madden submitted that Sergeant Weston was forced to discharge his weapon when DP advanced on him armed with a knife. He also submitted that Sergeant Weston had no time or space to use another tactical option. Mr Madden emphasised that Sergeant Weston gave DP every opportunity to drop knife and submitted that I would find Sergeant Weston's actions were a measured response to the threat he faced. I find that the actions of the officers present at Quakers Hill Police Station on 19 January 2016 were a reasonable and proportionate response to the actions of DP and the threat that he posed. I find that, at the time Sergeant Weston discharged his firearm, he did so as a last resort at extremely close range to protect himself and others from serious injury or death. I am satisfied that Sergeant Weston's actions were consistent with NSW Police Force policy, procedure and training.

Issue 6: Recommendations under s. 82 of the Act

A Coroner has the power under s. 82 of the Act to make any recommendations that are "necessary or desirable to make in relation to any matter connected with the death" having regard to the evidence before them. During the course of Sergeant Knox's evidence, counsel assisting asked him questions relating to the development of new tactical options and, in particular, less than lethal options for confronting persons armed with a knife. Sergeant Knox gave evidence that, whilst the WTPR is reviewing developments across Australia and internationally, there are no specific less than lethal options currently being considered in NSW.

Counsel assisting asked Sergeant Knox whether there was a formalised process for the WTPR to provide advice as to developments in less than lethal options and technology. Whilst Sergeant Knox indicated that informal advice is provided on an ongoing basis, he was not aware of a formal process for this to occur. At the conclusion of the proceedings, I indicated that counsel assisting would circulate a draft recommendation in relation to the WTPR providing formal advice as to developments in less than lethal options for confronting persons armed with a knife and that short written submissions on the draft recommendation would be welcomed from the legal representatives for the Commissioner.

On 21 November 2019, I received a short submission on behalf of the Commissioner indicating that, in practical terms, the provision of advice and review of developments in non-lethal or less lethal tactical options in respect of the use of force by NSW Police Force officers is something that the WTPR already does on a daily basis; however, should I form the view that a more formalised process is desirable, the Commissioner will consider requiring the Manager of the WTPR to provide a comprehensive report to the Assistant Commissioner for Education and Training Command every two years outlining:

The work that has been undertaken in the preceding two year period regarding less lethal tactics and techniques;

- Which tactics and technologies are considered viable;
- The tactics and technologies are being employed by other similar jurisdictions; and
- What tactics and technologies are being considered or are emerging in the near future.

I thank the Commissioner for his response and propose to make a recommendation to this effect.

FORMAL FINDING:

Identity of the Deceased
The deceased person was DP.

Date of Death
DP died on 19 January 2016.

Place of Death
DP died at Quakers Hill Police Station, Highfield Road, Quakers Hill NSW 2763.

Cause of Death
DP died as a result of a gunshot wound to the chest.

Manner of death
DP died after he attended Quakers Hill Police Station in possession of a knife and lunged at an officer, who discharged his weapon. DP intended to provoke police into shooting him; however his judgement was significantly impaired at that time by the effects of methylamphetamine intoxication and possible psychotic symptoms, which also impacted his behaviour.

RECOMMENDATIONS UNDER S. 82 OF THE CORONERS ACT 2009

After careful reflection on the evidence in the inquest and the submissions made by counsel assisting and the representative of the Commissioner, I make the following recommendation pursuant to s. 82 of the Act:

To the NSW Commissioner of Police:

That consideration be given to the creation of a formal process whereby the Assistant Commissioner for the Education and Training Command receives advice from the Manager of the Weapons Tactics Policy and Review Unit every two years regarding developments in non-lethal or less lethal tactical options in the use of force when dealing with offenders armed with a knife or cutting weapon, and then considers which options might be investigated or pursued by the NSW Police Force.

8. 56536 of 2016

Inquest into the death of Beanika Goak. Inquest suspended and papers referred to DPP by DSC Lee at Lidcombe on the 24 September 2020.

In accordance with *Section 78 of the Coroners Act* 2009 the Coroner, following the hearing of evidence and satisfied there is a prima facie case against a known person with a reasonable prospect of a conviction. The inquest is suspended the papers referred the papers to the Director of Public Prosecutions

9. 56558 of 2016

Inquest into the death of Roza Lowal Mawin. Inquest suspended and papers referred to DPP by DSC Lee at Lidcombe on the 24 September 2020

In accordance with *Section 78 of the Coroners Act* 2009 the Coroner, following the hearing of evidence and satisfied there is a prima facie case against a known person with a reasonable prospect of a conviction, The inquest has been suspended the papers referred the papers to the Director of Public Prosecutions

10. 56518 of 2016

Inquest into the death of Adut Mathang. Inquest suspended and papers referred to DPP by DSC Lee at Lidcombe on the 24 September 2020.

In accordance with *Section 78 of the Coroners Act* 2009 the Coroner, following the hearing of evidence and satisfied there is a prima facie case against a known person with a reasonable prospect of a conviction, The inquest is suspended the papers referred the papers to the Director of Public Prosecutions

11. 186812 of 2016

Inquest into the death of Mahmoud Allam. Finding delivered by DSC Lee at Lidcombe on the 25 March 2020.

On 3 June 2016, Mahmoud Allam, a 28-year-old young man, was taken into lawful custody and later transferred to Parklea Correctional Centre on 8 June 2016. Three days later, Mahmoud presented at a clinic within the correctional centre with cold like symptoms. Following repeated presentations over the next several days, Mahmoud was eventually transferred to hospital on the morning of 16 June 2016. Subsequent investigations confirmed the presence of a serious bacterial infection. The rapid progression of Mahmoud's disease was mirrored by the rapid deterioration of his condition. Mahmoud later tragically died on 19 June 2016, eleven days after entering a correctional centre.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or is sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be investigated in an objective manner. This is because a coronial investigation and an inquest seek to examine the circumstances surrounding that person's death in order to ensure, through an independent and transparent inquiry, that the State appropriately and adequately discharges its responsibility.

In this context it should be recognised at the outset that the operation of the Act and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum.

Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations.

These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

Recognition of Mahmoud's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Mahmoud's life in a brief, but hopefully meaningful, way.

Mahmoud was born on 24 February 1988 to his parents Nada and Youssef Allam. He was one of six children, with three brothers and two sisters. Mahmoud's family initially lived in Granville before later moving to Auburn. Mahmoud attended Auburn Public School and later Granville High School until Year 10. As young boy Mahmoud was very active and loved being outdoors. He was talented in many sports. As a young child, Mahmoud showed great interest and skill in gymnastics. Later, Mahmoud took his sporting talents to the rugby league field, where he played for the Berala Bears and later for the Guildford rugby league team. After receiving numerous sporting awards, Mahmoud's high school teachers suggested that he had the talent to pursue a career in sports. After leaving school, and while still maintaining his love for sports, Mahmoud began work as a painter. Mahmoud had a particular interest and skill in painting, and often assisted his family members with different painting tasks. This willingness to assist others typified Mahmoud's generous nature.

Mahmoud had many friends from many different backgrounds. He was a very sociable person. No doubt others gravitated towards Mahmoud because of his kind-hearted and caring nature. Mahmoud had a strong sense of community, was well known in his local area, and often gave his time freely and unselfishly for the benefit of others. Although Mahmoud did not have any children of his own, his family never held any doubts that he would have made a loving and devoted father. Apart from the bonds that Mahmoud had with his parents and siblings, he was also loved by his many nieces and nephews, and he adored them in return.

Mahmoud's strong sense of family, and the importance of it, only serves to underline what his loss means to those who loved him most. The enormous, tragic and sudden nature of their loss is truly distressing. Mahmoud leaves behind his loving parents and siblings, along with his extended family, all of whom are proud to call Mahmoud their beloved son, brother, and uncle.

Background to the events of June 2016

Mahmoud had his first interaction with the criminal justice system as an adult in 2006. He later served a period in custody before committing an armed robbery offence in 2012. This resulted in a further sentence of imprisonment of five years, with a non-parole period of two years and six months. Mahmoud was subsequently released to parole. However, on 3 June 2016 Mahmoud was arrested pursuant to a revocation of parole warrant as a result of being charged with further offences. Following his arrest, Mahmoud was detained in the cells at Penrith Court complex.

During a routine custody management assessment process Mahmoud reported no medical conditions, and made no complaints of any illness or pain, apart from sleeping problems and lower back pain. On 5 June 2016, Mahmoud was assessed by a nurse from Justice Health & Forensic Mental Health Network (**Justice Health**) in the cells at Penrith Court complex. It was noted that he had nil significant health issues and was suitable to be transferred to a correctional centre for normal cell placement. Mahmoud was subsequently taken to Amber Laurel Correctional Centre on 7 June 2016.

The events of June 2016

Admission to Parklea Correctional Centre

The following day, 8 June 2016, Mahmoud was admitted to Parklea Correctional Centre. On admission another assessment was performed by a Justice Health nurse as part of an intake screening assessment. Mahmoud again identified that he had been experiencing lower back pain, but denied any recent temperature or fever, or having used illegal or perception drugs in the preceding four weeks. Observations were taken of Mahmoud and they were found to be within normal limits. Mahmoud was prescribed Panadeine (presumably for pain relief in relation to his lower back pain) and also nicotine replacement therapy (**NRT**) patches. He was then cleared for normal cell placement.

11 June 2016

On the afternoon of 11 June 2016 Mahmoud attended the Area 3 clinic, a treatment room separate from the main clinic at Parklea that was generally used to treat "walk in" patients. Mahmoud saw a Justice Health nurse and reported cold like symptoms including a runny nose, ongoing back pain and reflux. Mahmoud's temperature was taken and he was found to be afebrile. Mahmoud was given Sudafed for his cold like symptoms, Panadeine for his pain, and Rennie for his reflux. No other remarkable findings were identified during this assessment.

12 June 2016

On the afternoon of the following day, 12 June 2016, Mahmoud again presented to the Area 3 clinic where he was seen by the same Justice Health nurse as the previous day. Mahmoud complained of a cough and was given medication consisting of a senega and ammonia mixture (used to treat a "wet" cough). In addition, Mahmoud was also given the medication that he had been provided with the previous day.

13 June 2016

At about 8:57am Mahmoud activated the call alarm button in his cell, a procedure known within the correctional setting as "knocking up". He spoke to a correctional officer and said that he needed to attend the clinic. In the recording of the knock up Mahmoud's voice can described as being hoarse or raw. At around 1:00pm (although the precise time is unclear) Mahmoud was later taken to the Area 3 clinic where he was assessed by a different Justice Health nurse than the one who saw Mahmoud on 11 and 12 June 2016. It was noted that Mahmoud was complaining of cold and flu like symptoms. Mahmoud was again given Sudafed and Panadeine, but not any further medication in relation to treatment of his cough.

After being returned to his cell, Mahmoud knocked up again at 4:20pm and 4:50pm. On each occasion Mahmoud requested cough medicine and complained to the correctional officers that he spoke to that it should have been provided when he had visited the Area 3 clinic earlier that day. Again, in the recording of the call Mahmoud's voice can be described as being hoarse. Despite Mahmoud's requests, it does not appear that any cough medication was initially provided to him. At 7:56pm, Mahmoud knocked up again and repeated his request. The correctional officer who answered the call indicated that she could do nothing more in relation to Mahmoud's request other than to pass it on to relevant Justice Health staff. Mahmoud did not consider this to be a satisfactory response, resulting in a heated exchange between himself and the correctional officer.

About five minutes after the call ended the same correctional officer used the knock up system to call Mahmoud to advise him that she had spoken to a Justice Health nurse. Mahmoud was informed that he would have to wait until the following day for his cough medicine. Mahmoud was again dissatisfied with this response and reacted in an angry manner.

14 June 2016

At about 6:42am on 14 June 2016 Mahmoud again knocked up and told the correctional officer that he spoke to that he had not slept and was having trouble breathing. Correctional officers subsequently attended Mahmoud's cell in order to take him to the main clinic. CCTV footage depicts Mahmoud stumbling and catching himself on a railing as he left his cell. As Mahmoud walked down the stairs from his cell he supported himself on the railing, and was assisted by a correctional officer. The footage also shows Mahmoud appearing to clutch his chest area. During the trip to the main clinic Mahmoud was unable to continue walking, even with the assistance of the accompanying correctional officers. A wheelchair was obtained and Mahmoud was taken to the main clinic in the wheelchair. On arrival Mahmoud was taken into the clinic for several minutes, but subsequently placed in a secure area known as the "clinic cage" at the clinic entrance.

He remained in this area for approximately 40 minutes, before being taken into the clinic at about 7:20am for an assessment.

Enrolled Nurse (**EN**) Lynda Steel assessed Mahmoud in the clinic. It was noted that Mahmoud was complaining of chest pain, appeared to be suffering from cold and flu like symptoms, and that he reported that he had been coughing up black phlegm after smoking NRT patches. Importantly, it was noted that Mahmoud had a small blind pimple at the end of his nose. EN Steel took Mahmoud's observations, which were within normal limits, and carried out an electrocardiogram (**ECG**) test which was also normal. EN Steel gave Mahmoud Panadeine for symptomatic relief, and arrangements were made for him to be kept in the clinic for observation for over an hour. Following this period of observation, Mahmoud reported to EN Steel that he was feeling much better and wanted to return to his cell. Arrangements were made for this to occur. CCTV footage of Mahmoud's return to his cell depicts him to be walking normally without assistance.

Due in part to a lockdown at Parklea from 11:00am onwards, Mahmoud remained in his cell for the remainder of the day (after making several telephone calls before being returned to his cell). Mahmoud's cellmate at the time, Mahmoud Dabboussi, noted that Mahmoud appeared to be displaying cold and flu like symptoms and that he had an "*ingrown pimple in his nose*".

Mr Dabboussi also noted that Mahmoud complained that his neck was hurting and that he did not have a pillow.

During the afternoon and evening Mahmoud made three more knock up calls:

At 2:19pm Mahmoud made a request for cough medicine although it appears that none was actually provided to him.

At 7:26pm Mahmoud requested a pillow after saying that his neck was twisted. Mahmoud also complained of a bad headache, back pain, being unable to walk, and feeling very low. The correctional officer who answered the call asked Mahmoud whether he wanted a nurse or a pillow. Mahmoud did not clearly indicate one way or the other, and the correctional officer indicated that arrangements would be made for roving officer to check up on him. However, it is not known whether this occurred.

At 8:31pm Mahmoud repeated his request for a pillow, repeated that his neck was twisted, said that he was very agitated, and that he had been vomiting phlegm for the previous three hours. The correctional officer who answered the call advised Mahmoud that he did not have access to any pillows.

15 June 2016

At 5:12am on 15 June 2016 Mahmoud again knocked up, complaining that he was getting an infection in his eye. Mahmoud was advised that correctional officers would attend his cell. However this did not occur for around 30 minutes, during which time Mahmoud made three further knock up calls. During one of these calls, Mahmoud complained of difficulty breathing. Once correctional officers attended Mahmoud cell, he was taken to the main clinic. On this occasion Mahmoud made his way there without assistance.

Mahmoud arrived at the clinic at about 5:54am. At some point after arriving EN Steel assessed Mahmoud and found that he had swelling and redness to the right tip of his nose that extended to his right eye. EN Steel also noted that it appeared that Mahmoud may have been squeezing the small blind pimple at the end of his nose (which had been noted the previous day), although Mahmoud denied doing so.

EN Steel formed the view that Mahmoud should be seen by a doctor, and arrangements were made for this to occur. Whilst Mahmoud was waiting, he remained for part of the time in an observation cell, and for part of the time in the clinic cage at the entrance. CCTV footage during this period shows Mahmoud appearing to be very agitated, repeatedly wiping his nose and eye area with toilet paper, repeatedly rubbing some sort of cream or ointment into his neck, and repeatedly getting up from the bed in the observation cell and the bench in the clinic cage.

Dr Chetan Valabjee, a locum medical officer, saw Mahmoud shortly after 9:00am. By this time Mahmoud had been at the clinic for just over three hours. According to Dr Valabjee's clinical notes, Mahmoud presented with "*right nasal localised cellulitis*" which had started with a carbuncle at the right nasal tip. Dr Valabjee assessed Mahmoud and found that he had no fever or headache, was clearly oriented to time place and person, and that vital sign observations taken were normal.

On this basis, Dr Valabjee noted that Mahmoud was systemically well. Dr Valabjee prescribed Telfast (an antihistamine), Panadeine, Voltaren (a non-steroidal anti-inflammatory) and loratadine (an antihistamine) for symptomatic relief, an intramuscular injection of penicillin, and oral flucloxacillin to be administered four times a day. Orders were also made for a nasal cavity swab to determine the nature of the bacteria causing the cellulitis, and for Mahmoud to be kept in an observation cell for the remainder of the day and overnight.

Mahmoud remained in an observation cell for the remainder of 15 June 2016. CCTV footage (which is only available until 4:20pm on 15 June 2016) shows Mahmoud to be in a similarly agitated state when he first presented to the clinic whilst waiting to be seen by Dr Valabjee. The footage depicts Mahmoud frequently wiping his eye and nose area, frequently rubbing his neck, frequently knocking or banging on the door of the observation cell, and frequently pacing around the observation cell between periods of rather fitful rest on the cell bed.

16 June 2016

Between about 4:30am and 5:00am on 16 June 2016 Mahmoud knocked up from the observation cell. He was subsequently seen by Registered Nurse (**RN**) Rosslyn Hayter. She noted that Mahmoud was complaining of difficulty breathing, a painful neck because he had been without a pillow, and back pain from a previous accident. RN Hayter performed a visual assessment and noted that Mahmoud was not displaying signs of shortness of breath or obvious respiratory distress. RN Hayter gave Mahmoud Panadeine and Voltaren for symptomatic relief, and cleared him to return to the observation cell. Although Mahmoud complained of being unable to walk back to the cell, he was subsequently able to do so.

It appears that shortly before 8:00am a decision was made to transfer Mahmoud to Blacktown Hospital. Following his arrival Mahmoud was assessed in the emergency department at around 10:45am. On examination, Mahmoud reported that his upper respiratory tract infection symptoms first appeared on 11 June 2016, and that his lower respiratory tract infection symptoms and pimple on his nose first appeared on 14 June 2016 Mahmoud also reported losing consciousness at some point on 16 June 2016. Arrangements were made for Mahmoud to be administered intravenous flucloxacillin, with investigations to be performed and input sought from the hospital's infectious diseases team.

A blood test was taken at 11:43am which revealed that Mahmoud's C-reactive protein was markedly elevated, indicating infection or inflammation. A chest x-ray performed shortly after 12:00pm revealed a left hemithoracic pneumothorax and fluid in the lung. Following this, infectious diseases clinicians later assessed Mahmoud and changed the antibiotic prescribed from flucloxacillin to vancomycin to address the possibility of Methicillin-resistant Staphylococcus aureus (**MRSA**). A CT scan of Mahmoud's head was ordered which revealed features suggestive of cavernous sinus thrombosis. Blood culture tests and a wound swab were ordered, which later revealed the growth of MRSA.

17 June 2016

Mahmoud's condition deteriorated during the remainder of 16 June 2016. Following examination on the morning of 17 June 2016 by neurological clinicians an urgent repeat CT scan was ordered. After it was performed at about 10:39am it revealed right paranasal sinusitis, features suggestive of partial right cavernous sinus thrombosis, a prevertebral collection in the neck, multiple bilateral pulmonary and subpleural nodules and a left pneumothorax. Arrangements were made to transfer Mahmoud to Westmead Hospital where he arrived in the emergency department at shortly before 12:00pm. On examination, Mahmoud reported that he had picked a pimple on the right side of his nose two days ago "*which resulted in spreading infection to write periorbital region*". Mahmoud also reported having "*snorted some cocaine*" two weeks earlier. Mahmoud repeated these reports when he was examined by infectious diseases clinicians later that afternoon.

On assessment, Mahmoud was found to have swelling and inflammation over his right eye, cheek and nose. It was also noted that swelling of the tongue and deterioration of voice quality suggested imminent airway obstruction. Mahmoud was considered to be suffering from MRSA bacteraemia. Controlled elective intubation took place and Mahmoud was subsequently admitted to the intensive care unit for infusion of intravenous antibiotics, including vancomycin. And intercostal catheter was inserted in response to the left pneumothorax. Mahmoud was noted to be febrile and tachycardic but otherwise in a stable condition over the course of the night.

18 June 2016

On review on the morning of 18 June 2016 Mahmoud was noted to be haemodynamically stable, but with a deterioration in his oxygenation overnight and patches of consolidation forming in all four lung quadrants. Although positive airway pressure provided some improvement in respiratory function, there was a subsequent rapid deterioration in Mahmoud's cardiovascular function.

Further investigations revealed an extension of the cavernous sinus thrombosis, involving the ophthalmic vein.

19 June 2016

On review on the morning of 19 June 2016, it was noted that Mahmoud had developed another right-sided pneumothorax which required another intercostal catheter to be inserted. Given Johns worsening condition extracorporeal membrane oxygenation was initiated. However, Mahmoud's condition continued to deteriorate rapidly, and he became haemodynamically unstable and required ongoing fluid resuscitation. Mahmoud also suffered episodes of rapid atrial fibrillation and developed multi-organ system failure, including renal failure and worsening lactic acidosis. Despite maximal life support therapy being provided, Mahmoud failed to respond to these intensive measures and so, following consultation between his family and treating clinicians, a decision was made to not initiate cardiopulmonary resuscitation. Following this poor prognosis, Mahmoud's family returned to his bedside and he progressed to asystole a short time later. Mahmoud was subsequently sadly pronounced deceased at 7:04pm on 19 June 2016.

What was the cause and manner of Mahmoud's death?

Mahmoud was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Kendall Bailey, forensic pathologist, on 21 June 2016. The autopsy identified "*marked reddening and swelling of the right side of the face and multiple lesions on the right side of the nose*". Diffuse pneumonia with multiple abscess formation was identified in both lungs.

Microscopic examination confirmed florid widespread pneumonia with fibrin deposition and diffuse alveolar damage. Subsequent neuropathological examination of the brain revealed inflammation of the meninges, the underlying cerebral cortex and within the ventricles. Signs of hypoxic ischaemic injury were also noted. In her subsequent autopsy report dated 9 February 2017, Dr Bailey opined that the cause of Mahmoud's death was MRSA sepsis.

What issues did the inquest examine?

Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the matters to be considered. That list identified the following issues:

- The circumstances and clinical features of Mahmoud's presentation to the clinic at Parklea between 11 and 16 June 2016;

- Whether the care and treatment provided by nursing and medical staff at Parklea to Mahmoud between 11 and 16 June 2016 was timely and appropriate, including, but not limited, to:

- the adequacy of assessments and investigations undertaken; and

- the adequacy of steps taken with respect to diagnosis, management, monitoring and treatment of Mahmoud's facial skin and soft tissue infection;

- the circumstances surrounding Mahmoud's transfer from Parklea Correctional Centre to Blacktown Hospital, including steps taken by correctional staff to notify Mahmoud's family of his hospital admission;

- The existence and adequacy of policies, procedures and protocols in place at Parklea in June 2016 for the recognition and management of community-acquired methicillin-resistant Staphylococcus aureus (**CA-MRSA**) infections in custodial populations; and

In order to assist with consideration of some of these issues, opinion was sought from the following experts as part of the coronial investigation:

Associate Professor David Andresen, a consultant infectious diseases physician and microbiologist; and Associate Professor Bernard Hudson, a consultant infectious diseases physician and microbiologist.

Both experts provided reports which were included in the brief of evidence. Further, both experts also gave evidence concurrently during the inquest. One aspect of the expert evidence should be noted at this point. At the commencement of the inquest, and prior to the tender of the brief of evidence, Counsel for Justice Health raised an objection in relation to the tender of the expert reports of Associate Professor Hudson and Associate Professor Andresen. The objection was made on the basis that the opinions expressed in the reports were from two senior infectious diseases physicians in relation to the standard of care exercised by primary healthcare practitioners, namely Justice Health nursing staff and a locum medical officer.

Both expert reports were subsequently admitted into evidence with an indication that appropriate consideration would be given to the different and higher level of expertise of the two experts, relative to that of the primary healthcare clinicians involved in Mahmoud's care and management. That degree of consideration has remained unchanged. The objection taken in relation to the expert reports has similarly been a recurrent theme in the written submissions made on behalf of Justice Health. That is, Counsel for Justice Health has repeatedly submitted that the Court has not received any expert peer opinion in relation to the management of Mahmoud's care by Justice Health clinicians. On this basis, it is submitted, the Court ought to be reluctant to criticise the conduct of any Justice Health staff in the absence of any such peer opinion.

When consideration is given to these submissions the following is noted:

Although objection was taken to the tender of the expert reports from Associate Professor Andresen and Associate Professor Hudson, no similar objection was taken to any aspect their oral evidence.

The submissions made by Counsel for Justice Health in relation to the limitations which must be placed on the expert evidence are, understood correctly, directed only towards the opinions expressed by Associate Professor Hudson, in both his report and in oral evidence.

The submissions do not appear to regard that similar limitations should apply to any opinion expressed by Associate Professor Andresen, particularly in circumstances where that opinion is not critical of any aspect of management provided by Justice Health clinical staff. It is accepted that both in his report and in oral evidence Associate Professor Andresen at times expressed reluctance in offering an opinion in relation to the reasonableness of care provided by primary healthcare practitioners, given his higher level of expertise and training.

The relevance of any opinion expressed by an expert in relation to the professional conduct of another person is not limited by whether that expert is a peer of that person. Rather, the issue is whether the expert has the relevant training, study or experience in order to be able to express any such opinion. In the present matter, no issue was taken in relation to the training, study or experience of either Associate Professor Andresen or Associate Professor Hudson, except to the extent that it was submitted, Associate Professor Hudson maintained in his evidence that he was a peer of a primary healthcare clinician. However, the correct position is that Associate Professor Hudson did not maintain that he was such a peer. Rather, Associate Professor Hudson indicated that by virtue of his training, study, and experience (which relevantly included experience as both a general practitioner and experience of a correctional environment in a professional context) he had the relevant expertise to express the opinions that he did.

In giving their oral evidence both experts were specifically requested to take into account, in assessing the adequacy and appropriateness of Mahmoud's management, that the relevant clinicians were primary health care practitioners (namely an enrolled nurse, a registered nurse and a general practitioner). Finally, it was made clear by both experts, and it is accepted, that the standard of care applicable to any assessment of the adequacy and appropriateness of Mahmoud's management is that of a primary healthcare clinician, and not that of a specialist infectious diseases physician.

Having regard to each of the above matters, appropriate consideration can be given (and has been given) to the expert opinions expressed by both Associate Professor Andresen and Associate Professor Hudson.

Methicillin-resistant Staphylococcus aureus

Staphylococcus aureus is a "highly successful opportunistic pathogen". It is a frequent coloniser of the skin and mucosa of humans and animals and can produce a wide variety of diseases. These diseases can include relatively benign skin infections, as well as life threatening conditions including pneumonia, sepsis, endocarditis, and deep-seated abscesses. In humans Staphylococcus aureus has a preference for the anterior nares (nostrils), especially in adults and is shed onto healthy skin. Nasal carriage of Staphylococcus aureus has become a way of persistence and the spread of multi-resistance staphylococci especially MRSA. Staphylococcus aureus is responsible for an array of infections, including skin and soft tissue infections, lower respiratory tract infections, bloodstream infections and other infections, including those of the urinary tract, brain and abdominal cavity.

Some strains of Staphylococcus aureus have developed resistance to antibiotics and are known as MRSA. MRSA are resistant to methicillin (an antibiotic of the penicillin class) and other closely related antibiotics such as, relevantly, flucloxacillin. MRSA is present in both healthcare environments and within the community, with the latter known as community-acquired methicillin-resistant Staphylococcus aureus (**CA-MRSA**).

In terms of treatment, "*established, overwhelming infection with CA-MRSA is difficult to reverse, even in young, healthy persons. The earlier that appropriate antibiotic therapy is applied in CA-MRSA infection, the more likely cure can be obtained with such treatment. Early recognition is facilitated by recognising early those patients who possess risk factors for CA-MRSA carriage and skin and soft tissue infections*". It is also noted that "*the systemic features of CA-MRSA infection, once present, can be difficult to recognise, especially in a feeble patients. Early use of blood tests and blood cultures facilitate early diagnosis and can be lifesaving*".

In both the written expert reports and in oral evidence there was some debate about whether there is evidence to support a conclusion that individuals in a correctional setting are at greater risk of CA-MRSA than those within the general community. Associate Professor Hudson expressed the view that "*in the last two decades, it has been recognised that residents of correctional facilities are at greater risk of CA-MRSA colonisation and infection than the general population*". Further, Associate Professor Hudson explained that experiences in the United States have led to the development of guidelines for the prevention and management of CA-MRSA in correctional facilities. Associate Professor Hudson expressed the opinion that similar extensive guidelines must be developed for Australian correctional facilities with a national, rather than a state, body being the preferable vehicle through which this might occur.

Associate Professor Andresen considered that "*socio-economic risk factors for MRSA such as ethnicity and social disadvantage almost certainly explain a substantial proportion of the elevated rates in North American custodial settings*".

On this basis, Associate Professor Andresen expressed the view that "*incarceration has never been demonstrated to predict MRSA in adult Australian populations*", in contrast to North America. Whilst of the view that caution should be exercised in extrapolating North American data, Associate Professor Andresen noted that as indigenous Australians are overrepresented in custodial populations and are also at an increased for MRSA (with one of the two most common community clones being very common in indigenous Australian populations) "*higher rates of MRSA in custodial populations would be at expected simply on the basis of the racial profile of Australian correctional inmates*".

Notwithstanding, Associate Professor Andresen expressed strong support for well conducted, local epidemiological studies to inform the development of relevant guidelines in the future.

Was Mahmoud appropriately cared for and treated at Parklea between 11 and 16 June 2016?

It is convenient to consider the first and second issues together, given that the clinical features of Mahmoud's presentation are directly relevant to the care and treatment that was provided to him. Further it is also convenient to consider the period between 11 and 16 June 2016 in two distinct stages.
11 to 13 June 2016

In his report Associate Professor Hudson noted that Mahmoud presented initially with coryzal symptoms on 11 June 2016, then with cold and flu like symptoms on 12 and 13 June 2016. On each occasion Mahmoud was provided with symptomatic relief for an apparent respiratory tract infection. In evidence, Associate Professor Hudson considered that Mahmoud's presentation on 11 and 12 June 2016 was consistent with an upper respiratory tract infection, and that it was reasonable to manage his presentation without further investigation. On this basis, Associate Professor Hudson considered the management of Mahmoud's condition to be appropriate. However, by 13 June 2016 Associate Professor Hudson considered that whilst MRSA was not indicated, Mahmoud should have been referred to a medical practitioner and pre-emptive investigation in the form of blood tests should have been performed. This is because Associate Professor Hudson noted that it was the third occasion in which Mahmoud had presented, with increasing symptomatology.

In this regard Associate Professor Hudson expressed the view that a person presenting for the third time in an outpatient setting with increasing symptomatology, such as that displayed by Mahmoud, would invite consideration of the possibility that something more clinically serious was present than merely an upper respiratory tract infection. This consideration, in turn, should have resulted in referral to a medical practitioner and blood tests being performed. Therefore, Associate Professor Hudson considered that Mahmoud's management on 13 June 2016 was inadequate. In evidence Associate Professor Andresen indicated that he felt uncomfortable applying the standard of care relevant to his practice to a different setting, namely the correctional environment in which Mahmoud was managed. However Associate Professor Andresen noted that by 13 June 2016 there was still nothing of concern regarding Mahmoud's presentation to warrant consideration of MRSA. Further, Associate Professor Andresen expressed the view that even if blood tests had been ordered, their results may not have led to any change in Mahmoud's management.

This is because whilst the blood tests may have revealed raised inflammatory markers, Mahmoud otherwise looked well. In this regard, Associate Professor Andresen explained that it was unclear to him how blood tests performed on 13 June 2016 "*would be helpful*".

Counsel for Justice Health submitted that a distinction ought to be drawn between three presentations by a patient to a clinic in a community setting as opposed to a correctional setting. This is because in a community setting a patient is not required to present in order to receive routine medications. In evidence Associate Professor Andresen acknowledged this difference, and that a third presentation in a correctional setting may not necessarily be a "*red flag*" as it might be in a community setting. This prompted Associate Professor Andresen to express his discomfort in "*sitting in judgement*" of the care provided to Mahmoud.

Associate Professor Hudson similarly acknowledged the differences between a correctional and community setting. However, whilst Associate Professor Hudson appeared to acknowledge that the reason for Mahmoud's third presentation was to receive medication, he also explained that it was an opportunity to see whether or not Mahmoud's clinical condition had improved, worsened, or remained the same. To this extent, Associate Professor Hudson considered that Mahmoud's presentation had two components: prescription of medication and an opportunity for review.

Conclusions: Notwithstanding the underlying reason for Mahmoud's presentation on 13 June 2016, the evidence from Associate Professor Hudson establishes that it represented an opportunity to review Mahmoud's condition. In Associate Professor Hudson's opinion seizing this opportunity should have led to Mahmoud being referred to a medical practitioner for further assessment and blood tests being performed.

Whilst this opportunity can be regarded as one that was missed, it could not be said that it represented inadequacy regarding Mahmoud's management. This is for two reasons. Firstly, the expert evidence was divided as to the clinical utility of any blood test results that might have been performed. Secondly, Associate Professor Hudson's consideration of Mahmoud's increasing symptomatology giving rise to the need to consider a more serious clinical condition was qualified on the basis of a patient presenting in an outpatient setting.

14 June 2016

EN Steel said in evidence that in reviewing Mahmoud on 14 June 2016 she performed a "*head to toe assessment*" during which she noted that Mahmoud complained of chest pain and phlegm, but made no complaints of shortness of breath or difficulty breathing, difficulty walking (even though he arrived in the treatment room in a wheelchair, which EN Steel explained was not an uncommon occurrence for inmate patients attending the clinic), neck or back pain, loss of consciousness, or difficulty sleeping. EN Steel said that she formed the impression that Mahmoud had flu like symptoms. She arranged for an ECG to be performed in relation to the complaint of chest pain in order to rule out any cardiac issues.

EN Steel also said that Mahmoud volunteered information that he had been smoking NRT patches and in response she informed him that this was dangerous and poisonous.

In particular, EN Steel said that she had particular regard to Mahmoud's heart rate and did not consider it to be elevated, and that his blood pressure and temperature (taking into account that it might have been affected by Panadeine) were also within acceptable clinical ranges. EN Steel said that she had received training in relation to MRSA whilst previously having worked in a hospital setting. She had no specific recollection of similar training being provided by Justice Health, but expressed some confidence that it would have formed part of an in-service program. EN Steel said that she did not give specific consideration to MRSA, and that she did not regard Mahmoud's presentation as warranting such consideration. This was despite her awareness that MRSA can manifest as skin infections in the form of pimples.

EN Steel explained that there was no medical officer available on 14 June 2016, but agreed that if she considered that further assessment of Mahmoud was required she could have raised the issue with either the on-call GP, or a registered nurse. However, EN Steel said that she did not consider that Mahmoud's presentation warranted further assessment, even by a registered nurse. Associate Professor Hudson noted that the "*clinical features of productive cough, difficulty breathing and generally feeling unwell indicate that, more likely than not, CA-MRSA pneumonia was already present on the morning of 14 June 2016*". In evidence, Associate Professor Hudson expressed the view that by the time of Mahmoud's fourth presentation he should have been referred to a medical practitioner and that it was inappropriate for a nurse to be the only healthcare professional to be seeing him. This was particularly so given that Mahmoud had presented with a new symptom, namely chest pain, and a persistent cough.

Further, Associate Professor Hudson considered that further investigation was warranted and that if the pimple had developed into a pustular lesion, then it would have been appropriate to perform a swab and further investigation. Associate Professor Andresen agreed that it would have been appropriate to perform a swab if a pustular lesion had been present, although this was unclear given the lack of a comprehensive description. Associate Professor Hudson also considered that given Mahmoud's presentation occurred in a correctional setting it would have been appropriate by 14 June 2016 to consider the possibility of MRSA.

Both Associate Professor Hudson and Associate Professor Andresen agreed that Mahmoud's respiratory rate was borderline elevated, that his vital signs would be difficult to interpret in someone who was agitated, and that his heart rate (which was regarded as being below the upper limit of normal) did not necessarily imply physiological arrangement (particularly in the case of a patient displaying agitation). Having regard to these vital sign measurements both Associate Professor Hudson and Associate Professor Andresen agreed that it would have been appropriate to have repeated the observations following a period of rest.

Both Associate Professor Hudson and Associate Professor Andresen agreed that Mahmoud's vital signs indicated that he was "*between the flags*" in the context of being asked to define whether a patient was systemically well or unwell. Associate Professor Hudson indicated that a patient being "*between the flags*" was one objective clinical marker but that it was also important to identify other clinical markers such as a patient's overall presentation and symptomatology. Associate Professor Andresen similarly agreed that an "*astute clinician*" may have made something more of these other clinical markers, notwithstanding that a patient might be "*between the flags*".

More specifically, Associate Professor Hudson considered that a patient presenting with flu like symptoms indicates that they are systemically unwell. Associate Professor Andresen explained that the definition of a patient being systemically unwell was a subjective one. He said that it was important for a clinician to examine how a patient appeared when sitting in front of them, and in this regard described such an examination as almost a clinician's "*gut feeling*".

Ultimately, Associate Professor Andresen deferred addressing whether he considered Mahmoud's presentation on 14 June 2016 could be described as being systemically unwell as he had not personally had the opportunity to examine him.

Both experts agreed that chest auscultation on 14 June 2016 was warranted, with Associate Professor Andresen indicating that a "*careful listen*" could assist in determining whether or not a chest x-ray was indicated. In evidence RN Steel said that she could not recall whether she used a stethoscope to auscultate Mahmoud's chest, even though it was her usual practice to do so when performing a full assessment of a patient. EN Steel also acknowledged that no chest auscultation was documented even though she "*most likely*" would have done so if this had occurred. In response to questions by counsel for Justice Health, EN Steel indicated that it was her usual practice to record any significant findings in the clinical progress notes, and that even if the chest auscultation was normal this would still be documented.

Conclusions: On the basis of Mahmoud's vital signs there was no clinical evidence which indicated that his management should have been escalated or that further investigative tests should have been performed. Whilst the expert evidence established that Mahmoud's respiratory rate was borderline elevated, the evidence also established that Mahmoud's vital signs would have been difficult to interpret due to his level of agitation.

Further, the expert evidence also established that a clinician's assessment of the patient in front of them was an important factor in considering the need for escalation and/or further investigation. In this regard, it is difficult to be critical of the management provided by EN Steel in the absence of a clinical finding which clearly demonstrated that escalation and/or further investigation on 14 June 2016 was warranted.

In evidence Associate Professor Hudson expressed the view that a nursing assessment of the kind performed by EN Steel on 14 June 2016 is protocol-driven, and that he would expect there to have been a protocol in place to indicate that a fourth presentation by a patient "*should ring alarm bells*". However, Counsel for Justice Health correctly notes that there is no evidence of any procedure, policy, or standard that would have supported Mahmoud's referral to a medical practitioner based upon his presentation on 14 June 2016. Having regard to these factors, it could not be said that the care provided by EN Steel on 14 June 2016 was either inadequate or inappropriate.

Although EN Steel said that it was her usual practice to perform a chest auscultation as part of her assessment of a patient, the absence of any documentation in this regard (which was also part of EN Steel's usual practice) indicates that it is most likely that a chest auscultation was not performed. Given that the expert evidence established that this was warranted, it can be concluded that the absence of a chest auscultation represented a gap in Mahmoud's clinical care. However, it is not possible to reach any conclusion about whether a chest auscultation might have altered the course of clinical treatment.

One final matter requires comment. As noted above both Associate Professor Andresen and Associate Professor Hudson considered that repeat observations following a period of rest may have provided greater clarity in relation to Mahmoud's vital signs, in particular his respiratory rate and heart rate. EN

Steel said that she placed Mahmoud under observation in order to ensure that his condition was not worsening and ensure that her treatment was sufficient. Although she could not recall how frequently she checked up on Mahmoud, EN Steel said that he raised no new complaints and that she did not observe any new symptoms.

However, there is no evidence that EN Steel repeated observations of Mahmoud's vital signs after he had been placed under observation. This represented a missed opportunity to obtain a greater degree of clinical clarity. However it is again not possible to make any determination about whether repeat observations might have revealed any findings of possible clinical significance, or whether such findings indicate the need for escalation and/or further investigation.

The inquest received relatively little evidence regarding the nature and extent of any training provided by Justice Health to clinical staff in relation to the detection, management and prevention of CA-MRSA. However, the sudden and unexpected nature of Mahmoud's death, and the rapid progression of his disease, provides an opportunity to ensure that appropriate training programs are in place for Justice Health clinicians who may be confronted with similar presentations in similar circumstances.

In this regard it has already been noted that there was some debate in the evidence of Associate Professor Hudson and Associate Professor Andresen as to whether CA-MRSA is more prevalent in correctional centres compared to other settings within the community. Associate Professor Andresen expressed the view that the question is an open one and whilst there is biological plausibility and some data from overseas correctional centres, it would be a mistake to extrapolate that data in the absence of sufficient understanding of the differences between correctional centres in different jurisdictions. However, notwithstanding, Associate Professor Andresen expressed the view that the risk of CA-MRSA in Australia in correctional centres is likely to reflect underlying socio-economic factors (such as poverty, ethnicity, household crowding) of inmate populations. Associate Professor Andresen considered that whether these factors are compounded by a correctional setting is a matter for further research.

However, even Associate Professor Andresen acknowledged that given the presence of these factors in study populations higher rates of MRSA are to be expected. Indeed, this is specifically recognised by the NSW Health Factsheet, *Staphylococcus aureus in the community – Information for clincians* (**the NSW Health Factsheet**). It relevantly provides that "*crowding and frequent skin to skin contact can increase the risk of infection so outbreaks tend to occur in schools, dormitories, military barracks, correctional facilities, and childcare centres*". Having regard to these matters, the following recommendations are desirable.

Recommendation 1: I recommend that Justice Health review its training programs and material for clinical staff to ensure that adequate and appropriate measures are in place for the detection, management, and prevention of community-acquired methicillin-resistant Staphylococcus aureus (CA-MRSA), including by considering whether: (a) existing training programs and material recognise that CA-MRSA is likely to be more prevalent in correctional centres than in other settings within the community; and (b) the circumstances of Mahmoud Allam's death (with appropriate anonymization, and conditional

upon consent being provided by Mahmoud's family and following appropriate consultation with them) should be used as a case study as part of any training programs delivered to clinical staff.

Recommendation 2: I recommend that Justice Health give consideration to whether it is necessary or desirable to develop a specific policy or guidelines concerning the prevention, detection and management of community-acquired methicillin-resistant Staphylococcus aureus.

In relation to Recommendation 2 it was submitted on behalf of Justice Health that whilst Justice Health is involved in the early identification and treatment of MRSA, the prevention of it is not within the purview of Justice Health. This is because, it is submitted, prevention of MRSA is centred around issues of personal hygiene, sanitation of clothing including of services, all of which are operational matters controlled by a correctional centre's operator. However, it is difficult to accept that a primary health care provider has no part to play in relation to the prevention of disease which might affect those persons who may ultimately be provided with care. Indeed, it is significant to note that RN Hayter considered that (whilst having its own inherent challenges) education regarding personal hygiene is provided to inmates on their admission to a correctional centre and throughout the course of their period in custody.

In evidence Associate Professor Hudson considered that the collection of data and analysis in a prospective and retrospective manner is indicated. Associate Professor Hudson agreed with this view, and further emphasised that education could be embarked upon whilst the process of information gathering is undertaken. Both experts agreed were supportive of appropriate training measures being put in place and awareness being raised, even in the absence of local data being available. Therefore it is desirable to make the following recommendation. In doing so, it is acknowledged that no evidence has been received regarding the feasibility of, and the limitations associated with, conducting the type of data collection and analysis contemplated.

Recommendation 3: I recommend that Justice Health give consideration to whether it is possible (having regard to relevant limitations) to conduct or commission research by (a) analysing historical patient data (already held by Justice Health); and (b) collecting future patient data (including appropriate social, economic and demographic data), in order to assist in determining the prevalence of community-acquired methicillin-resistant Staphylococcus aureus in correctional centres in New South Wales.

15 June 2016

EN Steel said that when she first approached Mahmoud on 15 June 2016 she could see that his swelling had "*obviously changed*" from the previous day. EN Steel described the swelling at the tip of his nose to be more prominent, and said that she saw Mahmoud rubbing his face. EN Steel also observed redness under Mahmoud's eye, but said she was unsure whether this was due to infection or Mahmoud rubbing his face.

EN Steel said that she could not recall seeing a pustular lesion but would have made a note of it if she had, and that at the time Mahmoud made no complaints of coughing, loss of consciousness, or vomiting. EN Steel also said that she formed the view that Mahmoud needed to be seen by a doctor, and told him that a GP would be available shortly and that he would have to be patient.

Dr Valabjee had not seen Mahmoud prior to 15 June 2016. Before his assessment he had been told by nursing staff that Mahmoud had a localised face infection which required review by a medical practitioner. Dr Valabjee said that it would have been his usual practice to review the clinical progress notes for a patient prior to an assessment, but had no specific recollection of whether he did so in Mahmoud's case. Overall, Dr Valabjee's assessment of Mahmoud took about 20 minutes (from 9:05am to 9:25am). At its conclusion, Dr Valabjee documented that Mahmoud was systemically well. In evidence, Dr Valabjee said that he would not have written this lightly.

Dr Valabjee also indicated that the documentation of Mahmoud being systemically well was a summation, and that he would have asked Mahmoud a number of questions such as whether he had been experiencing any breathing issues, nausea, headache, or bowel and bladder symptoms. Dr Valabjee said he did not have a specific recollection of asking Mahmoud these questions but said that he was "*reasonably confident*" that he had asked them as they are the type of questions that he had religiously asked 99 percent of patients whilst previously working in a rural health care setting.

Dr Valabjee agreed that it was important to determine whether Mahmoud was systemically well or not, because a different course of treatment would be called for if he was not systemically well. As at June 2016 Justice Health did not have any policy which specifically addressed CA-MRSA or skin and soft tissue infections in custodial populations. Instead, Justice Health adopted the *Therapeutic Guidelines: Antibiotic* (**the Antibiotic Guidelines**) published periodically by the Therapeutic Guidelines Limited.

The Antibiotic Guidelines relevantly provide that: oral antibiotic therapy "*is adequate for cellulitis and erysipelas not associated with systemic features of infection*"; initial intravenous therapy is usually required when two or more systemic features of infection are present, such as raised temperature, increased heart rate or respiratory rate, and increased white cell count; antibiotic choice for cellulitis and erysipelas without systemic features is dependent on whether the infection is likely to be caused by Streptococcus pyogenes or Staphylococcus aureus (including CA-MRSA); for patients with cellulitis and erysipelas without systemic features, and where Staphylococcus aureus is suspected based on clinical presentation, flucloxacillin (orally, six hourly for five days) is to be used; and for patients with cellulitis or erysipelas associated with two or more systemic symptoms (but not associated with hypotension, septic shock or rapid progression of systemic features), and where Staphylococcus aureus is suspected based on clinical presentation, who are at increased risk of CA-MRSA, vancomycin intravenously is to be used.

Dr Valabjee was asked whether the clinical progress notes regarding Mahmoud's presentations on 11, 12, and 13 June 2016 would have been relevant to his determination of whether Mahmoud was systemically well.

Dr Valabjee explained that he would have had an independent discussion with Mahmoud and taken a history from him. Dr Valabjee said that if Mahmoud did not disclose anything specific in the course of this historical review then he could only base his assessment on his discussion with Mahmoud. Overall, Dr Valabjee said in evidence that he stood by his assessment.

Dr Valabjee said that the area of redness that he observed was confined to the nasal cleft area and did not extend to Mahmoud's eye, otherwise he would have drawn it in the diagram that he made in the clinical progress notes. Dr Valabjee also said that at the time of his examination the cellulitis did not appear pustular in nature, and was simply red and localised.

Dr Valabjee said that he prescribed penicillin to treat streptococcus, and that he prescribed flucloxacillin to treat a suspected staphylococcus infection. He agreed that he ordered a swab of the nose to be taken to be sure that appropriate antibiotic cover was being directed to the organisms on Mahmoud's face, and to check the sensitivity of the medication in dealing with the pathogen.

Dr Valabjee said that he did not appreciate any significant medical limping when CCTV footage was played to him. He also said that he did not observe any puffiness to Mahmoud's face or any neck stiffness as he turned his head. Dr Valabjee was asked why blood tests were not ordered. He explained that the infection was localised to Mahmoud's face, and that a blood test may or may not have added much in terms of Mahmoud's immediate management. Therefore, Dr Valabjee considered that treatment for the infection and a swab was the first line of management. As Mahmoud did not have a temperature, his observations were within limits, and he was systemically well, Dr Valabjee did not consider that opting for pathology was appropriate as a first line of management.

Dr Valabjee was asked whether he considered the possibility of MRSA at the time that he assessed Mahmoud. Dr Valabjee said that the reason he ordered the swab was to determine what organism he was dealing with. He said that he was weighing up differential diagnoses in his mind at the time and that he tried to remain open as to what investigation to conduct. Dr Valabjee was also asked whether he considered that MRSA might be more prevalent in a correctional setting. He said that literature from the United States had demonstrated that it might be more prevalent, but that he had not seen or had any experience of this being replicated in Australia.

He said that based on his previous experience with Justice Health and as a locum medical officer, MRSA did not appear to be a rampant problem in settings where he had worked. However, Dr Valabjee sought to emphasise that this did not mean that he did not try to ensure that it was not present in his examination of Mahmoud. Dr Valabjee said that he had no specific recollection of reading a NSW Health Fact Sheet dated 30 June 2012 which stated that crowding can increase the risk of an outbreak occurring in a correctional facility, but said that he would have attempted to keep up-to-date with all relevant information. Dr Valabjee was also asked if he considered whether Mahmoud should have been transferred to hospital.

Dr Valabjee said that based on his review he considered that Mahmoud was stable enough to be managed in a medical observation cell with a planned review the following morning.

Dr Valabjee said that he did not see Mahmoud again following his review, and did not check on his condition before he left the clinic at 4:00pm later that day. Dr Valabjee also said that he did not ask nursing staff for an update on Mahmoud's condition, but explained that the nursing staff would have flagged any concern with him. Dr Valabjee said that he had an expectation that observations could be performed four times per day or once per shift, whatever was convenient for nursing staff. He agreed that his expectation regarding the level and frequency of observations was not documented. He further agreed that it would have been better, with the benefit of hindsight, for him to have documented his expectations regarding observations to be performed for Mahmoud overnight. Associate Professor Hudson considered that Mahmoud's presentation on 15 June 2016 warranted consideration of MRSA.

Associate Professor Hudson noted that Mahmoud had a skin infection, was in a correctional facility, had passed through another correctional facility prior to arriving at Parklea, and that Mahmoud's facial cellulitis was in what he described as being in a "*danger area*" or the "*danger zone*", involving the nose and upper lip. On this basis, Associate Professor Hudson considered that Mahmoud should have been referred for intravenous therapy, and that an intramuscular injection of penicillin together with an oral dose of flucloxacillin was inadequate. Associate Professor Andresen considered that it may have been reasonable for Mahmoud to have been sent for intravenous therapy at this point in the clinical course. However he did not think that it was reasonable to be critical of the decision to treat Mahmoud with oral therapy and close observations. Associate Professor Andresen considered that this was one of several reasonable courses of action available, and ultimately thought it was a matter for clinical judgement to be made at the bedside.

Associate Professor Andresen agreed that whilst Mahmoud had a bacterial infection, he looked systemically well. Associate Professor Hudson considered that it would be difficult to conclude that Mahmoud was not systemically well given that Dr Valabjee had made the assessment at the time with the patient in front of him. On this basis, Associate Professor Hudson indicated that Dr Valabjee's assessment would have to be accepted. Notwithstanding, Associate Professor Hudson considered that the mere fact of Mahmoud presenting with facial cellulitis in the "danger zone" warranted referral of itself, irrespective of whether he was systemically well or unwell. However, Associate Professor Andresen sought to emphasise that the issue was not so clear-cut, and that in certain cases of facial cellulitis oral therapy and close observations would be appropriate treatment. In such instances, Associate Professor Andresen considered that referral would be appropriate if the condition was progressing rapidly, in circumstances where daily assessment was required.

Conclusions: In evidence Associate Professor Hudson sought to emphasise the differences between flu and flu-like symptoms, with the latter implying aches and pains, temperature and general unwellness. On this basis he opined that a patient presenting with such symptoms would be regarded as being systemically unwell. Therefore, having regard to the overall context of Mahmoud's presentation, Associate Professor Hudson considered it to be obvious that Mahmoud was systemically unwell.

However, such an assessment should not detract from the fact that both Associate Professor Andresen and Associate Professor Hudson acknowledged that a conclusion as to whether or not a patient is systemically unwell is "*impressionistic*". That is, it would be difficult to second-guess, with the benefit of

hindsight, an assessment made by a clinician at the time with a patient in front of them. This is particularly so in circumstances where the evidence demonstrates that Dr Valabjee's assessment of Mahmoud on 15 June 2016 took about 20 minutes. Further, there is no basis upon which to conclude that Dr Valabjee did not appropriately illicit information from Mahmoud in order to properly reach a conclusion that he was systemically well. Therefore, the clinical conclusion reached by Dr Valabjee was one that was open to him. Similarly, Dr Valabjee's treatment plan of oral flucloxacillin therapy was also open to him, and consistent with the recommended choice of antibiotic therapy pursuant to the Antibiotic Guidelines. This is despite the fact that Mahmoud's facial cellulitis was located in the "danger zone". The Antibiotic Guidelines do not provide for intravenous antibiotic therapy in such instances (as opposed to oral antibiotic therapy).

In evidence, Associate Professor Hudson noted that the Antibiotic Guidelines (most recently published in 2019 do not refer to the "danger zone" or whether residence in a correctional centre is a risk factor for CA-MRSA. Both Associate Professor Hudson and Associate Professor Andresen considered that a national guideline would be highly desirable, whilst acknowledging a difficulty with the question of timeliness because the relevant expert group that contributes to the Antibiotic Guidelines only meets quadrennially. It is therefore desirable to make the following recommendations.

Recommendation 4: I recommend to the Chief Executive Officer, Therapeutic Guidelines Limited that consideration be given to referring the following issues to the antibiotic expert group that prepares the next edition of the *Therapeutic Guidelines: Antibiotic*: (a) whether there is a proper epidemiological basis for developing a particular treatment guideline or recommendation for choice of antibiotic therapy in relation to cellulitis in the so-called "danger area" or "danger zone" of the face (the area from the corners of the mouth to the bridge of the nose, including the nose and maxilla); and (b) whether there is a proper epidemiological basis for identifying residence in a correctional centre as a risk factor for patients with purulent cellulitis or in whom Staphylococcus aureus is suspected based on clinical presentation (with reference to Box 2.3.1 of the *Therapeutic Guidelines: Antibiotic* (2019)).

Recommendation 5: I recommend to the Chief Executive Officer, Therapeutic Guidelines Limited that consideration be given to whether there is an appropriate way to address the issues referred to in *Recommendation 4* prior to the publication of the next edition of the *Therapeutic Guidelines: Antibiotic,* such as by the establishment of a special or ad hoc working group, or otherwise.

One further aspect of Dr Valabjee's management of Mahmoud requires consideration. The solicitor for Mahmoud's family submitted that by 15 June 2016 Mahmoud's right eye was inflamed, consistent with EN Steel's observations during the morning of that day that Mahmoud's appearance had obviously changed from the previous day. It is submitted that this was indicative of a more widespread cellulitis than was appreciated by Dr Valabjee which in turn warranted referral to a hospital. In support of this submission, attention is directed to CCTV footage (and in particular, still images) of Mahmoud on the morning of 15 June 2016.

The evidence of EN Steel and Dr Valabjee is directly in conflict on this issue. On the one hand Dr Valabjee maintained that Mahmoud's facial cellulitis did not extend to his eye area, whilst on the other hand EN Steel said that it did. Both versions are supported by contemporaneous notes made by both EN Steel and Dr Valabjee.

Conclusions: Due to the limited quality of the CCTV footage it is difficult to embark upon an examination of the kind which the solicitor for Mahmoud's family invites. Indeed, it is not possible to reach a positive conclusion about the extent of Mahmoud's facial cellulitis as depicted in the footage, given the quality of the footage (with blurriness and shadow present). Therefore, reliance must be placed on the evidence given by both Dr Valabjee and EN Steel, and their documented accounts, given that they both had an opportunity to observe Mahmoud directly. Whilst there is no basis to consider either account unreliable, it is most likely that Dr Valabjee's observation is correct given EN Steel's acknowledgement that the redness which she reported observing might have been due to Mahmoud rubbing his eye, rather than being representative of an extension of his facial cellulitis.

Following his assessment Dr Valabjee requested that Mahmoud be placed in a medical observation cell, for review the following day in the clinic. According to the Justice Health *Observation Bed Policy* Dr Valabjee was required to advise nursing staff of "*the required level observation*" and the "*regularity of clinical measurements*". Furthermore, in accordance with the Justice Health *Clinical Handover Policy* Dr Valabjee was also required to ensure that "*any information handed over [was] documented in the patient's health record*".

In evidence Dr Valabjee acknowledged that he did not document his expectation to nursing staff regarding the level and frequency of observations that were to be made of Mahmoud. Dr Valabjee explained that in his mind a patient being placed in a medical observation cell "*encapsulated*" observation of that patient's vital signs. Dr Valabjee also said that as a general "*rule of thumb*" observations of a patient were generally performed four times per day or once per nursing shift. In this regard, Dr Valabjee seemed to deflect some responsibility in communicating his expectations of nursing staff regarding observations by seeking to explain that if a nursing staff member had been present during his consultation they would be aware of his expectation, and that if a nursing staff member was not so aware that they would seek clarification from him. In evidence Dr Valabjee acknowledged that, with the benefit of hindsight, it would have been better practice to have documented his expectations regarding observations to be taken of Mahmoud overnight.

Conclusions: Counsel for Justice Health submitted that there was no reason for Dr Valabjee to doubt that observations of Mahmoud (that is, once per shift) would not have been performed in accordance with relevant Justice Health policy. However, the issue is not one with respect to whether Dr Valabjee had any reason to doubt such practice, but whether he appropriately communicated his treatment plan to nursing staff. On this basis, given the concession made in evidence by Dr Valabjee himself, it would have been better practice for such expectations regarding observations to have been documented in the clinical progress notes.

During the course of the inquest Justice Health put into issue an aspect of Mahmoud's care whilst at Blacktown Hospital, namely when his antibiotic therapy was changed from flucloxacillin to vancomycin. From the documentary evidence there is no dispute that Mahmoud was first administered vancomycin at around 5:00pm on 16 June 2016. Certainly, an addendum to Mahmoud's Patient Health Record notes that by 5:08pm vancomycin was being administered intravenously "ATOR" (at time of report).

Counsel for Justice Health submitted that instructions for this change in therapy did not occur until around 4:12pm when Mahmoud was reviewed by clinicians form the infectious diseases team (Dr Dotel, Dr Harmer and Dr Sawaqed, along with two medical students) at Blacktown Hospital. However, it is submitted that preceding this review, Mahmoud had actually been reviewed by an infectious diseases registrar (Dr Jason Harmer) at 1:13pm. At that time, flucloxacillin remained as the antibiotic therapy. Therefore, it is submitted that the reasonableness of Dr Valabjee's assessment of Mahmoud on 15 June 2016 is affirmed by the management that Mahmoud subsequently received at Blacktown Hospital. In other words, when Mahmoud was initially reviewed by a clinician from the infectious diseases team, it was considered that flucloxacillin remained the appropriate antibiotic therapy, and that recognition of the need to change this therapy did not occur until some three hours later.

As has already been noted above, it is accepted that the antibiotic component of Dr Valabjee's management of Mahmoud was in conformity with the Antibiotic Guidelines and therefore reasonable. Therefore, it would appear to be unnecessary to identify precisely when Mahmoud's antibiotic therapy was changed at Blacktown Hospital. Part of the difficulty involved with undertaking such a task is that Mahmoud's Patient Health Record from Blacktown Hospital when provided in response to the coronial investigation was not assembled in chronological order, and does not contain timestamps in relation to progress note entries indicating when consultations occurred. As a result, as Associate Professor Andresen acknowledged in evidence, interpretation of the relevant records in effect now amounts to "*guesswork*". That said, given the (perhaps undue) attention that this issue received during the course of the inquest, consideration has been given to establishing when instructions were given for Mahmoud's antibiotic therapy to be changed.

According to Consultation and Case Conference Documents from Mahmoud's Patient Health Record from Blacktown Hospital, a "*Progress Note – Medical*" was made at 1:13pm and again at 4:12pm. Located within the same Patient Health Record are two "*Progress Note – Medical*" entries, one authored by Dr Sawaqed (**Dr Sawaqed's progress note**) with the other authored by Dr Harmer (**Dr Harmer's progress note**), neither of which bears a timestamp. Dr Harmer's progress note indicates that Mahmoud was "*awaiting CT orbits, which is scheduled for 4pm*". The progress note goes on to record, "*I have handed over to the ED MO assigned to this case…who will chase the report if in the ED, or handover to the ward JMO to chase if moved towards…If the R orbit is involved, we'll need to discuss with max fax at WMH, and change antibiotics*".

Justice Health submitted that Dr Harmer's progress note relates to the consultation as 1:13pm, and therefore indicates that Mahmoud's antibiotic therapy remained unchanged at this time.

It is acknowledged that Dr Harmer's progress note appears to be consistent with an initial consult being performed by a registrar from the infectious diseases team at 1:13pm ahead of a further consultation involving other, and more senior, clinicians from infectious diseases team at 4:12pm.

Dr Sawaqed's progress note indicates that a CT head with contrast was ordered in order to rule out orbital cellulitis and intracranial extension. This suggests that the scheduled "*CT orbits*" referred to in Dr Harmer's progress note had not taken place by 4:12pm, the time of the second consult. However, there is other evidence which suggests that Dr Sawaqed's progress note relates to the 1:13pm consult:

As at June 2016 Dr Nigel Wolfe was a staff specialist neurologist and head of the Department of Neurology at Blacktown Hospital. As the on-call neurologist for 16 June 2016 Dr Wolfe was contacted at around 9:30pm and asked to accept shared care (with the infectious diseases team) of Mahmoud. In his statement dated 11 December 2016, Dr Wolfe noted that on his review of the available medical records, Mahmoud was seen by infectious diseases team at 1:13pm. Although it is acknowledged that Dr Wolfe did not become involved in Mahmoud's management until after the two infectious diseases consults, and that his statement as to the timing of the consults represents an interpretation of the Patient Health Record, he had the advantage of providing contemporaneous care to Mahmoud and making his statement with reasonable contemporaneity to June 2016.

Dr Sawaqed's progress note indicates that the plan formulated for Mahmoud was for vancomycin to be administered intravenously, together with blood cultures to be taken and a wound swab to be performed. Pathology records indicate that the wound swab was performed and blood cultures taken at 2:05pm and 2:08pm respectively on 16 June 2016.

The Hospital Escort Journal completed by correctional officers who escorted Mahmoud to Blacktown Hospital records that at 1:20pm "*Doctors [sic] team visited [Mahmoud]*".

Finally, in evidence Associate Professor Andresen acknowledged that "*there are delays*" within hospital environments and therefore it was quite possible for some time to pass between when the order was given for Mahmoud's antibiotic therapy to be changed, and for it to be eventually charted. When asked whether he had an expectation that a change in antibiotic therapy would be performed quickly, associate Professor Andresen indicated that his expectation was that this would occur "*within a couple of hours*".

Conclusions: Accepting the limitations described above in relation to interpretation of Mahmoud's Patient Health Record, it is most likely that the order for Mahmoud's antibiotic therapy to be changed occurred during an infectious diseases team consult at Blacktown Hospital at 1:13pm. Whilst the issue is not without doubt, the contemporaneous records identified above support this conclusion.

Observations and medication administration on 15 and 16 June 2016

An issue also arises in relation to whether Justice Health nursing staff took vital sign observations of Mahmoud between the conclusion of Dr Valabjee's examination at around 9:25am on 15 June 2016 and when Mahmoud was assessed by RN Hayter at around 4:00am on 16 June 2016. This period of time covers three nursing shifts: the balance of the morning shift from about, relevantly, 9:25am to 3:00pm; the afternoon shift from about 1:00pm to 9:30pm; and the night shift from about 9:30pm to 7:30am the following day.

CCTV footage from each of these periods does not show any vital sign observations of Mahmoud being performed by any Justice Health staff member. However, it should be emphasised that there is no CCTV footage for much of the afternoon and night shift, between 4:20pm on 15 June 2016 and 5:00am the following day. That said, there are also no documented vital signs observations for any of the three shifts. Mahmoud's Standard Adult General Observation (**SAGO**) chart was unable to be located by Justice Health, in circumstances where it would ordinarily be expected to form part of his clinical records.

Although the inquest did not receive evidence from nursing staff rostered during the afternoon shift, evidence was given by RN Hayter who was the only staff member rostered on during the night shift. RN Hayter said that she had no personal interaction with Mahmoud between 9:30pm on 15 June 2016 and 4:00am the following day. RN Hayter said that she had no recollection of looking through the window to Mahmoud's cell in order to perform any type of observations. RN Hayter explained that the only observations that she made of Mahmoud were visual observations, namely periodically watching him on CCTV footage whilst she performed other duties.

When these visual observations were made, RN Hayter said that she noticed nothing alarming that would have caused her to request correctional officers to open Mahmoud's cell (so that further assessment could be conducted). RN Hayter said that it appeared to her that Mahmoud was walking and talking normally, did not appear to have any difficulty breathing, and was not showing any clinical signs indicative of an imminent medical emergency. When it was suggested that such observations would have been difficult to make from merely watching CCTV footage, RN Hayter sought to explain that if Mahmoud had been experiencing difficulty breathing he would have been sitting down and not walking normally, and he would not have been talking normally by virtue of needing to use auxiliary muscles "*to get air in*".

According to Mahmoud's medication chart he was scheduled to be administered flucloxacillin at 12:00am on 15 June 2016. According to the same chart, Mahmoud had earlier been administered flucloxacillin at 8:00am, 12:00pm and 6:00pm. Each of these notations was signed by the nurse administering medication. However, the 12:00am entry for flucloxacillin on Mahmoud's medication chart bears no such signature. In evidence RN Hayter said that she had no recollection of whether she administered flucloxacillin to Mahmoud at 12:00am or not. However she indicated that it would have been her general practice to sign a patient's medication chart when medication is administered.

That being so, RN Hayter frankly conceded that the absence of her signature probably indicated that flucloxacillin was not given to Mahmoud, explaining this omission to be a matter of "*human error*".

In her evidence RN Hayter said that she recalled Mahmoud to be banging on the door of his cell and calling out at intervals over a long period. RN Hayter had no specific recollection of what Mahmoud was calling out but said in evidence that she knew that Mahmoud wanted to leave the clinic and return to his cell. Further, RN Hayter said that Mahmoud made no request to be seen by a doctor. RN Hayter's recollection of Mahmoud's behaviour during the evening shift is consistent with the available CCTV footage. This footage depicts many occasions in which Mahmoud attempted to attract the attention of clinic staff, attempts which were apparently not responded to. Mahmoud's motivation in attempting to attract the attention of clinic staff members and engage with them is not known.

In evidence RN Hayter said that she spent about 30 minutes with Mahmoud on the morning of 16 June 2016. On behalf of Mahmoud's family it is submitted that this should not be accepted given that will it was a particularly busy morning, and RN Hayter's assessment was attended by three correctional officers in the cell because Mahmoud was being verbally abusive. Against this, it is submitted that RN Hayter explained in evidence that she had had a "myriad of discussions" with Mahmoud and that she had completed a detailed progress note. Further it is submitted that the presence of three correctional officers meant that RN Hayter's assessment was not quick or rushed, despite her acknowledgement later in evidence that Mahmoud's demeanour made it more difficult to provide a level of care to Mahmoud which was required.

Conclusions: Counsel for Justice Health acknowledges that RN Hayter should have, at the very least, taken vital sign observations and administered flucloxacillin as directed by Dr Valabjee. On behalf of RN Hayter it is submitted that although not perfect, the care provided by RN Hayter was appropriate given the clinical picture and her level of knowledge at the time. This submission is difficult to reconcile against RN Hayter's own acknowledgement that she had no personal interaction with Mahmoud, and her concession that it was likely she did not administer flucloxacillin to Mahmoud at 12:00am. It should also be noted that RN Hayter's understanding of Mahmoud's clinical picture cannot and should not detract from the requirements of Justice Health policy to perform vital sign observations during each nursing shift

Ultimately it is not possible nor, more importantly, necessary to reach any conclusion about the length of time that RN Hayter spent with Mahmoud on the morning of 16 June 2016. This is because in evidence RN Hayter acknowledged that she did not take Mahmoud's vital signs and that, in hindsight, she "*probably should have*" and that doing so may have made a difference to her assessment (even though she explained that Mahmoud's presentation was not in any way indicative of respiratory distress). However, it should be noted that in evidence RN Hayter also explained that she could not recall whether she had seen Mahmoud the previous day (15 June 2016, because he had a blanket over his face and so she may not have seen his face adequately) and therefore did not have a baseline from which to make an assessment of any worsening of Mahmoud's facial cellulitis.

Overall, the nature of observations performed of Mahmoud between 15 and 16 June 2016 was not adequate or appropriate in the circumstances. Even in the absence of portions of CCTV footage and documentary records such as a SAGO chart, it is most likely that vital sign observations were not performed and that flucloxacillin was not administered at 12:00am. Further, it appears to be at least somewhat surprising that Mahmoud's repeated attempts to attract the attention of persons within the clinic were not responded to. However, in this regard it is acknowledged that it is not possible to identify Mahmoud's motivation in doing so, and whether these attempts necessitated a response of some kind, especially a clinical one (as opposed to an administrative one which was within the responsibility of correctional officers). Finally, it should also be acknowledged that there is no evidence to suggest that even if Mahmoud had been administered flucloxacillin at 12:00am that this would have altered his clinical course, given that it is not an MRSA-active antibiotic. Having regard to the demonstrated departure from established Justice Health policies by Dr Valabjee, RN Hayter and EN Steel it is necessary to make the following recommendation.

Recommendation 6: I recommend that Justice Health review its training programs for clinical staff to ensure that they appropriately emphasise the importance of: (a) properly documenting all aspects of a patient's treatment plan in the patient's health record; (b) properly documenting the level/type and frequency of observation in the patient's health record in relation to patients who are to be placed in a clinical observation bed (or otherwise observed for a period in the clinic); and (c) giving timely and appropriate consideration to whether the medical care and treatment required by a patient can be practically and realistically delivered in a correctional centre setting, bearing in mind considerations such as staffing levels, security protocols and other similar matters.

Mahmoud's transfer to hospital and notification provided to his family

Section 7.3.7.3 of the CSNSW Operations Procedures Manual (**OPM**) deals with notifying the emergency contact person for an inmate in circumstances where an inmate is hospitalised. It provides: "*if an inmate is admitted to hospital as an inpatient (i.e. they will be remaining overnight in the hospital) with little or no warning, then the GM (or the GM's authorised officer) must ensure the inmates emergency contact person is notified*".

It goes on to provide: "*when an inmate is admitted as an inpatient with no advance warning…the GM (or authorised officer) is to ensure that the inmates emergency contact person is notified of the situation, as soon as possible and on the same day it is confirmed that the inmate will be admitted as an inpatient*". With this background in mind, the evidence established that Mahmoud's family were not notified of his transfer to hospital until the evening of 17 June 2016, by which time Mahmoud had already been transferred from Blacktown Hospital to Westmead Hospital.

Section 6.4.3.7 of the OPM provides for the use of telephones by inmates during hospital escort. It provides that "*inmates will be allowed one telephone call on admission to hospital. An escorting officer will make the call for the inmate…Thereafter, a bedside phone will be installed for the inmate to receive incoming calls. An escorting officer will answer all calls*…".

As the operator of Parklea Correctional Centre, GEO Group (**GEO**) was required to have relevant policies in place that were not inconsistent with the OPM. Section 5.22 of the GEO Group *Parklea Correctional Centre Operating Manual – Escorts (Policy No. PCC/OP019)* (**the GEO Escorts Policy**) deals with the use of telephones by inmates during hospital escort. Specifically section 5.22.1 provides that "*inmates will be allowed one telephone call on admission (inmates have been allocated a bed in a ward and not waiting in emergency) to hospital*". Further section 5.22.2 provides: "*thereafter, a bedside phone will be installed for the inmate to receive incoming calls*". The evidence established that GEO did not facilitate Mahmoud making a call to his family until the evening of 17 June 2016.

The detrimental effect of Mahmoud's family not being notified of his transfer to hospital until 17 June 2016, and Mahmoud not being able to make a phone call to them until the same day, should not be understated. Mahmoud's youngest sister, Rayan, explained that when Mahmoud was eventually able to make a call and spoke to his mother he enquired why his family had not visited him. Further, Rayan explained, "*Not only was Mahmoud suffering, he was suffering alone. We should have been given the respect to be by his side*".

The following is evident from the above policy documents:

Pursuant to Section 7 of the OPM, Mahmoud's family were to be notified once he was admitted to hospital, with admission being defined as remaining overnight at hospital; Pursuant to both Section 6 of the OPM and GEO Escorts Policy, Mahmoud was allowed one telephone call on admission, with admission not defined within Section 6 of the OPM.

On behalf of GEO it is submitted that regard must be had to the fundamental purpose underlying the relevant policies. That is, section 5.18 of the GEO Escorts Policy deals with security and general conduct on medical escorts. Specifically 5.18.1 provides that "*the primary responsibility of the escorting officers is to provide adequate security and supervision at a level appropriate to the circumstances pertaining to the patient*". Therefore, it is submitted, the primary reason that an inmate's family are not immediately notified when that inmate is transferred from a correctional centre to a hospital is for security reasons. There are, in essence, two considerations relevant to these issues of security: the need to mitigate the possibility of any security risk associated with an inmate's transfer (when an inmate is beyond the confines of a correctional centre), and the need to mitigate the possibility of any security risk if an inmate is only temporarily absent from a correctional centre (such as attending an emergency department and then being returned to a correctional centre without being omitted).

In Mahmoud's case it is submitted that having regard to an investigation report completed by the Corrective Services New South Wales (**CSNSW**) investigator (which did not identify any breaches of CSNSW policies by GEO Group staff). It was decided that 12:30pm on 16 June 2016 that Mahmoud was to be transferred from Blacktown Hospital to the intensive care unit at Westmead Hospital. It is further submitted that this was followed by a period of uncertainty, due in large part to bed availability, resulting in Mahmoud's transfer being delayed and him not being admitted to Westmead Hospital until 2:30pm on 17 June 2016.

Although not explicitly stated, the submissions made on behalf of GEO Group have been understood to be that non-compliance with the relevant policies relating to notifying Mahmoud's family of his transfer to hospital and allowing Mahmoud to call his family were due to the uncertainty associated with his transfer to Westmead Hospital and not being admitted there until 2:30pm on 17 June 2016.

In this context the following should be noted: The Blacktown Hospital records, together with the statement of Dr Wolfe, explicitly established that Mahmoud was admitted at Blacktown Hospital under the care of the infectious diseases team. The GEO Hospital Escort Journal records that Mahmoud was advised by doctors at 1:30pm on 16 June 2016 that he "*will stay over the weekend in [Blacktown Hospital]*". This reference to an overnight stay would appear to meet the definition of "admission" set out in Section 7.3.7.3 of the CSNSW Operations Procedures Manual. Although there appears to have been some initial uncertainty regarding bed availability, Mahmoud was allocated a ward bed by no later than 8:30am on 17 June 2016. Although Section 5.22 of the GEO Escorts Policy stipulates that admission is taken to mean when an inmate is allocated a ward bed and not waiting in an emergency department, Section 6.4.3.7 of the OPM contains no such stipulation. As GEO was required to have policies in place that were not inconsistent with respective CSNSW policies, Section 6.4.3.7 should be regarded as the prevailing policy.

Conclusions: Having regard to each of the above matters it is evident that Mahmoud had been admitted to Blacktown Hospital by at least 1:30pm on 16 June 2016. This in turn means that the relevant provisions of the OPM and GEO Escorts Policy were not complied with. For avoidance of doubt, it should be noted that Section 7.3.7.3 of the CSNSW Operations Procedures Manual requires notification as soon as possible and on the same day as admission. Even taking into account the matters submitted on behalf of GEO and the need to fulfil security requirements, it could not be said that the notification to Mahmoud's family was given as soon as possible.

One final matter should be noted. It was submitted on behalf of GEO Group that even if notification had been given to Mahmoud's family it is not known whether permission to visit him would have been allowed. Although there is no direct evidence as to this issue, it can be inferred that certain considerations will ordinarily apply in relation to the issue of whether an inmate is able to receive a visit from family members. That said, the issue here is one of notification rather than visitation. Again in the absence of direct evidence, it may be inferred that the purpose of providing such notification as soon as possible is so that an inmate's family members can be informed in a timely manner of an acute medical event which requires an inmate's hospitalisation and, in turn, take necessary steps to respond to such an event.

Formal Finding:

Identity

The person who died was Mahmoud Allam.

Date of death

Mahmoud died on 19 June 2016.

Place of death

Mahmoud died at Westmead Hospital, Westmead NSW 2146.

Cause of death

The cause of Mahmoud's death was MRSA sepsis.

Manner of death

Mahmoud died as a result of natural disease process, whilst in lawful custody. This natural disease process most likely involved development of facial skin infection in an inmate patient with community-acquired methicillin-resistant Staphylococcus aureus colonisation (CA-MRSA), followed by spread of the skin infection, concurrent with spread of CA-MRSA from the facial skin to the right cavernous sinus, and bloodstream invasion by CA-MRSA. Metastatic sites of infection included the lungs and epidural and prevertebral spaces, leading to a number of manifestations, including cavernous sinus thrombosis, encephalitis, epidural abscess, overwhelming sepsis and multi-organ failure.

Recommendations made pursuant to section 82 *Coroners Act 2009*

To the Chief Executive, Justice Heath & Forensic Mental Health Network:

1. I recommend that Justice Health & Forensic Mental Health Network (**Justice Health**) review its training programs and material for clinical staff to ensure that adequate and appropriate measures are in place for the detection, management, and prevention of community-acquired methicillin-resistant Staphylococcus aureus (**CA-MRSA**), including by considering whether:

    (a) existing training programs and material recognise that CA-MRSA is likely to be more prevalent in correctional centres than in other settings within the community; and

    (b) the circumstances of Mahmoud Allam's death (with appropriate anonymization, and conditional upon consent being provided by Mahmoud's family and following appropriate consultation with them) should be used as a case study as part of any training programs delivered to clinical staff.

2. I recommend that Justice Health give consideration to whether it is necessary or desirable to develop a specific policy or guidelines concerning the prevention, detection and management of community-acquired methicillin-resistant Staphylococcus aureus.

3. I recommend that Justice Health give consideration to whether it is possible (having regard to relevant limitations) to conduct or commission research by:

(a) analysing historical patient data (already held by Justice Health); and

(b) collecting future patient data (including appropriate social, economic and demographic data), in order to assist in determining the prevalence of community-acquired methicillin-resistant Staphylococcus aureus in correctional centres in New South Wales.

4. I recommend that Justice Health review its training programs for clinical staff to ensure that they appropriately emphasise the importance of:

(a) properly documenting all aspects of a patient's treatment plan in the patient's health record;

(b) properly documenting the level/type and frequency of observation in the patient's health record in relation to patients who are to be placed in a clinical observation bed (or otherwise observed for a period in the clinic); and

(c) giving timely and appropriate consideration to whether the medical care and treatment required by a patient can be practically and realistically delivered in a correctional centre setting, bearing in mind considerations such as staffing levels, security protocols and other similar matters.

To the Chief Executive Officer, Therapeutic Guidelines Limited:

1. I recommend that consideration be given to referring the following issues to the antibiotic expert group that prepares the next edition of the *Therapeutic Guidelines: Antibiotic*:

(a) whether there is a proper epidemiological basis for developing a particular treatment guideline or recommendation for choice of antibiotic therapy in relation to cellulitis in the so-called "danger area" or "danger zone" of the face (the area from the corners of the mouth to the bridge of the nose, including the nose and maxilla); and

(b) whether there is a proper epidemiological basis for identifying residence in a correctional centre as a risk factor for patients with purulent cellulitis or in whom Staphylococcus aureus is suspected based on clinical presentation (with reference to Box 2.3.1 of the *Therapeutic Guidelines: Antibiotic* (2019)).

2. I recommend that consideration be given to whether there is an appropriate way to address the issues referred to in Recommendation 2 above, prior to the publication of the next edition of the *Therapeutic Guidelines: Antibiotic*, such as by the establishment of a special or ad hoc working group, or otherwise.

12. 39421 of 2017

Inquest into the death of Ye Chiu. Finding delivered by DSC Truscott at Lidcombe on the 23 October 2020.

This is an inquest into the death of Ye Chiu (a pseudonym) ("Mr Chiu"). This is a required inquest pursuant to sections 23 and 27 of the *Coroners Act 2009* ("the Act") as Mr Chiu died whilst in lawful custody. Mr Chiu was a prisoner on remand, pending arraignment. Mr Chiu died on 6 February 2017 at Westmead Hospital, Westmead after sustaining fatal head injuries in a fall in the Goldsmith "G" Block at the Metropolitan Remand and Reception Centre ("MRRC"), Silverwater.

On 9 February 2017, a limited post mortem examination was carried out by forensic pathologist, Dr Rianie Janse Van Vuuren who prepared a post mortem report dated 19 October 2017 in which she found that the cause of death was head injuries. Following Mr Chiu's death, an investigation leading up to the hearing of this inquest was facilitated by the officer in charge, Detective Sergeant Andrew Tesoriero and Senior Investigation Officer Grant Simpson of the Corrective Services NSW ("CSNSW") Investigations Unit. The purpose of this inquest is to make and record findings as to the date and place of Mr Chiu's death, as well as the manner and cause of death, and to make any recommendations that may be necessary or desirable.

Background

I now respectfully adopt the entirety of the background summary thoroughly and helpfully detailed by Counsel Assisting in her opening address to the inquest. Mr Chiu was born in China and was 67 years old when he died. Mr Chiu married in 1977 and he and his wife ("Mrs Chiu") have two children, being a daughter born in 1979 ("A") and a son born in 1980 ("M"). Mr Chiu and his family migrated to Australia in October 1985. Mr Chiu was a very hard working man who, following their migration to Australia first worked as a kitchen hand, before progressing to be an apprentice chef and then a Chinese chef. Mr and Mrs Chiu purchased their first property at Eastwood in 1989. They moved to Penshurst in 1992. In 2009, Mr Chiu started to suffer from repetitive strain injury ("RSI") and developed arthritis in his right hand. He continued to work until his condition worsened and ceased work in 2014 when he became eligible for a Disability Pension.

Mental Health

In October 2015, Mr Chiu's family report that he started displaying strange behaviour with difficulty swallowing and restless nights. On 25 January 2016, Mr Chiu's general practitioner ("Dr W") diagnosed him with depressive anxiety disorder and prescribed the anti-anxiety medication Aropax. On 9 February 2016, Dr W recorded that there had been a partial relief of apprehension. On 16 February 2016, Dr W recorded

"*recent exacerbation [sic] of anxiety [sic] symptoms after [sic] visit to optometrist told cataract and glaucoma worry withdrawal negative though for 24 hr not coping with the above new poor sleep variosu [sic] somatic symptoms … anxious [sic] an agitated [sic] no suicidal [sic] thought focus on various health issue poor insight denies suicidal [sic] ideation".* Dr W made a referral for Mr Chiu to see a psychiatrist ("Dr SKL") and discussed a psychologist via a mental health plan. Dr W prescribed Ativan.
Mr Chiu's son, M reported that after a few weeks Mr Chiu became very anxious and his behaviour became very strange including being nonresponsive and displaying abnormal behaviours. This behaviour increased when he was taking medication. Mr Chiu told his family he was anxious because he was afraid of dying as his father had died at the age of 68. On 22 February 2016, Mr Chiu saw Dr SKL, who reported that Mr Chiu stated he had felt worried and depressed in the past six weeks; he did not sleep well, was socially withdrawn and he held no hope for the future. A mental examination revealed Mr Chiu was somewhat nervous and dejected but not suicidal. Dr SKL diagnosed a depressive disorder of recent onset and prescribed Aropax and Ativan.

On 18 March 2016, Mr Chiu saw Dr W and reported a relapse stating he felt his brain was not working, he was insecure, shaking and had a sense of doom. Mr Chiu was to recommence taking Ativan at night.

First Admission to St George Hospital

On 28 March 2016, Mr Chiu and Mrs Chiu had finished dinner and Mr Chiu had taken his medication. Mr Chiu's stance became shaky and he saw things on an angle; he became confused as to whether he had taken his medication. He was stiff, shaking and unresponsive. He was taken by ambulance to St George Hospital. At the hospital, a nurse drew blood and Mr Chiu's behaviour changed immediately. He became very paranoid and thought Mrs Chiu and their son had brought him to hospital to kill him. Over time Mr Chiu's rants became more aggressive and louder. He had to be sedated. When being restrained by nursing staff he screamed that they were trying to kill him. Mr Chiu was admitted involuntary to the St George Hospital mental health unit. He was scheduled under the *Mental Health Act*.

On 29 March 2016, Mr Chiu's sodium level was recorded as 122 mmol/L. A normal sodium level is considered to be in the range of 135 to 145. Mr Chiu was treated in intensive care for a few weeks. Mr Chiu was then moved to the mental health wing and later to the Older Person's Mental Health Unit. During his stay, Mr Chiu was trialled on anti-psychotic medication but he had reactions to each. He was prescribed Valium and sleeping pills and his mental state improved.

On 29 March 2016, Mr Chiu underwent a CT of the brain which found no acute intracranial abnormality. On 4 April 2016, Mr Chiu underwent an MRI of the brain which found no intracranial pathology. On 30 May 2016, Mr Chiu was discharged from the St George Hospital mental health unit. Mr Chiu's sodium levels were monitored throughout his stay and he was treated for hyponatraemia. It was noted by the treating team that his symptoms were consistent with a delirium related to hyponatraemia. Upon discharge Mr Chiu's levels were normal in the range of 137 to 140.

June – August 2016

When released from St George Hospital, Mr Chiu commenced seeing a psychologist, Flora Truong, an Older Persons Nurse and psychiatrist, Dr Carolyn Jones from St George Hospital (in addition to visits to his general practitioner Dr W). Mr Chiu's family reported his behaviour was up and down.

On 10 June 2016, Mr Chiu was reviewed by Dr Jones with a Cantonese interpreter and his daughter. Dr Jones noted: *"It is pleasing to report that Mr [Chiu] is managing well. He reports a normal appetite, good sleep, and reasonable energy levels. He is more open expressing when he feels anxious to his family, and this has been in situations of crowds. His diagnosis appears to be an anxiety disorder – with features of agoraphobia and previously panic episodes. This was complicated by organic mania (hyponatraemia and viral encephalitis) earlier this year … suggested to Mr [Chiu] that he could reduce his Melatonin to 2mg nocte and when he is next due for a diazepam prescription to reduce the dose to 4mg nocte".*

On 27 June 2016, Mr Chiu reported to Dr W that he had seen the psychologist and had a good response and was less anxious and coping on a reducing dosage. In July and August 2016, Mr Chiu saw the Older Persons Nurse five times, Ms Truong the psychologist four times, Dr W twice and psychiatrist Dr Jones on 19 August and 2 September 2016.

Dr Jones noted on 2 September 2016 that Mr Chiu's family were very concerned he was not maintaining improvement and Mrs Chiu was becoming exhausted and less able to cope. Mr Chiu described ongoing racing thoughts. He denied any thoughts or plans of self-harm or suicide however he made a comment that he felt like he was going to die. His recent bloods were normal. Dr Jones noted ongoing prominent anxiety with an episode of heightened arousal and suggested an increase in medication. Dr Jones noted that Mr Chiu was not currently meeting the requirements of the *Mental Health Act*.

Second Admission to St George Hospital – 3 September 2016

On 3 September 2016, the day after Mr Chiu saw Dr Jones, a small splash of oil fell on Mrs Chiu's hand. Mr Chiu became anxious that she was hurt; his breathing became laboured. Mrs Chiu and their daughter, A told Mr Chiu they wanted to take him back to hospital and he refused saying he was scared to go back to hospital. Mr Chiu's son, M arrived and they called an ambulance. Mr Chiu was physically taken to hospital after he refused to leave.

Mr Chiu was initially admitted to St George Hospital as a voluntary patient of the Older Persons Mental Health Unit. At the time of his admission Mr Chiu's sodium level was 130 and it was noted on 5 September 2016 that Mr Chiu's delirium was resolving and he had ongoing hyponatraemia which was improving. On 3 September 2016, Mr Chiu underwent another CT of the brain which found no acute intracranial pathology.

On 9 September 2016, Mr Chiu assaulted a nurse by attacking her from behind and strangling her. It was noted "*On review was settled, no remorse, some paranoid ideations re: the nurse calling the police on him."*

Mr Chiu's sodium level on 9 September was 128. There were no further acts of aggression but it was noted that: *"Mr [Chiu] remains fixated that the nurse he assaulted was going to call the police, and he has expressed a desire to die, asking Dr Jones for a lethal injection."*

Mr Chiu was presented to the Mental Health Review Tribunal and a four week involuntary patient order was made. He was transferred to the acute mental health unit. He settled over a few days and was transferred back to the Older Persons Mental Health Unit where his medication was adjusted with pregabalin being titrated upwards. He appeared to respond well to this change, with his anxiety becoming far less intrusive and more manageable. He attended escorted leave with family without incident and had weekend leave which all went well too.

On 16 September 2016, Dr Jones noted that Mr Chiu when first assessed had delirium in the context of hyponatraemia and anxiety. The hyponatraemia had resolved. Mr Chiu ceased all psychotropic medication on admission as he was historically very sensitive to medications. It was noted that anxiety seemed to be the most prominent symptom. Depressive symptoms were not prominent nor were there any clear psychotic symptoms. Cognition seemed to be improving but needed further investigation. Mr Chiu had become settled on the ward with no risky behaviours identified.

On 17 September 2016, a Registered Nurse at St George Hospital wrote a review of care plan stating: *"Suicidal Ideation/Thoughts of Harming Self Mr [Chiu] expresses lack of opportunity to harm himself in the ward. However may attempt to jump off from the building if he goes outside. Keep away all items that he may potentially use to harm himself. Continually assess his risk and maintain on 1:1 special obs Monitor his thoughts and feelings and allow patient to ventilate his fears Express hope and positive outlook towards the future Maintain safety"* Mr Chiu was subject to a neuropsychological assessment on 26 September 2016. It was noted Mr Chiu had been trialled on a variety of medications but had been keenly sensitive to all of them, even at very small doses.

Discharge Home

Mr Chiu was discharged on 26 September 2016. Mr Chiu's sodium levels had been monitored throughout his admission and upon discharge were 136. Following Mr Chiu's release over a few weeks his anxiety became apparent again; he was worrying about trivial things. He was regularly seeing Flora Truong, Dr Jones and his general practitioner. His general practitioner Dr W recorded on 30 September *2016 "on new medication copes well stable less anxious."*

The Alleged Offence

Turning to the event which resulted in Mr Chiu being on remand.

On 25 October 2016, Mr Chiu received a phone call from a family member informing him a family member from America would be visiting and arranging to catch up. Mr Chiu became anxious and was afraid they would come to learn he had a mental illness. He became anxious and told Mrs Chiu who tried to calm him down.

At about 6pm, Mr Chiu, Mrs Chiu, their daughter, A and Mr and Mrs Chiu's grandchild were having dinner. Mrs Chiu told A that Mr Chiu had been acting weird during the day. Mr Chiu said that nothing was wrong.

After the others finished dinner, Mr Chiu sat at the table on his own and continued eating. Suddenly Mr Chiu slammed his bowl on the table and entered the kitchen where Mrs Chiu was washing the dishes. According to the initial statements made to the police, Mr Chiu stood behind Mrs Chiu and wrapped both arms around her neck and squeezed tightly in a choke hold. Mrs Chiu attempted to free herself and they fell to the ground; he continued to choke her. Mr Chiu's daughter, A pulled his arms off Mrs Chiu; Mr Chiu resisted and tensed but A managed to free Mrs Chiu.

A removed Mr Chiu's grandchild (A's child) from the area. Once she left, Mr Chiu placed both his legs around the shoulders of Mrs Chiu. A returned to the kitchen and again freed Mrs Chiu. A and Mrs Chiu ran to the front door.

Mr Chiu chased them and again grabbed Mrs Chiu, pulling her to the ground and choking her. Two neighbours came to help and managed to pull Mr Chiu off Mrs Chiu. When police and an ambulance arrived they found Mr Chiu lying on the floor. Mrs Chiu clarified her evidence in a statement in February 2017 stating Mr Chiu had his arms around her chest, not her neck. Mr Chiu was charged with choking a person with intent to commit an indictable offence, with the intention of causing actual bodily harm pursuant to s 37(2) of the *Crimes Act 1990* (NSW).

Entering Custody

Mr Chiu appeared at Sutherland Local Court on 26 October 2016 and was remanded in custody. The initial remand warrant issued on 26 October 2016 was endorsed with the additional information of "receive mental health medication and treatment". Mr Chiu entered CSNSW custody at Sutherland Court cells at about 10.15 am on 26 October 2016. On 26 October 2016, the Inmate Identification and Observation Form ("IIO") was partially completed without the assistance of an interpreter. It was noted that Mr Chiu did not speak English. No health history was acquired and no psychiatric or psychological interventions were ordered. It is clear that there were deficiencies with how this form was filled out.

Mr Chiu was transferred to Surry Hills Court cells where he remained overnight. He was spoken to by the Services and Programs Officer ("SAPO") Hellen Rogers with the assistance of a telephone interpreter. Mr Chiu was unable to provide contact details of anyone who spoke English. Ms Rogers told Mr Chiu that on reaching a correctional centre a thorough exploration would be conducted regarding accessing people and agencies in order to advise them of his circumstances and to receive ongoing support. Ms Rogers was unable to facilitate a reception phone call as Mr Chiu was unable to provide any contact details.

Metropolitan Reception and Remand Centre – 27 October 2016

On the evening of 27 October 2016, Mr Chiu was received into the MRRC. Between 7.30 pm and 8.15 pm SAPO Margaret Rothwell conducted the Intake Screening Questionnaire ("ISQ**"**) process with the assistance of an interpreter. It was noted:

- Mr. Chiu was calm and co-operative, future oriented.
- At question 52 - Mr. Chiu stated he was "good".
- At questions 53 and 61 – Mr. Chiu has been treated for anxiety, last dosed before he came into custody.
- At questions 56 and 57 – at home or in relationship when Mr. Chiu is stressed he "deep rest".
- At question 18 - there is an AVO protecting his wife.
- At questions 58, 73, 74, 75, 76, 77 and 82 - he denied past and current self- harm/suicide ideation.
- At question 59 – he denied he has ever hurt others when stressed.
- There was no reception call as he said he has nobody to call.
- A referral to the Justice Health and Forensic Mental Health Network ("Justice Health") was listed as required. A referral was also initiated for Fundamental Support.

Between 9.18 pm and 10.01 pm Registered Nurse ("RN") Anna Grigore ("RN Grigore") conducted a Reception Screening Assessment and noted:

- Mr. Chiu spoke Cantonese and an interpreter was required.
- Mr. Chiu's community health provider was a psychiatrist at St George Hospital and his general practitioner Dr W, Hurstville.
- In the section "Active Allergies", a number of medications were listed.

Medical observations taken.

Mr Chiu *"has become unwell this year becomes anxious ++ does not know why he feels like this – cannot relate it to anything – except stopping work – says money is not a problem – live with wife says that when he feels nervous he feels as if his head is exploding has son and daughter -and x 2 grandchildren – says they won't have time to visit."*

Mr Chiu has been treated for depression. Mr Chiu has tried to hurt himself: "head butting" in cells. Mr Chiu had not tried to end his life, however felt suicidal when he first became ill. It was noted Mr Chiu had suffered from hyponatraemia since 1 September 2016 but it had resolved.

At 9.57 pm, RN Grigore completed a Justice Health Problem Notification Form ("HPNF") addressed to CSNSW requesting a Risk Intervention Team ("RIT") assessment.

It was recorded that it was Mr Chiu's first time in jail; he was a Chinese speaker and an interpreter was needed; he had situational distress, and he was vulnerable, mentally unwell and had charges of violence. At 10 pm, RN Grigore raised a Mandatory Notification for offenders at risk of suicide or self-harm ("MNF") and Mr Chiu was placed on RIT status. The risk assessment stated that Mr Chiu had been recently treated by a psychiatrist for a mental health problem. He stated he had attempted to hurt himself in the cells by head butting, that he had never attempted to try to end his life but felt suicidal when he first became ill.

Andrea Bowen reported "*At his screening he appeared to be calm, co-operative and future focused. Mr [Chiu] did not speak English very well and the interpreter service was used to conduct the screening interview*. A decision was made to transfer Mr Chiu to the Mental Health Screening Unit ("MHSU") for a period of observation and diagnostic clarification.

The Darcy Unit

Mr Chiu remained in the Darcy Unit between 26 October and 17 November 2016 awaiting an available bed in the MHSU. Whilst in the Darcy Unit, Mr Chiu was regularly reviewed by a mental health nurse and psychiatrist Dr Sunny Wade ("Dr Wade"). On 28 October 2016, Mr Chiu was seen by the mental health nurse for a mental health assessment. It was incorrectly noted that Mr Chiu needed a Mandarin interpreter; however, this was changed and it was noted he needed a Cantonese interpreter. It was noted he had had two previous admissions to psychiatric hospitals.

It recorded that he has a diagnosis of delusional anxiety, that he is sensitive to psychiatric medication. Mr Chiu provided a contact number for his son, M but commented that his children were too busy to visit him.

It was noted his behaviour was *"appropriate, co-operative, not agitated, friendly"* and his mood was fine. Mr Chiu *"was able to guarantee his personal safety, denying current self-harm and suicidal ideation, plans & intent".* A risk assessment indicated a low risk of suicide. On the same date, Mr Chiu's son, M called the MRRC and *"raised concerns about his father's [sic] mental wellbeing."* This was followed by an email to Client Liaison on 28 October 2016 outlining Mr Chiu's history and requesting he be allocated to an *"area for mental health inmates and receiving [sic] the adequate mental care whilst in corrections".*

On 29 October 2016, Mr Chiu was interviewed by the RIT comprised of Assistant Superintended Burgess, SAPO Ms Moffitt and Registered Nurse Fagaloa. The interpreter service was used to conduct the interview, however it was noted it was *"difficult to conduct interview under these circumstances".* Further, *"the interpreter service was difficult when eliciting certain information as questions may have been lost in transition and several times the interpreter stated she could not understand question and/or hear properly inmate's response."*

It was noted Mr Chiu was *"[a]lert, responsive and generally settled in context to being first time in gaol and charged with serious domestic violence related assault against his wife."* Mr Chiu's son, M, was consulted during the RIT interview for background information.

Mr Chiu's mental health history was noted including previously expressed suicidal ideation. He denied thoughts, plans and intent to deliberately self-harm and/or suicidality. Mr Chiu was assessed as being at low risk of immediate suicidality and deliberate self-harm due to him having future plans and he did not present as anxious nor upset. Mr Chiu was cleared from a safe cell, and was required to remain in Darcy Unit until seen by a psychiatrist and a primary health or general practitioner. On 31 October 2016, Mr Chiu was further assessed with the use of an interpreter. On 1 November 2016, Mr Chiu was referred for placement in the MHSU by Dr Wade for diagnostic clarification and a period of close observation. A telephone interpreter was used. Dr Wade took detailed notes which included Mr Chiu's history.

Dr Wade noted:

- *Mr. Chiu's mood was normal; he had no sleep problems, poor appetite, was tired, had no motivation, his concentration was okay and he had no problems with his memory; he stated he had no worries or concerns and no anxiety.*
- *Mr. Chiu stated he does not believe he has a mental illness.*
- *Mr. Chiu stated he recalled in the past wanting to die but "no longer thinks that and can't recall why he had those thoughts".*
- Dr Wade spoke to Mr. Chiu's son, M.
- The review indicated an onset of mood disorder/ anxiety episodes with first psychiatric contact in the last nine to ten months.
- *Some cognitive deficits on brief testing. He noted limitations due to the interpreter and low educational attainment.*
- *No current evidence of major mood disturbance or psychosis, although Mr. Chiu appeared anxious. He denied any thoughts of self-harm.*

Mr Chiu's history of hyponatraemia and side effects to anti-psychotics.

An assessment was conducted on 4 November 2016 by a Cantonese speaking nurse. It was noted that Mr Chiu felt confused and anxious. On 8 November 2016, Dr Wade spoke to the St George Older Persons Mental Health Service and obtained information regarding Mr Chiu's admissions. Dr Wade requested further information from St George Hospital. It was noted Mr Chiu had sensitivities to psychotic medication and that no medications were currently charted.

On 9 November 2016, Mr Chiu was reviewed by the Clinical Nurse Consultant, Marco Ree. It is noted a Mandarin interpreter was used. Mr Chiu was assessed on 10 November 2016. During this assessment, Mr Chiu complained of dizziness and headache. He refused to attend the clinic. It was recorded Mr Chiu *"speaks Mandarin"* which was later that day corrected to *"speaks Cantonese"*. Mr Chiu was transferred to Westmead Emergency Department complaining of weakness, dizziness and being unable to mobilise.

He was discharged post review. Mr Chiu's sodium level was 131 and it was noted that this is not "*impressively low*". Mr Chiu was further reviewed on 11 and 12 November 2016.

On 15 November 2016, SAPO Geraldine Veneziano ("Ms Veneziano") noted three messages had been left by Mr Chiu's son, daughter and son-in law. Ms Veneziano spoke to Mr Chiu's son-in-law who advised that Mr Chiu's family was concerned he had not received mental health treatment since his admission into custody. Mr Chiu advised his son he was hearing his son's voice and that he had a premonition that he was going to die. Mr Chiu advised his son that he had given up and requested that he be left in gaol and had refused gaol visits. Ms Veneziano confirmed that Mr Chiu had been seen by Justice Health staff, they were aware of his mental health concerns, he was receiving treatment accordingly, and that he had been referred to the MHSU for more assertive mental health treatment.

On the same day, a detailed review of Mr Chiu was conducted by Dr Wade. Mr Chiu's sodium level was 133. The review included a review with Dr Jones of St George Hospital. An interview of Mr Chiu was conducted with the assistance of a Cantonese telephone interpreter, and the following was noted:

- *Mr. Chiu could not sleep and had a reduced appetite.*
- *Mr. Chiu's mood was described as a "bit confused, and unhappy, and hungry"; he indicated "I don't know when I can go home". Mr. Chiu was feeling anxious as there was no court date.*
- *Mr. Chiu does not want to share a cell as he "would be worried they would do things to me".*
- *Mr. Chiu denied thoughts of harm to self or others.*
- Mr. Chiu "*currently presents as relatively mentally stable; medically stable as per GP (although note mild low sodium); although ongoing anxiety and some somatic complaints*." *Mr. Chiu was on no current medications due to a stable mental state and previous reported side effects.*

Mental Health Screening Unit – 16 November 2016

On 16 November 2016, Mr Chiu was accepted into the MHSU sub-acute pods 19/20 as a one-out cell placement. On 17 November 2016 at 1.36 pm, Mr Chiu was admitted to the MHSU within the MRRC for further observation of his mental state and diagnostic clarification. Mr Chiu's treating doctor was Dr Johnathan Adams ("Dr Adams").

The admission documentation noted a history of mental health issues, a history of medical issues and the need for a Cantonese interpreter. A formal interview could not be conducted as they were unable to secure a phone interpreter. Physical observations were obtained and were normal. A second unsuccessful attempt was made to obtain an interpreter; an in-person interpreter was booked for the next day. On 18 November 2016, a joint reception interview was completed by Michelle Curran (SAPO) ("Ms Curran"), Dr Adams (psychiatrist) and Mason Mei (mental health nurse). A face-to-face Cantonese interpreter was used. The case note report notes the following:

Mental health issues arose 12 months prior to the alleged offence characterised by anxiety, paranoia and uncharacteristic violence with manic and disinhibited episodes. Mr Chiu has been case managed via St George CMHT. Mr Chiu as had two psychiatric admissions due to uncontained behaviour. It was Mr Chiu's first time in custody. Mr Chiu presented to interview as polite, settled and co-operative and denied any mental health issues or associated history. He was unsure as to why he had been transferred to MHSU but was coping at the time and mixing in the pod without concern. Mr Chiu denied any deliberate self-harm or suicidal history. Mr Chiu denied any current psychotic phenomena, however the psychiatrist queried possible cognitive issues. A full work up would be conducted. Mr Chiu stated he had not received any contacts or visits from family since entering custody, which was in contradiction to OIMS information that his last visit was on 16 November 2016.

Nil immediate risk issues were identified and Mr Chiu would remain in the MHSU for further monitoring and medical work-up. Following the interview, Ms Curran called Mr Chiu's son, M who provided a history of Mr Chiu's mental health and raised a concern that at times Mr Chiu appeared confused as he seemed unable to recall receiving visits from his family. Mr Chiu was reviewed on each of 18, 19, 20 and 21 November 2016. Some of these were file based ward rounds.

Admission to Westmead on 22 November 2016

On 22 November 2016, Mr Chiu was transferred to Westmead Emergency Department after complaining of dizziness with an onset of central chest pain. He was discharged and was returned to the MRRC on 23 November 2016. Mr Chiu's sodium level was 130.

Return to MSHU on 24 November 2016

Mr Chiu was further reviewed in the MHSU on 24 November 2016. On 25 November 2016, Mr Chiu was reviewed by Dr Adams with the assistance of a telephone interpreter as an in-person interpreter was unavailable. Mr Chiu's mood was reported as "*very happy*" and he was happy to have seen his son. Mr Chiu had problems sleeping, but his appetite was good. He had no ideas of deliberate self-harm or suicide. Mr Chiu stated he felt safe. Dr Adams noted there was no clear evidence of psychosis, that his mood was likely low but there were varying reports and that he was not confused or delirious. A general practitioner's opinion regarding the hyponatraemia and a full neuropsychology review was needed. Mr Chiu's sodium level was 131.

On 29 November 2016, Mr Chiu refused to attend an outpatient appointment. On 2 December 2016, Mr Chiu was seen by a general practitioner and underwent a further comprehensive review by Dr Calum Smith ("Dr Smith") with the assistance of an interpreter. It was noted Mr Chiu was future oriented and denied thoughts of deliberate self-harm or suicide. Mr Chiu's sodium level was recorded as above 130 which was noted as *"not likely to be having chemical effect"*. Mr Chiu was reviewed on 4, 5, 6 and 7 December 2016. These reviews are all outlined in the Justice Health notes which are in the brief of evidence. On 8 December 2017, Dr Adams conducted a review of Mr Chiu via a telephone interpreter. Dr Adams spoke to M, A and A's husband.

Dr Adams noted that Mr Chiu had a stable presentation and was not currently on psychotropic medication. Mr Chiu's children reported a significant improvement over recent weeks. Dr Adams noted that Mr Chiu had clearly stabilised without medication. There were no clear symptoms of psychosis or mood disorder now. Dr Adams noted an underlying cognitive functioning needs assessment and Mr Chiu's deterioration of mental health prior to the onset of aggression seemed to be secondary to psychiatric medication and antidepressant side effects. Dr Adams also queried an organic component. Mr Chiu was to remain in the MHSU for now.

Dr Adams requested a referral to a CSNSW neuropsychologist following concern about a possible underlying cognitive decline. This appointment had not occurred as at the time of Mr Chiu's death. Mr Chiu was reviewed on 9 December 2016, 14 December 2016, 20 December 2016 and 21 December 2016. On 22 December 2016, Mr Chiu appeared by AVL at Central Local Court and was remanded in custody. There were further reviews on 25 December 2016 and 26 December 2016.

Mr Chiu was reviewed on 27 December 2016. Mr Chiu complained he had trouble sleeping and requested medication to help him sleep; further, he could not eat as he did not like the food. Mr Chiu denied self-harm, suicidal thoughts or psychotic symptoms. He was polite and co-operative and whilst he appeared distressed from poor sleep, no psychotic symptoms were observed. On 29 December 2016, Mr Chiu was reviewed by Dr Adams with an interpreter. Dr Adams noted there were no symptoms of psychosis or mood disorder; however, Dr Adams noted the interpreter stated that he believed Mr Chiu was speaking in an illogical manner. Dr Adams prescribed a food supplement due to weight loss. Mr Chiu was not prescribed sleeping tablets due to previous reported side effects and confusion.

There were further reviews on 30 December 2016, 4 January 2017, 5 January 2017, and 6 January 2017. Mr Chiu was further reviewed by Dr Adams on 6 January 2017 with a telephone interpreter. Dr Adams also spoke to the general practitioner, Dr Yee who had been monitoring Mr Chiu. Dr Adams unsuccessfully attempted to contact Mr Chiu's son, M. Dr Adams suggested that there be ongoing monitoring of Mr Chiu's sodium levels. Dr Adams considered a neuropsychological assessment was still required but was not urgent and could be completed elsewhere given Mr Chiu's stable clinical presentation. Dr Adams noted "*no evidence of MHD*". Mr Chiu was to continue with no medication. Dr Adams requested Mr Chiu be provided Sustagen due to weight loss and poor diet. There continued to be almost daily reviews of Mr Chiu on 12 January 2017, 13 January 2017, 14 January 2017, 16 January 2017 and 17 January 2017. On 12 January 2017, Mr Chiu's sodium level was 138 and it was noted his sodium level "*has normalised*".

On 17 January 2017, the plan to discharge Mr Chiu from MHSU was explained to his family. Dr Smith spoke with Mr Chiu's son, M who reportedly said his father's presentation was *"very good"* and Dr Smith recorded that Mr Chiu was "*his old self again*".

Dr Adams reviewed Mr Chiu again on 20 January 2017. Mr Chiu had remained settled, had no symptoms of any mental illness, no problematic behaviour was compliant with routine and was not on any medication. It was noted his sodium levels had normalised.

Dr Adams concluded that Mr Chiu was suitable for discharge and noted that neuropsychological testing was awaited. Dr Adams noted there needed to be a discussion with CSNSW regarding the most appropriate placement given Mr Chiu's vulnerability.

Decision to Discharge from MHSU – 20 January 2017

On 20 January 2017, a decision was made to discharge Mr Chiu from the MHSU to the MAIN. On 31 January 2017, a joint discharge plan was completed by Offender Services and Programs ("OS&P") and Justice Health. At the time of discharge, it was noted *"there were no significant concerns regarding Mr Chiu's risk to himself or others. It was noted Mr Chiu had not been prescribed any medication during his period of observation in the MHSU with no recommendation for medication upon discharge from the MHSU and was considered appropriate by the treating team to be discharged to the MAIN*."

While Mr Chiu remained in the MHSU he continued to be reviewed. He was reviewed on 21 January 2017, 27 January 2017, 28 January 2017 and 31 January 2017.

Discharge Plan – 31 January 2017

On 31 January 2017, Mr Chiu's discharge plan was prepared and finalised. The MHSU Discharge Plan noted the following:

In the section titled "Alerts", yes was noted for "Self Harm" and "Suicidality". A question mark was placed beside "Brain Damaged", and a comment "awaiting psychometric testing".

In the "Summary of Illness" section, "Acute/Chronic Confusional State" was recorded.

In the housing placement section, "one out cell placement" had been inserted and then crossed out and "Normal cell placement" had been handwritten.

It was noted that ongoing mental health supported was required.

A comment stated that "*During his admission, Mr [Chiu] was regularly seen by his treating psychiatrist (ADAMS and SMITH) and mental health nurses, alongside the assistance of a Cantonese interpreter. Mr [Chiu] was not prescribed psychiatric medication during his admission to which he stabilised in mental health. Mr [Chiu] was cleared from the MHSU by his treating psychiatrist on the 20/1/2017 due to his current presentation. Mr [Chiu] was recommended a one out cell placement due to his vulnerability in regards to age and non-English speaking background".* There is then handwritten comment stating: *"** SMITH changed cell placement to NCP @ 31.1.17".*

It was noted Mr Chiu "*[c]urrently denies any SH/S thoughts or plans and able to guarantee his safety".*

It was noted that: "*Psychiatrist has raised concerns about him potentially being a vulnerable inmate due to age and limited English."*

The change in housing placement from *"one out placement"* to *"normal cell placement"* was made by Dr Smith and initialled by RN Benjamin Vafo'ou on 31 January 2017.

There was evidence at the inquest from Dr Smith as to why this was done. The MHSU Discharge Management Plan noted that Mr Chiu was waiting for psychometric testing and required ongoing mental health support but was cleared for normal cell placement.

Review

A mental health review was scheduled with Dr Adams on 3 February 2017. This did not take place as the telephone lines were down and the interpreter service was not able to be accessed.

Transfer to Pod 12 Goldsmith "G" Block – 4 February 2017

On Saturday 4 February 2017, once a bed was available, Mr Chiu was discharged from the mental health unit and transferred to cell 404 in Pod 12 of Goldsmith "G" Block within the general population. Mr Chiu was booked into the MRRC reception at 9.01 am and arrived at Pod 12 at about 1.30pm. Cell 404 was located on the top landing within Pod 12 and was shared with two other inmates, Prisoner K and Prisoner A.

When Mr Chiu was moved to Pod 12 on 4 February 2017, the receiving officer, Harbir Singh ("SCO Singh"), checked the case file for any threat assessment and the Inmate Profile Document for any alerts. Mr Chiu was placed *"in best available cell 404 with two other inmates"* and it was noted Mr Chiu was *"cleared by MH assessment team to move".* SCO Singh stated:

"I went through the case file and didn't find anything concerning. Inmate was placed on Normal Cell Placement by Justice Health. Inmate was then placed in cell 404. There was no concern raised to me by any MH staff or Justice Health staff regarding Inmate [Chiu]. I didn't notice anything of concern regarding inmate before ceasing duty."

There was only one vacant bed, on the top landing in cell 404. As Mr Chiu did not speak English, they had an inmate from Pod 11 translate to Mr Chiu where he was to be housed. Officers knew Mr Chiu did not speak English and sought to place him in Pod 11 where there were inmates he could converse with; however, there were no vacancies. Mr Chiu was informed they would try to move him to Pod 11 the following day. There were no issues raised regarding Mr Chiu overnight on the evening of 4 February 2017. Mr Chiu was to be seen by the Justice Health Outreach staff on 11 February 2017 (being seven days post-discharge from MHSU).

The Incident Causing Death

On 5 February 2017, Senior Correctional Officer ("SCO") Gary Kukreja, First Class Correctional Officer Rajeev Rampal and Probationary Correctional Officer Susan Rowan were rostered in Pod 12. Breakfast items were delivered at about 8.35 am and Mr Chiu's cell was unlocked at 8.40am. The next seven minutes were captured on CCTV footage. At 8.46.34 am, Mr Chiu turned and walked towards the stairs.

He stopped halfway along and placed his right foot on the bottom of the three rails and took hold of the top railing with both hands, pulled himself up and placed both feet on the second railing as he turned to face towards the cells with his back to the open space.

At 8.46.41 am, Mr Chiu is seen to be momentarily seated, hanging backwards over the top railing which he held with both hands. At 8.46.42 am, Mr Chiu appears to let himself go and he fell backwards, turning in the air so his right side was facing the floor. Mr Chiu landed head first on the concrete floor on the ground level.

The distance Mr Chiu fell was 3.62 metres.

The following has been noted about Mr Chiu's behaviour whilst receiving first aid treatment:

- Mr. Chiu was combative.
- Mr. Chiu was reported to be agitated and uncooperative.
- Mr. Chiu required physical restraint to hold him still, to allow medical staff to administer treatment.
- Mr. Chiu *"was uncooperative and constantly tried to move and get up."*
- Officers *"began to help hold him still as the medical team were now there treating him"."*

When ambulance paramedics attended, it was necessary to administer Mr Chiu a sedative for agitation. Once sedated, Mr Chiu was transported by ambulance to Westmead. The ambulance report noted "no **immediate** life threat" [emphasis added] but "altered conscious state; behaviour agitated".

The incident was reported to police at 10 am on 6 February 2017.

Transfer to Westmead Hospital

Mr Chiu was escorted to Westmead Hospital by Correctional Officers Byron Aperocho ("CO Aperocho") and Mason Talolua ("CO Talolua"). The Westmead admission documentation notes Mr Chiu's admission time was 10.11 am and records "Intended Overnight". Once at Westmead Hospital, Mr Chiu was placed in resuscitation room number 1, moved to get a CT scan and then returned to room number 1. CO Aperocho and CO Talolua were then told by a doctor that Mr Chiu "*received serious injuries and would be required to stay in hospital*". Mr Chiu's sodium levels were monitored. Upon admission at 10.14 am, his sodium level was 134. Mr Chiu underwent a series of X-rays and CT scans. CT scans at 5.28 pm showed that Mr Chiu's initial cerebral haemorrhages were expanding and increasing in size.

At 6.30 pm Mr Chiu was moved to intensive care. COs Aperocho and Talolua were aware of this. At 8.25 pm, CSNSW at MRRC were informed that Mr Chiu had been transferred to the Intensive Care Unit ("ICU"). Michael Green, who was the Manager of Security at the MRRC ("Mr Green"), reports that advice from the treating doctor was to contact next of kin. At 8.40 pm Mr Chiu's son, M was contacted.

At 9.15 pm, Mr Chiu became unresponsive and was intubated. A cerebral CT scan was performed at about 9.35 pm, from which it was noted that Mr Chiu needed urgent surgery. He was taken urgently to theatre afterwards, but was comatose thereon. At 9.40 pm Mr Chiu's son, M attended Westmead Hospital. At 10 pm, Mr Chiu underwent emergency surgery and returned to the ICU at 2:25am. Mr Chiu's son visited his father at 2.30am. During the course of 6 February 2017, family members visited Mr Chiu. At 6 pm the medical team conducted a family conference.

At about 6.55 pm, Mr Chiu's life support was turned off. Mr Chiu was formally declared life extinct at 7.13pm. The Report of Death of a Patient to the Coroner was completed by Dr Kathirgamanathan, and recorded Mr Chiu's "*cause of death was a traumatic brain injury".* In her post mortem report, Dr Van Vuuren provided the opinion that the direct cause of death was head injuries.

Issues

There was no controversy surrounding Mr Chiu's identity or the time, place and medical cause of Mr Chiu's death. The issues involved the manner or circumstances of Mr Chiu's death. These issues at the Inquest involved both Justice Health and CSNSW separately and conjointly, and were as follows: Whether Mr Chiu's death was suicide, an attempt at self-harm or an accidental fall.

Justice Health

- The adequacy of Mr. Chiu's care and treatment whilst at the MRRC.
- The appropriateness of the decision on 20 January 2017 to discharge Mr. Chiu from the MHSU to the MAIN (being a remand unit or "pod").
- The appropriateness of Mr. Chiu's transfer on 4 February 2017 to the MAIN, in circumstances where the previous day's mental health review did not proceed due to a lack of interpreter and Mr. Chiu was yet to undergo the recommended neuropsychological assessment.
- The availability of interpreters for medical consultations.

CSNSW and Justice Health

- The appropriateness of the decision to change Mr. Chiu's cell designation from one out to a normal cell placement on 31 January 2017.

CSNSW

The CSNSW investigation report, with reference to the report completed by the relevant officer, indicates that the officer who reviewed Mr Chiu's reception into the main gaol *"didn't find anything concerning".*

I find that the evidence indicates that the CSNSW officer had reviewed Mr Chiu's Inmate Profile Document, the MHSU Discharge Plan and the HPNF dated 31 January 2017. Accordingly, he had appropriately relied upon Justice Health's treating team's decision that Mr Chiu was fit for discharge into the main prison population.

The appropriateness of the decision to place Mr Chiu in a pod where no other inmates spoke Cantonese such that he had very limited means of communication. Why upon entering corrections not all paperwork was correctly and accurately filled in, including why Mr Chiu's IIO form was not filled in with the assistance of an interpreter, resulting in obvious deficiencies in the information collected. For example, Mr Chiu's next of kin details were not recorded in the OIMS and remained inadequately documented throughout his custody as a result of a Checking Officer Assessment not occurring when Mr Chiu was received at MRRC.

Why Mr Chiu's family was not informed of his injuries or the emergency event on 5 February 2017 until 8.40 pm that evening, despite him arriving at the Westmead Hospital at 10 am that morning. The consequence of a lack of timely notification was that Mr Chiu's family was deprived of the opportunity to visit him whilst he remained conscious.

The Evidence

The brief of evidence includes Mr Chiu's CSNSW records and medical records from both Justice Health and the practitioners treating Mr Chiu prior to his incarceration. There are a number of CSNSW policy documents which existed as at February 2017 in the brief of evidence, and the inquest heard evidence as to how some of those policies have since been amended. Statements were made by, and evidence was taken from, Mr Chiu's treating doctors whilst at MRRC: Dr Smith, Dr Sarah-Jane Spencer and Dr Adams.

The records kept by Justice Health and the steps taken by the treating team were reviewed by three experts, all of whom are psychiatrists: Dr Anthony Samuels ("Dr Samuels"), Professor Matthew Large ("Pr Large") and Dr Danny Sullivan ("Dr Sullivan"). Their opinions, as expressed in their respective reports, were discussed when they gave evidence in conclave during the inquest. They focused on the treatment received by Mr Chiu whilst at the MRRC and whether it was appropriate to discharge him from the MHSU on 4 February 2017.

In addition to the statements taken from both inmates and CSNSW officers regarding the events of 5 and 6 February 2017, two witnesses from Corrective Services provided a statement and gave evidence at the inquest: Mr Green (Acting Governor/ Manager of Security, MRRC, Silverwater) and Terrence Murrell ("Mr Murrell") (General Manager of the State-wide Operations Branch of the Custodial Corrections Division of CSNSW).

The Chiu Family

Both Mr Chiu's daughter and son attended the inquest. Mr Chiu's daughter and son and Mrs Chiu provided statements that were included in the brief of evidence. Mrs Chiu did not attend the inquest as she remains traumatised and grief-stricken that her beloved husband died when all the family wanted was for him to receive mental health intervention rather than imprisonment. The nature and prosecution of the charges and the court proceedings were issues outside of the scope of this inquest.

Mr Chiu's daughter and son each gave a family statement in the inquest and it is apparent that they, like their mother, have been gravely affected by Mr Chiu's death and the circumstances surrounding it. Mr Chiu was a loved husband, father and grandfather.

He came from a humble background and his children spoke of Mr Chiu's selfless commitment in providing for his family and often working 12 hour days, six days a week until his retirement. Mr Chiu would help with his grandchildren and had happy and strong bonds with them.

Mr Chiu's son and daughter spoke of how Mr Chiu changed from the wise and confident man they had known for over 30 years to becoming like a shell of himself, due to the grip of his anxiety and depression. They spoke of their deep loss and sadness in losing their father and their children losing their grandfather. They visited Mr Chiu every week and noticed he had become settled in the MHSU and he felt safe and did not want to leave that unit and had become anxious about doing so.

They spoke of how the delay of nearly 12 hours before being told about his fall and his injuries has caused them great trauma. The Chiu family has been left traumatised by a train of events outside of their control resulting from their father's deteriorating mental health coming into collision with the criminal justice system. I acknowledge their trauma and loss and extend my sincere condolences but I suspect my words give them little, if any, comfort.

Mr Chiu was a Vulnerable Prisoner

Mr Chiu was, at age 67, an older prisoner, he had never previously been in any trouble with the police, and this was his first time in prison. He was a migrant to Australia who had worked hard all of his life. He spoke very little English. He suffered from anxiety and depression. For these reasons he was a vulnerable prisoner. From reading his CSNSW and Justice Health records, Mr Chiu was a quiet prisoner; he kept to himself, he caused no trouble and it would appear that he had not been the subject of any unwanted attention from other prisoners. Although it pained him greatly that he had hurt his wife, Mr Chiu received significant support from his children and they were able to advocate for his care.

When Mr Chiu was received into the MRRC on 26 October 2016 the need for a mental health screening was appropriately raised, however Mr Chiu was unable to be immediately admitted into the MHSU. He remained in the Darcy Unit without any adverse events for a period of three weeks before being transferred. When Mr Chiu returned to the MAIN pod from the MHSU, CSNSW officers appreciated Mr Chiu's need to be with prisoners with whom he could communicate; however, following their inquiries it was apparent that Mr Chiu could not be accommodated that day in a pod with prisoners who spoke Cantonese. Mr Chiu was advised by CSNSW, with the assistance of another prisoner, that although there was no placement available to him that day in a pod with prisoners who spoke Cantonese, there hopefully would be a placement the following day. Mr Chiu indicated that he understood this. Despite his communications being limited due to language, Mr Chiu was understood and other prisoners appeared to accommodate his requests.

One prisoner described that after Mr Chiu returned to the G Block he *"had to point to things, or only knew a few words, or was very limited. And there wasn't really any, any other Chinese people in that, in that pod.*

Or even maybe one or two that could translate for him…it was very hard to understand… him". Another prisoner said Mr Chiu *"was very quiet 'cause he couldn't hardly speak English, I didn't make much of a conversation out of him."* He communicated by pointing. On the Saturday evening Mr Chiu wanted the light left on and his cell mates *"left it on all night for him".*

Before Mr Chiu was transferred to MHSU he was accommodated in a single cell called a "one-out" cell, as he was considered a potential risk of harm to others. Whilst Mr Chiu was in the MHSU he was housed in a one-out cell. As such, for the entirety of his period in the MRRC (until the night of 4 February 2017) Mr Chiu was not required to share a cell. Mr Chiu's son said that Mr Chiu told him in their conversations that he wanted his own cell. The night of 4 February 2017 was the first night on which Mr Chiu shared a cell. It is not known why he asked for the light to be left on all night or whether he usually slept with the light on even in his own cell. Whilst Mr Chiu was in the G Block from 4 to 5 February 2017 there was no apparent event triggering his self-harm.

Mr Chiu's intentions – an accidental or deliberate fall

Between 26 October 2016 and 17 November 2016, Mr Chiu was accommodated in the Darcy pod awaiting an admission to the MHSU and he was regularly reviewed by mental health nurses and a psychiatrist, Dr Wade. On 27 October 2016, Mr Chiu told RN Grigore that during his first night in custody he tried to hurt himself by head butting the wall. Mr Chiu denied ever attempting to end his life but reported that he did feel suicidal when he first became ill. On 1 November 2016, Mr Chiu told Dr Wade that in the past he had wanted to die but "*no longer thinks that and can't recall why he had those thoughts*".

On 15 November 2016, Mr Chiu's son-in-law reported to SAPO Ms Veneziano that Mr Chiu was saying he could hear his son's voice and that he had a premonition that he was going to die, that he had given up and requested that he be left in gaol and had refused gaol visits. I find that whilst Mr Chiu was at the MHSU, he never indicated that he had any intention to self-harm and there was no basis upon which Justice Health staff would have suspected he was at such a risk should he be transferred from the MHSU to G Block in the MAIN.

The CCTV footage shows the incident and though it occurred very unexpectedly, it occurred within five minutes of Mr Chiu leaving his cell and going downstairs with a cup and perhaps a carton of milk or cereal. He returned upstairs and looked into the cell next door. One of his cellmates was about to clean the cell with a bucket and broom. Mr Chiu looked in his cell and then turned to the railing on the landing by the stairs. He stepped onto the bottom railing and pulled himself up with his hands, onto the top railing where he sat with both feet on the second railing and looking in the direction of the cell. Within three seconds of taking that position, Mr Chiu appears to release his hands, tumbling backwards and turning in the air. He landed head first onto the concrete floor on the ground level.

Looking at the CCTV footage alone is insufficient to determine whether Mr Chiu had simply lost his balance or whether he deliberately let himself flip backwards off the landing.

As soon as the incident occurred, a prisoner who spoke Mandarin (rather than Mr Chiu's spoken language, Cantonese) attended the scene and told police that Mr Chiu was saying *"I want to die".* However, that prisoner said it was not very clear because he also thought Mr Chiu was trying to get up. The prisoner told Mr Chiu not to struggle and to let the doctors help him. He thought Mr Chiu was confused. At the time, the prisoner was telling the Justice Health nurses that Mr Chiu was saying *"I want to kill myself".* Although Mr Chiu was agitated, resisted medical assistance and required sedation, little weight can be placed on that to ascertain his intentions given his agitated state and the injuries he had suffered.

Prior to his incarceration, Mr Chiu did have a history of suicidal thoughts. On 9 September 2016, whilst at St George Hospital it was noted: *"Mr [Chiu] remains fixated that the nurse he assaulted was going to call the police, and he has expressed a desire to die, asking Dr Jones for a lethal injection.*" On 21 July 2016, Mr Chiu's son, M told a registered nurse at the hospital that after some weeks of feeling anxious Mr Chiu said *"what's the point living like this".* Mr Chiu's son said that Mr Chiu's mother had died by suicide, by jumping from her unit balcony, and the family were worried that Mr Chiu might do the same (although he had not been expressing any suicidal thoughts or plans).

On 17 September 2016, the St George Hospital care plan noted:

Suicidal Ideation/Thoughts of Harming Self

Mr [Chiu] expresses lack of opportunity to harm himself in the ward. However may attempt to jump off from the building if he goes outside.

Keep away all items that he may potentially use to harm himself.

Continually assess his risk and maintain on 1:1 special obs.

Monitor his thoughts and feelings and allow patient to ventilate his fears

Express hope and positive outlook towards the future.

Maintain safety.

I note that the information set out above was not conveyed to either CSNSW or Justice Health. Those assisting me sought an expert report from Dr Samuels, psychiatrist and former Clinical Director of Justice Health. He was asked to provide his opinion as to Mr Chiu's intentions on the morning of 5 February 2016. Dr Samuels stated unequivocally that, given Mr Chiu's previous expressions of suicidal intent and admissions, Mr Chiu intended to end his life or cause himself serious damage. Dr Samuels commented that Mr Chiu acted purposefully and immediately. Dr Samuels did not think it was a frivolous or attention-seeking act.

Pr Large noted in his evidence that *"Falling three to four metres, you wouldn't necessarily expect to die but you would expect to be injured so I...would classify this as deliberate self-harm resulting in death",* which Pr Large opines *"falls within the rubric of suicide".* Whilst I accept the height might not be such to cause a person to think they would die from such a fall, the act of flipping so that the landing is head first, lends me to not accept the subtlety suggested by Pr Large.

A finding that a death is intentionally self-inflicted should not be made lightly. The evidence must be clear and cogent in relation to intention. Taking into account Mr Chiu's history and circumstances and his fall involving a backwards flip to land on his head I am satisfied according to the Briginshaw standard that Mr Chiu deliberately intended to end his life.

The adequacy of psychiatric care and treatment at the MRRC

Mr Chiu was in the Darcy Unit for three weeks prior to his transfer to the MHSU and during that time he received regular reviews by a psychiatrist, Dr Wade and the mental health nurses. Mr Chiu was not placed on any medications *"given [his] relatively stable mental state and side effects"*. When Mr Chiu was admitted to the MHSU he was placed under the care of forensic psychiatrist Dr Adams, who was employed by Justice Health as a staff specialist at the MHSU for two days per week.

Dr Adams arranged to review Mr Chiu on the day of his admission; however that could not proceed as no interpreter attended. The appointment on the following day also did not go ahead according to plan, as the interpreter did not attend in person and provided the interpretation service via telephone, which had an unclear line. However, Dr Adams was able to perform an initial review and decided to admit Mr Chiu to the MHSU, and provided the following reasoning:

"… Mr [Chiu] presented as reasonably stable. He denied experiencing any ideas of self-harm or suicide. My impression was of a change of mental health in the preceding 12 months, necessitating two admissions to psychiatric units in the community prior to his arrest. I noted a history of psychotic symptoms and organic issues prior to his arrest, thought to be the result of low sodium. However, given his history and the nature of the current charges, I deemed it necessary to admit Mr [Chiu] for a full assessment. I did not prescribe any psychiatric medication as Mr [Chiu] did not display symptoms that would lead to a diagnosis of a mental illness requiring treatment with medication. I made recommendations that Mr [Chiu] be followed up with a general practitioner and to obtain blood results".

The following week, on 25 November 2016, another review with a telephone interpreter occurred. Dr Adams said in his statement: *"I elicited no evidence of psychotic symptoms. I considered Mr [Chiu's] mood most likely to be low although there were varying reports about his mood (including Mr [Chiu's] report that he was happy to have seen his son that day). Mr [Chiu] denied experiencing any ideas of self-harm or suicide. There was no evidence of a confusional state or delirium. Again, no psychiatric medication was prescribed or deemed necessary. I did think Mr [Chiu] required a GP opinion in view of his hyponatraemia and a referral for neuropsychological assessment once his sodium levels had stabilised (to fully investigate the possibility of underlying cognitive dysfunction, which was not evident on basic testing)."*

Dr Adams said that the reason he requested a more in depth neuropsychological assessment was to ascertain whether Mr Chiu was experiencing a cognitive deficit. He did not think the assessment was urgent and it was for abundant caution. He had not observed any clear signs of deteriorating cognitive functioning, nor any clear signs of cognitive dysfunction.

On 8 December 2016, Dr Adams noted that Mr Chiu remained stable without clear symptoms of psychosis or mood disorder and he remained stable without any medication. In reviewing Mr Chiu's history, Dr Adams was of the opinion that Mr Chiu's deterioration in mental health prior to onset of aggression seemed to be secondary to the psychiatric medication and anti-depressant side effects. This led to a change in his behaviour in the context of hyponatraemia. Dr Adams explained that some people, particularly older people, can develop an electrolyte imbalance from psychiatric medication. Dr Adams thought that had occurred in Mr Chiu's case.

On the same date, Dr Adams met with Mr Chiu's children to gain collateral information. They reported to him that they had noticed a significant improvement in Mr Chiu's mental health. On 29 December 2016, Dr Adams' registrar Dr Smith conducted a review. On 6 January 2017, Dr Adams again reviewed Mr Chiu. Dr Adams found no signs of major mental illness. He explained that as referring to "*the absence of a mental illness such as an anxiety disorder, a mood disorder, a psychotic disorder or any clear evidence of cognitive impairment during his period with us*".

On 20 January 2017, Dr Adams reviewed Mr Chiu and again found that Mr Chiu remained stable with no symptoms of mental illness, no problematic behaviour and no prescribed medication. Dr Adams considered that it was suitable to discharge Mr Chiu. Dr Adams gave consideration to whether Mr Chiu was at potential risk of future deterioration. He determined there was a minimal likelihood of that. The Chiu family's legal representative, Mr Jack Amond ("Mr Amond") asked Dr Adams a number of questions about the decision to discharge Mr Chiu from the MHSU. Dr Adams said that he had no recollection of any discussion with Mr Chiu's son indicating that his father was terrified of entering the general prison population for fear of harm from other prisoners.

He said that the discharge was completed on 31 January 2017 with input from the multi-disciplinary team and that Mr Chiu could have been discharged from that time onwards. Dr Adams said that the review on 3 February 2017 did not occur as the telephone lines were down, however the review was unnecessary given that Mr Chiu had been observed daily by nursing staff, had been reviewed regularly by Dr Smith and there was no reported change since 20 January 2017.

Dr Adams clarified during re-examination that Mr Chiu was not expected to be reviewed after the decision to discharge had been made; instead, Dr Adams had sought to review Mr Chiu because he was still in the unit on the day that Dr Adams was working there. Mr Amond raised whether it would have been preferable for Mr Chiu to have a one-out cell given that he was a vulnerable prisoner. Dr Adams said that there are positives to having a vulnerable prisoner in a cell with other prisoners and that there are a lot of factors to take into account. Dr Adams did not see any medical reason for Mr Chiu to have a particular cell placement.

All three experts agreed that Mr Chiu received appropriate and adequate care and treatment whilst at the MRRC. They agreed with the approach adopted by Dr Adams and agreed with his findings. I accept the experts' opinions and their reasoning which I note align with those indicated by Dr Adams. I find that Mr Chiu received appropriate care and treatment from Dr Adams and the members of the Justice Health team in the MRRC.

Decision to Discharge

The decision to discharge Mr Chiu into the main prison was supported by the experts Pr Large and Dr Sullivan but not Dr Samuels who considered that it would have been better for Mr Chiu to have been accommodated at Long Bay Prison Hospital either as a psychiatric patient or in the Aged Persons Unit. Dr Samuels was concerned that Mr Chiu was vulnerable given his past psychiatric history, his age, lack of English and due to it being his first time in custody. I take Dr Samuels' position as not cavilling with the MHSU multi-disciplinary team's decision to discharge Mr Chiu *per se,* but rather considering that it was not in Mr Chiu's best interest to be housed in the main gaol. Part of that reasoning is that Mr Chiu's actions, for which he was incarcerated, were done whilst mentally ill.

The decision to discharge was appropriately based on Dr Adam's assessment of Mr Chiu and the resolution of his mental health problems. The fact that discharge meant he would return to the main prison rather than home or a less punitive environment is not a determinative factor. Dr Samuels did not disagree with Dr Adams' findings that Mr Chiu no longer required assessment, screening or treatment in the MHSU. Pr Large and Dr Sullivan agreed that Mr Chiu was not mentally ill at the time of discharge.

I find that the decision on 20 January 2017 to discharge Mr Chiu from the MHSU was appropriate. Mr Chiu had been fully assessed over a period of nearly three months and remained stable for a significant part of that admission, not requiring any further observation or intervention. There was no impediment to attending a neuropsychological assessment after his discharge and there was no need to have such an assessment prior to discharge. I note that Dr Spencer gave evidence further to the discharge process and it was evident that the decision involved the multi-disciplinary team and a planned review within seven days of discharge. Pr Large suggested that an earlier post-discharge review would probably be preferable.

However, it is noted that given the contained environment in which prisoners are held, any deterioration in mental health is more readily evident and nursing staff are available to escalate such a discharge review. Dr Samuels raised in his report whether Mr Chiu should have been in the MRRC and suggested that he could have been scheduled as a mentally ill patient and transferred to Long Bay Hospital. He noted Mr Chiu's vulnerabilities and questioned his discharge to the G Block in the MAIN on that basis.

Dr Samuels raised whether, if Mr Chiu was not scheduled, he could have been discharged to the Aged Care and Rehabilitation Unit at Long Bay Hospital. Pr Large and Dr Sullivan both queried whether there would have been a legal basis to schedule Mr Chiu and Pr Large pointed out that the criteria is not the "best interests" of the person. Given Mr Chiu's stability and resolution of his hyponatraemia through withdrawal of psychiatric medication, there was no basis for Dr Adams to have scheduled Mr Chiu.

Likewise, according to Dr Spencer, Mr Chiu was not eligible to be considered for transfer to the Aged Care and Rehabilitation Unit at Long Bay Hospital as it used to treat inmates with advanced medical conditions, such as for palliative care and dementia. I find that there was no impediment to discharging Mr Chiu after 20 January 2017 and in the context of there being no change to his presentation, the fact that he was not reviewed on 3 February 2017 is without criticism.

Likewise, the decision to discharge Mr Chiu without a neuropsychological assessment is without criticism given that it was not immediately required and there was no impediment to such a test being performed whilst Mr Chiu was accommodated in the main prison.

Ensuring the Availability of Interpreters

Dr Spencer, the Clinical Director for Custodial Mental Health at Justice Health states in her statement at [5(2)]: "Wherever possible interpreters from the Health Care Interpreter Service are used in medical consultations where communication is essential for patients who are not fluent in English." That requirement is consistent with the policy applicable at the time. This policy has since been amended. The policy provided:

"Health care interpreters are to be used in all health care situations where communication is essential including admission, obtaining consent, conducting assessments, counselling, explanation of treatment including associated risks and side-effects, health education and discharge planning… A professional healthcare interpreter should be used in the following situations: …Obtaining medical and psychiatric histories, in assessment and ongoing treatment/management/in-depth case review… In the event that a health care interpreter cannot be provided on site, telephone interpreting or deo conference interpreting through HCIS or HLS should be used in the first instance. Where this is not possible, the TIS telephone number 131 450 can be used."

Dr Adams conducted most of his reviews with the use of telephone interpreters, apparently due to difficulties with interpreters attending in person. The policy applicable at the time (and the current policy) makes it clear that it is preferable that face-to-face interpreters are used. There is no doubt that is particularly the case in a health care setting, and perhaps more so in mental health care. Indeed, the policy explains that face-to-face interpreting is more reliable than over the telephone.

Policy Directive PD2006_053, which was in place in 2016 to 2017 provided: *"While telephone interpreting may be used, face-to-face interpreting is more reliable and therefore is the preferred option in the provision of health care.Telephone interpreting does not allow for interpretation of non-verbal forms of communication such as body language and gestures. It may also be easier to misunderstand what is said or not heard clearly over the telephone.*

In the event that a health care interpreter cannot be provided on site, telephone interpreting or videoconference interpreting, where it is available, should be considered…" I note that Dr Adams recorded in his notes when the telephone line was not particularly clear and he would record when an in-person interpreter had been booked but did not attend. Dr Spencer said that the availability of interpreters poses difficulties for a number of reasons, including the interpreters' willingness to attend the prison and challenges progressing through security.

Whilst it is good that the doctors record the difficulty in the patient's record, there appears to be a need for Justice Health to engage with Health Care Interpreter Service to sure up a more reliable system so that when an interpreter is booked they actually arrive and the doctor does not have to resort to telephone interpreting or making another appointment.

There is no evidence that there was any impact on Mr Chiu's treatment caused by the non-attendance of an interpreter. However, the preference for in-person interpreting should be the norm, not the exception. Even video-conferencing is preferable to telephone interpreting and there should be no impediment to the implementation of same as part of the suite for telehealth. This is particularly so given the impact on provision of services resulting from the Covid-19 pandemic.

Mr Chiu's cell designation from one-out to normal placement

On 16 January 2017, Dr Smith reviewed Mr Chiu, apparently with the assistance of an in-person interpreter. Dr Smith spoke with Mr Chiu about the plan for him to soon be discharged from the MHSU. Mr Chiu told Dr Smith he would like a one-out cell and Dr Smith told him that he would not necessarily have a cell to himself. Dr Smith explained that it was the decision of CSNSW and that Justice Health only needs to advise as to whether there is a medical or mental health reason requiring a one-out cell. The following day, Dr Smith spoke with Mr Chiu's son about the plan to discharge Mr Chiu back to the main prison. Mr Chiu's son raised concerns about his father's vulnerability and Dr Smith explained the decision making process to Mr Chiu's son. The MHSU Discharge Plan was devised by the multidisciplinary team and set out the information summarised above at [119].

During his evidence, Dr Smith was asked questions about why he changed the discharge summary from a one-out to normal cell placement. He said that there was no mental health-related reason that Mr Chiu should have a one-out cell. After being shown documentation, Dr Smith agreed with the legal representative for Justice Health, Mr Bradley that this was the view of the professional staff at Justice Health.

Dr Smith was aware that Mr Chiu had been in a one-out cell prior to his admission to MHSU and on the basis he was a potential risk to other prisoners due to his mental state at the time. It would appear the decision to change the recommendation occurred between 9 am and 9.14 am on the day of Mr Chiu's discharge. There is no evidence to suggest that there was any factor such as cell availability that played a role in the decision to change the cell placement recommendation.

At the time of discharge, Mr Chiu was not indicating a risk to himself or other prisoners and accordingly there was no basis to recommend a one-out cell. However, Mr Chiu's vulnerabilities were still noted by Justice Health on the discharge plan so that CSNSW could make an appropriate cell placement. I find that it was not appropriate for Justice Health to recommend to CSNSW that Mr Chiu be considered for normal cell placement.

The decision to place Mr Chiu in a pod and cell where there were no other Cantonese speaking prisoners

On 4 February 2017, Mr Chiu was transferred to Pod 12 within G Block in the MAIN. CSNSW officers were aware that there were Cantonese speaking prisoners in Pod 11 but that there were no vacancies. They placed Mr Chiu in a cell in Pod 12 with two English speaking prisoners who appeared to accommodate Mr Chiu's concerns about a noisy exhaust fan and wishing to keep the light on overnight, although he had to point to things as part of his communication.

The CSNSW officers arranged for one of the Cantonese speaking prisoners from Pod 11 to enter Pod 12 and go to Mr Chiu's cell. That prisoner explained to Mr Chiu that the officers were trying to get him a bed in Pod 11 although could not that night and there might be a vacancy the following day. As at February 2017, inmate accommodation was governed by Section 7.17 of the CSNSW Operations Procedures Manual ("OPM") titled "Inmate Accommodation". That policy states at 7.17.2:

Where possible a cell placement conference will be convened involving both Justice Health staff and Corrective Services NSW staff to consider the information and appropriate cell placement".

This policy is consistent with a decision about cell placement being made involving factors other than a prisoner's health. Although ultimately the decision rests with CSNSW, there would need to be good reason to depart from a recommendation by Justice Health. It would however, in my view, be open on such a policy to withhold a person's discharge from the MHSU until an appropriate cell placement was available. It would not be appropriate however for a recommendation to be changed due to the unavailability of an appropriate cell. I note that the current policy in relation to cell placement also includes factors of old age and inability to speak English, in addition to the consideration of culturally appropriate accommodation. I find that although it was unfortunate there was no bed available in a pod with other Cantonese speakers, it was not inappropriate for Mr Chiu to be discharged to a pod and cell where there were no other Cantonese speakers.

Despite alerts raised by Justice Health in the MHSU Discharge Summary, CSNSW Officer Singh noted that "he didn't find anything concerning" when considering Mr Chiu's cell placement

Mr Green reported that *"it is reasonable to conclude that if the HPNF stated Mr Chiu was fit to be discharged from the MHSU to a normal cell then he did not present a current risk of self-harm – otherwise he would not have been discharged."*

I note that SCO Singh says he took into account the MHSU discharge summary, the Inmate Profile Document and the HPNF of 31 January 2017. I do not necessarily disagree with Mr Green, but I think that it is incumbent upon a CSNSW officer to lend their mind at least collaboratively with the Justice Health material and whilst Mr Chiu was not assessed as presenting a current risk of self-harm at discharge, the discharge summary did signal an alert and whilst a consideration of that alert was unlikely to have resulted in different cell placement, it was an alert and may well cause an officer to find something concerning. Circumstances can change very rapidly, especially with vulnerable inmates, and a discharge from the MHSU that is not without alerts should not be overlooked.

In any event, given that Mr Chiu was not a risk to others, placement in a cell with others could well have been considered a protective factor (leading to a normal placement, noting such an alert). I find that SCO Singh not identifying the alerts as "concerning" had no effect on Mr Chiu's accommodation or wellbeing.

Incomplete Prisoner Intake Documentation

On 26 October 2016, Mr Chiu was initially in custody at the police station and after he was charged he was bail refused and taken to the local court. CSNSW manage the cells in the court system so Mr Chiu entered CSNSW custody for the first time when he appeared in court. The CSNSW officers at the court cells are required to complete the IIO form and this and other documents are the initial documents placed on the prisoner's file.

The IIO was incomplete in numerous respects; most relevantly, Mr Chiu's family contact details were incomplete. The explanation may be due to a number of factors, such as Mr Chiu not wanting at that time to give that information or being unable to due to his mental state and/or limited language or there being insufficient time to complete the document in its entirety. It is apparently not uncommon for the form to be incomplete due to the circumstances. Given that there is a reception and checking process when the prisoner is transferred to a reception prison, any deficiencies are required to be addressed at that point.

In Mr Chiu's case, the forms did not receive the attention and checking process required and consequently at no stage was contact information about next of kin or the Emergency Contact Person ("ECP") placed on the form or Mr Chiu's management file. There are a number of documents that accompany a prisoner, including a warrant issued by the court, which form part of a prisoner's management file. There are numerous questions on the IIO. Of note, Mr Chiu's next of kin details were not recorded, his health history was not reported, no psychiatric or psychological interventions were ordered and no special needs were noted.

When Mr Chiu was received at MRRC he underwent a reception screening process. That process involves two interviews, one being with a Justice Health nurse and the other with a CSNSW officer. The IIO is used to inform the CSNSW interview. The CSNSW officer completes an Inmate Screening Questionnaire ("ISQ"). The CSNSW Reception Policy provides that an admission interview is to be conducted and it must be conducted in a language the inmate understands.

The *Policy and Procedures for Reception, Screening, Induction and Orientation of Inmates in CSNSW* relevantly provides*:*

"When an inmate is received into custody of CSNSW from court, the receiving officer must ask for and obtain all relevant information about the inmate from police, court staff, legal representatives, judiciary, Community Corrections, health workers, family and friends. This information must be noted on the Supportive Information section of the ***Inmate Identification and Observation FORM (IIO)*** *and communication between staff … This information is to be used for completing a risk assessment (IIO) in relation to health, suicide/self-harm, escape or other behavioural issues."*

Mr Chiu was interviewed with the assistance of an interpreter; however he declined to provide details of his family contacts.

After interviews are completed, the IIO and other reception documents (such as the ISQ) are generally reviewed or checked to ensure compliance and to ensure that required information is on the CSNSW management system, the Offender Integrated Management System ("OIMS"). As a result, appropriate decisions in relation to prisoner classification, cell placement, alerts and special needs (to name a few) are recorded and actioned.

The role of a Checking Officer during an inmate's prison reception is to:

- collect the case file;
- authorise any alert information into the appropriate OIMS screen;
- review that Priority 1 referrals (being referrals requiring immediate attention) have been actioned; and
- complete the Checking Officer's Assessment ("COA") – Intake Screening form.

The COA may affect an inmate's classification. During Mr Chiu's reception on 27 October 2016 at MRRC, no COA occurred and subsequently it was not recorded on OIMS. The COA section of the checklist on the covering page of Mr Chiu's Case Management File ("CMF") is not endorsed.

Section 9.4 of the *Policy and Procedures for Reception, Screening, Induction and Orientation of Inmates in CSNSW* sets out under the section regarding COA that:

"Following completion of the ISQ the checking officer … of the reception wing/pod, who has not directly screened the inmate, is to collect the case file and authorize any alert information on to the appropriate OIMS screen. The checking officer is also responsible for reviewing that Priority 1 referrals have been actioned prior to completing the [COA] – Intake Screening. This must be done prior to the initial classification."

Throughout the 11 weeks Mr Chiu was in the MRRC, it would have been clear to anyone looking at the CMF that not all assessments had been carried out. In his statement, Mr Murrell confirms that despite the failure to check the documents, Mr Chiu's mental health requirements and appropriate cell placement were known and appropriately addressed: *"Therefore, the failure to perform the COA after the ISQ of 8.15pm 27 October 2016 did not delay CSNSW custodial officers learning of Mr Chiu's mental health problems because: Officers became aware of those problems that same night, By 29 October 2016 even an officer of the rank of Assistant Superintendent had become aware, and By 29 October 2016 there were in Mr Chiu's Case Management File at least seven documents describing those problems for custodial officers to read".*

I accept that the failure to perform the COA had no effect on the appropriate placement of Mr Chiu upon his reception into custody and no effect on the care and treatment he received. As Mr Chiu had declined to provide his family contact details during the screening process, there was no ECP entered on OIMS. However, because Mr Chiu's children visited him, their details and identification as family was on OIMS but at a location other than where it would be expected. That information was contained in the visitor information section of the management system.

It is noted that although the Justice Health file contains family details, Justice Health information is managed separately and does not form part of the CSNSW system.

When CSNSW sought to advise Mr Chiu's family that he had been admitted into Westmead Hospital, there was a short delay of about 10 minutes before the officer obtained the visitor information details. It is not that delay in being notified of Mr Chiu being injured about which the family complain. The failure to record Mr Chiu's next of kin details in OIMS had no material effect on the promptness of Mr Chiu's family being contacted.

CSNSW Delay in Notifying Mr Chiu's family of his Hospitalisation

By 8.50 am on 5 February 2017, Mr Chiu was being assisted after his fall. He was conveyed to hospital. The ambulance report noted *"no immediate life threat"* but *"altered conscious state; behaviour agitated"*. The Westmead Hospital records indicate that Mr Chiu was admitted at 10.11 am and record *"intended overnight".* Throughout the course of the day Mr Chiu's cerebral haemorrhages were being monitored as they were placing pressure on his brain and by 6.30 pm he was moved to intensive care. It was not until two hours later at 8.25 pm that the information that Mr Chiu had moved to intensive care was communicated to CSNSW at the MRRC. At this time, CSNSW at the MRRC also learned that the treating doctor advised the next of kin should be notified.

Mr Chiu's son, M received a telephone call at 8.40 pm from Superintendent Murray Stewart. Mr Chiu's son, M requested to visit his father and Mr Stewart advised him he would speak with the doctor on his behalf. Mr Stewart again telephoned Mr Chiu's son at 9 pm to advise that he was unable to speak with the doctor but that Mr Stewart had approved him for a visit. Mr Stewart said Mr Chiu's son, M should take sufficient identification and that his visit would be subject to the doctor's instructions. The hospital records indicate that at 9.15 pm, Mr Chiu became unresponsive and intubated. Mr Chiu's son, M arrived at the hospital at 9.40 pm shortly before his father was taken into emergency surgery. Mr Chiu never regained consciousness.

Had the family been notified at the time of Mr Chiu's admission, they would have been able to request to visit Mr Chiu and despite the ongoing medical intervention could have provided him comfort and been there for his last conscious period. When Mr Chiu was transported to hospital in the morning, CSNSW tasked two officers to provide a security escort. They were COs Aperocho and Talolua. They were informed by a doctor that Mr Chiu had received serious injuries and would be required to stay in hospital. Their reports do not indicate the time at which they were told this. Mr Green was on duty at the prison when Mr Chiu was injured and conveyed to hospital. He completed his shift at 1.30 pm. In his evidence Mr Green said he is not always in the office and is required to attend various locations throughout the MRRC. He had two conversations with the escorting officers between 10 am and 1.30 pm.

Mr Green furnished a report in which he says after Mr Chiu's death he spoke to CO Aperocho, who conveyed to him that he had contacted MRRC at about noon to advise that Mr Chiu had become an in-patient.

Mr Green has no recollection of being advised of this and does not know who the person is that CO Aperocho spoke with. Mr Green has no recollection of receiving that information from a staff member. Although logs of incoming calls have been produced for other periods of that day there has been nothing produced by CSNSW for the period 10 am to 1.30 pm. Given that Mr Green did not leave his shift until 1.30 pm, if a telephone call had been made at around noon to advise that Mr Chiu had been admitted, it would be reasonable to expect that Mr Green would have been advised. In his evidence, Mr Green suggested that the advice about whether a prisoner is being admitted to hospital is information that is important for the rostering of escort staff.

When an inmate is admitted as an in-patient with no advance warning (e.g. heart attack, appendicitis, serious assault) the GM (or authorised officer) is to ensure that the inmate's emergency contact person is notified of the situation, as soon as possible and on the same day it is confirmed that the inmate will be admitted as an in-patient."

It is clear that the policy does not require an admission to have already occurred; rather, it requires that it has been indicated that an admission will occur. On the basis of that policy, Mr Chiu's family should have been advised of his admission shortly after 10.11 am. Superintendent Stewart was not advised by CO Aperocho that Mr Chiu was transferred to the ICU until two hours after it occurred. I have no doubt that the escort officers went with Mr Chiu from the Emergency Department ("ED") to the ICU. Accordingly, even on that transfer (from the ED to the ICU) the policy (requiring that the Emergency Contact Person be notified as soon as possible) was not complied with. Superintendent Stewart complied with the policy in that he informed Mr Chiu's son as soon as he learned of it, however he should have been advised of the transfer earlier. If that had occurred, Mr Chiu's family would have been able to visit before he lost consciousness.

Counsel Assisting suggested that there was insufficient evidence to determine whether CSNSW had been informed prior to 8.25pm that Mr Chiu had been admitted as an inpatient. I am of a different view, given that CO Aperocho said he advised someone in Mr Green's office at around noon. Even if that is incorrect, CO Aperocho was still at the hospital when Mr Chiu was transferred to the ICU. The policy does not apply to when the head of security is informed; it applies to any CSNSW officer, of which CO Aperocho was one. The policy was not complied with and the reason it was not complied is likely because there is confusion about what approach CSNSW should take in circumstances where a prisoner is under the care of a health professional, be it in the prison where Justice Health are applying first aid with the NSW Ambulance Service, or outside of the prison where the NSW Ambulance Service and then a NSW Health hospital provide care to a prisoner. The evidence of both Mr Green and Mr Murrell was that CSNSW take a reactive approach. Their evidence was that it is a matter for Justice Health or the hospital to tell CSNSW that an inmate is suffering a life threatening injury or has been admitted to hospital, and there is no obligation on CSNSW to make this inquiry.

With respect, such an approach invites a non-compliance with the policy to notify the ECP. The policy was subsequently amended and is now found in the *Custodial Operations Policy and Procedure*s - 6.2 Hospitalisation of inmates, at Part 1.3, which provides the following procedure:

"Contact the inmate's Emergency Contact Person (ECP) as soon as possible and on the same day that it is confirmed that an inmate is: admitted as an in-patient (remaining overnight in the hospital) with little or no advance warning (such as with a heart attack, appendicitis, serious assault) their medical condition becomes life threatening".

I doubt whether that change in policy would correct the "reactive" approach Mr Murrell and Mr Green described. I note that Mr Murrell gave evidence at the inquest stating that the policy is again under review. There are discussions which have been initiated by the Ministry of Health involving CSNSW, Justice Health, Ambulance NSW and the Local Health District regarding inmates in public hospitals. Mr Murrell gave evidence that CSNSW will consider raising with stakeholders the possibility of an escort having a checklist form which can be provided to the Nurse Unit Manager, to then be provided to CSNSW in the event the inmate needs to become an inpatient or has a life threatening condition.

If there is no system in place involving an appropriate person at the prison remaining in contact with someone at the hospital as to the health status of the prisoner for the purpose of advising the ECP, then the policy would be difficult to comply with. If the individual at the hospital is an escort officer, then they need to be specifically tasked with that purpose as part of their security mandate. I accept there are numerous security issues involved in circumstances where a prisoner is hospitalised and their family want to visit. There is much balancing to be done for the numerous stakeholders to ensure the safety of fellow patients, staff and the public, the security of the prisoner and the provision of their medical treatment. There are a multitude of unwanted scenarios that could occur as a result of a policy whereby every time a prisoner is unexpectedly conveyed to a hospital an ECP is notified.

The fact remains that Mr Chiu was very seriously injured, he was not a person with criminal associates, he was an older man and he had family who visited him and who would want to know that he had been injured and hospitalised. Nobody at MRRC was tasked with keeping abreast of what condition he was in or what was happening for the purpose of his family's notification and involvement. It is that approach and purpose which needs to be addressed. CSNSW have acknowledged that the failure in compliance with the policy caused the delay in notifying Mr Chiu's family. The Commissioner for CSNSW apologises and recognises the distress this has caused. The Commissioner offered his sincere condolences to Mr Chiu's family for their loss. I anticipate that a policy and approach change will also assist Mr Chiu's family and other families in the future.

The submissions of Counsel Assisting were very thorough and well-balanced and were adopted by parties in the inquest. Counsel Assisting put forward a recommendation that is directed at the issue in relation to ECP notification. The recommendation is directed at CSNSW and it was suggested by them that Justice Health and the Ministry of Health be included but given the separation of services I have determined that it should remain a recommendation solely directed to CSNSW.

Recommendation to the Commissioner of Corrective Services NSW

That Corrective Services ("CSNSW") amend their policies to ensure that when a prisoner is subject to a medical emergency requiring conveyance to hospital that the following occurs:

The prisoner's Emergency Contact Person ("ECP") is recorded on the escort and transfer documents. The Escort Officer (or another identified appropriate officer) ensures that the ECP information is transferred to the hospital triage document so the hospital has the prisoner's ECP details.
A CSNSW staff member is identified and allocated the responsibility of:

- identifying the health status of the prisoner on a regular and frequent basis to enable a decision to be made that the prisoner's ECP be informed of the prisoner's condition; and
- managing and facilitating the visiting access the ECP has to the prisoner with the Escort Officers; and
- managing updating the ECP as to the condition of the prisoner.

That an audit of the policy should occur within a reasonable period of time of the commencement of such policy to ensure that it is being complied with and is consistent with any Memorandum of Understanding ("MOU") between CSNSW, Justice Health and Forensic Mental Health Network and the Ministry of Health NSW.

Formal Finding:

Identity: Person known in these proceedings by the pseudonym Ye Chiu

Date of Death: 6 February 2017

Place of Death: Westmead Hospital, Westmead

Cause of death: Head injuries

Manner of death: Ye Chiu died from injuries sustained in a fall from the upstairs land in the Goldsmith "G" Block at the Metropolitan Remand and Reception Centre from height, such fall being deliberate with the intention to end his own life.

13. 100899 of 2017

Inquest into the death of SB. Finding delivered by State Coroner O'Sullivan at Lidcombe on the 11 December 2020.

SB was a remand prisoner at Parklea Correctional Centre ("Parklea") at the time of his death. Shortly after 8am on 3 April 2017 he was found hanging in the doorway of his cell by prison sweepers. He had left what appears to be a suicide note. He had last been seen shortly before 6pm the preceding evening.

At the time of his death SB was alone in his cell. His usual cellmate had been transferred to attend court the morning prior to his death. SB was 38 years old (born on 18 June 1978). It was his first time in custody, and he faced serious criminal charges. He had raised various issues relating to his mental health with prison psychologists and Justice Health, and had been prescribed medication initially by a general practitioner, and later a psychiatrist. SB's parents, sister and partner attended the inquest and their love for SB was clear. They each continue to grieve the loss of SB and I extend my sincere condolences to the family.

Nature of an inquest

This inquest is a public examination of the circumstances of SB's death. Unlike some other proceedings, the purpose of an inquest is not to blame or punish anyone for the death. The holding of an inquest does not itself suggest that any party is guilty of wrongdoing. The primary function of an inquest is to identify the circumstances in which the death occurred.

The role of a Coroner, as set out in s. 81 of the Coroners Act 2009 (NSW) ("the Act"), is to make findings as to the identity of the person who died, the date and place of the person's death, and cause and manner of death. The manner of death refers to the circumstances in which the person died. Pursuant to s. 82 of the Act, a secondary purpose of an inquest is for the Coroner to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the person's death. This involves asking whether anything should or could be done to prevent a death in similar circumstances in the future.

During the coronial investigation, sufficient documentary evidence was gathered to answer the questions about SB's identity, the date and place of his death and the medical cause of his death. The inquest was therefore focused on the manner of SB's death.

The proceedings

The inquest into SB's death was held at the Coroner's Court of New South Wales at Lidcombe from 16 19 November 2020.

An issues list was distributed in advance of the inquest, which included the following:

- The psychiatric and psychological care and/or treatment provided to SB by Justice Health, Corrective Services NSW (CSNSW) and/or GEO Group at Parklea Correctional Centre in 2016 and the adequacy and appropriateness of that care and/or treatment.
- Consideration of relevant policies, procedures or protocols (hereafter "policies") of Justice Health, CSNSW and/or GEO Group regarding a prisoner's mental health care and/or treatment, including policies relating to the communication between the three entities of such issues, and whether those policies were adhered to, and the adequacy or otherwise of them.
- Whether the cell placement and observation of SB was appropriate and/or sufficient.
- The presence of hanging points in SB's cell, Cell 6 in Area 2C at Parklea.
- Relevant policies in relation to identifying and monitoring inmates at risk of self-harm and/or suicide, including whether the requirements of those policies were met, and the adequacy or otherwise of those policies.
- Whether any recommendations from the Coroner are necessary or desirable, including for prisoners' health and safety

SB's family was particularly concerned to understand whether SB had been properly diagnosed and prescribed the appropriate medication for his mental health concerns. In preparation of my findings, I have been assisted by the oral submissions of counsel assisting, as well as those made on behalf of the family and other interested parties, and the written submissions of Mr Rooney on behalf of the Justice Health and Forensic Mental Health Network ("Justice Health").

The Evidence:

SB was born and lived most of his life on the South Coast of NSW. He was the youngest of four children. His parents were the operators of a holiday resort. SB left school after year 10, and after a period working in the Snowy region and as a mechanic, SB joined the family business. SB met his partner in his early 20's. They had two children together, a son now aged 13 and a daughter now aged 9.

At the time of his death SB was a remand prisoner at Parklea Correctional Centre in north-western Sydney. SB had been charged on 19 November 2016 with serious sexual offences alleged to have been committed against his son. Following his being charged, SB was refused bail by the Local Court. An interim AVO was also in force, which (among other things) prevented any contact between SB and his son. At the time of SB's death, Parklea was operated by the GEO Group Australia Pty Ltd on behalf of the Commissioner of Corrective Services. As of 1 April 2019, that arrangement concluded, and Parklea is now operated under a similar arrangement by the MTC Broadspectrum consortium ("MTC Broadspectrum").

At the time of SB's death, the majority of health services at Parklea were provided by Justice Health pursuant to a tripartite agreement between the Commissioner of Corrective Services, Justice Health and the GEO Group.

Justice Health, or the Justice Health and Forensic Mental Health Network as it is formally called, is a Statutory Health Corporation established under the Health Services Act 1997. Under the tripartite agreement Justice Health was responsible for the provision of a range of health services, including general health services, mental health services and drug and alcohol services. Relevantly, psychology services were not provided by Justice Health. Rather, psychologists at Parklea were employed by GEO.

Health services at Parklea are now provided under a contract by St Vincent's Correctional Health. Pursuant to that arrangement, St Vincent's provides all mental health services, and all health services previously provided by Justice Health, albeit with continued oversight by Justice Health. According to the evidence of Julie Ellis, Director of Operational Performance Review Branch for CSNSW, the psychological mental health assessments carried out in SB's case by GEO psychologists, would now be carried out by St Vincent's clinicians.

Medical History:

SB had a history of difficulties with alcohol and insomnia prior to his arrest and incarceration. There were also reports of blackouts or unconscious events. SB had attended alcoholics anonymous at times, but in the period leading up to his arrest, he had been regularly drinking significant amounts of alcohol.

In 2009, SB had been prescribed antidepressants (mirtazapine) by his GP, during a period in which he had separated from his partner. This appears to have been the only time prior to his incarceration in 2016 that SB was prescribed antidepressants.

Arrival at Parklea:

On the afternoon of 19 November 2016, SB was received into the custody of Corrective Services NSW. Documentation completed on his entry into custody indicated that he required an interview for placement due to the nature of the charges he faced. It was also identified that it was his first time in custody. No medical or mental health concerns were identified at that time.

Justice Health completed a 'D&A and MH Summary for RSA for CSNSW' electronic form in which it was recorded that SB consumed alcohol most days, on average 3-4 beers. The form lists the assessment date as 19 November 2016. It was recorded that SB last consumed alcohol on 18 November 2016. It was also recorded that SB had never been treated for a mental health problem, had never tried to hurt himself and had never tried to end his life. The form also recorded under 'Patient concerns' that SB was concerned about being granted bail.

On 25 November 2016, SB was transferred to Parklea. He was placed in protective custody due to the nature of the offences he was charged with.

At approximately 2000 hours on 25 November 2016, SB was seen by a Justice Health nurse and a Health Problem Notification Form ("HPNF") was completed. It was again identified it was SB's first time in custody. The following was noted "Observe for vomiting, tremors, agitation, flulike symptoms, unsteady gait, may c/o stomach cramps – alcohol withdrawals".

Under the heading 'What the CSNSW/GEO officers need to do' reference was made to "2 out cell placement for 2 weeks then NCP". The phrase '2 out cell placement' means that an inmate is to be housed with another inmate. 'NCP' refers to normal cell placement, which means that an inmate may be housed either on their own ('one out'), or with a cellmate ('two out').

On 29 November 2016, SB was moved to Area 3B cell 3.

On 1 December 2016, SB completed a 'Patient Self-Referral Form', which was submitted to Justice Health. SB complained of insomnia and said that he was stressed and feeling "vague and weird". SB was placed on the waitlist to see a GP.

On 12 December 2016, SB completed another 'Patient Self-Referral Form'. He again complained of difficulties with sleep and said that depression was an issue for him. He asked to see a doctor. He was noted to already be on the waitlist.

On 24 December 2016, SB completed a further 'Patient Self-Referral Form'. SB referred again to his sleep difficulties and said that he was having "bad thoughts" at night. He was again noted to be on the waitlist to see a GP.

On 30 December 2016, Clinical Nurse Consultant ("CNC") Ford was copied into an email in relation to booking an MRI for SB and arranging the necessary referral.

On 2 January 2017, SB completed a fourth 'Patient Self-Referral Form', in which he complained of neck problems and headaches.

On 11 January 2017 SB contacted the Justice Health mental health line requesting mental health review for increasing insomnia and depression. Arrangements were made for SB to see the mental health nurse.

On 12 January 2017, a Mental Health Triage form was completed by RN Robyn Osborne. The reason for referral was listed as "3 x self-referrals + MH calls". SB reported poor adjustment to the custodial environment. He also reported his previous use of antidepressants and said he would rather not take medications. SB was referred to psychology and to a GP. RN Osborne also provided SB with information in relation to the cell call and the self-referral processes at Parklea.

RN Osborne emailed the GEO Group Head Psychologist, Dr Lutchman, to refer SB for psychology. She also referred SB to a Justice Health GP to assess possible antidepressant treatment.

On 19 January 2017 SB was placed in in cell 6 of area 2C (a wing reserved for protected prisoners). From this date until the morning before his death, SB shared this cell with another prisoner, TM.

On 25 January 2017, SB underwent an MRI of his brain at Blacktown Hospital. This had been recommended by his community GP.

On 28 January 2017, SB completed a 'Patient Self-Referral Form' stating "I am very depressed all the time. I have been in jail 2 months plus and I am still struggling mentally & emotionally. I have only been on depressants once before but now I feel I really need help.

I would never hurt myself but I honestly cannot fix my mental thoughts and I am just down all the time. Please please help!"

On the same day, RN Sunderland made an entry in the clinical records in respect of a phone call received from SB's family with concerns for his wellbeing.

It was noted that morning and night staff attempted to have SB attend the clinic, however, he did not attend.

On 29 January 2017, RN Sunderland made an entry in the clinical records noting that further attempts were made to see SB. SB did not go to the clinic when he was called.

On 30 January 2017, an entry by RN Cole, noting that SB was seen that morning. SB stated that he was feeling depressed and was not sleeping well. He said that previously he was a big drinker and was on antidepressant medication for a short time many years ago, but experienced side effects. RN Cole's impression was "presents as anxious, needs review."

The plan was that SB was placed on the GP list for the next day. On 31 January 2017, an entry was made in the clinical records by Dr R. Balzer, general practitioner. SB reported feeling depressed, and not sleeping well. Dr Balzer prescribed Mirtazapine 30mg, which is also known under the brand name Avanza. Dr Balzer told the inquest part of the reason that he chose mirtazapine was for its dual effect as an antidepressant and as an aid for sleep.

On 3 February 2017, a nursing entry was made in the clinical records. The note records that SB had good eye contact, was cooperative and interacted well. A history of depression was noted and that SB had been reviewed by a GP with medication commencing on 31 January 2017. SB reported he was feeling "okay" but would like to wait for the medication to work. SB reported that he had no thoughts of self-harm due to his thinking of his partner and two children. SB stated that he never mentioned any suicidal thoughts to anybody.

SB was first seen by a psychologist on 15 February 2017 when he was seen by Ms Cathy Yu, a GEO psychologist. SB had been referred to her for anxiety. She recorded that SB presented as moderately distressed. He reported a history of severe anxiety and alcohol abuse with episodes of blackouts. SB reported compliance with his medication. He denied thoughts, plans or intentions to harm himself or others. SB stated that he previously had fleeting thoughts of suicide but acknowledged his family as a significant protective factor. SB reportedly denied any thoughts or plans of hurting himself, and guaranteed his safety. Ms Yu recorded the following; "Referral triaged to PSYCH1 to follow up. Inmate reminded of self-referral process, and agreed to self-refer should mood deteriorate further before next seen".

Ms Yu said in evidence that all she had at the time of seeing SB was the referral. She did not have access to the Justice Health file and notes. On reviewing her notes, Ms Yu said that she assessed SB as being at low risk, and that this assessment was essentially triage. She said that the PSYCH1 line triaged an inmate for follow up at the highest priority.

In evidence Mr Pietersen, another GEO psychologist, said that explained that the PSYCH1 line was for suicide/self-harm, and that a person should be followed up again within two to three weeks.

On 16 February 2017, SB's father wrote to Justice Health noting that SB was not well. He noted that he and his wife were watching SB's health deteriorate. SB had been subject to blackouts and suffered from insomnia and panic attacks. The letter said that SB had been given antidepressants, which only served to exacerbate his condition. SB's father stated that SB required specific medical attention and an appointment had been arranged by SB's family to see a sleep disorder specialist on 21 February 2017.

On 17 February 2017 SB again saw Dr Balzer. SB said that he was continuing to experience low mood. Dr Balzer increased the dose of mirtazapine to 45mg and prescribed Seroquel (quetiapine) 50mg twice daily. Dr Balzer said in the evidence that he increased the mirtazapine to increase the antidepressant effect and added Seroquel (which is mainly an antipsychotic) to overlap by helping with agitation and also SB's poor sleep.

On 24 February 2017, an entry was made in the clinical records by Acting Nurse Unit Manager (NUM) Balagtas. It recorded SB was seen in the main clinic NUM's office that morning to discuss his current health care needs. SB said that he was having "deep depression and anxiety" and said that he was unsure whether the current medication was working. RN Balagtas followed up with the psychology department who said that he was on the priority one list for follow up.

On 25 February 2017, SB completed another 'Patient Self-Referral Form'. On this occasion he requested to see a psychiatrist regarding his "mental stability". He referred to difficulties in coping.

On 27 February 2017, RN Balagtas received an e-mail response from the GEO Group Psychologist Team Leader, Dr Lutchman, noting that SB was due for a follow up "soon".

SB made a further request to Justice Health on 1 March in relation to his mirtazapine (Avanza) being supervised. SB noted that this meant that he had to take it early and that he would wake up at 4am when his depression and anxiety was worst and would not be able to go back to sleep.

On 6 March SB's brother called Parklea and said that he feared for his brother's life. He was critical of the clinic and said that SB was suffering from sleep disorders (possible from medication), panic attacks and claustrophobia. These concerns were referred to the area manager and psychology.

On 7 March 2017, SB did not attend an appointment with the clinic to see a general practitioner. It is documented in PAS that the reason why SB did not attend was 'C7 cancelled by DCS', indicates that the appointment was cancelled by the Department of Corrective Services (in this case – GEO).

On 7 March 2017, SB was seen by a psychologist, Mr Matthew Pietersen. A case note by the psychologist that SB presented as moderately distressed. SB told Mr Pietersen that his medication was mildly effective, and raised a medication review. He also reported frequent panic attacks when first waking. The note recorded that SB denied thoughts, plans or intentions to harm self or others, and that "previously had fleeting thoughts of suicide however acknowledged family (children) as strong protective factor".

The inquest heard that on this date, SB disclosed to Mr Pietersen that he had experienced suicidal ideation as recently as that morning. This fact was not recorded in the Offender Integrated Management System (OIMS). Mr Pietersen gave evidence that he found this suicidal ideation to have not been 'intensive' and noted his use of the word 'fleeting' in his case note in this regard. Mr Pietersen said that from the notes, he believed that the suicidal ideation was a one off.

The following day, at Mr Pietersen's request, Ms Yu sent an email to Justice Health nursing staff advising that SB was requesting a medication review.

On 9 March 2017, CNC Ford made an appointment for SB to be reviewed by a psychiatrist. CNC Ford had no specific recollection of the circumstances leading to him booking the assessment with a psychiatrist, but observed that contact had again been made with the mental health line.

On 14 March 2017, SB was seen by another Justice Health GP, who made an entry in the clinical records that Avanza and Seroquel were "helping somewhat", and that SB was for review by the mental health team.

SB was seen again by Mr Pietersen the psychologist on 15 March 2017. He again presented as moderately distressed. An assessment administered by Mr Pietersen on this day recorded that SB agreed with the statement "I have thoughts of killing myself, but I would not carry them out". SB was to be further followed up by psychology. In evidence Mr Pietersen said that he would discuss such a response if it was new information, but noted that the criteria for the question was how the person has been feeling for the preceding two weeks (which included the time of the previous assessment).

On 20 March 2017, SB was seen by Dr Malik, a Justice Health psychiatrist. The clinical notes record "Denies suicidal thoughts", and that SB said "if I didn't have kids I would have. I'd never do it with kids; it just passes on the pain to them." Dr Malik diagnosed anxiety/adjustment disorder and prescribed Venlafaxine 75mg (also known under the brand name Effexor) in addition to the medications already being taken by SB.

In evidence Dr Malik said that he had no basis to place SB on a green card at the time he saw him. Dr Malik said that he had no access to the psychologist's assessments, and agreed that it would have been useful to know the results of those, particularly any reference to suicidal ideation.

On 23 March 2017, CNC Ford sent an email to RN Osborne asking that she make new waiting list entries for all patients who had been seen by psychiatrists whilst CNC Ford was on leave; this included SB. On 23 March 2017, RN Osborne replied to CNC Ford's email and informed him that she had arranged for SB to be reviewed by a general practitioner.

On 30 March 2017, SB was visited at Parklea by his solicitor, Mr Craig Lynch. This seems to have been a difficult meeting and to have involved some significant discussion regarding the prosecution brief and the strength of the evidence against SB, as well as a forthcoming Supreme Court bail application. Mr Lynch later recalled that SB said that that "he previously thought of committing suicide but would not and could not do it". SB told Mr Lynch that he had not spoken with psychologist because otherwise he would get put in a padded cell.

SB said that this was what other inmates said. Mr Lynch was so concerned that he contacted SB's mother after the visit and told her of his concern.

Later on 30 March 2017, SB's mother called Parklea and spoke with Ms Yu. Ms Yu's note records concern for SB's well-being on the part of SB's mother, but that she was "vague" about his risk of self-harm. It goes on to record "She insisted for her son to be monitored and reported that he would be best to be housed with someone, i.e. not in safe cell". Ms Yu agreed to assess SB. In evidence, Ms Yu could not recollect the words used, but agreed that she and Mr Pietersen were concerned and went to assess him.

A case note recorded by Mr Pietersen noted that SB was seen at his cell door after lock-in by both Mr Pietersen and Ms Yu. SB reported having disclosed some situational stress and coping concerns to his immediate family at a visit that day, particularly regarding upcoming Court stressors. SB denied thoughts, plans or intentions of harm to himself or others and again acknowledged his family as a strong protective factor. SB guaranteed his safety and repeatedly confirmed he was not at risk of harm and that he would notify staff if needed. SB declined the offer of a further psychological appointment on 31 March 2017, and agreed to self-refer if necessary. The plan was for SB to remain on PSYCH1 line for follow up.

Ms Yu told the inquest that both her and Mr Pietersen agreed that SB was low risk, and that if either of them considered differently, they would have initiated the Risk Intervention Team ("RIT") process. This would have necessitated the involvement of Justice Health. Ms Yu said that it was her understanding that in order for green card status to be activated, the RIT process was required (which involved a period in an assessment cell).

Mr Pietersen in his evidence agreed that SB was assessed as low risk, and said that had he been assessed higher (as moderate risk), he would have taken steps to place SB on a green card.

During 31 March and 1 April SB made a number of calls to his mother, father and sister.

2 and 3 April 2017

At 0843 hours on 2 April 2017, SB's cellmate, TM was taken from the shared cell and temporarily transferred from Parklea for a court appearance in Newcastle.

At 0919 hours on 2 April 2017, SB telephoned his solicitor Mr Lynch. He provided brief instructions regarding his case. Mr Lynch later said that SB did not sound anxious and that he did not highlight any concerns.

Later in the day, was visited by his mother and father. According to his father, SB was very agitated and depressed as his case was moving very slowly and his bail application had been moved back to May. SB was reportedly concerned that even if he got bail, he would still not be able to see or talk to his family (partner and children) due to the terms of an AVO that was in force. His father later said that it appeared to him that the medication that SB was receiving made things worse and that his mental health continued to decline.

Shortly after 3:20pm the muster of inmates was completed and they were locked in. At 5:42pm a medication round was conducted and SB received his medication from a Justice Health nurse. Security checks of the cells were later conducted during the evening and night on several occasions, albeit this did not involve any sighting of SB. SB was alone in his cell.

Shortly after 8am on 3 April 2017 a group of prison sweepers were tasked with delivering milk to the cells. At 8:07am, one came to SB's cell. He could not see through the Perspex window in the door. A second sweeper came over. They called out to SB. The sweepers called for the assistance of officers, two of whom were at the cell door within a minute. On opening the door the officers immediately saw SB hanging in the doorway. The officers activated what is known as a CERT 1 alert and worked together to cut SB down. The prison sweepers also assisted. The officers then started chest compressions and called for an ambulance.

Further officers arrived and provided assistance. Within 5 minutes, a nurse from Justice Health arrived with a defibrillator. The nurse took over CPR. Further Justice Health nurses arrived, and an airway bag was used. Ambulance paramedics arrived approximately 10 minutes after the arrival of the Justice Health nurses and took over CPR.

Ambulance records indicate that they arrived at SB's cell at approximately 8:28am, and that SB was in asystole throughout their time treating him. The paramedics administered adrenaline with no effect. At 8:47am the senior paramedic declared SB to be deceased.

SB's body was later taken to Royal Prince Alfred Hospital, arriving at 2:55pm. A certificate of life extinct was issued.

A report was obtained by the family from an emergency physician, Professor Gordian Fulde, regarding the resuscitation attempts. That report was provided to those assisting me, and was included in the brief. Professor Fulde considered that the CPR administered was appropriate.

Forensic examination of the scene identified that SB had used a bed sheet and towel to hang himself. SB's body was observed to still have the ligature around his neck. The towel and sheet had been tied to the lowest of three ventilation flaps above the door. A chair appeared to have been used and kicked away.

The note later located in SB's cell was addressed to his family. It referred to his love for them, and his appreciation of the support that they had provided to him whilst he was in custody. It included the statement, "The pain of being in here and not seeing my family is too much."

Autopsy Report and Toxicology:

A limited autopsy was conducted on 5 April 2017 by Dr Rebecca Irvine of the Department of Forensic Medicine. Dr Irvine identified the direct cause of death as hanging. She did not identify any suspicious findings, or any findings inconsistent with the history provided to her. In her report she also noted the toxicological findings, which included the medications prescribed to SB.

Forensic Toxicologist, Professor Alison Jones found that Venlafaxine was in SB's blood at a level that was inconsistent with having taken the drug in a manner consistent with what was prescribed to him. The inquest heard from Professor Jones that this could wholly be explained by the rate of SB's metabolism. Similarly, Mirtazapine was in SB's blood at a level that inconsistent with having taken the drug in the manner prescribed to him. Professor Jones opined that issues relating SB's metabolism could only partially explain this.

This leaves open the possibility that SB was hoarding his medication and took an excessive dose. However, the evidence was that SB received his medications in a supervised fashion, and it was the evidence of his cellmate, TM, that he never saw SB take any steps to hoard medication. Ultimately, I am unable to resolve this issue.

In her report, Professor Jones raised the theoretical possibility that the levels of mirtazapine (along with the venlafaxine) in SB's blood may have had an effect on SB's neurotransmitters and thereby changed his behaviours. She noted some literature pointing to the potential for increased feelings of anxiety, panic and impulsivity as a result of mirtazapine. Professor Jones qualified this significantly, noting that the evidence regarding this is conflicting. She also noted that some drugs take some time to have an effect.

Issues explored at the inquest

I will now consider the issues identified in the list of issues as circulated prior to the inquest.

Issue 1: Adequacy of care and treatment provided at Parklea

The first issue concerns the psychiatric and psychological care and/or treatment provided to SB by Justice Health, CSNSW and/or GEO Group at Parklea Correctional Centre in 2016 and the adequacy and appropriateness of that care and/or treatment.

During the coronial investigation, medical records from Justice Health, GEO and Corrective Services were obtained and statements of doctors, nurses, psychologists and psychiatrists involved in SB's care at PCC were obtained. Policy documents from Justice Health, Corrective Services and GEO that were in place at the time of SB's death and subsequently also formed part of the brief of evidence.

Corrective Services NSW were not directly responsible for providing either psychiatric or psychological care to SB.

Psychological care was provided to SB by psychologists at GEO. GEO psychologist Matthew Pietersen was responsible for the area in which SB was housed, assisted by Cathy Yu, who was not sure whether she was a provisionally registered psychologist or registered psychologist at the time. Both gave evidence at this inquest.

Psychiatric care was provided to SB by psychiatrists at Justice Health. SB was seen on one occasion by Dr Malik, a consultant forensic psychiatrist who at the time was employed by Justice Health. Dr Malik gave evidence.

Dr Sarah-Jane Spencer, a consultant forensic psychiatrist and the current Clinical Director, Custodial Mental Health and Co-Director (Clinical Services) for Justice Health gave evidence. Dr Spencer considered the therapeutic regime implemented by Dr Balzer and Dr Malik to be appropriate. In her opinion the use of Seroquel in combination with antidepressants was not controversial.

Expert forensic psychiatrist's Dr Adam Martin and Dr Olav Nielssen provided opinions in these proceedings, and gave oral evidence. Dr Martin considered that the diagnosis of anxiety and adjustment disorder raised by Dr Malik (on 20 March 2017) was appropriate. He noted that adjustment disorder is described in the DSM-5 and essentially describes a reactive depression/anxiety state of clinical significance, causing impairment.

In his report Dr Nielssen expressed the opinion that SB had developed a severe form of depressive illness in which he felt he had no future, and that suicide was a reasonable course of action. Dr Nielssen indicated in oral evidence that adjustment disorder can be different way of describing a state of depression. He said that specific label does not alter the appropriate treatment.

Given the available information, Dr Martin considered it likely that SB had longstanding problems with mood with a background of alcohol use disorder and previous head injuries. Dr Martin also indicated that adjustment disorders, in particular, are very common presentations for Justice Health clinicians, as people present in highly stressful circumstances, having been isolated from their family facing serious charges with associated feelings of shame.

When asked about adequate and appropriate care, Dr Martin said that an assessment of whether an individual receives adequate and appropriate care should be seen in the context of the overall load of clinical presentations of correctional centre inmates.

From his experience and knowledge, Dr Martin opined that there is an overwhelming demand of mental health presentations among correctional centre inmates.

He said that at any one time, review of most inmates' records would demonstrate multiple known risk factors for suicide. He said that, in a general sense, most inmates would present with adjustment issues and it would be very common for inmates to have a background of mood disorder, self-harm, substance use disorder, relationship dysfunction and poor coping abilities.

In his opinion, a person presenting as SB did would not have met criteria for referral to the Mental Health Screening Unit or treatment as an involuntary patient at Long Bay Hospital or the Forensic Hospital.

Dr Martin noted that SB was seen by a mental health nurse, reviewed by a general practitioner, initiated on anti-depressant treatment, which was subsequently increased, and was then referred to a psychiatrist. As indicated above, he supported the diagnosis made by Dr Malik.

He noted that suicidal thoughts were asked about and follow-up was arranged. Dr Nielssen noted that staff at the Justice Health clinic (and the prison psychological services) responded promptly to referrals from SB's mother and his solicitor, and that on each occasion he was seen very soon afterwards. Dr Martin considered that Dr Malik's clinical impression and management plan, while brief, was reasonable given the aforementioned context of high demand mental health services within the correctional setting.

In relation to the prescription of medication, Dr Martin considered that the decision by Dr Malik to add Venlafaxine (75 mgs daily), to the already prescribed, Mirtazapine (45 mgs) and Quetiapine was reasonable. In his opinion, a combination of Mirtazapine and Venlafaxine is a well-known and reasonable combination. Both experts confirmed that mirtazapine was a first line antidepressant.

Similarly, Dr Nielssen said he was not critical of the medication regime employed by the doctors who saw SB. He noted that the appropriate time for a further review of SB's medication would have been shortly after his death, and that at least two weeks is required to ascertain whether a new or altered medication regime is working.

Dr Martin said that the addition of Venlafaxine to Mirtazapine demonstrates that Dr Malik was aware of there being a serious mood disorder requiring treatment. He said that follow-up by a general practitioner would have been reasonable and would mirror management intervention in the community where a psychiatrist would assess a person, diagnose, make management changes and would request follow-up for further general practitioner review.

Dr Martin also commented on the 'off-label' prescription of the antipsychotic medication Quetiapine, which Dr Nielssen had raised in his report. Dr Martin said that the prescription was not controversial and that it is common practice among clinicians in various settings, including correctional centres, as well as the community, for adjunctive low-dose Quetiapine prescription. He said this was for its anxiolytic and sedative properties when a person is presenting with distress, agitation and sleeplessness. Dr Martin said that it would not be common practice or particularly helpful for clinicians to document the rationale for specific choice of medications and the lack of documentation for explaining such a rationale would not have had any material impact in relation to SB's trajectory.

Dr Nielssen initially disagreed with certain limited aspects of Dr Martin's opinions about medication; however, in the course of giving concurrent evidence in Court, their positions became more closely aligned.

In evidence he was not critical of the off-label prescription of Quetiapine, but still considered that some further clinical documentation of the basis for its use would have been appropriate, although largely for the purpose of making clear the basis of the decision I retrospect.

The clinical notes of Dr Balzer were of exceptional brevity, lacking any level of detail. Both experts agreed that they should have been more fulsome. This was readily accepted by Dr Balzer in his evidence. There was no suggestion by either of the experts that if Dr Balzer's notes included more detail that this would have led to a different outcome.

On the basis of all the evidence, in particular the unanimous views of the experts and Dr Spencer, I find that the overall care and treatment of SB was appropriate. Relevant to this conclusion is the fact that none of the clinicians who saw SB had all of the information. I return to this issue later in these findings.

I also observe that there were some initial delays in SB receiving treatment via Justice Health. This was some months prior to SB's death, and was therefore not the focus of the inquest. However, it is to be hoped that delays in inmates receiving medical assistance will be minimised in the future, wherever possible. As outlined later in these findings, I note that the current contractual arrangements for the operation of Parklea by MTC Broadspectrum include a key performance indicator in relation timely provision of primary health services.

In particular, I find that that the diagnosis and corresponding prescribing of medication was appropriate. Whilst the clinical documentation was brief, particularly in the case of Dr Balzer, in my assessment it did not materially impact the outcome.

In the case of Ms Yu and Mr Pietersen, they were junior clinicians at the time that they saw SB. They carried a large workload. Whilst there were further matters that could have been included in the case notes, they were generally detailed, and on the available evidence the appropriate assessments of SB were carried out. Once commenced, the psychologists appropriately continued to follow SB up. In the case of the final psychological assessment conducted jointly by Ms Yu and Mr Pietersen on 30 March 2017, whilst it was conducted at the door of SB's cell, this seems to have been an appropriate response to the situation at hand.

Issue 2: Consideration of relevant policies in relation to mental health care and/or treatment and communication between Justice Health, CSNSW and GEO Group

The second issue considers the relevant policies, procedures or protocols (hereafter "policies") of Justice Health, CSNSW and/or GEO Group regarding a prisoner's mental health care and/or treatment, including policies relating to the communication between the three entities of such issues, and whether those policies were adhered to, and the adequacy or otherwise of them.

It is significant that neither Justice Health, CSNSW or GEO Group staff were in receipt of all of the relevant information in relation to SB.

It is also significant that none of SB's treaters were in receipt of information in relation to SB's mental health that was offered by TM for the first time in his oral evidence at this inquest.

The inquest heard from TM that on one occasion he found SB to have dismantled a razor blade for the purposes of self-harm and that on another occasion SB spoke of wanting to hang himself, but TM talked him out of it.

The inquest also heard from TM that one and a half weeks after Dr Malik reviewed and changed SB's medication on 20 March 2017; SB stated that he "wanted to end it".

I also observe that when SB was reviewed by both Dr Malik and Dr Balzer, neither clinician was aware that on 7 March 2017, SB had experienced suicidal ideation and had expressed this to GEO Psychologist Matthew Pietersen.

It was the evidence of Dr Malik that he would have been assisted by having such information and any other information regarding psychological assessments of SB to inform his psychiatric assessment of SB. Dr Spencer and the experts agreed that more information is generally of assistance, as long as it can be easily identified.

At the time of SB's death, no route existed to transfer information from GEO Psychologists to Justice Health. The GEO, Justice Health and Corrective Services witnesses, and the experts, all agreed that this would have been of assistance.

The need for an effective flow of information between the different clinicians was highlighted by the fact that had a general practitioner reviewed SB's medication as planned by Dr Malik (in the week or so after 30 March 2017), the general practitioner would not have been aware that SB had been assessed by GEO Psychologists on 30 March after hours, after concerns were raised for his mental health by family members.

The inquest heard that since the time of SB's death, significant changes have been made to this process. It was the evidence of Julie Ellis, Director of Operational Performance Review Branch for CSNSW that clinicians such as general practitioners, psychiatrists and mental health nurses now have access OIMS. In addition, OIMS is able to be filtered in such a way as to only include the relevant medical information required by the user.

I am satisfied that there has also been a change in the allocation of responsibilities at Parklea. The inquest heard from Ms Ellis that if an inmate at Parklea were to now seek after hour's mental health care and/or treatment, they would be seen by a Mental Health Nurse (employed by St Vincent's) who would update OIMS. This information would therefore be available to the treating general practitioner and/or psychiatrist.

There has also been a significant change in the way an inmate is assessed as at risk. Approximately three weeks after SB's death, Corrective Services NSW introduced a new framework for assessing an inmate who is at risk, which is more directive than the policy in place at the time. The new policy includes a list of factors that require an 'at risk' notification to be made.

Given these changes, I do not consider it necessary or desirable to make any recommendation on this issue.

Issue 3: Whether the cell placement and observation of SB was appropriate and/or sufficient

The third issue considers whether the cell placement and observation of SB was appropriate and/or sufficient.

As a result of the Health Problem Notification Form completed on 25 November 2016, SB was initially placed in a 'two-out cell placement' for a period of two weeks meaning he was to share a normal cell with a selected cellmate and was not to be left alone at any time.

The rationale was that it was SB's first time in custody and Justice Health were concerned that SB had the potential for alcohol withdrawal. At that time, Justice Health and GEO staff were not aware of any history of self-harm or suicidal ideation.

On 19 January 2017, SB was moved to Area 2C, cell 6. His cellmate from this date was TM, however, there was no requirement that he be with a cellmate at all times.

The issue in the inquest focussed on whether SB should have been placed on a 'green card' or 'two-out cell placement' on 30 March 2017 after being seen by the GEO psychologists. When subject to such a status, an inmate is never left alone in their cell. They are also ineligible for certain work as this requires them to be alone at times.

GEO Psychologist, Matthew Pietersen, stated it was within his authority to activate a green card. He had knowledge of SB's suicidal ideation as recently as 7 March 2017 during his own assessment of SB. However, his evidence was that on 30 March 2017 he assessed SB as being low risk. He said that had he assessed him as being at moderate risk he would have activated the green card procedure.

It was the opinion of the experts Dr Martin and Dr Nielssen that only with the benefit of hindsight, that on 30 March 2017 the psychologists could have considered the activation of a green card status, without a progression to a mandatory notification of risk and the activation of review by a Risk Intervention Team. Neither suggested that they would have necessarily done so.

Dr Martin noted that SB was not presenting with current suicidal thoughts or plans, and that it would have been counter-therapeutic, for instance, for SB to have been placed in an isolation cell under camera monitoring (as would have been the case had he been subject to assessment by the Risk Intervention Team). Dr Martin noted that it seemed apparent that SB may have been down-playing his thoughts to everyone.

Both Dr Martin and Dr Nielssen said that it is very difficult to predict who might or might not attempt self-harm, and that the prediction of when it might occur is similarly difficult. They both said that while the risk factors were well known, these were not great predictors of which individuals will in fact take that step. Both experts also said that the risk of suicide fluctuates over time. Dr Nielssen also noted that the prison population was a high risk population, and that the suicide risk for prisoners is even greater in the year after release from custody.

Dr Spencer noted that Justice Health clinicians use their clinical judgement in making recommendations regarding cell placement. She said that generally they are weighing up a significant number of factors, and are balancing risk versus what the inmate may be articulating as being in their best interests.

A number of the clinicians and experts noted that many inmates do not like being subject to green card status, due to the additional restrictions it places on them. It was noted by Dr Spencer that the remand population in particular are resistant, as they are required to go to court a lot, meaning that those on a two out cell placement, will have to be found a new cellmate immediately, rather than await the return from court of someone they may be well settled with.

I am satisfied that with the benefit of hindsight, SB could have been placed on a green card but accept the evidence of the experts that it was open to SB's treaters not to have done so in the circumstances.

As to Dr Malik, Dr Balzer and the other Justice Health clinicians, it should be remembered that they had no knowledge of any suicidal ideation of SB, and the most recent interaction with SB had been on 20 March 2017 when he was seen by Dr Malik. There does not appear to me to have been any clear basis on which Justice Health staff should have reached the conclusion that SB should be made the subject of a recommendation for two-out cell placement.

I also find that there was nothing raised on 2 or 3 April 2017 with the custodial staff that would have warranted anything other than the normal cell checks of SB's cell. These do not involve sighting the inmate.

I conclude that that with the evidence available to the relevant treaters at the relevant time, the cell placement and observation of SB was appropriate and/or sufficient.

Issue 4: The presence of hanging points in SB's cell, Cell 6 in Area 2C at Parklea

The fourth issue considers the presence of hanging points in SB's cell, Cell 6 in Area 2C at Parklea.

It is apparent that hanging points in the custodial environment continues to be a matter of concern. It has been a long standing issue in many prisons, and I note that other recent inquests have made findings and recommendations in this regard, including in relation to Parklea.

It was the evidence of Ms Ellis that all hanging points of the type used by SB have been removed at Parklea, and that there has been a review and reduction of hanging points more generally in Areas 1,2 and 3.

The new wing at Parklea (area 6) that opened in March of this year has made significant improvements to the overall design of the cells, and appears to significantly reduce the risk of hanging. Some older areas have been closed and are being assessed for further improvements. Those categories of inmates considered at higher risk (fresh custodies, inmates identified as at risk, and remand inmates) are now housed in the new wing.

I accept the evidence from Ms Ellis that a remand inmate such as SB would now be housed in this new area and that significant improvements have been made. Given this and the relatively recent recommendations made by Deputy State Coroner Ryan in the Inquest into the death of L, I consider that it is not necessary or desirable to make any further recommendation on this issue.

Issue 5: Policies in relation to identifying and monitoring inmates at risk of self-harm and/or suicide

The fifth issue considers relevant policies in relation to identifying and monitoring inmates at risk of self-harm and/or suicide, including whether the requirements of those policies were met, and the adequacy or otherwise of those policies.

There is significant overlap between this issue and other matters already touched upon.

It was the evidence of the experts that the appropriate assessments were administered following concerns raised about SB's mental health and that in the months leading up to his death, these assessments were administered in a fairly timely fashion.

No evidence was given to the inquest from the current provider at Parklea, MTC Broadspectrum Consortium; however the inquest heard evidence from Ms Ellis that the current contractual arrangements between CSNSW and MTC Broadspectrum outline a number of Key Performance Indicators. These include serious self-harm incidents, timely provision of primary health services, chronic health care plans and health screening as well as a number of other matters.

I accept that no specific deficiency in the following of the relevant policies has been identified.

I also accept that upon review of the current contractual arrangements with MTC Broadspectrum, and the CSNSW Identification of 'at risk' inmates' policy that came into existence approximately three weeks after SB's death, that the relevant policy framework has changed very significantly since SB's death, and that no recommendation is required in relation to this issue.

Issue 6: Whether any recommendations from the Coroner are necessary or desirable, including for prisoners' health and safety

As I have noted, some improvements have already been implemented at Parklea. The policy in relation to identifying 'at risk' inmates was amended three weeks after SB's death, there is greater use of OIMS allowing for a more efficient flow of information between treaters, mental health care and treatment is a Key Performance Indicator for the new provider at Parklea and substantial work has been completed on the removal of hanging points.

In addition to the issues already considered, Dr Fulde raised the issue of tear resistant sheets and towels. This issue had also been the subject of a recommendation by Deputy State Coroner Ryan in the *Inquest into the death of L*. Having heard evidence from Ms Ellis on this issue, I am satisfied that there is nothing further that can be presently achieved in that regard.

Counsel Assisting ultimately submitted that it was not necessary or desirable to make any recommendation in relation to SB's death. I accept that submission.

Formal Finding:

The identity of the deceased: The deceased person was SB.

Date of death: SB died between 5:52pm on 2 April 2017 and 8:07am on 3 April 2017.

Place of death: SB died in his cell at Parklea Correctional Centre, Quakers Hill NSW.

Cause of death: The death was caused by asphyxiation by ligature.

Manner of death: SB's death was intentional and self-inflicted, in circumstances where he was an inmate in Parklea Correctional Centre.

14. 136779 of 2017

Inquest into the death of MW. Finding delivered by DSC Truscott at Lidcombe on the 24 January 2020.

This is an inquest into the death of a man known in these proceedings as MW, who was 52 years old when he died on the 5th of May 2017 at Parklea Correctional Centre ("PCC").

Mr MW was born in 1965. At the time of his death he was in custody awaiting extradition to the United States of America pursuant to an arrest warrant issued on 6 January 2017 under subsection 12(1) of the Extradition Act 1988 (Cth). MW was in the lawful custody of Corrective Services NSW ("CSNSW") at the time of his death. Accordingly, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act 2009 ("the Act").

The role of a Coroner and purpose of this inquest

Under s81 of the Act, a Coroner is to make findings as to:
The identity of the deceased;
The date and place of the person's death;
The physical or medical cause of death; and
The manner of death, in other words, the circumstances surrounding the death.

Pursuant to s 82 of the Act a Coroner is empowered to make recommendations concerning matters such as public health or safety issues arising out of the death in question.

There is no controversy in this case as to MW's identity, the date or place of his death, nor the cause of death. The investigation into the death of MW focused on the manner of his death.

Evidence and Issues of Inquest

The only witness called in the inquest was Detective Sergeant Joseph Coorey who is the Officer in Charge of the investigation. The brief of evidence compiled by Detective Sergeant Coorey was tendered.

Mr McAuley who is instructed to represent the interest of MW's teenage children joined the proceedings a few days prior to the commencement of the inquest. He raised a number of matters which, rather than adjourning the hearing date, were resolved by an agreement that following the tender of the brief and Detective Sergeant Coorey's evidence the proceedings would be adjourned and a statement from two persons would be respectively obtained to answer concerns raised by Mr McAuley. Following receipt of those statements Mr McAuley indicated through Ms Chytra that he did not wish to make any further submissions.

Dr Balzer provided a statement dated 29 November 2019 about which Mr McAuley drafted a number of questions dated 10 December 2019.

In answer to those questions Dr Balzer wrote a response statement dated 14 January 2020. Dr Balzer's 2 statements together with Mr McAuley's questions are tendered as Exhibit 2.

The second witness statement was taken from a registered nurse Ms A Hanson dated 21 November 2019. This statement is Exhibit 3.

MW's Personal History

MW was previously married and had two children from this union. MW's marriage dissolved around 2014 when he was charged by Australian Federal Police for offences under the Commonwealth Criminal Code Act. MW's wife had custody of their two children. MW had two brothers and a sister. MW moved out of the family home to live with his brother for about eighteen months until he found his own unit. He had held a job for several years up until his incarceration in January 2017. At the time of the inquest his children were teenagers at school.

MW's Criminal History

MW experienced his first arrest and charge in January 2014 after which he was on conditional police bail until June 2014. During that time the NSW Police had received information from police in the United States that a warrant for MW's arrest had issued on 6 February 2014 and that they wished to extradite MW to prosecute him for offences including and relating to those he had been charged with in NSW. As a result, the NSW charges were withdrawn, and authorities from the United States commenced their extradition process.

On 24 January 2017 MW was arrested by the Australian Federal Police and transported to the Surry Hills Police Station where the warrant was executed. Thereupon, MW appeared before the Local Court, Central via Audio Visual Link ("AVL"). He was refused bail and remanded to 29 March 2017. By the time of his death he had appeared before the court numerous times and had eventually come to learn he would be extradited to the United States.

Reception and Intake Screening

Following his first court appearance, MW who had not previously been in custody was transferred on 25 January 2017 from the NSW Corrective Services Cells at Surry Hills Police Station to the PCC. At that time, PCC was operated by GEO Group Australia Pty Ltd ("GEO") through a contractual agreement with the NSW Commissioner of Corrective Services. Health and psychiatric services were provided by the Justice Health and Forensic Mental Health Network ("The Network"); except for psychology services which were provided by GEO. Since April 2019 GEO and The Network are no longer involved in the operation of PCC. MTC-Broadspectrum and St Vincent's Correctional Health Services now operate PCC.

Upon his arrival at PCC, MW underwent a reception process which involved both a Correctional Intake Screening undertaken by a Corrections Officer employed by GEO and a Health Assessment Screening undertaken by a registered nurse employed by The Network. MW told the nurse that he had no medical history and no mental health history.

He denied any thoughts of self-harm and guaranteed his own safety. MW requested protective custody due to the nature of his charges. He was subsequently housed in cell 21 Wing 2A, a wing reserved for protected inmates. From the 6th of February 2017, MW shared his cell with fellow inmate JB. MW had a future Court date scheduled for the 15th of May 2017. At the time of his death MW was classified as an unsentenced inmate. MW's Health Assessment on 25 January 2017 did not indicate that he had any health issues. The nurse conducting the screening assessment recorded that MW appeared alert and orientated. She noted that MW's speech was clear and coherent and that he looked settled and that he denied any thoughts of self-harm. MW said that he had no medical, drug or alcohol issues. However, he indicated that two years prior he had been treated for depression and anxiety but was not currently taking any medications.

A mental health assessment test to measure whether MW was experiencing any non-specific psychological distress called "Kessler 10" was conducted. MW scored 21/50 which falls within criteria (20-24) which describes that a person may be experiencing mild levels of distress consistent with a diagnosis of a mild depression and/or anxiety disorder. On 26 January 2017 MW's intake documents (ISQ) underwent further screening where it was noted that he had a history of anxiety and depression but that he did not have thoughts or plans to self-harm. The GEO corrections officer referred MW to psychological services for coping strategies. The ISQ records that MW "Declined any other referrals-states will self-refer if required".

Psychological Services and Medical Treatment and Inmate Management

The following day 27 January 2017, psychologist Mary Girgis attended upon MW. He commented to her that he had been unaware that an appointment had been made. Ms Girgis noted that MW presented as calm, polite, co-operative and coherent during the interview. He presented as stable in his mental state with no perceptual disturbances or psychotic phenomena evident. MW reported a history of depression and anxiety. MW denied any suicidal ideations or thoughts of self-harm or plans to do so. He guaranteed his own safety and the safety of others. His insight and judgement appeared to be intact. MW denied experiencing any anxious or depressive symptoms and stated he had managed symptoms for years and was actively using coping strategies he had learned from his previous psychologist. He stated that he did not need to speak to a counsellor and that he had been coping well, denying any difficulties with his sleep and appetite. Ms Girgis advised MW that he could receive psychological assistance and advised him how he could make a referral to obtain an appointment.

On 3 February 2017, MW saw Ms Girgis again. MW had not arranged an appointment but had approached Ms Girgis at the gate. Ms Girgis agreed to see him and during interview she noted that MW appeared calm, polite, co-operative and coherent and rapport was easily established.

It was noted however that MW appeared agitated and that his mood could be described as sullen. Ms Girgis noted that MW said that he was becoming increasingly agitated and anxious and that he had yet to receive his initial phone call. He said that he had been unable to make any phone calls because he had no money in his account and could not access his property. MW told Ms Girgis that he had been trying to employ his usual techniques to calm his anxiety but they were ineffective. Ms Girgis gave MW some grounding techniques and provided him with supportive counselling.

Ms Girgis also amended his referral to welfare stating he is yet to be seen. Ms Girgis also provided MW with a "brain gym" as MW thought that having this kind of distraction would be helpful. Again MW denied any suicidal ideation or thoughts or plans of self-harm. He guaranteed his own safety and the safety of others. As a result of his attendance on Ms Girgis, steps were put in place to address the issues raised by MW and on the 8 February 2017 a phone call between MW and his brother was facilitated. On 10 February 2017 MW attended the medical clinic where he was assessed by Dr Balzer. Dr Balzer was a General Practitioner who worked for The Network from October 2016 to March 2017. MW told the doctor he had two issues. One was an infected toe ("Paronychia") which was drained and he was provided with oral antibiotics. The second was that his sleep had been poor since his incarceration. Dr Balzer prescribed Avanza 30mg (mirtazapine) for assistance with sleeping.

In his first statement Dr Balzer remarks that in the RSA clinical summary of 25 January 2017 he noted that MW had denied any thoughts of self-harm and that MW did not express any thoughts of self-harm. In his second statement, Dr Balzer said that his mental state examination of MW involved reviewing the "Health Problem Notification Form" ("HPNF") and RSA Clinical Summary completed on 25 January 2017. Dr Balzer noted that The HPNF notified that it was MW's first time in custody and that he had no thoughts of self-harm. Dr Balzer sets out that the RSA Clinical Summary, which he noted included the Kessler 10 test results, MW had indicated that 2 years previously he had been treated at a medical centre in Hurstville for anxiety and depression and that MW had been asked whether he had ever tried to hurt himself or end his life, or whether there was a family history of self-harm or suicide. Dr Balzer noted that MW replied in the negative to those questions.

Dr Belzar said that he did not have access to Ms Girgis's notes from her 2 meetings with MW. Given that Ms Girgis was a psychologist employed by GEO rather than the Network such files would not normally comprise a medical file kept by The Network. Given the matters discussed with Ms Girgis one would not expect that she would have had occasion to refer MW to The Network for any medical or mental health treatment. She did facilitate arrangements for MW to contact his brother as he had sought. On 29 March 2017 MW appeared in the Central Court Local Court via AVL from PCC. Corrections Officer Jason Singh noted in the NSW Corrective Services case notes report that MW advised him that his Court matters were adjourned for 2 weeks and that he denied any thoughts of self-harm and was satisfied with the outcome.

On 12 April 2017, MW again appeared in the Central Local Court via AVL from PCC. Following his appearance, Corrections Officer Francine Bakopoulos interviewed MW after his court appearance and noted that he confirmed that he was feeling okay and did not have any thoughts of self-harm or suicide or any other immediate concerns.

Those checks were made in conformity with Policy No. PCC/OP205. Clause 6.6-6.8 sets out AVL Checklist screening "to ascertain any changes to an inmate's circumstances likely to affect their current placement and assess if they (sic) are any immediate concerns or self-harm or suicide". In the event of a change, it is noted for The Network Staff to create a form whereby a change of the inmate's (cell) placement is recommended.

There was no indication by MW which would have triggered such a notification and indeed his placement with JB was stable for the duration of his time in PCC. On the 17th of April 2017 MW was given nurse-initiated medicines of paracetamol and Sudafed (phenylephrine) a nasal decongestant.

On the 23rd of April 2017 RN Hanson attended MW to provide him with the Avanza prescribed by Dr Balzer. MW told RN Hanson that he felt he no longer needed the medication and had not taken it for 7 days. RN Hanson accordingly told him that he would be placed on the Mental Health list for review. MW was last visited by his brother GW on the 27th of April 2017. GW has provided a statement in which he says that MW was excited to see him and they had spent an hour together. MW told GW that he feared for his life in gaol and that because he did not want to be around other inmates using the phones he had been unable to contact his GW.

GW said that he sensed that MW was uneasy about his situation. MW told his brother that he was concerned about not being able to get Legal Aid and that he was not being told anything. GW said that MW's mental state appeared stable just concerned about his situation. Prior to this meeting, and about 3 weeks before he died MW had sent a letter to GW in which he disclosed that he had a life insurance policy through his superannuation fund. In the letter MW explained to GW how he wanted things divided up between his ex-wife and children. GW did not mention in his statement whether MW's comment that he was in fear for his life was related to him sending the letter to GW about his life insurance. There was no mention in GW's statement at all about whether they had had any conversation about the letter.

Whilst in custody, MW was attended by legal representatives on 5 occasions and he had 5 Local Court appearances via AVL, with his last appearance being on 3 May 2017. He only had one family member, his brother, visit him. He was next due to appear in court on 15 May 2017.

Events leading up to the death of MW

On 5 May 2017, MW's cell mate, JB, was due to appear in Court. At about 4.30 a.m. JB was preparing to be collected from his cell. He spoke briefly with MW who wished his cell mate good luck for his bail application. JB was later interviewed by investigating police and he said that he saw no indication that MW had been in a low mood or that he was contemplating suicide. Prison staff did not find anything adverse upon removing JB from the cell that morning. This was the last time MW was seen alive. About 8.20 a.m. Corrections Officers Watene, Fiso and Brooks were conducting rounds in wing 2A. As Ms Watene opened cell 21 she observed MW hanging by a bed sheet.

The bed sheet was attached to a grill above the cell doorway. Assistance was summoned and Corrections Officers Fiso, Watene and Brooks assisted in cutting MW down. MW was placed on the floor where the Officers commenced Cardiopulmonary Resuscitation ("CPR").

The Network Health staff attended shortly after and took over resuscitation attempts. Oxygen and a defibrillator were used without success. MW's pupils were observed to be fixed and dilated with no response to light. He had no signs of cardiac or respiratory activity; his lower extremities were cold to the touch. Life was pronounced extinct at 8.30 a.m. Paramedics arrived at 8.40 a.m. as required by protocol.

Investigation following MW's death

On 5 May 2017 at about 9.23 a.m. police attended MW's cell. A Crime Scene was established and maintained.

Photographs were taken, and MW's body was transferred to the Department of Forensic Medicine, Glebe Morgue. An external Post Mortem examination was ordered and carried out including the taking of a blood sample for toxicological testing. Specialist police from the NSW Police Corrective Services Investigation Unit took carriage of the matter and Detective Coorey prepared the Brief of Evidence to the Coroner. During a search of MW's cell, an envelope was located on a shelf. A letter inside the envelope was addressed to 'W Family C/O GW *telephone number*'. In this letter MW acknowledged that his action would upset everyone and apologised.

The police obtained and reviewed CCTV footage which shows MW entering cell 21 at approximately 2.54pm on 4 May 2017 when he and JB were locked in for the night; at 4.32 a.m. On 5 May Correctional Officers approaches cell 21 and a minute later MW's cellmate JB leaves the cell. This is in accordance with the account provided by JB and Correctional Officers. The police canvassed neighbouring inmates. Two of the prisoners said that they had played cards with MW the previous day and they had not noticed anything out of the ordinary. Another prisoner said that he had an AVL Court appearance on 3 May - the same day as MW's last court appearance. He said that following their respective appearances MW did not seem upset.

Dr Sairita Maistry, Forensic Pathologist carried out the Post Mortem examination on 10 May 2017. Doctor Maistry noted that there was a visible ligature mark which encircled MW's neck sloping upwards into the occiput. She reported that the pattern and dimension of the ligature mark on MW's neck generally matched the dimensions of the sheet ligature. She noted conjunctival petechial haemorrhages. No other traumatic injuries were present externally. Doctor Maistry concluded that the direct cause of death was in keeping with hanging.

Modifications to Prisoner Cells

The issue of hanging points in PCC has been raised by the evidence in this case (and previous inquests including that of "L").

The brief of evidence includes a statement prepared by Tony Mannweiler who is currently employed as GEO's Contract Compliance and Risk Manager at Ravenhall Correctional Centre in Victoria. At the time of MW's death Mr Mannweiler was the Contract Compliance Manager at PCC. In September 2017 modifications were made to a number of cells, including the one occupied by MW to remove numerous hanging points. Accordingly, there is no need to further address that issue by any recommendations in this matter.

Submissions on behalf of the Family

In his submissions Mr McAuley suggested that it was clear that MW had an anxiety depressive disorder. Whilst MW may have been diagnosed with such 2 years prior to his incarceration there was no evidence to conclude that he was suffering such a disorder during his incarceration at PCC or specifically at the time of his death. Mr McAuley suggests that when MW advised RN Hanson that he no longer required the Avanza and had not been taking it for 7 days there should have been an alert about MW's mental health placed on the prisoner information centre which would have resulted in a medical review and a review of his cell placement so that he would not be permitted to be alone in a cell at any time thus minimising his opportunity to self-harm.

With respect, given that the prescribed medication was to assist MW's sleep, having not taken the medication for a period of 7 days without any apparent adverse outcome or change in his behaviour, would not necessarily suggest that he was suffering from a mental health condition or experiencing self-harm ideation. In any event, RN Hanson did place him on a Mental Health Review List and indicated to MW that as a result of what he had told her she would organise a medical review.

There is no record that MW was reviewed in the following 2 weeks prior to his death. There is no evidence that since 23 April 2017 MW was displaying any signs which should have caused a concern about his mental wellbeing. MW's brother did not suggest that he was concerned by the letter or his meeting with MW and if he was he did not raise any concerns with any personnel employed by GEO or The Network. The screening and referral process during intake was appropriate and compliant with policy OP205 which was attached to Mr Mannweiler's statement.

Conclusion

There is no evidence relating to MW's state of mind but his legal situation and pending extradition placed him in a parlous if not, for him, an insurmountable situation. I am satisfied that those who were managing his custody had no reason to suspect that he might take the absence of his cell mate as an opportunity to end his own life.

Given the cell modifications that have occurred in that wing of PCC and the adherence of the applicable policies in relation to the screening and management of MW this inquest is not one where recommendations of any kind need be made.

Formal Finding:

The deceased known as MW died at Parklea Correctional Centre on 5 May 2017. The manner and cause of MW's death was suicide by hanging whilst in lawful custody.

15. 202885 of 2017

Inquest into the death of Eric Whittaker. Finding delivered by State Coroner O'Sullivan at Lidcombe on the 28 February 2020

Introduction

This is an inquest into the death of Eric Whittaker (**Eric**), a proud Kamilaroi man who was only 35 years of age when he passed away at Westmead Hospital on 4 July 2017. Eric was part of a large and loving family, many of whom attended the inquest so that they could patiently hear the evidence about the tragic circumstances of his death.

Eric was rightly proud of his Aboriginality and of his family. I was humbled to have them in Court for the entirety of the inquest and in particular to hear about Eric as a loving partner, son, grandson, nephew, sibling, cousin and father. I extend my deepest sympathies to Eric's family, who will always grieve their great loss. Eric was the father of four beautiful, bright children and they are a great credit to him, to their devoted mother and to Eric's extended family.

At the time of his death, Eric was an inmate who had been held on remand at Parklea Correctional Centre (**Parklea CC**) until he became seriously unwell in the early hours of 2 July 2017 and was subsequently transferred to Blacktown, and then Westmead Hospital. The pathologist at autopsy, Dr Sairita Maistry, has confirmed the cause of Eric's death was a subarachnoid haemorrhage, which occurred as a consequence of Eric suffering a ruptured cerebral artery aneurysm.

In the hours preceding his transfer to Blacktown Hospital, Eric was placed in a cell on his own in Unit 3A of Parklea CC. During this period, he likely experienced great confusion, as well as physical pain. Eric first came to the attention of night rovers at around 4:50am when those two correctional officers heard Eric shouting in a distressed and panicky tone. One of those officers then attended the cell and spoke to Eric, who was pleading for help, saying that he was claustrophobic and asking to be let out. The officer asked Eric what symptoms he had, and since Eric was not able to describe any medical condition, the officer did not believe that there was any medical issue that needed attending to. Rather, like his fellow officers after him, he thought Eric was distressed but not physically unwell in any way that warranted medical intervention.

Between 5:24am and 7:59am on 2 July 2017, Eric used the emergency intercom system, known as a "stenofon" call or "knock up" call, on 20 occasions seeking the assistance of correctional officers and often pleading for help. Despite his distress, the correctional officers who responded to the knock up calls failed to recognise the signs of a medical emergency and failed to make the effort required to get Eric seen by clinic staff. This resulted in a delay of care to Eric that is disgraceful in the circumstances of this case. True it is that Eric could not clearly articulate what was wrong with him, but by the time he had made several knock up calls, it should have been obvious to any correctional officer who was adequately trained and exercising due diligence, that Eric needed to be assessed by medical staff at the Parklea CC Clinic (**Clinic**).

Instead, he was not taken to the Clinic until the commencement of the morning shift at around 8:00am on 2 July 2017, with the result that vital hours to treat Eric's condition were lost.

The knock up calls Eric made from his cell on 2 July 2017 were recorded and admitted into evidence. It was both necessary and heartbreaking to hear them played during the inquest. I can only imagine how difficult it must have been for Eric's family to have heard the content of those calls and to appreciate his obvious distress in the immediate period before his death. It compounds their grief to know that he suffered alone before he passed away.

It is not possible to know for certain that earlier medical intervention would have saved Eric's life; but it may have done. Certainly, any intervention would have saved him hours of physical and emotional torment and spared his family this additional distress.

The number of Aboriginal people dying in custody continues to be a national shame and a great concern to this Court. From 1987 to 1991, the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) was appointed by the Commonwealth Government to study and report on the underlying social, cultural and legal issues behind the disproportionate numbers of Aboriginal deaths in custody. The final report, published in 1991, made 333 recommendations aimed at reducing the numbers. Yet by 2017, when Eric tragically died, and still today, indigenous Australians continue to be massively overrepresented in the numbers of persons dying in custody.

Although the action and inaction of several correctional officers came under scrutiny in this inquest, the aim is not to attribute blame to any individuals involved in the circumstances of Eric's death. Rather, the inquest sought to understand how, in a wealthy country like Australia, and almost 30 years following the release of the final report of the RCIADIC, a prisoner in Eric's situation did not receive urgent medical care and treatment.

Another important objective of the inquest is to identify any recommendations that are necessary and desirable to make so as to minimise the risk that another inmate with an acute medical condition would die in similar circumstances. I was pleased to note the changes in policy that have been introduced by the GEO Group Australia Pty Ltd (**GEO Group**), and Corrective Services NSW (**CSNSW**), in order to address the shortcomings that existed at the time of Eric's death. Had those changes not been made before and during the inquest, I would have made recommendations aimed at bringing them into effect. An inquest often sharpens the minds of interested parties and encourages them to implement reforms before findings are bought down, and that appears to be the case here.

To their credit, from the outset of the inquest, Eric's family have expressed a desire for lessons to be learnt from his death, in order to ensure that another family might be spared the type of pain and loss that they have experienced. I thank them for their enormous contribution to this inquest, and for their courage and grace.

The Inquest

The *Coroners Act 2009* (**the Act**) provides that where a person dies in lawful custody, an inquest into their death is mandatory and must be presided over by a senior Coroner (ss. 23 and 27).

Section 81 of the Act requires me to make a finding as to the identity of the individual who has died, the date, and place of death and the cause, and manner of death. “Cause of death” refers to the physical cause and “manner” refers to the circumstances leading up to and surrounding the death.

A secondary, but equally important function is governed by s. 82 of the Act, which empowers me to make any recommendations that are considered “necessary or desirable” in relation to Eric’s death.

Having a public inquest is particularly important when a person dies while in the custody because prisoners are a vulnerable group within our community. Their vulnerability is three-fold. First, it is well accepted that many prisoners suffer from some form of physical or mental illness, including those related to illicit drug use. Second, the loneliness and distress of custody may well exacerbate any mental distress. Third, prisoners do not have the agency to make their own decisions about the type of medical care that they can access, and are away from family and friends who might otherwise care for them. They are completely dependent on the authorities who detain them; in this case, the employees of a correctional centre which was privately operated, and contracted by the State to provide correctional services.

A hearing for the inquest into Eric’s death was held before me at the State Coroner’s Court in Lidcombe from 14 to 18 October 2019. The inquest heard oral evidence from 17 witnesses, including expert evidence from a neurologist, Dr David Rosen; a toxicologist, Professor Alison Jones; and an emergency physician, Professor Anna Holdgate.

Eric’s Background

Eric James Whittaker was born 10 December 1981 into a large and loving family. The Court had the privilege of hearing stories of Eric, or Ek as he was sometimes called by his siblings, as he grew up. A persistent theme from the stories of his family is of a young man who was fun loving, kind and protective of those he loved.

Eric’s sister Kayla told the Court that as children they played, shared, laughed, were brutally honest and protected one another. As they grew up, they shared stories, and she knew that Eric was a kind, gentle, curious and somewhat cheeky young man who never stopped being her big brother. He loved music and dancing, and it is not hard to imagine him stealing the show at the break dance competition at Lethbridge Park.

Eric’s sister Shandelle told the Court stories of her brother that showed what a fun loving prankster he was and how much he made his family laugh. Those stories were tempered by other memories of him being gentle and wise, and able to comfort his younger sister in times of distress. Anyone hearing Shandelle speak about Eric can understand why he was “the best, most kind, loving big brother” a sister could ever want and need. From his cousin Steve, the Court heard about Eric growing up with a very loving family. Eric was a man of good qualities that were instilled in him from an early age by his parents and grandparents. He was well mannered, polite, courteous and considerate.

Eric treated people the way he wanted to be treated, with respect, compassion, empathy and understanding. He was non-judgmental and well-liked by family friends, his peers and all who met him.

Eric's extraordinary children gave the Court a great insight into the man Eric was. They spoke of their memories of him teaching them how to ride bikes, going to the zoo, watching TV, playing handball, going to the shops and the park. They miss him dearly and he will always be in their hearts.

In May 2004, Eric met and fell in love with his partner, Jessica Holmes, the mother of their four children. Jessica told the Court that it was love at first sight and described some of their happier family memories. They went on holidays, fished on weekends and spent hours at the park. They took the kids to the movies, played footy on the oval and went out for dinner, making precious memories as a family that they will always treasure. I heard from Jessica that Eric adored his kids, and would have done absolutely anything for them because, in her words, he was a great dad.

Sadly, Eric suffered throughout his life with depression and that may help to explain his struggles with an addiction to illicit drugs. Eric tried hard to battle his addiction, sometimes moving away from family so that he would not subject them to it. In 2015, Eric and Jessica separated, although Eric continued to play a very big part in their lives and maintained regular contact with his children.

As a consequence of his addiction to illicit drugs, Eric came into contact with the criminal justice system and had a significant criminal history within New South Wales, mostly relating to theft offences and drug possession. As a result, he spent periods in and out of correctional centres in New South Wales. That did not stop him loving or being loved by his family, who never lost contact with him for any lengthy period.

Arrest and Entry into Police Custody

On 27 June 2017, Eric was arrested by police on Bourke Street, Woolloomooloo and charged with two outstanding warrants for a failure to appear in Court. The warrants were for relatively minor charges of having goods in custody suspected of being stolen and possession of a knife in a public place. These offences were alleged to have been committed on 13 April 2017 and 30 May 2017, respectively.

Eric was taken to the Kings Cross Police Station where he was entered into custody. According to a pro-forma questionnaire filled out by police, Eric reported that at the time of his arrest he was not using prohibited drugs.

That electronic form recorded that Eric had a mental illness – "anxiety, depression" – but that he otherwise appeared "calm and compliant" and was not agitated, aggressive or intoxicated.

Eric was refused bail by police and transported to the Surry Hills Cells during the afternoon of 27 June 2017. A "prisoners transfer note" recorded that Eric was found with an uncapped syringe in his pocket, and was a self-confessed ice and heroin user.

On his arrival, Eric was subject to a further reception questionnaire entitled: New Inmate Lodgement and Special Instruction Sheet. That document recorded that he had no medical problems requiring review on his reception at a correctional centre.

Police records indicate that Eric had reported no general medical conditions. It was further noted that Eric had answered no to the question: “do you use any non-prescribed drugs?” Eric was described as “calm and cooperative”. He was not thought to be agitated or mentally disturbed and there were no apparent signs of being under the influence of drugs or alcohol.

Eric subsequently appeared at Central Local Court on 27 June 2017 where he was formally refused bail by the presiding Magistrate.

Admission at Parklea Correctional Centre

On 30 June 2017, Eric was transferred from Surry Hills Cells to Parklea CC. Parklea CC is one of only two privately operated correctional centres in NSW, the other one being Junee Correctional Centre. At the time of Eric’s admission, Parklea CC housed prisoners on remand (such as Eric) as well as minimum and maximum security inmates.

At the time of Eric’s death and until 31 March 2019, Parklea CC was managed by the GEO Group. Since 1 April 2019, the Parklea CC has been operated by a joint-venture known as MTC-Broadspectrum. GEO Group continues to operate the privately operated prison at Junee.

Eric arrived at Parklea CC by truck at around 6:10pm, along with several other inmates. Correctional Supervisor Anthony Mott interviewed Eric in order to complete the Reception, Screening and Induction Checklist, which variously includes the Reception Accommodation Checklist, the Gang ID form (not relevant to Eric), Information about Correctional Centre Discipline and Indemnity for Lost Property, which are all apparently explained to newly arrived inmates.

Eric was provided with prison attire and dinner while he was placed in the holding cell waiting to be screened by Justice Health and Forensic Mental Health Network (**Justice Health**) nursing staff. A Registered Nurse (**RN**) employed by Justice Health, Jeremy Nuevo, completed a Reception Screening Assessment. The Drug and Alcohol Screening Tool specifically lists the questions asked of Eric relating to his use of drugs. It appears that Eric denied using any drugs or alcohol in the four weeks prior to his incarceration and RN Nuevo assessed Eric as neither intoxicated nor withdrawing from drugs or alcohol. As part of the assessment, Eric was asked if he had anything causing concern and he answered: “no”. In responding to the question: "How do you think you will cope in prison?, Eric’s answer is recorded as: "Wonderful". In accordance with the assessment by RN Nuevo, Eric was housed in the general inmate accommodation (Area 3A) as a “Normal cell placement”.

On 1 July 2017, Eric participated in a Questionnaire with an Operational Services Officer employed by the GEO Group, Ms Tanya Kearney. The purported purpose of the screening is not medical, but rather to assist in the transition to Parklea CC. Ms Kearney completed the questionnaire by hand and later entered the information into the system.

There were no specific concerns or fears recorded. In addressing Question 53 asking whether the inmate had been treated or medicated for a mental health issue, it is recorded: “depression/anxiety/not medicated”. In responding to Question 56 asking: “At home what do you do when stressed?, Eric apparently answered: “Pot, Ice, Heroin”.

Ms Kearney noted that Eric "presented well", "maintained eye contact" and "answered questions appropriately". She found Eric to be very polite and respectful, and to have answered all questions clearly and in a manner that corresponded with the questions asked. Eric showed no signs of intoxication or other matters that were of concern to her.

Question 73 on the Intake Screening Questionnaire asked whether the inmate would have custody of their children following their release. In response to this question, it would appear that Eric indicated that he had no children. This response is in direct conflict with the Inmate Identification and Observation Form completed at Eric’s reception at the Surry Hills Cells. On this form, Eric stated that he had four children – aged 10, 11, 14 and 18 – and that they were in the care of their mother, Jessica Holman.

CCTV footage of Area 3A at Parklea CC was made available to the inquest. Footage from 1 July 2017 shows Eric walking around the common area, apparently communicating with other inmates and walking with full motor control. He appeared calm and showed no signs of agitation. There are no reports of any unusual or erratic behaviour exhibited by Eric on that date.

At 3:08pm on 1 July 2017, Eric walked up the stairs that led to the first level tier of cells in Area 3A at Parklea CC towards cell 17, which he had been assigned. Prior to entering his cell, Eric can be seen on CCTV footage stopping at cell 18 and communicating with the occupant of this cell. The vision of this interaction is obscured by a grate and the bars of the upper tier. The entire interaction lasted less than 30 seconds. Police investigators spoke with the inmates who were the occupants of cell 18 – John Boyd and Richard Van Gaalen – some months after Eric’s death. Neither was able to recall this discussion with any certainty.

Eric then entered his cell for a short time before exiting and walking down the stairs once more, carrying a red cup. He disappears from camera view at 3:09pm and returned moments later carrying the cup. Eric again walked up the stairs to the first tier and re-entered cell 17, which he occupied as “one-out”. At 3:10pm, the door to cell 17 was closed and secured by correctional officers. There were no further movements in or out of cell 17 until the following day on the 2 July 2017.

Welfare Check

At around 4:50am on 2 July 2017, two correctional officers who were rostered on as night rovers, David Stankovski and Sukhvir Gill, attended Unit 3A as part of a routine security check. Shortly after attending, Mr Stankovski attended cell 17 to conduct a welfare check after hearing Eric shouting in what he perceived as a distressed and panicky tone.

Mr Stankovski gave evidence that he could hear an inmate who he now knows to be Eric shouting in a distressed and panicky tone words to the effect of: "*Help me, let me out of here. I don't fucking belong in here. I don't belong in prison. I can't handle being in here. Please let me out I have to call Mum. No one knows where I am*".

Mr Stankovski approached Eric and asked him what the problem was. His memory was that Eric said: '*Let me out, I'm claustrophobic, I have been fucking wrongly accused, I'm not meant to be locked up. No one knows where I am. I don't deserve to be here'. Eric kept repeating: 'Let me out, I don't like being locked up*.' Mr Stankovski then asked Eric if he wanted to be seen by the nurse, to which he replied: '*Open the door - let me out'*. Mr Stankovski's evidence was that he tried asking the same question in a number of ways, such as: '*Is there anything bothering you? Do you have any symptoms*?', however Eric kept repeating his earlier responses. Mr Stankovski thought that Eric "might be coming down off something".

Mr Stankovski returned downstairs and reported some of what he had observed to the night shift supervisor, Correctional Manager Operations (**CMO**) Peter Toulson. He explained to Mr Toulson that Eric was pacing backwards and forwards and shouting in his cell. When asked by Mr Toulson about the condition of Eric's cell, Mr Stankovski replied with words to the effect of: "*no cell mate, no self-inflicted wounds, no marks, cell neat and tidy".* Mr Toulson then directed Mr Stankovski to finish the security check and informed him that he would do a handover with the day shift. Mr Stankovski said that no further calls were receiving during his shift to attend Eric's cell.

In closing written submissions received on behalf of Eric's family on 24 December 2019, it was submitted that a referral should be made by me to the Director of Public Prosecutions, pursuant to s. 78(4) of the Act, with respect to the conduct of Mr Stankovski. While not expressly stated, I have proceeded on the basis that Eric's family submit that the evidence in the inquest has enlivened s. 78(1)(b) of the Act. That provision allows for certain procedural steps to be taken in relation to the conduct of an inquest in circumstances where a coroner forms an opinion as to the likelihood of a known person being convicted of an indictable offence that is causally related to the death of the person who the inquest is concerned with.

As is the case in every inquest over which I preside, I have considered the possible application of s. 78 of the Act in relation to the circumstances of Eric's death. However, in view of the evidence given during the course of the inquest, I have not formed any opinion that would result in the enlivenment of s. 78(1)(b) of the Act, including and in particular as it extends to the conduct of Mr Stankovski. For that reason, the legal representatives were advised on 23 January 2020 that I did not require any submissions from any interested party, or counsel assisting, addressing this issue.

The Knock-Up Calls

During the night shift on 2 July 2017, Correctional Officers James Dobry and Tevita Fa'ao were rostered on to perform the role of the Upper Control Room (**UCR**) operators. Part of the UCR operators' responsibility involved responding to knock up calls made by inmates in their cells. Inmates are directed that use of the stenofon is reserved for medical emergencies.

At 5:09am, Mr. Dobry responded to a knock up call from cell 31 in Unit 3A to advise that an inmate was screaming for help. As a result, Mr Dobry contacted Mr Stankovski by radio and instructed the night rovers to conduct a welfare check in Unit 3A. Mr Dobry was subsequently advised that a welfare check had already been conducted, that the inmate was alright but just wanted to go home and the shift manager had been notified.

At 5:24am, Eric contacted the UCR for the first time using the stenofon located in his cell. All of the knock ups were recorded and I have extracted a number of them below so that there is an adequate understanding of the nature and scope of the calls made by Eric. However, it must also be said that reading the transcripts of the knock up calls in isolation does not provide a complete picture of the obvious distress and suffering felt by Eric on 2 July 2017. The tone of Eric's voice, as well as the tone of correctional officers who responded to the knock up calls, was critical to my understanding of the manner of Eric's death.

The first knock up call was answered by Mr. Dobry. He would ultimately respond to three further knock up calls made by Eric at 5:29am, 6:06am and 6:25am. Mr. Dobry gave evidence that it did not occur to him that Eric might be having a medical emergency, but rather, he thought he was experiencing an "emotional reaction".

In the first knock up call at 5:24am, Eric stated:

"Open my door I'm stuck inside, please unlock my door"

In the second knock up call at 5:29am, the following exchange took place:

Control: "State your medical emergency."

Whittaker: "Someone unlock my door, please"

Control: "What's your problem?"

Whittaker: "I'm stuck in the room please help me."

Control: "Yes it's called a cell and you've been seen by the rovers just two minutes ago so what's the problem?"

Whittaker: "The room please someone come and unlock."

Control: "What's your medical emergency?"

Whittaker: "In the room I need to go some..."

Control: "Yes your locked in a cell that is called a cell you're in gaol okay, you've just been seen by the night rovers, what is your problem?

Whittaker: "I need to get out please."

Control, "Where do you want to go?"

Whittaker: "To go somewhere please help me, help me."

Control: "Okay, well you've been seen by the rovers, shift manager's been notified so you stay there until day staff comes."

Eric's tone can be described as distressed and panicked and he was pleading for assistance. Mr Dobry's tone was brisk and direct, without any obvious sympathy or concern.

Mr Dobry gave evidence that when he is working and communicating on the radio he speaks in the same official tone of voice and he did not mean any disrespect to Eric. He agreed that his voice might be heard as being robotic and he said that coming from New York, he is a fast speaker. Having heard Mr Dobry give evidence, I accept that his natural tone is brisk and unemotional and can come across as clinical or harsh. I accept that he did not mean any disrespect to Eric, but because of his lack of understanding and inquiry, he failed to respond appropriately to an inmate who was so obviously exhibiting distress.

A third knock up call made at 5:35am was answered by a different Correctional Officer, this time Mr Tevita Fa'ao, who went on to respond to two further knock up calls made at 5:49am and 5:54am. The first knock up call at 5.35am proceeded as follows:

Control: "????(Indecipherable) State your emergency."

Whittaker: "Unlock my door, please unlock my door please."

Control: "Where do you want to go mate?"

Whittaker: "Please help me baby, help me get out of this room please."

Control: "What are you doing here?"

Whittaker: "The toilet, that's all and the door shut on me."

Control: "Eight o'clock staff will be on site and they can open your door for you mate"

Whittaker: "Help me please help me. Unlock my door, please unlock my door"

Control: "What's your name?

Whittaker: "Eric, my name's Eric.

Control: "What's your last name?"

Whittaker: "Whittaker."

Control: "What's wrong?"

Whittaker: "What happened?"

Control: "What's wrong with you?"

Whittaker: "I come in to use the toilet and the door shut on me, please unlock my door, help me please".

Control: "What do you mean you went to use the toilet and the door shut on you?"

Whittaker: "Yes it did, the door shut on me, help, now I'm stuck in the room, I can't get out."

Control: "Well you're in prison mate, that's what you've got to understand, well you're in prison, the door is secure you can't get out till eight o'clock."

Whittaker: "What, I'm stuck in this room till eight? No let me out, please"

Control: "We can't mate you're in prison okay. I'll let the staff know that when they come in they can check you to see what your issues are yeah."

Whittaker: "(Crying)"

Eric was again distressed and both his intonation and his words reflected confusion. Mr Fa'ao did attempt to be gentle in his response and there is some care reflected in his tone. Mr Fa'ao gave evidence that he thought Eric was "just sad from being in gaol". It is clear that Mr Fa'ao recognised that Eric was emotionally distressed and tried to be compassionate and provide some reassurance to him. As with Mr Dobry, it did not occur to him that Eric may have been experiencing a medical emergency and that was the reason for his knock up calls. Mr Fa'ao gave evidence that "a lot of people cry in gaol" and he had not had any training to recognise if Eric had a mental health issue.

Having had the opportunity to reflect, Mr Fa'ao accepted that it should have been evident to him that Eric was suffering from some sort of physical or mental health issue that warranted intervention. He agreed that this case demonstrated that correctional officers like him needed better training about how to recognise when there is a prisoner in need of medical care.

At 6:00am, Correctional Officer Paul Hanson commenced his shift in the UCR, taking over from Mr Dobry. Mr Hanson gave evidence that Mr Dobry told him not to worry about requesting a welfare check for Eric because he had been checked by the Night Rovers during the night. Mr Hanson also claimed that Mr Dobry had referred to Eric as a "spinner" (a derogatory term used to refer to inmates with mental health issues) who had been knocking up all throughout the night; approximately 20-30 times. Mr Dobry strongly denied this claim. He said that he remembered doing a handover with Mr Hanson where he said we have an inmate in the cell who was in need of help, rovers had been notified and the shift manager had been notified.

Mr Hanson made no complaint at the time about Mr Dobry having used a derogatory term and, in light of the vehement denials by Mr Dobry, it is not possible for me to be satisfied that it happened. Regardless of the words that were used, the conversation Mr Dobry had with Mr Hanson conveyed to him that there was no significant medical condition or need for urgent medical care of Eric, with the result that none was arranged.

At 6:18am, Mr Hanson responded to a knock up call made by Eric, who reported his emergency as being stuck in his cell. Eric could be heard begging the UCR for help, saying: "*Please come and let me out please, unlock my door please, I'm stuck in here please help me out. Help please, help me*". Mr Hanson told Eric to give him a couple of hours and then he would come down.

At 6:25am, a further knock up call made by Eric was answered by Mr Dobry. The exchange was as follows:

Control: "State your medical emergency."

Whittaker: "Please unlock my door, get me out of here please,"

Control: "What's your medical emergency?"

Whittaker: "I need to get out of here..."

Control: "Rovers have been notified, shift manager notified, they'll be there shortly, till then you'll have to wait."

Eric made subsequent knock up calls to the UCR at 6:29am, 6:31am, 6:38am, 6:42am, 6:44am, 6:49am, 6:53am and 6:56am. Each of these was answered by Mr Hanson, who told Eric that he would have to wait and to stop using the knock up button. Subsequent calls were made at 6:57am and 7:10am that went unanswered, or at least there is no record that they were answered.

During the 6:57am knock up, Eric stated: "*Please I'm getting claustrophobic right now and I've got an appointment with Centrelink can you please get me out of here (Sounding tired and out of breath)".*

During the 7:10am knock up, Eric can be heard sobbing and said: "*(Sobbing) Let me out, please, (sobbing) bloody hell (sobbing and sounds of items being moved)*".

Eric attempted a final knock up call at 7:51am. This was answered by Correctional Officer Mathew Riley. During this final knock up call, which lasted approximately nine minutes, Eric was extremely distressed and can be heard panting and sobbing. Despite its distressing content, it is important that I set out the contents of this call in full:

Whittaker: "Emergency. Please come and release me I'm getting claustrophobic right now. Please help me [hyperventilating]. Help. Please, somebody open my door. Please [hyperventilating] Release me please. Come and help me please [hyperventilating]. Come and visit me please. Get me out of here. Please help me. Help me [sobbing] help me. [Hyperventilating/sobbing] Please release me. Help [sobbing]. Whoo. Help me now. Help. I'm getting claustrophobic [hyperventilating]. Ah, release me [laughing], whoo-hoo. whoo. [hyperventilating] [sobbing]. What would I do? Please. I'm starting to get claustrophobic right now. Someone please release me [sobbing]. Please [hyperventilating]. Release me. Fuck."

Control: "Yeah."

Whittaker: "Open my door please."

Control: "What's up?"

Whittaker: I need to be released."

Control: "Huh?"

Whittaker: "I need to be helped. Please open my door. Please."

Control: "What is it?"

Whittaker: "I've got nowhere to go in here"

Control: "Can you breathe?"

Whittaker: "Hardly."

Control: "Are you asthmatic?"

Whittaker: "Yes."

Control: "You are asthmatic."

Whittaker: "Yes. Please open my door. Please open my door [long pause] Please open my door too."

GEO Group's procedures at Parklea CC required all knock up calls to be recorded in the emergency call system register. Despite Eric knocking up on 20 separate occasions on 2 July 2017, only one entry was made with respect to cell 17 in Area 3A. That entry was recorded at 5:23am and noted that Eric had stated he wanted out of his cell. Mr Fa'ao gave evidence that his understanding at the time was that knock up calls should only be recorded in emergency situations.

Mr Hanson gave evidence that he was concerned about Eric because of the tone of his voice, because of his distress, his confusion and his persistent calls. As a result, he made mention of his concern to Mr Riley, and he requested through the shift manager, Derrick Brown, to get the morning staff to check on Eric as soon as possible. There was, however, no recognition of the possibility of a medical emergency that required immediate attention.

Derrick Brown was the CMO who came on shift at 6:00am on 2 July 2017. He was aware of the stenofon policy in place at the time of Eric's death which stated that: "If the call alerts them to a serious incident or potential serious incident, the officer must immediately arrange for staff to attend the cell and investigate the situation and take any responsive actions required. The CMO and/or area manager are to be informed immediately of the situation". It was Mr Brown's expectation that, as the CMO on at a night shift, he would be told of a potential serious incident, in which case he would assess it himself or speak to the attending officers.

Mr Brown gave evidence that he was at no time during the morning shift told anything about Eric's situation. He had an expectation that staff in the UCR would have told him about an inmate who was in that much distress, and was extremely disappointed when he found out, after Eric's death, that he had not been informed. In an interview with the GEO Group investigator, Mr Brown said that had he been informed, he would have gone and assessed the situation himself.

He said: “Look in that call you can hear it in him, that he’s sick, he’s so delirious and he’s frightened. That is not normal actually”. When asked his view on the action or inaction of staff in the UCR, Mr Brown said:

“I don’t even know how to say this, right. They should’ve acted on it, bottom line. Yeah, we do deal with a lot of mental health issues here, especially the clinic. They deal with those sorts of issues every minute of the day. But, yeah, it should’ve been dealt with”.

On no occasion did any of the correctional officers who answered the knock up calls arrange for a welfare check or review by Justice Health medical staff. Each of the correctional officers gave evidence that if they had perceived a medical emergency, they would have placed a “CERT” call – that is a Centre Emergency Response Team – which would have triggered an immediate clinical review by Justice Health medical staff.

The thrust of the evidence given by the correctional officers was that because Eric did not complain of an acute episode – such as self-harm, chest pain, assault or some other medical emergency – they did not perceive that he had legitimately used the stenofon and therefore did not consider the need to active a CERT. I had the benefit of reviewing two investigation reports, one prepared by Mr Robert Lang of GEO Group’s Office of Professional Integrity and another by Senior Investigation Officer employed by CSNSW, Mr Kenneth Johnston.

Mr Lang listened to the 20 calls and found that on each occasion, Eric was in a distressed state. Mr Lang made findings that there were 186 minutes (over three hours) during which it “should reasonably have been known by a large number of PCC correctional employees that inmate Whitaker was emotionally and mentally distressed”. He recommended disciplinary action against a number of officers. He was particularly concerned that Mr Stankovski thought that Eric “might be coming down off something” and found that “the suspicion that the inmate was drug affected alone should surely have prompted an intervention causing the inmate to be medically examined with the objective of determining whether or not he was drug affected and if so the most appropriate means of managing any associated risks”. I respectfully agree with that conclusion.

After listening to the stenofon calls, Mr Johnston concluded:

“The investigation has highlighted a number of issues in relation to the actions and inactions of officers charged with the duty of care for Eric. It could be argued that it should have been clear to all officers who dealt with Eric whether in person or by the Stentofon system that he was clearly delirious and completely unaware of his surroundings. He could not be reasoned with nor conduct a rational conversation. Clearly Eric was suffering from a health issue whether it would be drug induced or a psychotic or medical episode is not the issue, what is apparent is that some type of medical intervention should have occurred.”

I agree entirely with that those findings. I accept that where a prisoner cannot clearly articulate their medical issue, it may be difficult to distinguish between the emotional distresses many prisoners experience and something more medically significant. I accept that there will be prisoners who use the stenofon inappropriately to express frustration. However, I do not accept that the majority of inmate’s exhibit signs like the sobbing, confusion and distress that Eric was demonstrating on 2 July 2017 and I do not accept that those symptoms can be ignored over a three hour period, where 20 calls were made.

Correctional officers must be trained to recognise that the symptoms Eric exhibited might be signs of mental illness, drug withdrawal or clinical distress, and the way to determine that is to seek medical attention.

I have given thought to what training could be given to correctional officers to help them recognise that the signs of distress exhibited by Eric warrant clinical review, but the stark reality is that it should already have been evident to them, based on their fundamental understanding of human distress and the duty of care they owed, that Eric needed to followed up for a welfare check, which should in turn have led to medical intervention. I endorse the evidence given by Dr Rosen, who gave expert evidence but spoke also of basic humane responses. When asked by counsel assisting how correctional officers could be trained on what to look out for when a prisoner appears "extremely distressed, fearful and confused", he said:

"Yeah, no I thought about that and in one sense the, the answer is very simple and intuitive. Most of us in this room would recognise the distress in a baby that isn't telling us what is wrong.

Most of us would recognise the distress in an Italian tourist who was critically ill, without actually understanding what we were being told. So, you know, can one give any more of a lesson or instruction, than simply to be observant and to understand what distress is?

In fact, how do you instruct somebody or teach someone to, to understand and respond to distress, I don't know where to start really. I mean it's just, there can't be anybody in this room that wouldn't fully appreciate distress when they saw it, without a lesson.

Look, I don't want to sound facetious but it goes without saying that if there is sign of distress, if there is somebody who clearly is in need or seems to be asking for help and you can't provide that help, then the next step is to find someone who can provide that help."

Release from Cell 17

At 8:05am, two correctional officers, Michael Tago and Jesse Peteru, attended cell 17 in Area 3A to conduct a welfare check on Eric at the request of Correctional Supervisor Gregory Beencke. Mr Tago and Mr Peteru can be seen on CCTV footage and appeared to communicate with Eric without opening the cell door. Both gave evidence that Eric told them he was claustrophobic and couldn't breathe. They requested their supervisor, Correctional Supervisor Christine Walsh, to attend Eric's cell.

At 8:08am, Ms Walsh was granted authorisation to open the door to cell 17. Mr Tago gave evidence that at the time the cell door opened, Eric appeared to have urinated, vomited and defecated on himself.

At 8:16am, CCTV footage captured Eric walking out of cell 17. He appeared to be very unsteady on his foot.

He was holding on to nearby railings to maintain balance and ultimate required assistance from Mr Peteru and Mr Tago to get down to the ground level of Unit 3A. Once there, Eric remained on the ground floor, awaiting the arrival of nursing staff. He can be seen on CCTV to initially sit on the floor at the foot of the stairs. However, he appeared at that stage to have considerable difficulty sitting still. He alternately leaned forward, moved his legs and flailed his arms. At one point, Eric lay face down on the floor next to the railing, alternating between a face-down lying position and a semi-kneeling position.

He also used the railing to pull himself along the floor whilst lying on his back. At 8:28am, a Justice Health nurse attended Eric on the ground floor of Area 3A. Eric's erratic movements continued while the nurse attempted to conduct a physical assessment. At 8:33am, Eric was assisted into a wheelchair and almost immediately taken from Area 3A.

Transfer to Parklea Correctional Centre Clinic

At 8:38am, CCTV footage captured Eric arriving at the Parklea CC Clinic. Endorsed Enrolled Nurse (**EEN**) Elizabeth Vucetic was on shift at the time of Eric's arrival. EEN Vucetic was the only nurse in the Clinic as her supervisor, RN Teresita Lee, was attending a medication round and welfare checks in the segregation unit.

EEN Vucetic noted that Eric was incontinent of urine and faeces. She also noted that correctional officers had informed her that he had vomited during his transfer to the Clinic. EEN Vucetic attempted to perform a set of general observations while Eric was in the wheelchair. Nursing and correctional staff were unable to transfer Eric into a bed because he was so agitated; moving up and down, kicking his legs, talking and screaming. Eric was subsequently secured by correctional staff in the Clinic's holding cell. He was treated with oxygen therapy on a non-rebreather mask, although it is clear from the CCTV footage that he could not or would not keep the mask in place.

Because RN Lee was absent from the Clinic, EEN Vucetic contacted the After Hours Nurse Unit Manager, Valerie Bailey. At approximately 9:00am, while EEN Vucetic was on the phone, RN Keith Cayanan came into the Clinic and received a handover of Eric's medical status. RN Cayanan entered the holding cell and took another set of observations. Clinical notes indicate that Eric was disoriented and complaining of being unable to breathe.

He was shaking and not able to sit still. His pupils were observed to be dilating from 7mm-3mm. Eric also admitted to nursing staff that he had consumed heroin and ice two days prior.

At around 9:25am, EEN Vucetic contacted the Remote Offsite Afterhours Medical Service (**ROAMS**) by telephone and spoke with the on-call Drug and Alcohol Doctor, Dr Sergiu Grama. EEN Vucetic relayed to Dr Grama Eric's symptoms, observations and the fact that he was distressed and screaming out for help. Dr Grama asked for a further set of observations, following which he gave a phone order for a 5mg dose of Haloperidol (an anti-psychotic medication) and 10 mg dose of Maxolon (anti-vomiting medication). Those drugs were administered.

At 9:35am, EEN Vucetic made notes about Eric's presentation in the Justice Health clinical file.

At 9:50am, Dr Grama telephoned the Clinic back with advice to send Eric to hospital. In the intervening period, Dr Grama had spoken to the Drug and Alcohol Medical Director, Dr Jill Roberts, who had confirmed that Eric needed to be transferred to hospital.

At 9.55am, NSW Ambulance was contacted on Triple 0 and the Hospital transfer documentation completed by RN Cayanan. The transfer notes indicate that Eric had not been diagnosed with anything prior to transfer but there was a record to "query substance withdrawal, disorientation, agitation, elevated heart rate and elevated blood pressure".

Transfer to Blacktown Hospital

At 10:04am, CCTV footage captured NSW Ambulance personnel arriving at the Clinic. They subsequently departed for Blacktown Hospital at 10:25am.

The ability for Eric to be absent from a correctional centre for the purposes of medical treatment was authorised under s. 24(1) of the *Crimes (Administration of Sentences) Act 1999*.

At the time of Eric's transfer to hospital, GEO Group had operating procedures in place that determined when and how restraints should be used on inmates during medical escorts. The hospital escort journals completed by correctional officers contained clear instructions that the inmate was to be handcuffed and ankle cuffed at all times.

Eric arrived at Blacktown Hospital at 11:00 am on 2 July 2017 and was immediately admitted at 11:01am. Admission notes indicate that Eric was agitated and restless. It is also apparent that ambulance officers administered 10 milligrams of Droperidol, an anti-psychotic and sedative medication, during Eric's transfer to hospital. Further sedative medication was administered at Blacktown Hospital due to Eric's non-compliant behaviour and agitated state.

At 11:45am, a chest x-ray was conducted which identified no issues with Eric's lungs or heart. At 2:25pm, a CT scan was conducted upon Eric's brain, abdomen and pelvis. It was noted that the appearance of his brain were highly suggestive of global hypoxic ischaemic injury. A CT angiogram showed a ruptured anterior communicating cerebral artery aneurysm. It is apparent from the medical records that treating doctors suspected, but were unable to confirm, that Eric had a subarachnoid haemorrhage. Medical staff noted there were no obvious signs of external head injury, no bruising, no contusion and no blood in the ears. Following the CT scan, Eric was transferred to the Intensive Care Unit (**ICU**) and intubated.

At 5:30pm, an analysis of Eric's blood and urine was conducted. The urine screen was positive for stimulants and benzodiazepines. This was a screening test and therefore did not indicate the levels at which these drugs were present. Professor Jones stated that those toxicology results indicated that the most likely scenario was that Eric had ingested amphetamines on the evening of 1 July 2017 while he was in custody at the Parklea CC.

At around 5:40pm, Eric's condition deteriorated significantly. His blood pressure was noted to be extremely high. He was administered 3mL of Propofol and his blood pressure reduced. Approximately 10-15 minutes later, his blood pressure plummeted so that he became hypotensive and resuscitation attempts had to be commenced. Eric was administered adrenaline and a defibrillation machine used while a central venous catheter was inserted. Once his condition stabilised, it was noted that Eric's pupils were dilated and non-reactive.

At 9:36pm, a further angiogram CT scan (using contrast dye) of Eric was conducted as a matter of urgency. This contrast scan identified a 5.5mm aneurysm related to the anterior communicating artery. The scan did not exclude the possibility of a subarachnoid haemorrhage. Extensive brain oedema (fluid and swelling) was noted as being present.

At 11:30pm, Eric was transferred to Westmead Hospital for urgent neuro-critical care and neurosurgical opinion.

Transfer to Westmead Hospital

At around 12:20am on 3 July 2017, Eric arrived at the Westmead Hospital ICU and his care was continued by medical staff there. Medical records indicate that Eric was reviewed by medical officers during the morning ward round on 3 July 2017. During this round, it was noted by the treating doctors that Eric's eyes were fixed and dilated at 5mm and there was an absence of several other reflexes. Eric's limbs were also noted as indeterminately twitching, consistent with brain injury. This led the attending doctor to suggest brain death testing be conducted.

An entry in the medical records at 11:38am indicates that the ankle restraints on Eric were removed for medical purposes and then re-applied shortly after at 11:46am.

At 4:05pm on 3 July 2017, the existence of a severe subarachnoid haemorrhage and absent brain-stem reflexes was confirmed. It was noted that Eric's brain death was imminent. It was subsequently noted by medical staff that restraints were removed by a correctional officer at 3:41 pm.

On 4 July 2017, further testing was conducted and Eric was formally declared brain dead at 12.55pm. At 4:55pm, Eric's family were advised of his brain death and advised that his life support apparatus would need to be removed.

Cause of death

On 6 July 2017, an autopsy of Eric was performed at Glebe Morgue by Dr Sairita Maistry. Dr Maistry concluded that the direct cause of Eric's death was a subarachnoid haemorrhage with an antecedent cause of ruptured cerebral artery aneurysm.

An additional CT scan of Eric's brain was conducted by a radiologist, Mohammed Nasreddine, at the request of Dr Maistry on 5 July 2017. Mr Nasreddine's report dated 4 December 2017 confirmed evidence of an extensive subarachnoid haemorrhage.

The Court heard evidence from three experts who touched on the causes of Eric's aneurysm and his cause of death. Dr David Rosen is a neurologist at Prince of Wales Private Hospital, with a private practice, Sydney Neurology, located in Camperdown. Professor Anna Holdgate is a senior staff specialist in emergency medicine working at Liverpool and Sutherland Hospitals, with 23 years of clinical experience as a specialist in emergency medicine. Professor Alison Jones is a specialist physician and clinical toxicologist and is a staff specialist toxicologist at Western Sydney Local Health District.

Dr Rosen explained that a brain aneurysm is like a little bubble, or swelling, or an outpouching of the wall of the artery. In some cases, the artery, or the aneurysm, will rupture and because of the high pressure within the artery, a jet of blood is emitted from the artery. Dr Rosen said that the outpouching in the artery may sit there for a long period of time and may never rupture; effectively meaning that many people may have an aneurysm their entire life without knowing or being affected by it.

Dr Rosen gave evidence that it was "most likely" that Eric had the brain aneurysm when he came into custody on 27 June 2017, but it is not possible to say how long he had that underlying condition for.

Professor Holdgate explained that an aneurysm might form because of a hereditary predisposition, or a history of high blood pressure, smoking or other cardiovascular risk factors. Some particular illnesses that affect the development of blood vessel walls can also increase the risk of developing an aneurysm.

Professor Holdgate said that the majority of people living with an aneurysm don't actually realise that they have one, but in a small number of cases, the aneurysm can burst. Once someone has an aneurysm, anything that increases the pressure within the blood vessel, increases the risk of rupture. That means that anything that increases blood pressure, such as the use of illicit drugs, can increase the risk of rupture of an aneurysm.

Dr Rosen told the Court that we will never know what caused Eric's aneurysm to rupture, although he considered possibilities included the fact that he had used amphetamines in custody, as had been revealed by the urine screening taken at 5:30pm on 2 July 2017 at Blacktown Hospital. Professor Jones gave evidence that the tests suggested that Eric had consumed amphetamines on either the afternoon, evening or night of 1 July 2017. Professor Jones said that the known effects of amphetamines on the vascular system include heightened blood pressure, which could have easily been the most proximal event, prior to the rupture. In other words, Professor Jones continued, the rupture may have been caused by the acute effects of intoxication with amphetamine or amphetamine-like drugs. Further, agitation and stress may provoke high blood pressure and cause re-bleeding.

According to Dr Rosen, when an aneurysm does rupture, blood pours out of the artery into the subarachnoid space of the brain that contains cerebral spinal fluid. The immediate effect of blood entering that space under high pressure is that the pressure inside the skull rises to a point where the perfusion of the brain is compromised.

Approximately two-thirds of persons survive a burst aneurysm and they may present with a very wide spectrum of symptoms. The most common symptom for presentation would be the most severe headache someone has ever experienced, commonly described as like being hit on the back of the head or the head with a baseball bat. There are also a range of other symptoms that can accompany this primary symptom, depending on the location of the aneurysm. This includes: loss of function, confusion as a result of damage to certain structures within the brain, paralysis, agitation, emotional distress and even coma.

Dr Rosen explained that to diagnose effectively, it is important to have a high index of suspicion about the symptoms being exhibited. He said that the definitive treatment for a ruptured cerebral aneurysm is to locate the aneurysm. The initial CT scan will simply look at the whole brain and get a picture of the brain, but not necessarily showing any of the blood vessels. The second test is an angiogram which involves injecting dye into a blood vessel so that the dye goes to the arteries in the vein and outlines the arteries, making it relatively easy to see whether or not there's a swelling of an artery, indicative of a ruptured aneurysm.

Dr Rosen continued that the next step is to clip or seal the aneurysm to prevent it from ever bleeding again. In the meantime, the presence of blood within the subarachnoid space is damaging to the surface of the brain and that means that there are a series of events unfolding within the brain that need to be managed.

In Eric's case, by the time the diagnosis was made at Blacktown Hospital, "his level of consciousness was deteriorating and a number of events outside the brain were unfolding, effecting his circulation and his lungs and probably also there was a degree of swelling within the brain that was compromising the blood flow to the brain". Tragically, it was too late to save him.

Although Dr Rosen could not be certain that earlier intervention would have saved Eric, he was adamant that about three vital hours were lost during which time Eric's chances for survival could only have been improved by timely interventions.

Standard of Medical Care and Treatment

Professor Holdgate was not critical of the care that Eric received by nursing staff at the Clinic. Eric entered the clinic at 8:35am on 2 July 2017. Although he was recognised as being distressed and unwell, he had a range of symptoms that could have represented a range of conditions. His initial vital signs, apart from one errant reading, were normal, but he continued to deteriorate. Professor Holdgate thought it was reasonable in the first instance to try a small dose of sedation to see if that helped Eric improve, and then once it didn't, nursing staff consulted the doctor again, who recommended they call an ambulance. Professor Holdgate considered the period of time Eric spent in the Clinic before an ambulance was called, approximately one hour, was reasonable.

Professor Holdgate also gave evidence that once Eric got to Blacktown Hospital, the medical treatment he received in the Emergency Department and ICU was appropriate.

Consideration of Proposed Recommendations

Use of Restraints

An issue of great concern to Eric's family and to this Court was the continued use of restraints on Eric while he was in hospital, even after Eric had been completely sedated. The sight of Eric with shackles in his hospital bed was deeply distressing to his family who, understandably, thought of it as disrespectful, degrading and unnecessary. Any family would be distressed by that sight, but it is likely more damaging for Aboriginal families, given the historical context in this country.

Professor Holdgate explained that hospital staff use restraints firstly as a last resort, and secondly for the briefest period of time possible, as a bridge to achieving control of agitation through other means such as administration of medications. Within an hour of entering the ICU at Blacktown Hospital, Eric would have been unconscious from the medications he had been given. He was also placed on a breathing support apparatus. There could have been no possible justification for continuing to shackle Eric after that time.

Eric remained unconscious when transferred to Westmead Hospital. For the entire time he was admitted there, he would have been completely incapable of moving. When asked whether she could understand the family's distress at seeing Eric shackled at Westmead Hospital, Professor Holdgate replied: "[t]hat photograph is horrific for a clinician, yeah".

As the State Coroner, I share the views of Professor Holdgate and Eric's family that the shackling of an unconscious man in hospital is horrific. I accept that there are some prisoners in need of medical care who do present a security risk and will require some form of restraint for some period of time. But that was not the case for Eric; who was receiving treatment for a catastrophic brain injury and organ failure.

Although there is no suggestion that the restraints on Eric contributed to his death, this inquest provided an opportunity for CSNSW to reflect on how to improve its policies to ensure that correctional officers take greater responsibility for removing shackles where there is no security risk.

It was gratifying to see the new policies introduced by CSNSW relevant to Guarding Inmate Patients. In summary, they require that:

All handcuffs are to be removed at the request of health professionals while the inmate is undergoing consultation, examination or treatment.

- Handcuffs may be removed from inmates who are severely incapacitated.
- Where circumstances change during a medical escort, for example where the inmate's condition deteriorates or they become severely incapacitated, a review of initial escort assessment must be completed.
- Under the topic of “risk assessment”, staff are advised that a risk level may decrease due to deterioration in the inmate's health and the requirements for restraint should be reviewed.
- Under the heading, “End of Life Care" it notes that for "an inmate receiving end of life care, security arrangements can be reviewed to assess supervision requirements and visiting arrangements by family and friends”.

Those policies will still require that correctional officers are adequately trained in the exercise of their discretion and in being sensitive to the emotional distress of families faced with the possible death of a loved one.

Changes to Stenofon Policies and Procedures

At the time of Eric’s death, GEO Group had a number of relevant policies and procedures in place at Parklea CC that governed the roles and responsibilities of the UCR, including in relation to the use of the stenofon system. These policies included as follows:

Parklea Correctional Centre Operating Manual: Stenofon (Cell Alarms Procedures) 6.6.16;
Parklea Correctional Centre Operating Manual: Upper Control Area (Base) 14.11.16; and
Parklea Correctional Centre General Manager’s Instruction 117, 4.8.16.

The Stenofon Policy relevantly provided that correctional officers who receive a knock up call alerting them to “a serious incident or potential serious incident” must immediately inform the Officer in Charge (**OIC**) or CMO (in circumstances where a knock up call is received after-hours). The General Manager’s Instruction 117 also directed that the UCR operator was not to decide which knock up calls may or may not require attention at their discretion.

The investigation report prepared by Mr Lang found multiple breaches of these policies and initiated disciplinary action against Mr Dobry, Mr Fa’ao, Mr Hanson, Mr Stankovski and Mr Gill. Mr Lang concluded that it should reasonably have been known to those correctional officers that Eric was in significant distress during the early hours of 2 July 2017 when he was repeatedly calling for help.

Mr Lang also made the following recommendations by way of amendments to GEO Group policies and procedures:

"12.1.6 The PCC Policy No. OP065 - Stenofon (Cell Alarms) Procedure is amended to include a requirement for PCC Control Room Operators to immediately initiate a Welfare Check following the receipt of any stenofon cell alarm call where an inmate is presenting in a clearly emotional and/or distressed and/or disoriented state.

12.1.7 The PCC Policy No. OP065 - Stenofon (Cell Alarms) Procedure is amended to include a requirement for PCC Control Room Operators to immediately advise their manager/supervisor following the receipt of any stenofon cell alarm call where an inmate is presenting in clearly emotional and/or distressed and/or disoriented state.

12.1.8 The CMO is required to attend at the PCC Upper Control at least twice during the night shift period, consult with Control Room Operators and review the Logs/Journals.

12.1.9 The Control Room Operator training package is further reviewed to ensure that it will provide adequate instruction and guidance on how to respond as well as to whom and when to report cell alarm calls from inmates who are clearly distressed, disoriented and/or apparently intoxicated."

In written closing submissions dated 28 November 2019, counsel assisting submits that I should endorse these recommendations and make formal recommendations, pursuant to s. 82 of the Act, to that effect.

In written closing submissions dated 16 December 2019, GEO Group has confirmed that the recommendations made by Mr Lang have already been implemented. In particular, the Stenofon Policy was amended on 1 September 2017 and now directs, relevantly, that a correctional officer who receives a knock up call from an inmate who is presenting in a clearly emotional/distressed and/or disoriented state must immediately inform the OIC or CMO of the location where the call was made.

In those circumstances, I am satisfied that no recommendations should be directed to GEO Group.

As GEO Group is no longer the operator at Parklea CC, counsel assisting also submits that these recommendations should be extended to the Commissioner of CSNSW, so as to ensure that the new operator of Parklea CC, MTC-Broadspectrum, has similar policies and procedures in place.

In written closing submissions dated 13 December 2019, the Commissioner of CSNSW submits that existing policies for responding to knock up calls would require correctional officers to immediately attend the cell to check on the welfare of an inmate who is presenting with a similar condition to that of Eric in the early morning of 2 July 2017.

The current CSNSW policy – Custodial Operations Policy and Procedures (**COPP**) Section 5.5: Cell security and alarm calls – was admitted into evidence.

This policy provides that correctional officers must immediately go to a cell in circumstances where an inmate knocks up in physical or mental distress. The policy also relevantly requires correctional officers to escalate calls raising concerns by immediately notifying the Centre's OIC.

Although the current Parklea local operating procedure for MTC-Broadspectrum has not been made available to this inquest, I accept the submission of the Commissioner of CSNSW that any MTC-Broadspectrum local policies cannot be inconsistent with overarching CSNSW policies.

Accordingly, I do not propose to extend any of the recommendations proposed by counsel assisting to the Commissioner of CSNSW or MTC-Broadspectrum.

Formal Finding:

The identity of the deceased

The deceased person was Eric Whittaker.

Date of death

Eric died on 4 July 2017.

Place of death

Eric died at Westmead Hospital, Westmead NSW 2145

Cause of death

The direct cause of Eric's death was a subarachnoid haemorrhage with an antecedent cause of ruptured cerebral artery aneurysm.

Manner of death

Eric died while detained as an inmate on remand at Parklea Correctional Centre after he suffered a ruptured cerebral artery aneurysm that went untreated for several hours in the morning of 2 July 2017.

Closing Remarks

Eric's death is a tragedy that has caused great hardship to his family and is an immeasurable loss, particularly for his four children. That was so eloquently put by Steve, Eric's cousin, when he said: "the last two years have been just this constant perpetual state of grief that we'd be in as a family and stuff, because you know, we've had, you know, numerous deaths and stuff, and as an Aboriginal person you live with this constant state of, you know, being traumatised and in a constant state of grief".

Eric's parents, Margaret and James, and his Aunt, Dianne, gave the Court a statement that summed up so much heartbreak on hearing of Eric's death. They said:

"The family are at a loss for words and they demand answers. We feel that the correctional protocols have been ignored and his basic human rights have been violated. The family wish only to have this young man's dignity back. We, the family, are here today to show you that Eric is loved and missed, and that a great injustice has occurred while he's in custody."

So many indigenous families have felt a similar crushing pain on learning of the death of their loved one while they were in custody. I am reminded of the words of the *Uluru Statement from the Heart*, which urges us as a country to do better. It includes the following passage:

"Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are alienated from their families at unprecedented rates. This cannot be because we have no love for them.

And our youth languish in detention in obscene numbers. They should be our hope for the future. These dimensions of our crisis tell plainly the structural nature of our problem. This is the torment of our powerlessness."

I am encouraged that the GEO Group and Commissioner of CSNSW have made policy changes in response to Eric's death. It shows a willingness to learn from this tragedy and to improve the standard of care provided to vulnerable inmates. There is, of course, so much more that needs to be done to tackle inherent disadvantage and incarceration rates. Sadly, much of that is beyond the power of this Court, but I hope that Eric's passing has contributed in some way to improving the system for others.

It is fitting to share again the words of Eric's sister, Kayla, who I am sure was speaking on behalf of all the family when she said:

"He endured many struggles, hardships and pain throughout his short life. He was a kind, loving and giving person. Always gentle and putting others before himself. Walking away from those he loved most so that his actions didn't impact them, I think that shows true courage and selflessness. My big brother Eric. A true warrior."

16. 256693 of 2017

Inquest into the death of Christopher McGrail. Finding delivered by DSC Truscott at Lidcombe on the 10 June 2020.

Christopher Peter McGrail died at Gold Coast University Hospital on 6 August 2017 after being shot by police during a confrontation with officers outside a duplex in North Street in Grafton earlier that afternoon. Mr. McGrail was 44 years of age at the time of his death. The inquest into Mr. McGrail's death was conducted in accordance with the provisions of the *Coroners Act 2009* (**Act**). The coroner's role pursuant to s. 81 of the Act is to hand down findings as to the identity of the deceased, date and place of death; and the manner and cause of death. Under s. 82 of the Act, a coroner is empowered to make recommendations, if necessary or appropriate.

The brief of evidence prepared during the course of the coronial investigation into Mr. McGrail's death included the formal interviews of the involved officers, statements from many eyewitnesses, forensic crime scene evidence, and reports prepared by expert witnesses. The brief also included video footage of the incident captured on both the camera of the Taser used by police and the mobile telephones of civilian witnesses. This material was sufficient to determine Mr. McGrail's identity, where and when he died, and the medical cause of his death. As a result, the inquest was primarily focused on the manner of Mr. McGrail's death.

To this end, the inquest examined the circumstances surrounding Mr. McGrail's state of mind and his intentions over the course of the events leading up to and resulting in his death, and the appropriateness of the actions of the police officers involved in the incident with Mr. McGrail on 6 August 2017.

Inquest is required and must be conducted by a Senior Coroner

A coroner has jurisdiction to hold an inquest if it appears to the coroner that the death is *"a reportable death".* Mr. McGrail's death was a reportable death as it was a sudden, and violent or unnatural death. Furthermore, the death occurred in unusual circumstances. The circumstances surrounding Mr. McGrail's death also attract the provisions of ss. 22, 23 and 27 of the Act.

Pursuant to s. 27(b) of the Act, an inquest is mandatory when jurisdiction to hold an inquest arises under s. 23 of the Act. One of the circumstances that are prescribed is when the death is a result of, or in the course of a police operation. Further, s. 22(1) provides that any inquest arising under s. 23 can only be heard by a senior coroner, defined as the State Coroner or a Deputy State Coroner.

As the learned authors of *Waller's Coronial Law and Practice in New South Wales* (4th Ed) have observed,

"[t]he purposes of a s 23 inquest are to fully examine the circumstances of any death in which police … have been involved, in order that the public, the relatives and the relevant agency can become aware of those circumstances".

In the present case, the police operation was initiated when the involved officers attended the duplex at 1/202 North Street, Grafton in response to a broadcast over the Police VKG radio regarding a triple-0 call reporting that a bloke called "Hoppy" (a nickname for Mr. McGrail) was *"going off his head"* and acting violently.

The Coronial Investigation – Role of Investigators

Where a death is reported to the coroner, a police officer is assigned to investigate the death and prepare a brief of evidence.

When the death occurs as a result of a police operation, the police response and investigation is required to comply with the Guidelines for the Management and Investigation of Critical Incidents prepared by the NSW Police Force (**NSWPF**). These are commonly referred to as the "Critical Incident Guidelines". One of the reasons the Critical Incident Guidelines have been developed is to address any concerns that an investigation by police of fellow officers would be conducted with absolute impartiality.

This matter was immediately recognised by NSWPF as a critical incident and by about 5:30pm on 6 August 2017, steps had already been taken to form what is described as the Critical Incident Investigation Team (**CIIT**). In accordance with the Critical Incident Guidelines, the CIIT was initially headed by Detective Sergeant Paul Fredericks from the Richmond Local Area Command (separate to the Coffs/Clarence Local Area Command). Following Mr. McGrail's death, arrangements were made to transfer responsibility for the critical incident investigation to Detective Chief Inspector Grant Taylor of the Homicide Squad.

Non-Publication Orders

The brief of evidence provided by investigators contained an amount of audio, video and photographic material, some of which is both sensitive and distressing. This material has been removed from Exhibit 1 and placed in a separate folder marked as Exhibit 2, over which I have made a non-publication order pursuant to s. 74 of the Act and a non-access order pursuant to s. 65 of the Act.

Additionally, the events at 1/202 North Street on 6 August 2017 immediately prior to police arriving have been the subject of a criminal investigation that resulted in the person known in these proceedings by the pseudonym Frank Samuel being charged with a number of serious offences that are yet to be finally determined by the Courts. For that reason, I order that there be no publication of his name under s. 74 of the Act, until such time as his matters are concluded.

FACTUAL BACKGROUND

Mr. McGrail was born in Sydney on 6 October 1972. His parents separated when he was four years old, and Mr. McGrail lived with his mother. Mr. McGrail had a difficult progression through the education system and attended a special educational facility for children with behavioural or disruptive issues for part of his schooling. In his teenage years, he was placed in specialised care for troubled youth. Ultimately, he was expelled from school in year 10 and did not undertake any further education.

When he was 16 years old, Mr. McGrail moved to Brisbane to reside with his grandmother for a short time. This arrangement did not work out and he returned to live in NSW. In 1990 and 1991, Mr. McGrail spent time in juvenile detention centres.

In April 1992, at age 19, Mr. McGrail was charged with malicious wounding and assault occasioning actual bodily harm arising out of a fight in which he was stabbed in the thigh. He was later sentenced to terms of imprisonment for these offences. As a result of the limp he developed due to his injury, Mr. McGrail became known as Hoppy.

After being released from custody, Mr. McGrail met Amanda Skinner and they commenced their relationship. They had four children together, a son followed by three daughters, born between 1997 and 2003. Mr. McGrail's youngest daughter was born with significant disabilities requiring particular medical care and support. Mr. McGrail's last steady employment as a labourer ceased around the time of her birth.

Mr. McGrail had commenced intravenous drug use prior to meeting Ms. Skinner. During their relationship, he was a frequent cannabis user. He was also known to use amphetamines and consume large amounts of alcohol.

Mr. McGrail and Ms. Skinner remained together for around 23 years. The relationship was marred by domestic violence, resulting in Mr. McGrail serving a number of sentences of imprisonment for offences committed against Ms. Skinner. Both as a result of his domestic violence and substance abuse issues, Mr. McGrail spent a substantial portion of his adult life in custody. In March 2015, Mr. McGrail returned to custody for domestic violence offences against Ms. Skinner. This marked the end of their relationship.

On 27 June 2015, whilst Mr. McGrail was in custody for these offences, his son, Clinton, committed suicide. Clinton was 18 years old.

Clinton's death had a profound effect on Mr. McGrail, evidenced by his Facebook posts and the statements made by his family and friends. Despite Ms. Skinner's continued support, Mr. McGrail struggled to cope. His mental health declined and his drug use escalated following his release from custody in November 2015.

Mental Health History

Mr. McGrail was a patient at the Bulgarr Ngaru Aboriginal Medical Centre ("Bulgarr Ngaru") in Grafton from 2004 onwards.

In August 2008, Mr. McGrail presented to Bulgarr Ngaru with depression and was prescribed Aropax, 20 mg daily. He presented with depression again in October 2010, also reporting heavy daily cannabis use, regular intravenous amphetamine use and alcohol abuse.

In August 2014, Mr. McGrail was referred to Annaliese Grace, psychologist, under a Mental Health Treatment Plan as part of his parole supervision by Community Corrections. He attended sessions in September and October 2014.

Mr. McGrail sought a further referral to Ms. Grace in February 2015 and attended one session in March 2015, before being incarcerated.

In February 2016, three months after his release on parole, Mr. McGrail presented to Bulgarr Ngaru with hypertension and depression. He again reported cannabis and intermittent methylamphetamine use. Mr. McGrail was commenced on Amlodipine for his hypertension and was referred to Richard Miller, psychologist. Mr. McGrail attended a single session with Mr. Miller on 2 March 2016, which focused on Clinton's death.

On 27 July 2016, Mr. McGrail presented to Bulgarr Ngaru with stress related to his recent incarceration and his relationship with Ms. Skinner. He refused a referral for counselling.

Mr. McGrail again presented to Bulgarr Ngaru 10 May 2017 and 1 June 2017 for depression. On 1 June 2017, he was prescribed Cipramil 20mg. Throughout June 2017, Mr. McGrail made numerous posts on Facebook referring to the anniversary of Clinton's death.

On 12 July 2017, Mr. McGrail posted on Facebook asking for a firearm and stating, "*My son needs me*".

On 14 July 2017, Mr. McGrail made a further Facebook post alluding to suicide.

Relevant Events Leading up to 6 August 2017

Shortly after 6:28pm on 15 July 2017, Police responded to an incident broadcast over VKG radio at the Clocktower Hotel in Grafton. Staff had reported that Mr. McGrail had been requested to leave due to his intoxication, and that he was now on the road being verbally abusive to patrons. Upon arrival Police observed Mr. McGrail leaving the area and did not approach him.

Later that night, Mr. McGrail made three calls to 000 making nonsensical requests for police to return his "*family history*". Police attended Mr. McGrail's last known address but did not locate him.

A few hours later, shortly after 1am on 16 July 2017, Mr. McGrail ordered a taxi to collect him from an address in Bacon Street, Grafton. During the journey, Mr. McGrail was belligerent and accused the driver of being a police officer. At one point, Mr. McGrail asked the taxi driver to drive the taxi into the side of a bridge. The taxi driver stopped the vehicle and requested that Mr. McGrail get out. Mr. McGrail began to speak of his son's suicide, at which point the taxi driver agreed to take him home. However, at the end of the journey, Mr. McGrail swung his arm and hit the taxi driver in the face with his phone. After he exited the taxi, Mr. McGrail threatened to kill the driver. As the taxi drove off, Mr. McGrail punched the driver's side window.

Police were called and attended the location where Mr. McGrail had been dropped off. Senior Constable Tim Bentley and Constable Ryan Martin observed Mr. McGrail to be acting aggressively, alleging police corruption and looking towards Constable Martin's firearm. A decision was made to schedule Mr. McGrail pursuant to s. 22 of the *Mental Health Act 2007* (**MH Act**) and he was conveyed to Lismore Base Hospital.

Records of Lismore Base Hospital note that Mr. McGrail was, "*Brought in by police for concerns re paranoid delusions from Grafton*". He was examined by Dr Khosa-Halait who concluded that he was not demonstrating any abnormality of perception. Mr. McGrail was given a sedative and referred for psychiatric consult.

At 1:24pm on 16 July 2017, Dr Owens assessed Mr. McGrail and noted that Mr. McGrail had readily admitted to intravenous methamphetamine use several days prior. Dr Owens concluded that it seemed *"likely that Mr. McGrail's behaviour and altered mental state were the result of methylamphetamine intoxication. Psychosis, drug-induced or otherwise, is a differential diagnosis, but his absence of documented psychiatric presentations and his admission of recent methamphetamine use makes intoxication a more likely explanation at this time."*

Dr Owens recorded that Mr. McGrail reported no thoughts of self-harm or thoughts of harming others at the time of the assessment. Mr. McGrail was discharged and given a train ticket to Grafton.

At 7:50pm, police attended the Lismore Transit Centre in response to a report of a male causing trouble. On arrival, they saw Mr. McGrail sitting on one of the seats and spoke with him. Mr. McGrail was hostile and uncooperative with police, who issued him with a move on direction.

16 July 2017: Petrol tanker incident and re-admission to Lismore Base Hospital

At about 11.30pm that same evening, Mr. McGrail approached the Mobil service station on Ballina Road in Lismore. At the time Mark Moroney, a fuel tanker driver, was refuelling the service station. Mr. Moroney heard a male voice say, *"I love the smell of fuel".*

He was shortly thereafter approached by Mr. McGrail who said, *"How about I light it up?"* Mr. McGrail was holding a cigarette lighter and, when warned by Mr. Moroney about the volatility of the area, said *"I don't give a fuck. I will do it man. I am a head case."* Mr. McGrail was also heard to say, *"I don't care if I do it cause then I can see my son"*. Mr. McGrail then approached the dip hole where the tanker was filling. Mr. Moroney wrestled him to the ground and prised the lighter from his hand. He then held Mr. McGrail on the ground, with the assistance of the service station attendant, until the police arrived.

Police attended and handcuffed Mr. McGrail. A search of his person located a number of used and unused syringes. During their interaction, police observed Mr. McGrail to be delusional, stating that the service station was not a real service station and that he wanted to blow it up because he believed it was part of a greater conspiracy involving corruption within the church. The officers determined to deal with Mr. McGrail under s. 22 of the MH Act and conveyed him back to Lismore Base Hospital.

Upon arrival, Lismore Base Hospital staff observed Mr. McGrail to be hostile, uncooperative and paranoid, noting that he claimed that *"he saw some things last night and our lives would be in danger if he told us"*. Hospital records also indicate that upon his admission to the High Dependency Unit, Mr. McGrail stated that he believed police were playing tricks on him, and that the service station staff were police officers in disguise. The records note that he denied thoughts of self-harm or harm to others.

On 19 July 2017, Dr Bhuyan completed a Form 1 - Clinical Report as to Mental State of Detained Person. The report noted that Mr. McGrail had been *"admitted as an involuntary patient due to drug induced psychosis"* and was observed by Dr Bhuyan to be *"thought disordered, agitated"* and *"delusional"* with *"poor insight and judgement"*.

Dr Bhuyan concluded that Mr. McGrail was mentally ill and suffering from a thought disorder. He assessed Mr. McGrail's risk of harm to others as significant.

Mr. McGrail remained an inpatient until 24 July 2017. On that day, Dr Bhuyan completed a further mental health risk assessment for Mr. McGrail. He noted that Mr. McGrail's drug induced psychosis had resolved and recorded a diagnosis of antisocial personality disorder. Dr Bhuyan further recorded that Mr. McGrail was not expressing suicidal ideas or hopelessness/despair, and was not exhibiting self-harming behaviour. Mr. McGrail was discharged later that day.

It was noted in the Mental Health Discharge / Transfer Summary that Mr. McGrail had *"been very settled on the ward"*, and had *"no more delusions around the police"*. It was also noted that he understood he had suffered from drug induced psychosis and had *"nil suicidal/homicidal thoughts"*. The document recorded that Mr. McGrail had discussed his profound sorrow and grief concerning Clinton's suicide.

25 July 2017 to 3 August 2017: Events following discharge from Lismore Base Hospital

On 25 July 2017, Mr. McGrail reported to Grafton Community Corrections as required by the terms of a good behaviour bond imposed in July 2016. Mr. McGrail expressed a wish to sue the police for being detained against his will. He stated that he had not used methylamphetamine for nine days and was adamant that he would not enter a rehabilitation facility. He expressed an interest in going to visit his mother in Tasmania.

Later that day, Mr. McGrail attended an appointment at Bulgarr Ngaru and was informed that he had tested positive for Hepatitis C. The clinical notes indicate that Mr. McGrail reiterated his claim to have not used methylamphetamine for nine days and stated that he was planning to attend Balund-a, a residential diversionary program run by Corrective Services NSW.

Despite this intention, on 26 July 2017, Mr. McGrail travelled to Queensland and stayed with a friend. It appears that Mr. McGrail thought this would assist him to abstain from drug use.

On 30 July 2017, Mr. McGrail returned to Grafton. He was observed at Grafton railway station rambling and swearing. Mr. McGrail was heard to say that he was being followed. Mr. McGrail then caught a taxi to Ryan Street in Grafton. During the journey, Mr. McGrail displayed erratic behaviour and spoke of another taxi being an undercover police car. As he was getting out of the taxi at Ryan Street, Mr. McGrail suggested that his guitar case contained an M16 and told the taxi driver, *"I've got a few scores to settle"*.

Later that day, Ms. Skinner collected Mr. McGrail from Ryan Street and drove him to her house. He remained living with her until 4 August 2017. Over the course of the stay, Ms. Skinner observed Mr. McGrail to have mood swings and to be in states of agitation. He expressed thoughts that everyone was a police officer and watching him.

Ms. Skinner believed Mr. McGrail may have relapsed into drug use.

At 7:47am on 1 August 2017, Mr. McGrail posted a picture of a skull on his Facebook page with an associated quote, *"Death is not the greatest loss in life. The greatest loss is what dies inside us while we live".* At about 8:16am, he posted a childhood photograph of Clinton together with a video of himself playing a song he wrote for Clinton.

Later that day, Mr. McGrail presented to Bulgarr Ngaru. He reported to Dr Leaver that he had been abstinent from drugs for 15 days, and agreed to commence medication for his Hepatitis C. He advised Dr Leaver that he was going to address his substance abuse the following week.

On 2 August 2017, Mr. McGrail attended an appointment with Community Corrections. Case notes record that Mr. McGrail completed a referral form to Balund-a.

His recent drug induced psychotic episode and placement into a psychiatric unit appeared to have motivated him to complete the program. Mr. McGrail also expressed an intention to visit his mother in Tasmania after completing treatment.

This was Mr. McGrail's last contact with Community Corrections.

At 3:26am on 3 August 2017, Mr. McGrail posted an image with a reference to police corruption on his Facebook page. At 5:36am, he posted a meme comprising an image of the actor Jared Leto in the character of the Joker from the film, Suicide Squad together with the words *"I will remember and recover, not forgive and forget"*. Mr. McGrail posted a message accompanying the meme again referencing police corruption. This was the last Facebook post by Mr. McGrail.

Later that day, Ms. Skinner and Mr. McGrail exchanged telephone calls and text messages to arrange a meeting on 4 August 2017. The purpose of the meeting was for Mr. McGrail to repay Ms. Skinner money he owed her from his time in Queensland.

4 August 2017 – Assault on Amanda Skinner

At about 10:30am on 4 August 2017, Ms. Skinner met Mr. McGrail at the ANZ Bank at Grafton Shopping World. A dispute arose between them regarding how much money Mr. McGrail owed Ms. Skinner, and Mr. McGrail hit Ms. Skinner twice in the face with his fist, causing an injury above her right eye. He also told her that he had an axe and would use it. Ms. Skinner hit and kicked Mr. McGrail to defend herself. She tried to give the money to a bystander, asking him to count it, but the bystander did not want to get involved. Mr. McGrail then became aggressive towards the bystander. During the altercation, Ms. Skinner saw the strap of an axe on Mr. McGrail. Ultimately, a security guard intervened, and Ms. Skinner attended Grafton Police Station to report the incident.

Mr. McGrail followed Ms. Skinner to Grafton Police Station. When he first arrived, Mr. McGrail told police he wanted Ms. Skinner charged with assault. When asked to recount what happened, he said, *"I have my right to silence"* and told police to *"check the footage"* (presumably a reference to CTV footage from the shopping centre). Mr. McGrail was subsequently arrested for the assault upon Ms. Skinner, at which point he again urged police to watch the footage and alleged they were *"all corrupt, taking her side fabricating evidence"*.

Mr. McGrail was asked whether he had anything on his person that he should not have, to which he replied that he had a tomahawk under his shirt, *"for [his] protection"*. Police took possession of the tomahawk and took Mr. McGrail into custody.

Whilst at Grafton Police Station, Mr. McGrail complained of chest pain to the custody manager and was taken to Grafton Base Hospital for assessment. He was later returned to police custody after he became aggressive, refused to be examined and walked out of triage stating he no longer had any pain. Following his return to Grafton Police Station, Senior Constable James Callegari continued the process of charging Mr. McGrail with offences arising from the assault of Ms. Skinner and completed an application for a Provisional Apprehended Domestic Violence Order (**ADVO**) to protect Ms. Skinner.

Shortly after 3:00pm, Sergeant Christopher Goodman completed a Risk Assessment Report and determined to grant Mr. McGrail conditional bail. Mr. McGrail was released from police custody at about 3:20pm.

At about 11:36am on 5 August 2017, Mr. McGrail video recorded himself whilst a passenger in a car driven by a friend, Braiden Ward. In one of the recordings, Mr. McGrail stated:

"This is Chris McGrail's journal and last testament… Got all me belongings cause Braiden Ward, helped me out… with the interim AVO order by Amanda Skinner and Grafton Police which is probably the 100th one issued over a twenty odd year period… be rendered in lies … aiding and abetting of lies…

Braiden here is a witness to these journals and my last will and testament… just saying my little good byes there… I need to turn off now cause I'm going to have a bit of lunch and I don't want you looking at me cause I got no teeth… Stay tuned for the next part of the journal, thank you.

Sometime that day, Mr. McGrail attended Grafton Police Station in order to collect medication he believed Ms. Skinner was going leave at the station for him. Mr. McGrail entered the station and began filming the conversation he had with Senior Constable Stephen Bennett and Detective Senior Constable Geoffrey Dean. He was told to stop filming by Detective Senior Constable Dean. He apologised and apparently deleted the. According to Senior Constable Bennett, Mr. McGrail was at the police station for about twenty seconds and spoke in a normal voice.

It is not known where Mr. McGrail spent the evening of 5 August 2017. At 9:58pm, he sent a text message to a contact saved in his mobile phone as "Granny" stating, *"Got taste here"* followed shortly thereafter by another text message sent to "Granny" stating, *"Over in a sec"*. Shortly prior to 1:00am on 6 August 2017, Mr. McGrail sent a further text message to "Granny" that simply stated, *"Granny"*. This was the last text message sent from Mr. McGrail's telephone, although there were a number of further telephone calls to and from his service after that message.

EVENTS OF 6 AUGUST 2017

Events Prior to Confrontation with Police

On the 6 August 2017, Mr. McGrail attended a residence in Mary Street, Grafton where he was observed by Frank Samuel to be fidgety and talking very fast. Mr. Samuel considered this to be consistent with Mr. McGrail's usual demeanour after he had consumed methylamphetamine. Mr. McGrail stayed for about an hour and a half, drinking wine with Mr. Samuel and others. Whilst there, Mr. McGrail showed his phone to his friends saying, "*Hey boys, have a look at this red rabbit on my mobile phone. It's a tracker or something*". He became increasingly upset and it appeared to anger him when the others told him that they could not see any red rabbit.

Shortly after midday, Mr. McGrail asked Mr. Samuel if he wanted to come with him for a walk to get some money from a friend. Mr. Samuel agreed and they walked to 1/202 North Street, Grafton (**the duplex**). Mr. McGrail took a full bottle of wine with him.

The Incident at the Duplex

The duplex was the residence of Justin Kay and his partner Theresa (known as Tess or Tessa) Holmes. Sara Sullivan, a friend of Tessa Holmes', was also staying in a spare bedroom.

Shortly before 3:00pm, Justin Kay was working on his truck, which was parked outside the duplex. He was in the company of his younger brother Dylan Kay, their cousin Stephen Wedmaier, and their friend Jason Taylor. Ms. Sullivan was inside the duplex, but Ms. Holmes was not home at that time.

Witness accounts of what occurred next vary, and it is difficult to determine the precise details and sequence of events. I do not consider it necessary to resolve the factual differences, but summarise the witness accounts to provide some insight into the nature of Mr. McGrail's mental state and behaviour prior to the attendance of police that later that afternoon.

According to Justin Kay, Mr. McGrail arrived in a highly agitated state and became angrier when Justin Kay did not initially recognise him. Mr. McGrail then sought the attention of Mr. Taylor, who initially ignored him. Shortly thereafter, Justin Kay heard a loud bang and soon saw that Mr. McGrail's knuckles were bleeding. Mr. Taylor attempted to calm Mr. McGrail, but he continued to act aggressively towards everyone. Mr. McGrail accused Justin and Dylan Kay and Mr. Wedmaier of being undercover police officers, asking them about their police ranks and badge numbers. Mr. McGrail spoke about the police being responsible for Clinton's death and at one point said, *"Today is the day I'm going to meet up with my son"*.

According to Dylan Kay, when Mr. McGrail arrived, he was drinking what smelled like wine and *"smelt like grog pretty bad"*. Mr. McGrail was asking for Ms. Holmes and *"started to get cranky"* when he was told she was not home. Mr. McGrail began kicking tools and other items around the truck and tried to open the diesel cap while operating his lighter to get an open flame. Mr. McGrail could not get the cap open.

According to Mr. Wedmaier, Mr. McGrail approached him in an angry state, knocked his hat off his head, and began asking questions about Mr. Wedmaier' s identity, police rank and mobile phone. Mr. McGrail went over to the truck and kicked a number of toolboxes and plastic tubs over, stating, *"Where the fuck is Tess? I am not leaving anywhere until I see Tess"*.

According to Mr. Taylor, Mr. McGrail approached Mr. Wedmaier in an aggressive manner, accusing him of doing something with his phone. Mr. McGrail had an angry look on his face and was shaking his arms in an agitated manner. Mr. McGrail mentioned his son, Clinton, a number of times and at one point said, *"Clinton's dead and he's not coming back"*.

When they all started to ignore Mr. McGrail, he became angrier and punched the door of the truck, cutting his hand in the process. Mr. Taylor tried to calm Mr. McGrail down, but Mr. McGrail accused them all of being *"copper dog informants"* and accused them of lying.

Around this time, Ms. Holmes arrived home with grocery shopping and Mr. Wedmaier helped her take the bags into the house. According to Ms. Holmes, she saw blood on the tiled floor of the duplex and noticed that items had been smashed. When she asked Mr. McGrail (who had followed her inside) what was wrong, he turned to Ms. Sullivan and said, *"I wouldn't expect you to be living with these informant dogs"* before waving his arms around violently. He then came up close to Ms. Holmes and screamed, *"I know you're a Police informant dog! A police woman. Show me badge number, your school photos, your Facebook… I Googled you and know that you're an informant copper dog and all your family are copper dogs!"*

Ms. Holmes cowered in the corner of the kitchen, crouched down with her arms up towards her face. She heard Mr. McGrail say to Mr. Samuel, *"Go and get something out of the garage so I can kill this bitch and put her out of her misery"*. Mr. Wedmaier told police that he heard Mr. McGrail say things like, *"No one's going anywhere until it's sorted".* Mr. Samuel went towards the garage and returned with a hammer. Mr. Samuel handed the hammer to Mr. McGrail, who raised it above his head while standing over Ms. Holmes.

Mr. Wedmaier thought that Mr. McGrail was going to hit Ms. Holmes with the hammer and tried to intervene. Mr. McGrail accused Mr. Wedmaier of being a "*dog*" and chased him from the house with the hammer. Mr. Wedmaier ran outside and continued home.

According to Dylan Kay, Mr. McGrail told Ms. Holmes that he had proof of her talking to "*the dogs*". Mr. McGrail said to Ms. Holmes, who was crying, *"If you don't shut the fuck up, I'm going to kill you."* He then raised the hammer above his head and said to Ms. Holmes, *"Today is the day you're going to die."* Ms. Holmes said, *"I don't understand why you're here and why you're doing this."* Mr. McGrail replied, *"We will all be dancin' in heaven tonight with my son."*

At about this time, Justin Kay entered the house. He stood between Mr. McGrail and Ms. Holmes. He yelled at Mr. McGrail to stop, who replied, *"No. Today is the day she's going to die.*" Justin Kay pulled Ms. Holmes up off the floor and told her to get help. Ms. Holmes and Ms. Sullivan then ran out the front door.

Mr. McGrail followed Ms. Holmes and Ms. Sullivan outside. At that time, Kayla Cowan was standing in the yard. Mr. McGrail grabbed Ms. Cowan by the hair and began screaming abuse at her. Ms. Cowan freed herself, or was let go, and Mr. McGrail went back into the house. Ms. Sullivan offered Mr. McGrail the keys to one of the cars and said, *"Just take one of the cars and go."* Mr. McGrail said, *"No. It all ends here today.*" He then turned to Mr. Samuel and said, *"Make sure them two bitches don't go anywhere*". Mr. McGrail then went back inside the duplex.

Mr. Samuel stood between the women and the road, initially preventing them from leaving. After some discussion, Mr. Samuel agreed not to tell Mr. McGrail if they left.

Whilst this was occurring, Mr. Taylor had secreted himself in the bathroom of the duplex. At 3:44pm, Mr. Taylor telephoned Triple-0 and anonymously reported that a bloke called "Hoppy" was *"going off his head"* and was violent. Mr. Taylor requested police assistance. After he was told the police were on their way he left the duplex, jumping over the rear fence.

Further Events at the Duplex

Justin Kay and Dylan Kay recall the further events prior to the arrival of police differently. According to Dylan Kay, whilst Mr. McGrail was outside (during the incident with Ms. Cowan), Dylan sent a text message to his sister asking her to call the police. When Mr. McGrail saw him on his phone, he head-butted Dylan and threatened, *"If I catch you on your phone again I'll slit your throat*". Mr. McGrail then pushed Dylan into the garage, where Justin was, knocked something out of Justin's hand and smashed a fluorescent light tube that had been on the bench. He told Justin and Dylan to go back into the duplex.

Mr. McGrail followed them back inside the duplex and said, *"You two are up to something".* He locked the doors, shut the blinds and said, *"You two are going to die here tonight"*. Mr. McGrail then began to talk about the police saying, *"All the police in New South Wales are corrupt and they can't keep getting away with it. I'm going to expose them*".

Mr. McGrail demanded Justin remove his shirt, threatening to slit his throat if he did not comply. Dylan told Justin to do as Mr. McGrail said, at which point Mr. McGrail kicked Dylan in the genitals. Mr. McGrail then put his arms around Justin and said, *"You don't have any idea what it's like to lose your son"*. Dylan saw that Mr. McGrail had two knives in one of his hands.

Mr. McGrail put one of the knives to Dylan's throat and said, *"You are gonna die today… Do you know what SBP is? .... It's called suicide by police. They are gonna put a bullet in my head and the only way they'll do that is if I kill you"*.

About this time, Mr. Samuel came back inside the duplex and suggested that Dylan was hiding something. Mr. McGrail threatened Dylan with the knife saying, *"What do you know? I could cut your jugular and you'd bleed out instantaneously… You'll bleed out in two minutes… Or I can just stab you in the heart."* Mr. McGrail then ordered Mr. Samuel to leave and told Justin and Dylan to *"write on a piece of paper what your family will get after we die here today"*. When Dylan had difficulty finding a pen, Mr. McGrail said, "*Hold your wrist out so I can cut your wrist and you can write it in blood?"* Dylan begged him not to. Mr. McGrail just laughed and walked away.

Mr McGrail then turned his attention to Justin Kay asking him, *"What's my son's name?"* When Justin could not answer him, Mr McGrail briefly held a knife out to Justin's chin before elbowing him in the face. Mr McGrail then asked Dylan whether he had any children.

When Dylan said, *"No"* Mr McGrail said, *"Good. No one will miss you"* and lightly ran a knife across Dylan's throat.

Mr McGrail asked Justin and Dylan questions which suggested he suspected them of being police officers. He accused them of lying when they said they did not know what he was talking about.

Around this time, Mr Samuel asked for money to buy a drink. Mr McGrail let Justin go out to his truck to find his wallet. Whilst Justin was outside, Mr McGrail and Mr Samuel bailed up Dylan and asked him who was hiding in the roof. They accused Dylan of lying when he said, *"No one"*.

After Justin returned, Mr Samuel walked Dylan out to his car so he could also retrieve his wallet. As Mr Samuel and Dylan started to walk back inside the duplex, Mr McGrail said to Dylan, *"You got three seconds to get out of here"* at which point Dylan ran back to his car. Mr McGrail approached him with a knife, and Dylan drove away. At that stage, the only persons then remaining at the duplex were Mr McGrail, Mr Samuel and Justin Kay.

Dylan drove to the home of his sister, Christy Kay. Dylan was hysterical and told Ms Kay that Justin was in danger. Despite Dylan pleading with her not to go, Ms Kay drove to the duplex.

According to Justin Kay, after Ms Cowan had managed to get free from Mr McGrail, Justin went back inside to have a look at the damage that had been caused. At that time, Mr McGrail was still outside *"ranting about dogs and coppers and how he was going to finish it all today"*. Mr McGrail came back inside the duplex and slammed the door shut, locking it behind him. Mr McGrail struck Justin on the bridge of his nose causing him to momentarily lose his bearings and his nose started bleeding.

Upon regaining his bearings, Justin saw that Dylan was leaning against the glass sliding door with his hands in front of his face saying, *"Please don't."* Mr McGrail raised a glass bottle above his head in a striking position and said, *"Are you ready to die today? You better get a pen and paper and write out your will."* Mr McGrail put the bottle down and kneed Dylan in the groin.

Mr McGrail then turned to Justin and saw that he was looking at a television, connected to a camera monitoring the front of the house. Mr McGrail punched the television causing it to fall to the ground and yelled at Justin, *"Who are you looking for?"* Mr McGrail then saw Dylan looking at his phone and screamed, *"Who are you calling?"* Mr McGrail then went quiet and was pacing.

Mr Samuel asked Justin and Dylan if they had any money. When Justin went to retrieve his wallet from his truck, he saw that Ms Holmes and Ms Sullivan were still outside. As he took $10 from his wallet, Justin told Ms Holmes to get help. Ms Holmes and Ms Sullivan then drove to Grafton Police Station in Mr Taylor's car. When Justin returned to the house, he handed the money to Mr Samuel and told him it was all he had.

Inside the house, Justin Kay saw Mr McGrail yelling at Dylan. At one point, Mr McGrail pushed Dylan up towards the kitchen cupboard ranting, *"We're all going to die here together and you are coming with me"*. Shortly thereafter, Mr McGrail picked up a steak knife and a carving knife from the dish-drying rack. He was talking about his son and asked Justin, *"Do you know my son's name?"* When Justin was unable to properly answer, Mr McGrail said, "*Well, you're going to meet him today"*.

Mr McGrail walked around the room with the knives in one hand and the bottle of wine in the other. He held both knives to Justin's left eye and said, *"The clubs are making me do this. They have my daughters and they'll kill them if I don't reveal the boys in blue for who they are. Even if it means I have to take one here"*, pointing to the middle of his forehead. Justin felt Mr McGrail tense up, and one of the knives stab him between his nose and his left eye causing a wound that required five stiches.

At some point, Mr McGrail dropped the steak knife, but still kept hold of the carving knife. He also told Mr Samuel to leave saying, *"Just go bro. You don't need to see this"*.

Mr McGrail walked over to Dylan and held the carving knife to his throat. Justin yelled out, *"Just leave him alone, Hoppy. He's just a kid."* Mr McGrail ran the knife across Dylan's throat, but did not cause any injury.

Justin felt that he was losing consciousness as a result of loss of blood. In an attempt to lure Mr McGrail away from Dylan, Justin walked outside. A few minutes later, Mr McGrail came outside, followed by Dylan and Mr Samuel. Justin told Dylan to get into his vehicle and leave, which he did. As Dylan reversed out of the driveway, Mr McGrail stabbed towards Dylan through the open driver's side window.

Following Dylan's departure, Mr McGrail appeared to become more relaxed. He sat down on the front step and said, *"Won't be long now. They're all gone. It'll soon be all over."* Mr Samuel said, *"I'm going back. You coming with me or are you staying here?"* Mr McGrail replied, *"You go bro. I'm seeing this through to the end."* Mr Samuel then left on his scooter.

Mr McGrail put the bottle of wine and knife on the ground in front of him, and was mumbling that his son didn't deserve to die. At this time, Christy Kay arrived in her car. Justin gestured for her to leave, but Mr McGrail gestured for her to come towards him. Ms Kay noticed that Mr McGrail was smiling. It was around this time that police arrived.

The Confrontation with Police

As a result of Mr Taylor's call to Triple-0, and the report made at Grafton Police Station by Ms Holmes and Ms Sullivan, Senior Constables Amanda Crouch and Stephen Bennett drove from Grafton Police Station to the duplex. The officers had been advised that a man named "Hoppy" had a knife and possible hostages. They left the station at 4:03pm and arrived at the duplex at 4:07pm.

Upon arrival, Senior Constables Crouch and Bennett parked in the driveway of the duplex. They observed Mr McGrail and Justin Kay standing against a parked car in the driveway of Unit 1.

Senior Constable Crouch identified herself as a police officer asked, *"What's happening here?"* Mr McGrail replied, *"It's not happening here. It's all going on next door.*" The officers then walked across to Unit 2. Mr McGrail picked up the bottle and knife and a shirt with the one hand and said to Justin Kay, *"This is it. Are you ready to die?"*

Senior Constables Crouch and Bennett spoke to the occupants of Unit 2, who directed them back to Unit 1. Senior Constable Crouch asked Justin about his facial injury; however Justin refused to explain what had happened. Senior Constable Crouch then asked Mr McGrail about his hand injury. Mr McGrail said, "*Don't touch me, I've got Hep C"*. Senior Constable Crouch said she wasn't going to touch him and repeated her question. Mr McGrail replied, "*None of your fucking business*". Senior Constable Crouch became concerned about Mr McGrail' s level of agitation and so took the wine bottle from his hand and threw it onto the lawn.

Senior Constable Crouch noticed a bulge near the top of Mr McGrail's shorts and asked what it was. Mr McGrail replied, "*None of your fuckin' business*". Senior Constable Bennett saw a blade sticking out of Mr McGrail' s jumper and said, "*Mate, drop the knife*". Mr McGrail replied, "*No*".

Mr McGrail then produced the knife from his jumper. Senior Constable Bennett said, *"Put that down"* and Senior Constable Crouch said, *"Drop the knife."* Mr McGrail replied, *"No*". Senior Constable Crouch took a number of steps backwards, drew her firearm and held it in the cover position. Mr McGrail then began moving towards the officers with his chest puffed out, looking angry. Senior Constable Crouch said Mr McGrail was holding the knife out in front of him.

At 4:09pm, Senior Constable Crouch made a broadcast over VKG saying, *"Yeah radio, how far off are 14? We've got a male here armed with a knife.*" In her evidence, Senior Constable Crouch confirmed that she was asking about Sergeant Dallas Leven, who was using the call sign "Grafton 14". Senior Constable Crouch was aware that Sergeant Leven was on his way to the scene to provide backup.

Mr McGrail put the knife up to his own neck saying, *"You have to shoot me.*" Senior Constable Bennett said, *"Mate, just drop the knife mate. You're not in trouble. It's alright mate, just put the knife down.*" Senior Constable Bennett then addressed Mr McGrail by his name and said, *"Chris, it's all right, mate. Just put the knife down.*"

Upon seeing Mr McGrail put the knife up to his own throat, Senior Constable Crouch holstered her firearm and drew her Taser. She pointed the Taser towards Mr McGrail and deployed it. Senior Constable Crouch said she did this as she was concerned Mr McGrail was at imminent risk of self-harm.

Although both prongs struck Mr McGrail, it had the limited effect of causing Mr McGrail to turn backwards and stumble but not fall to the ground. In her evidence, Senior Constable Crouch described seeing Mr McGrail pull off the Taser probes.

As Mr McGrail continued to come towards her, Senior Constable Crouch dropped the Taser, and redrew her firearm.

At 4:10pm, Senior Constable Crouch made a broadcast over VKG requesting further police assistance and advising that she had deployed the Taser.

It was about this time that Sergeant Leven arrived at the scene. He exited his vehicle with his OC spray in his hand. Whilst Senior Constable Crouch had Mr McGrail covered with her firearm, Sergeant Leven approached Mr McGrath and deployed the entire can of spray. In his evidence, Sergeant Leven said he could see the arch of the spray and that it struck Mr McGrath's face, but the spray appeared to have little if any effect. Sergeant Leven noted that Mr McGrail was wearing sunglasses and queried whether they had provided protection. When it was apparent there was no effect, Sergeant Leven drew his firearm and covered Mr McGrail, who still had hold of the knife.

At 4:11pm, Senior Constable Crouch made a further broadcast reiterating *"we got a male armed with a knife"* and stating, *"We're at gun point.*"

Mr McGrail was moving around and yelling. The officers and the officers continued to call on him to *"drop the knife"*. According to Senior Constable Crouch, Mr McGrail was saying things to the effect, *"Shoot me, kill me, straight through the head, I want to die.*" According to Senior Constable Bennett, Mr McGrail was saying, *"Shoot me, shoot me. I got nothing to live for anymore. Youse have killed my son.*" Sergeant Leven heard Mr McGrail say, *"Shoot me",* and "*I'm gonna be with Clinton.*"

Mr McGrail continued to move towards the officers, who retreated across the grass and down the road in an easterly direction. Senior Constable Bennett retreated across the road to the opposite footpath. Sergeant Leven and Senior Constable Crouch formed a triangular position in relation to Mr McGrail. At points throughout the incident, the two officers crossed into each other's line of fire.

As Mr McGrail advanced upon the officers, he held the knife towards his own throat in a variety of ways and repeatedly said, *"Shoot me"*. In their evidence, Senior Constable Crouch and Sergeant Leven both described that, a various times, Mr McGrail focussed his attention on one of them, pointing the knife and stepping quickly in that officer's direction. He would then shift his attention to the other officer, stepping quickly in their direction. Both officers reacted by stepping backwards.

Vehicles continued to pass down North Street and, at one point, a family drove into a nearby driveway and children got out of the car. Senior Constable Crouch called out saying, "*get them into the house*".

Sergeant Leven continued to call on Mr McGrail to drop his knife. Sergeant Leven is heard on the Taser footage to say, *"Chris, put it down, put it down … put it down mate"* and, *"Come on Chris, I've known you for 10 years."* Sergeant Leven also recalls saying, *"I don't want to shoot you"* and *"Chris, you know me. Just put the knife down please."* Mr McGrail said, *"I'm not your fucking mate*."

By this point, Sergeant Leven had moved to a position about 60 metres from the duplex. In his evidence, Sergeant Leven stated that he was aware that there was a boat parked behind him next to a tree and he was concerned that he would be pinned against the boat. He also knew that the ground was uneven and was concerned that he could trip and fall especially, since he was walking backwards.

Mr McGrail held the knife out in front of him so that it was pointed at Sergeant Leven. Mr McGrail looked at him and said, "*Get ready*". He then cocked his arm and held the knife out high in a driving motion. He advanced quickly on Sergeant Leven, still pointing the knife at him. Sergeant Leven fired two shots just as Senior Constable Crouch was about to fire. Mr McGrail slumped into a half kneeling position, but did not drop the knife.

Mr McGrail was holding his abdomen area and Sergeant Leven was concerned he was trying to stand up. The officers continued to call on Mr McGrail to drop the knife. Senior Constable Bennett moved forward and deployed a short burst of his OC spray in an attempt to make Mr McGrail drop the knife; however Mr McGrail did not do so. Sergeant Leven then used his foot to push Mr McGrail in the left upper arm and shoulder area. He pushed Mr McGrail to the ground in an effort to disarm him. This action had the desired effect of knocking the knife out of his hand. Senior Constable Bennett then approached Mr McGrail and kicked the knife away from him. At 4:14pm, Senior Constable Crouch made a radio broadcast reporting that shots had been fired and requesting an ambulance. Sergeant Leven commenced providing first aid to Mr McGrail. He saw that Mr McGrail had bullet wounds to his abdomen and upper right leg and had a Taser probe in his stomach and chest region. Sergeant Leven placed pressure on Mr McGrail's abdomen and back to stem the bleeding.

At 4:19pm, an ambulance arrived at the scene. In the course of treatment, Paramedic Young removed a Taser prong from McGrail' s left chest and Paramedic Cross noticed a second Taser prong near McGrail' s groin, either caught up in his shorts or pierced in his skin.

Mr McGrail arrived at Grafton Base Hospital at 4:42pm. After further treatment, due to the extent of his injuries, Mr McGrail was airlifted to Gold Coast University Hospital. He arrived at 7:33pm. Mr McGrail underwent emergency surgery, however he was pronounced deceased at 11:50pm.

Eyewitness Accounts

A significant number of civilians witnessed the events leading up to and including the shooting. These witnesses did not give oral evidence in the inquest, but their statements were tendered as part of the brief of evidence:

Justin Kay described seeing Mr McGrail waving the knife towards the police in a threatening way. He saw the female police officer point her gun at Mr McGrail, then put it away and take out her Taser. He heard the female officer say, "*Please put it down, we will shoot you, please don't make us do it*" and Mr McGrail reply, "*Well hurry up. Do it"* or similar. He saw the officer deploy her Taser, and then saw Mr McGrail pull off the probes and keep moving towards the police.

Justin heard all of the officers continually calling out to Mr McGrail, "*Put it down, we don't want to do this*". Justin saw Mr McGrail lunge at the police and thought it looked like Mr McGrail was about to hurt someone. He heard two shots and saw Mr McGrail fall to his hands and knees.

Christy Kay described seeing Mr McGrail produce a knife and heard the officers tell him to put the knife down. Mr McGrail was yelling at the officers saying, "*shoot me*", "*I hate you*" and "*you took my son*". Ms Kay observed Mr McGrail to be hit with the Taser, and then pull the prongs out. She also saw an officer attempt to subdue Mr McGrail with OC spray. Ms Kay described Mr McGrail continually lunging at the female officer and calling on the police to shoot him.

When Mr McGrail was approximately one metre away from the police, she heard two gunshots and saw Mr McGrail struggling to stand. As Mr McGrail went to the ground, one of the officers came forward to assist him.

Robyn Tracey was driving along North Street. She described seeing Mr McGrail staggering on his feet and police with their weapons drawn. She heard the police attempting to negotiate with Mr McGrail, telling him to put the knife down. Ms Tracey saw Mr McGrail made slashing movements with the knife, which caused the police to move backwards. She then saw Mr McGrail lunge at one of the officers and heard two gunshots. She saw that Mr McGrail didn't let go of the knife until the officer kicked it out of his hands and he fell to the ground.

Myles Tracey described hearing screaming and seeing Mr McGrail in the middle of the road with a knife. He heard police telling Mr McGrail to drop the knife and saw that police had their firearms drawn. He heard a male police officer say, *"Put it down now or I'll have to shoot ya – come on Chris. I have known you for ten years. I know this is not you. You are a good bloke. Put the knife down or I'll have to shoot"* and saw Mr McGrail lunge forward, holding the knife out. Myles then heard gunshots. He saw that Mr McGrail continued to stand on the road until police kicked his leg to make him fall. Another officer then sprayed Mr McGrail with OC spray.

Eric Tracey described hearing yelling and seeing uniformed police with their firearms drawn. He saw Mr McGrail holding something and heard police telling him to put the knife down. Mr McGrail seemed "*out of his mind*". Eric turned away from his window and then heard gunshots.

Lesley Knight described seeing two male police officers and one female police officer with their firearms drawn. She observed that Mr McGrail had a knife, holding it down by his side, and that the officers were calling on him to drop the knife. Mr McGrail kept moving towards the police, who were stepping back. At one point, Mr McGrail held the knife out to the side and said, "*shoot me, I want to die*". One of the male officers tried to reason with him, but Mr McGrail continued to move towards the police. Ms Knight heard a gunshot and saw Mr McGrail still standing. She then heard a second shot and saw Mr McGrail bend forwards, holding his stomach. She noticed that he still had hold of the knife. Ms Knight stated that the female officer swept Mr McGrail' s leg out from under him, causing him to fall to the ground.

Errol Kirdy observed Mr McGrail walking towards three police officers, who were stepping backwards. He heard the officers calling on Mr McGrail to drop the knife. One of the officers tried to reason with Mr McGrail, but he continued to move towards the police.

Mr McGrail then raised the knife and Mr Kirdy thought that he was going to lunge at the officer, who was about two metres away. Mr Kirdy saw Mr McGrail lift the knife up and then heard a shot. Mr McGrail stayed standing and police continued to tell him to drop the knife. Mr Kirdy then heard a second shot and saw that Mr McGrail went to his knees. One of the male officers then pushed Mr McGrail over with his foot and the female police officer kicked the knife out of his hand.

Sheree Gray described hearing someone yelling, "*you killed my son*". She observed Mr McGrail in the middle of the road with a knife, and three police officers. She heard an officer yell, "*get inside*". The police repeatedly told Mr McGrail to put the knife down. Ms Gray heard Mr McGrail say, "*Do it. I don't want to be here anyway*". She saw him walk towards the police, who backed away. She heard two gunshots, however Mr McGrail remained standing. When Mr McGrail fell down, she saw the police move in to render assistance.

Heidi Robinson described seeing Mr McGrail surrounded by police with their firearms drawn. Ms Robinson took out her iPhone and began filming. She heard police yell, "*put it down*" or "*get down*", however Mr McGrail continued walking towards them. She saw Mr McGrail lunge towards police and then she heard two shots. One of the police officers kicked the blade out of Mr McGrail's hand once he was on the ground. Ms Robinson gave her iPhone containing the recording to the police to assist the investigation.

Ron Skinner described seeing Mr McGrail thrusting a large knife at police and yelling, "I will fuck *kill you*". He saw one of the officers attempt to subdue Mr McGrail with OC spray, but this had no effect. He heard the police continue to call on Mr McGrail to drop his knife. Mr Skinner described Mr McGrail as *"manic and [wanting] to hurt"* one of the police officers. He observed that Mr McGrail's efforts *"became more aggressive, he was making real efforts to lunge and stab at one of the police officers"*. Mr Skinner then heard a loud bang. He saw the officer who had fired the shots move towards Mr McGrail and push him down with his foot. Mr McGrail still had hold of the knife until he fell down.

Paul McKenzie described seeing three police officers walking backwards up North Street. One of the male officers was calling on Mr McGrail to drop his weapon. Mr McKenzie described Mr McGrail as being "*really worked up and agitated towards the police*". He heard Mr McGrail yell something like, "*do it*". He observed Mr McGrail move quickly towards the male police officer "*in a lunging move with the knife raised in a position that it appeared that the male police officer was about to be stabbed."* Mr McKenzie heard two quick gunshots and saw Mr McGrail fall to his knees. Mr McGrail continued to hold the knife until one of the officers kicked it out of his hand.

Judith Timms was being driven along North Street by her daughter. She described seeing three police officers with their firearms drawn standing around Mr McGrail. She heard police telling Mr McGrail to "*get down on the ground*". Mr McGrail had his arms extended out to the side (like a crucifixion pose) and kept saying, "*just shoot me*". As her daughter began to reverse the car, Ms Timms heard two gunshots and saw Mr McGrail clutch his chest.

Forensic Evidence and Video Footage

The video footage of the incident and the extensive crime scene investigation establish the following:

The distance that the police retreated from the duplex while Mr McGrail was moving towards them was about 90 metres. As set out above, over that time, Mr McGrail was moving towards Sergeant Leven and Senior Constable Crouch in an erratic start/stop fashion. When Mr McGrail moved forward, it was with large quick steps. Sergeant Leven and Senior Constable Crouch walked backwards in an attempt to keep their distance from Mr McGrail.

Sergeant Leven was between Mr McGrail (who was in front of him) and a boat parked at the edge of the driveway (which was about 1 to 5 metres to his rear). The crime scene photographs and a computer aided design ("CAD") analysis prepared by Senior Constable Fenton show that the ground was uneven. There were potholes on the road and a dip in the grass, near the boat. The boat was positioned on the kerb.

It is not possible to precisely state the distance between Mr McGrail and Sergeant Leven at the time Sergeant Leven discharged his firearm. However, I find the distance was likely between 1 and 5 metres. This measurement relies on both eyewitness testimony, and the crime scene measurements and analysis.

The footage of the incident recorded by Ms Robinson on her mobile phone shows that immediately following the shots, Mr McGrail pivoted slightly to his right and then put both his hands out and fell to his knees. He remained on at least one knee. Sergeant Leven is seen using his foot to push Mr McGrail on the shoulder, which caused him to drop the knife. Mr McGrail is then seen to lay on his back on the ground. It is clear from this footage that Mr McGrail did not move any significant distance from the position he was at the time the shot was fired.

The location where Mr McGrail lay down was marked by a blood stain 1.5 metres in diameter. The distances from the centre of that location to the two fired cartridges at the scene were approximately 5.6 metres and 6.2 metres respectively. A forensic ballistics investigator conducted an ejection pattern test involving the discharge of ten cartridges from Sergeant Leven's firearm. All ten cartridges were ejected to the right rear quadrant of the pistol falling between 700mm and 3,850mm to the rear of the pistol and between 830 mm and 2,670mm to the right of the pistol.

That Mr McGrail was very close to Sergeant Leven is further confirmed by an optical (visual and microscopic) and chemical examination of two areas surrounding the bullet holes in the singlet worn by Mr McGrail. This examination revealed the presence of nitrates, a known chemical component of burnt propellant, which is consistent with the distance of the muzzle of the firearm to the singlet at the time of discharge being in the intermediate range.

Ballistics analysis established that the two shots were fired from a single firearm. Two fired cartridges were collected from the scene and were subject to a microscopic examination. Comparison with test fired cartridges from Sergeant Leven's firearm confirmed that the recovered and test cartridges were fired from the same weapon. I am satisfied that it was Sergeant Leven who fired the two shots.

The evidence of the directly involved officers and the civilian witnesses establishes that at the time Sergeant Leven discharged his firearm, Mr McGrail was in possession of the same knife he had when Senior Constables Crouch and Bennett first approached Mr McGrail and Justin Kay out the front of the duplex. The footage captured by Ms Robinson on her mobile phone depicts Senior Constable Bennett approaching Mr McGrail after he had been pushed to the ground by Sergeant Leven.

He appears to kick something on the ground away from Mr McGrail, consistent with his evidence that he kicked the knife away. A crime scene officer located a black handled straight edged Avanti Infinity knife approximately 5.4 metres west of the where Mr McGrail had laid on the ground. It measured 25 cm in length, with a 13 cm blade.

The recordings from the Taser camera and Ms Robinson's mobile telephone establish that throughout the entire time the police interacted with Mr McGrail, including after the shots were fired, they were on him to *"Put the knife down!"* The footage also records Mr McGrail saying "*I want to be shot"*, *"I want to be with my son"*, "*you killed my son*", "*you have to shoot me*" and "*shoot me dead*". This is relevantly consistent with the eyewitness evidence.

Post-mortem Examination

At about 10:25am on 8 August 2017, Dr Dianne Little, Forensic Pathologist, performed a post-mortem examination on Mr McGrail. Relevantly, Dr Little identified two gunshot wounds: one to the right chest and one to the right thigh. Dr Little concluded that the cause of Mr McGrail's death was gunshot wounds to the trunk and right thigh and subsequent effects of significant blood loss.

Toxicology

Mr McGrail's post-mortem blood analysis revealed the following:

88mg of alcohol per 100ml of blood;

0.28mg/kg of methylamphetamine;

0.02mg/kg of amphetamine (the breakdown product of methylamphetamine);

Diazepam and Nordiazepam (the breakdown product of diazepam) were detected at a level of less than 0.02mg/kg; and

0.002mg/kg of tetrahydrocannabinol (THC).

Mr McGrail' s blood analysis also identified his prescribed antihypertensive (amlodipine) and antidepressant (citalopram) medication within and below therapeutic ranges respectively. Records obtained from the Pharmaceutical Benefits Scheme and Bulgarr Ngaru do not indicate that Mr McGrail had been prescribed diazepam by a medical practitioner.

Those assisting me obtained an expert report from Dr Jonathan Brett, a consultant in clinical toxicology and pharmacology, which was tendered in the inquest. In brief, Dr Brett has opined as follows:

All drugs detected at post-mortem are subject to post-mortem redistribution, making their absolute concentrations difficult to interpret;

It is not possible to determine with any accuracy how long prior to his death Mr McGrail consumed the methylamphetamine as the dose and route of consumption are not known. However, assuming the typical intravenous dose, Dr Brett opined Mr McGrail likely consumed methylamphetamine in the hours prior to his death;

It is not possible to differentiate with certainty as to whether Mr McGrail' s psychosis was methylamphetamine induced or caused by an underlying psychotic disorder, however as the evidence suggests an improvement in Mr McGrail' s psychotic symptoms and functioning during periods of abstinence or lighter use, Dr Brett is of the view that methylamphetamine induced psychosis is more likely; Acute methylamphetamine intoxication against a background of methylamphetamine dependence, methylamphetamine induced psychosis, antisocial personality disorder, grief reaction, sleep disturbance and alcohol intoxication all contributed to impairments in Mr McGrail' s cognitive function, mental state and behaviour immediately prior to his death;

Mr McGrail's blood alcohol concentration (0.88ml/100ml) is likely to have caused a degree of intoxication (although this depends on his pre-existing tolerance), leading to disinhibition and acute cognitive impairment;

It is unlikely that citalopram would have had a significant impact on Mr McGrail' s cognitive functioning prior to his death, either alone or as a result of any drug interactions with illicit drugs taken;

The diazepam and its metabolite Nordiazepam (both detected in low concentrations) are also unlikely to have had a significant impact on Mr McGrail' s mental state or behaviour immediately prior to his death.

ISSUES AT THE INQUEST

Prior to the inquest, a list of issues to be explored concerning the manner of Mr McGrail' s death was circulated to the interested parties. These issues were as follows:

- Did Mr. McGrail engage in a deliberate and conscious course of conduct with the intent of ending his own life? To that end, what was Mr. McGrail's state of mind and intentions over the course of the events leading up to and resulting in his death? In particular:

- To what extent, if any, was Mr. McGrail exhibiting suicidal intent/ideation immediately prior to his death?
- To what extent, if any, was Mr. McGrail's behaviour immediately prior to his death affected by the methamphetamine, amphetamine and other substances that were later detected in his blood?
- Was Mr. McGrail suffering from a mental illness or mental health condition immediately prior to his death? If so:
- What was the mental illness or mental health condition from which he was suffering?
- To what extent, if any, was Mr. McGrail's behaviour immediately prior to his death affected by the mental illness or mental health condition from which he was suffering?

- Were the actions of the involved officers on 6 August 2017 appropriate? In particular:
- Were Sergeant Leven's, Senior Constable Crouch's and Senior Constable Bennett's interactions with Mr. McGrail consistent with Police Protocols and Training relating to dealing with persons exhibiting mental illness or disturbances and/or intoxication?
- Were each of those police officers adequately trained in Police Protocols relating to dealing with persons exhibiting mental illness or disturbances and/or intoxication?
- Was there any alternative to the use of lethal force available to Sergeant Leven having regard to the circumstances?
- Whether there are any recommendations that are "necessary or desirable to make in relation to any matter connected with the death" arising from the evidence and findings at the inquest, pursuant to s. 82 of the *Coroners Act 2009*.

In addition to hearing the evidence from each of the involved officers, I received reports and heard evidence from a number of expert witnesses, including Senior Constable Adrian van der Valk from the NSWPF Weapons and Tactics Policy Review Unit (**WTPR**) and Chief Inspector Matthew Hanlon from the NSWPF Mental Health Intervention Team (**MHIT**). Dr Kerri Eagle, Forensic Psychiatrist, provided a report termed a "retrospective psychiatric assessment" in respect of Mr McGrail' s mental health issues and gave evidence in the proceedings.

Ms Skinner raised an issue through her counsel regarding Mr McGrail being released to bail after being charged with another assault upon her. Detective Chief Inspector Taylor indicated that he had identified and referred that issue to the Region Commander. Whilst I accept that police bail would not ordinarily follow given Mr McGrail' s criminal history, the seriousness of his assault upon Ms Skinner, and him threatening her with a tomahawk, that issue was not sufficiently proximate to the issues for the inquest. Additionally, given that the matter had been dealt with by the police command, I did not direct that such issue be part of the inquest.

Likewise, Mr McGrail' s discharge from the mental health unit at Lismore Base Hospital a week after trying to set the petrol tank alight would ordinarily accompany police involvement which would include a consideration whether to proceed with an arrest and charge and bail. Detective Chief Inspector Taylor said that he had also identified that issue in his investigation and referred that matter to be dealt with at a command level.

I accept that had Mr McGrail been in custody on 6 August 2017 the events of that day would not have occurred but the consideration of the manner of his death or the prevention of death and public safety does not reside in his own arrest and custody. Accordingly, they were not issues pursued in this inquest.

Issues 1 and 2: Mr. McGrail's state of mind and his intentions over the course of the events leading up to and resulting in his death

Mr McGrail' s medical records indicate that he had struggled with substance abuse issues throughout much of his life, and also experienced periods of depression. It appears that at least over the course of the month leading up to his death, Mr McGrail had developed strong fixations with the police and what he perceived as their corrupt practices. In his mind, these practices appeared to be linked to the suicide of his son. Over the same period, witness accounts establish that Mr McGrail also repeatedly expressed a wish to be with his deceased son.

The evidence from the directly involved officers and civilian witnesses (set out in detail above) regarding the events of 6 August 2017 suggests that Mr McGrail wanted to end his life, and intended to do so by engineering a situation in which the police would be forced to take lethal action against him. Specifically, at the time of the incident, Mr McGrail repeatedly expressed a desire for police to shoot him and, according to Dylan Kay, referred to "suicide by police".

As part of her retrospective psychiatric assessment, Dr Eagle was asked to comment on Mr McGrail' s state of mind and intentions over the course of the events leading up this death and also on the actions of the involved police officers, as they related to their interactions with someone exhibiting signs of mental disorder and intoxication.

In both her report and her oral evidence, Dr Eagle acknowledged the limitations of her analysis, noting that she of course did not meet Mr McGrail and was reliant on the records of the perspective of other people rather than having the opportunity to make her own observations or hear from Mr McGrail about his own perspectives. Despite these limitations, Dr Eagle was of the view that she had significant collateral information and clinical information upon which to found her opinions.

Dr Eagle's report was cogent and compelling, as was her evidence. Having regard to the available material, Dr Eagle expressed the following opinions regarding Mr McGrail's mental state generally and on 6 August 2017:

Mr McGrail had likely developed a substance induced psychotic disorder and had experienced at least one psychotic episode (characterised by persecutory delusions involving police) which developed during or soon after intoxication with methamphetamine. Whilst it is difficult to distinguish between a substance induced psychosis and a primary chronic psychotic disorder, Dr Eagle noted that Mr McGrail did not display other signs or symptoms that would be characteristic of schizophrenia or another similar disorder, and his symptoms (as exhibited on 16 July 2017) appeared to resolve following treatment in the context of abstinence from substance abuse.

Further there was no evidence that Mr McGrail had experienced episodes of psychosis prior to 2017. In her evidence, Dr Eagle expanded on this point, noting that methylamphetamine is a known drug associated with substance induced psychotic episode (**SIPE**). She explained that people become more sensitive to SIPE with increasing use of methylamphetamine and that can lead to an increasing number of episodes.

Mr McGrail had a severe substance use disorder evidenced by his inability to control his substance use, his level of dependence, his withdrawal when not using it, the impact of his use throughout his lifetime, its impact on his relationships and employment.

Mr McGrail had unresolved grief and loss and a high level of distress as a result of his son's death, which was exacerbated by other stressors and his persistent abuse of substances. I note that it was around the time of the anniversary of Clinton's death that Mr McGrail' s distressed posts on Facebook commenced together with his apparent escalating drug use. Mr McGrail had previously been diagnosed with major depression by his treating doctor. Dr Eagle was of the view that she had insufficient information of the signs and symptoms he presented with to reach a firm conclusion regarding this diagnosis and noted in her evidence that it can be difficult to distinguish between that mood disorder and the symptoms of a mood disorder due to concomitant methylamphetamine and alcohol use.

Mr McGrail would likely have satisfied the criteria for anti-social personality disorder, noting his problematic behaviours of criminal offending, aggression, impulsivity and recklessness that had persisted since adolescence. In her evidence, Dr Eagle noted that this disorder simply describes a number of behaviours, but does not provide insight into the reasons why a person is engaging in those behaviours.

On 6 August 2017, Mr McGrail was experiencing a SIPE. He displayed signs of a mood disturbance, including high levels of distress and suicidal thoughts, and the use of drugs and alcohol would have exacerbated this mood disturbance. His behaviour immediately prior to his death was likely the result of a complex interaction between psychotic symptoms precipitated by illicit substance use, intoxication, and mood disturbance and personality factors. Overall, it is likely that the psychotic condition was the primary condition that precipitated or contributed to Mr McGrail' s behaviour immediately prior to his death.

The evidence strongly suggests that Mr McGrail was exhibiting suicidal ideation and intent immediately prior to his death. In this regard, Dr Eagle noted the frequency of Mr McGrail' s expression of suicidal thoughts in the period immediately prior to his death, as well as his distress, hopelessness and "last resort" thinking.

Mr McGrail's intoxication would have contributed to impairments in his cognitive function, as well as his mental state and behaviour immediately prior to his death. Dr Eagle noted that it is difficult to be more specific regarding the extent of the contribution of his intoxication in light of Mr McGrail' s psychotic symptoms, mood disturbance and personality traits. Dr Eagle expanded on the effects of Mr McGrail's psychosis and intoxication in her oral evidence. Dr Eagle opined that these factors would likely have had a severe effect on Mr McGrail' s judgement, resulting in adverse effects on his behaviour, communication, hearing, and ability to process what others were saying, as well as not being able to properly consider the impact or consequences of his behaviour. Dr Eagle was of the view that the police attempts to have Mr McGrail put the knife down had less chance of success due to the persecutory or paranoid beliefs, his underlying antagonism towards police, and his fixed delusion regarding the police.

Mr McGrail' s overall judgement was substantially impaired and the nature of Mr McGrail' s persecutory ideas seemed very fixed. It was amongst this that Mr McGrail consistently expressed an intention to end his life and acted in a manner reasonably consistent with that intention. Accordingly, it appears that he was capable of forming the intention to end his life and intended to do so by provoking police to shoot him. Dr Eagle noted that Mr McGrail had expressed suicidal ideation immediately prior to his death and, despite suffering from a SIPE, Mr McGrail would still have been able to form an intention to end his life as these features are not mutually exclusive. However, she noted that the capacity to form an intention is fluid and whereas he previously may not have had the motivation or capability to act on that intention or may have reflected on his behaviour, on this occasion, the impairment of his judgment because of psychosis and intoxication may have contributed to him proceeding to act on that intention.

In cross examination, Dr Eagle agreed with Ms Melis that examples of "last resort thinking" included Mr McGrail saying to police *"Shoot me dead"*, *"I want to be dead", "No one is getting out of here alive. This is my last option".* Ms Melis suggested that Mr McGrail engaged in behaviours to provoke the police, to which Dr Eagle responded that the longer the police interacted with Mr McGrail, the more his behaviour deteriorated. Dr Eagle noted as Mr McGrail' s behaviour escalated, it became harder for police to de-escalate the situation.

Ms Melis put to Dr Eagle that Mr McGrail' s behaviours suggested that this incident had all the hallmarks a concept known by a variety of terms but the rudimentary term is "Suicide by Police" (**SBP**). She also drew Dr Eagle's attention to Dylan Kay's statement where he reports that Mr McGrail said *"It's called Suicide by Police. They are gonna put a bullet in my head and the only way they'll do that is if I kill you"* as an indication of Mr McGrail's thinking. Dr Eagle stated that the SBP term was designed for research and she would not be drawn on describing Mr McGrail' s death in those terms.

Mr Johnson raised with Dr Eagle that when the police first arrived and Mr McGrail directed them to the next door duplex, he appeared at that stage to be relatively calm. Dr Eagle commented that it is hard to interpret what Mr McGrail was thinking at that time, and to understand what he thought he was going to achieve by that. Dr Eagle was unable to say whether it appeared to be an opportunity for the situation to be settled.

The evidence from Justin Kay establishes that after the police were directed to Unit 2, Mr McGrail picked up the bottle and knife and a shirt with the one hand and said to Justin, *"This is it. Are you ready to die?"* However when the police returned, the situation did not escalate until after the contents of the bottle were discarded and Mr McGrail was asked about what he had in his pants. It was at that stage that Mr McGrail pulled the knife out, and Senior Constable Crouch drew her firearm. Mr Johnson suggested to Dr Eagle that the drawing of a firearm would have been perceived by Mr McGrail as a threat, to which Dr Eagle responded that that a drawn firearm would universally be seen as a threat.

I note that that after Mr McGrail was covered by the firearm, rather than threatening to use the knife against Justin Kay or the police, Mr McGrail held it to his own throat. This caused Senior Constable Crouch to re-holster her firearm and instead deploy the Taser. Although the Taser had apparent effect and Mr McGrail went to the ground, he recovered instantly and removed the wires to the prongs. Dr Eagle opined that though Mr McGrail might have sensitivities to loud noise, he may have been less sensitive to pain, due to adrenaline (which can dampen down the pain). Taking into account the totality of the evidence from the directly involved officers, the civilian eyewitnesses, the video footage and the expert evidence, I find that at the time Mr McGrail interacted with police on 6 August 2017, he was experiencing a complex interaction of the effects of methamphetamine and alcohol intoxication, a SIPE, and a severe disturbance of mood with expression of suicidal thoughts.

Ms Melis, on behalf of the NSW Commissioner of Police ("the Commissioner") submitted that I would conclude that Mr McGrail's death was self-inflicted. Although Mr McGrail was repeatedly urging the police to shoot him throughout the incident (and prior to their arrival had indicated that he would do some harm to others to warrant the police shooting him), I do not think that an injury causing death which is inflicted by another can be described as a self-inflicted death. Further, the heightened distress and anguish and effect of intoxication whilst experiencing a psychotic episode lends a lack of clarity to Mr McGrail' s true state of mind when not in that state.

Whilst I accept Dr Eagle's evidence that Mr McGrail was capable of forming the intention to end his life and forming an intention to do so by provoking police to shoot him, I am unable to positively conclude that he would have formed this intention absent the effects of his psychosis and intoxication.

Issue 3: Were the actions of the involved officers on 6 August 2017 appropriate?

Sergeant Leven and Senior Constables Crouch and Bennett all gave oral evidence at the inquest, which was consistent with the accounts given in their directed interviews. Their accounts have been set out in detail above. Their accounts were supported by the available video footage, eyewitness accounts and forensic evidence. There has been no submission made against the truthfulness or credibility of any of the directly involved police officers.

Senior Constable Bennett did not draw his firearm at any stage. Senior Constable Crouch drew her firearm in response to Mr McGrail brandishing the knife, but she re- holstered when he threatened to harm himself and she drew and deployed the Taser. When Mr McGrail pulled the Taser wires off himself and continued to advance on her, Senior Constable dropped the Taser and re-drew her firearm.

Senior Constable Crouch gave evidence that she did not reload her Taser, nor did she pick her up her Taser from the ground (which housed the video recording device), as there was no time to do so and she needed both hands on her firearm.

Sergeant Leven arrived at about this time and exited his vehicle with OC spray in his hand. When he saw that the Taser had not incapacitated Mr McGrail, he dispensed the can of the spray. Sergeant Leven gave evidence that he saw the arch of the spray and that it struck Mr McGrath's face, but the spray appeared to have little if anyeffect.

It was from that point that the police were always in retreat and Mr McGrail continued to advance on them. It would have been apparent to Mr McGrail that the police were in retreat and the descriptions of his conduct as given by the police and eyewitnesses establish that at all times, Mr McGrail was the aggressor. Sergeant Leven gave evidence that at no time did he feel that he had control of the situation and that the police movements were constantly being dictated by MrMcGrail.

Initially both Senior Constable Crouch and Sergeant Leven moved about 20 metres down the road on the same side of the street as the duplex. Senior Constable Bennett was across the road, forming a triangle. At one stage, Senior Constable Crouch left her position near Sergeant Leven and went across the road to cover Mr McGrail who at that point was in the middle of the road. The officers continued to retreat down the road.

Senior Constable Crouch and Sergeant Leven both described Mr McGrail focusing and moving towards either of them at different times. His movements were erratic in that he would move with rapid large strides in the direction of one officer, stop and then repeat toward the other officer. Ultimately, Mr McGrail focussed on Sergeant Leven.

Senior Constable Crouch saw Mr McGrail advancing on Sergeant Leven with the knife held out in front of him pointing towards Sergeant Leven. She formed the opinion that Mr McGrail was going to stab Sergeant Leven and intended to fire at McGrail. However, before she fired, Sergeant Leven fired two shots causing Mr McGrail to stumble to the ground.

Senior Constable Bennett observed that Mr McGrail *"picked up a bit of speed really and he's come at Sergeant Leven. He got closer and closer and I think he got within three or four metres and* [Sergeant Leven] *pulled the trigger"*.

The transcript from the Taser footage indicates that from the time the Taser was deployed until the time the two shots were fired, 3 minutes and 24 seconds elapsed. The recording demonstrates Mr McGrail's aggression and distress, and the immediacy of the threat posed by Mr McGrail as an extremely heightened individual.

The recording commences with Senior Constable Crouch commanding Mr McGrail repeatedly and clearly to put the knife down. She was met with his responses such as *"you have to shoot me….I want to be with my son….You killed him".* Senior Constable Crouch yelled at him *"Get away from me"* and he said, *"You have to shoot me...in the middle of the head, I want to be shot*". Senior Constable Crouch repeated *"Put your knife down".*

Sergeant Leven also attempted to engage with Mr McGrail. After Mr McGrail screamed that he wanted to be shot Sergeant Leven said to him, *"Put the knife down mate"*. Mr McGrail continued screaming and though many of the words Mr McGrail said are largely indecipherable due to his distress he can be heard to say *"I'm sick of this … I'm sick of this … you killed my son … you killed my son".* Sergeant Leven said *"Chris put it down*" and Mr McGrail continued screaming at him. Sergeant Leven interchanged between *"Put it down"* and *"Chris put it down".* At one stage Sergeant Leven told him *"Put the knife down, I'm outta OC spray".* Mr McGrail said "*… I fucking (don't) ... want to hurt any more … I've got nowhere to live … my daughter…"* Sergeant Leven repeated *"Put the knife down mate"* and Mr McGrail screamed something and then screamed "*…nooooooooo".* Sergeant Leven pleaded with him *"Put the knife down, please. Please"*. The audio recording has indecipherable screaming, apart from one aspect of Mr McGrail' s response being a screamed *"gooooo … goooo".*

Senior Constable Crouch repeated her command *"Put the knife down"*. Mr McGrail screamed at her and Sergeant Leven told him *"Do not come near her and says Move…go! Go!"* Mr McGrail continued screaming at Sergeant Leven, who told him to *"stand back mate…stand back…stand back…stand back...stand back…stay back…stay back..."*

During this time, Sergeant Leven was walking backwards whilst Mr McGrail advanced on him. Mr McGrail called on Sergeant Leven to *"shoot now mate…"* and Sergeant Leven replied "*(undecipherable)… now Hoppy …"* Sergeant Leven continually told Mr McGrail to *"Go back"* and to "*put the knife down"*. Sergeant Leven directed Senior Constable Crouch to *"Watch him … we're in cross fire now"*, to which she responded *"I can't go anywhere".* The transcript incorrectly cites Mr McGrail saying *"Neither can I"*, however it is in fact Sergeant Leven's voice. This is consistent with Sergeant Leven's oral evidence, in which he stated that he was mindful of a boat parked on the kerb across the driveway behind him. He didn't want to get pinned there, and nor did he want to keep walking backwards because the ground was uneven and he was concerned he may trip.

Mr McGrail ignored Senior Constable Crouch's command to *"Drop the knife"* and the last exchange is between Sergeant Leven and Mr McGrail. The exchange between them is as follows:

Sergeant Leven: *"Put the knife down! Please! Please!"*

Mr McGrail: (screaming) *"my son ..."*

Sergeant Leven: *"Put it down! Put it down! Drop it! Drop it! Drop it mate! Put the knife down Chris! Please put the knife down! Please! Please put the knife down!"*

Mr McGrail: (indecipherable screaming)
Sergeant Leven: *"Don't… Don't"*
Mr. McGrail: (indecipherable screaming)

Sergeant Leven: *"Put it down mate! ... Put it down ... come on Chris, I've known you for ten years … Don't… Don't".*

Two shots can then be heard on the recording, after which Sergeant Leven and Senior Constable Crouch further command Mr McGrail to put the knife down.

The seriousness and immediacy of the threat facing the officers is also recounted by a number of the civilian witnesses: Justin Kay stated that "Hoppy was lunging towards the police officers and it looked like he was to go [sic] and hurt somebody. It was then I heard the two shots and Hoppy fell to his hands and knees".

Robyn Tracey stated that she estimated "the man with the knife was only a couple of metres from the Police Officer [Sergeant Leven]. I then saw the man with the knife lunge at the Police Officer. Then I heard the sounds of two shots being fired from the Police Officer's gun at the trunk of the man's body."

Myles Tracey said that he heard the policeman near the boat [Sergeant Leven] say, "*Put it down now or I'll have to shoot ya – come on Chris. I have known you for ten years. I know this is not you. You are a good bloke. Put the knife down or I'll have to shoot*". As Sergeant Leven said that, Mr McGrail "lunged forward – I heard the noises – Boom, Boom. There were two quick shots".

Errol Kirdy said that Mr McGrail *"*just kept coming towards the male officer [Sergeant Leven]. The gap was still around 2 metres, it was pretty close. The male officer was going backwards towards the boat and then all of a sudden the man in the singlet [Mr McGrail] raised his right hand up towards his face and he was directly facing that male officer. I thought the man was going to lunge at the police officer. I don't know if that is what he was going to do, but that is what I thought he was going to do. As the man lifted the knife up, I heard a gunshot and realised that the male police officer near the boat [Sergeant Leven] had shot the man*"*.

Nikolas Scroop said that Mr McGrail "was walking with the knife in his hand and was getting closer and closer to the male officer till the man was about three metres away from the male police officer when he [Sergeant Leven] discharged two shots at the man".

Ron Skinner described Mr McGrail as "manic and wanted to hurt" one of the police officers. He said that Mr McGrail's efforts "became more aggressive, he was making real efforts to lunge and stab at one of the police officers" before he heard a loud bang.

According to Paul McKenzie, "The police were stilling [sic] calling for the man to drop the knife when the man with the knife moved quickly towards the male police officer in a lunging move with the knife raised in a position that it appeared that the male police officer was about to be stabbed. At this stage I heard two quick shots fired and the man with the knife slumped on the ground onto his knees."

During her evidence, Senior Constable Crouch remarked that having listened to the audio recording she realised that she had engaged in "verbal looping" repeating the phrase "*put it down*". Though she recognised that was the result of her being under pressure, she stated that she would like to be able to change that so when under pressure she can modulate and readjust in an attempt to de-escalate or change the dynamic.

I was impressed by her insight and candour. Though she regretted leaving the Taser on the ground, I think given the circumstances she need not have that regret. She had far more pressing priorities.

I commend Senior Constable Crouch for having the presence of mind to understand that Mr McGrail' s initial actions with the knife were a sign that he might not be a threat to others and so she re-holstered her firearm which was both an attempt to de-escalate the situation but also to use a lesser force to stop Mr McGrail.

Senior Constable Crouch said that there was an occasion when she had engaged with Mr McGrail at the police station a year earlier, but on this day she did not recognise him at all. It was only after the incident that she learned who he was and realised that she had met with him on markedly different terms.

Sergeant Leven has been in the police force for over 25 years. In his evidence, he was asked how many times he had occasion to deal with people who were mentally ill and/or affected by drugs. His response was that during the course of his career there were too many such occasions to keep count. He was also asked how many times he had discharged his firearm. He replied, "*This once*".

In many ways the Taser footage transcript speaks for itself, but it was very apparent from hearing Sergeant Leven in the witness box that he is not only an experienced police officer, but that he has the qualities of a calm, considered and caring person. From listening to the transcript and hearing his evidence it is not difficult to remark that he was able to use those qualities and be mindful of his duties and his options. By doing so he lengthened the time, he kept the distance, and he was aware of his surroundings including his fellow officers. He was able to provide direction and keep more junior officers safe as he tried to engage and de-escalate Mr McGrail. He did this whilst under constant and intense life-threatening pressure.

Sergeant Leven said he became aware of the repetitiveness of his commands and tried to moderate his language. He said that the longer he interacted with Mr McGrail the more Mr McGrail's behaviour deteriorated. Mr McGrail became more insistent, he took deliberate long steps towards him, and he was more demanding to be shot. When Sergeant Leven said, *"Come on mate"*, Mr McGrail responded *"I'm not your fucken mate".* When he told Mr McGrail he had known him for ten years and didn't want to shoot him, Mr McGrail was just as angry.

Sergeant Leven also gave evidence that Mr McGrail removed the knife from his neck saying "*Get ready! ... Are you ready?*" Mr McGrail then gripped the handle, bent his elbow like the knife was cocked, pointing it in Sergeant Leven's direction and moved quickly towards him in long quick strides. Sergeant Leven described Mr McGrail pointing the knife in his direction and "*moving purposefully, coming at me with a knife, with long quick strides, my life was in immediate danger*".

Sergeant Leven considered that he had exhausted all tactical options.

He had retreated about 90 metres, and the police could not disengage from the scene because Mr McGrail may have sought to harm a bystander. Sergeant Leven said that before he fired his weapon, he made sure nobody was standing behind Mr McGrail in case he missed and they were struck. He said he aimed at the chest (referred to as the centre body mass), which provided an increased likelihood of hitting him and therefore stopping him. Sergeant Leven was asked why he fired twice, to which he said that he thought that was consistent with his original training. In this regard, Senior Constable Adrian van der Valk said that the current training is to discharge one round, reassess and if necessary fire another.

The two shots were in such quick succession that there was no time to reassess. The rapidity of events and the threat that Mr McGrail provided may explain the two shots. Sergeant Leven said "*it was very important to me that I hit him. He stopped advancing. It was a huge relief that he stopped advancing towards me*". The prevailing circumstances did not allow for any period of reassessment between the two shots.

At the time he discharged his weapon, Sergeant Leven believed that it was necessary in order to defend himself and that in the circumstances as Sergeant Leven perceived them, it was a reasonable response to the threat posed by Mr McGrail. Senior Constable Adrian van der Valk of the NSWPF WTPR reviewed the actions of the directly involved police officers on 6 August 2017, including the use of lethal force by Sergeant Leven. His report was tendered as part of the brief of evidence and outlines the training given to police in relation to the tactical options police officers have when faced with situations such as involving a person armed with a knife.

Senior Constable van der Valk expressed the view that Sergeant Leven *"used as many reasonable force options available to him given the speed, mobility and veracity* [sic] *of the attack upon him by Mr McGrail just prior to the discharge of the firearm".* He concluded that *"Sergeant Leven's use of force option is consistent with NSWPF policy, procedure and training practice guidelines"*.

In his supplementary statement, Senior Constable van der Valk expressed the view that the various tactical options used by Senior Constables Crouch and Bennett during the course of the incident were also appropriate and in keeping with NSWPF policy, procedure, and training practice guidelines.

In particular, Senior Constable van der Valk opined that:

The commands directed at Mr McGrail by both Senior Constables Crouch and Bennett were appropriate and reasonable in the circumstances;

Senior Constable Crouch's deployment of her Taser was in keeping with NSWPF policy, procedure, and training practice guidelines; Senior Constable Crouch's actions to draw and cover Mr McGrail with her firearm in circumstances where an armed and threatening subject was continually refusing to obey police directions was also in accordance with NSWPF policy, procedure, and training practice guidelines; and Senior Constable Bennett's use of his capsicum spray was also in keeping with NSWPF policy, procedure, and training practice guidelines.

Senior Constable van der Valk remarked in his evidence (which was also reinforced by Chief Inspector Hanlon) that, despite all the training a police officer can undergo, when it comes to time to use that training in a scenario such as occurred on 6 August 2017, a variable and unknown factor will play a significant role and that is the individual police officer's unique psychophysical response to stress and adrenal Sergeant Leven embodied his training and he demonstrated a remarkable ability to discharge his duties in the manner he is trained to do.

The mobile telephone footage shows that after Mr McGrail was shot he was on one or both knees on the ground. Sergeant Leven then used his foot and pushed Mr McGrail on the upper chest/shoulder area causing Mr McGrail to fall back onto the roadway.

It was distressing for Ms Skinner to see Mr McGrail treated this way while wounded, however Sergeant Leven explained that he did that to disarm Mr McGrail so that the scene would be safe and so that he could provide Mr McGrail with urgent first aid (which Sergeant Leven then did). Sergeant Leven provided comforting words and support to Mr McGrail and placed pressure on his wounds to stem the bleeding. He then assisted the paramedics until he had to leave the scene.

Part of the review of the police actions on that day involved a review of their compliance with their education and training regarding dealing with people who are suffering from mental illness or, as in the present case, a psychotic episode. I note that each of the involved officers had previously participated in the One Day Mental Health Workshop Program conducted by the NSWPF MHIT, although Senior Constable Bennett had no memory of having done so. The details of that program are provided in the statement of Acting Sergeant Dawn Pointon and the statement of Chief Inspector Matthew Hanlon. Notably, Sergeant Leven and Senior Constable Crouch had undertaken that training in 2015.

Chief Inspector Matthew Hanlon, the Manager of the NSWPF MHIT, considered that all officers attempted to de-escalate the incident in accordance with the NSWPF mental health training guidelines. He noted that Sergeant Leven and Senior Constable Crouch, by seeking to increase the distance between themselves and Mr McGrail whilst continuing to engage him into compliance, were giving effect to the two key principles of de-escalation, namely distance and time. Chief Inspector Hanlon also observed that Sergeant Leven endeavoured to use empathy in his verbal commands by addressing Mr McGrail by his first name and appealing to the fact that he had been known him for 10 years, telling Mr McGrail he did not want to shoot him and pleading with Mr McGrail to "*just put the knife down, please*".

Chief Inspector Hanlon has described the officers' conduct as demonstrating a high level of compliance with the training and in particular with the de-escalation techniques taught during the one-day workshop. Independently of the NSWPF, Dr Eagle expressed the view that having reviewed the conduct of the officers, she was of the opinion that they had attempted to appropriately engage and de-escalate Mr McGrail. Mr McGrail did not respond to these attempts likely in part due to his mental state at the time; however these attempts did appear to slow the incident down to some degree.

Dr Eagle concluded that, from a psychiatric perspective, it was not apparent that any other approaches or strategies would have been effective in avoiding the fatal outcome.

Both Mr Madden on behalf of the directly involved officers and Ms Melis on behalf of the Commissioner made submissions consistent with Counsel Assisting, in particular that I would find that the police acted lawfully, appropriately and according to their training in very difficult circumstances. They appropriately reiterated the difficult circumstances that the police were in and commended their handling of it. They both submitted that there was clear evidence that Mr McGrail deliberately acted the way to achieve the outcome of being shot by the police.

I am of the view that Sergeant Leven's discharge of his firearm was justified, having regard to the circumstances which he faced. He was acting within his duty as a police officer and he was acting in self-defence. Sergeant Leven had every reason to believe that he was going to be seriously injured or killed. I find that Sergeant Leven exhausted all tactical options available to him and, in discharging his firearm, did so in compliance with NSWPF policy, procedure and training practice guidelines.
I consider that his actions were reasonable and proportionate to the threat that he faced.

Issue 4: Whether any recommendations are necessary or desirable

In their evidence, Senior Constable van der Valk and Chief Inspector Hanlon were asked questions about the integration of tactical options training with mental health training, a matter which has been subject to recommendations in previous inquests. Senior Constable van der Valk gave evidence that police tactical training includes role playing scenarios involving sharp edged weapons. I note that now over a number of years the police force has ensured the delivery of mental health education to over more than 17,000 police officers. It is now incorporated in the Academy training so that all new recruits have undertaken the mental health training. Given the logistics involved with the rostering and size of the police force the education strategy now targets police officers who train other police officers.

Chief Inspector Hanlon gave evidence that his unit is in the completion stage of developing an electronic learning package which he hopes will be available to all police in July of this year and he intends to seek that it be given a mandatory status.

In his submissions, Counsel Assisting described the progress of the integration of mental health training with tactical training as perhaps being somewhat limited. In submissions on behalf of the Commissioner, Ms Melis submitted that this isn't the case, as weapons trainers are armed with the knowledge gained through the mental health training and are passing it on to those they train.

In any event, the evidence in this inquest demonstrates that Sergeant Leven had participated in mental health training and he had acted, throughout the deployment of his tactical options, in a manner consistent with his training. Accordingly, any recommendation addressing the integration of mental health training into tactical options training does not arise on the evidence in this inquest.

I do not consider that there are any other matters arising from the evidence that would lead me to make a recommendation. No submissions were made to the contrary.

Formal Finding:

Identity:

Christopher Peter McGrail

Date of death:

6 August 2017

Place of death:

Gold Coast University Hospital in Southport, Queensland

Cause of death:

Gunshot wounds to his trunk and right thigh

Manner of death:

Mr. McGrail died from the effect of significant blood loss associated with two gunshots inflicted by a NSW Police Officer who was acting in the course of his duties when Mr. McGrail advanced on him in North Street, Grafton. Mr. McGrail was holding a large kitchen knife and had refused to drop it, despite many commands and requests to do so. The officer fired two shots after Mr. McGrail raised the knife and lunged at him. At the time, Mr. McGrail was experiencing a complex interaction of the effects of methamphetamine and alcohol intoxication, a substance induced psychotic episode and a severe disturbance of mood with expression of suicidal thoughts.

17. 275511 of 2017

Inquest into the death of George Cameron. Finding delivered by State Coroner O'Sullivan at Lidcombe on the 3 December 2020.

George Cameron died at 81 years of age on 8 September 2017 at Parklea Correctional Centre. At the time of the death, Parklea Correctional Centre was managed by the GEO Group Pty Ltd on behalf of Corrective Services. On 31 March 2019, GEO handed over management of Parklea Correctional Centre to MTC Broadspectrum. MTC Broadspectrum currently manages Parklea.

As Mr Cameron was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act.

The role of a Coroner and purpose of this inquest

The role of a coroner, as set out in s 81 of the Coroners Act, is to make findings as to the following:

- the identity of the deceased;
- the date and place of the person's death;
- the physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

Evidence at Inquest

A short inquest was held on 3 December 2020. The brief of evidence compiled by Senior Constable Cambridge was tendered (Ex.1).

Custodial History

On 5 September 2017, Mr Cameron was arrested in relation to several serious offences relating to an incident alleged to have occurred at Hornsby Westfield shopping centre on the 5 September 2017. He was refused bail by police and appeared at Hornsby Local Court on 6 September 2017. He was refused bail at Hornsby Local Court and remanded into custody. The next court date was to be 9 November 2017.

On 6 September 2017, he was transferred from Hornsby Police cells to Parklea Correctional Centre. Upon arrival at Parklea, he was initially placed within the observation cells in the prison's reception area. At about 11 p.m. on 6 September 2017, Justice Health completed a Reception Screening Assessment. The assessment identified several physical conditions requiring monitoring. Consequently, Mr Cameron was placed in a "2 out" cell, meaning he would be housed with another inmate who could ensure his physical wellbeing and raise the alarm should Mr Cameron have any health issues. The Reception Screening Assessment also canvassed Mr Cameron's mental health.

Mr Cameron denied previous attempts at self-harm or suicide. When asked if there was anything causing him concern, Mr Cameron responded, “Yes. Just being here.” When asked how he thought he would cope in prison, Mr Cameron said, “As I always do. Well.”

The Reception Screening Assessment returned a Kessler score of between 10-19. The Kessler scale is a simple measure of psychological distress, with a score in the aforementioned range indicating that the person is likely to be well. The Reception Screening Assessment records that Mr Cameron had guaranteed his own safety to interviewing Justice Health staff, which means that he denied thoughts of self-harm or suicidal ideation and had no intention to self-harm whilst in custody.

Mr Cameron was housed in cell 37 within the clinic area. The placement was selected in response to Mr Cameron’s health issues and a need for him to be protected from other inmates due to the nature of his charges. Cell 37 is monitored by closed circuit television, but areas of the cell were not visible due to the lighting and the bunkbed.

Circumstances of Death

Mr Cameron arrived in the cell at 9:17 p.m. on 7 September 2017. At 8:05 a.m. on 8 September 2017, he used the intercom system to contact correctional staff and request his regular medication as well as some additional medication to assist with constipation. At 8:10 a.m., Mr Cameron contacted correctional staff and requested to speak with his wife. At 8:52 a.m., Mr Cameron again contacted staff and asked to speak with his wife. He was informed that he would not be able to make a phone call until he was cleared by reception screening. Mr Cameron was served a morning meal at 8:57 a.m. At 9:48 a.m., Mr Cameron contacted correctional staff and requested constipation medication.

CCTV shows that at 10:59 a.m., Mr Cameron removed bedding from a black plastic bag on the bottom bunk. At 11:04 a.m., he placed the bedding back into the plastic bag. At 11:04 a.m., Mr Cameron stood up and took hold of the plastic bag that contained the bedding and again removed the bedding. He retained hold of the plastic bag. In the CCTV, Mr Cameron is visible on the lower bunk, but the upper bunk obscures his head. At 11:20 a.m., Mr Cameron’s legs can be seen to twitch. At 11:21 a.m., his legs twitch again and his left hand slides across his body to fall to his side.

Within her statement, Correctional Officer Yonita Nelson states that at about 11:42 a.m. she opened cell 37 and observed George Cameron to have a black plastic bag over his head. She grabbed the plastic bag off his head and saw that he was pale and not breathing. She requested medical assistance. Staff commenced cardio-pulmonary resuscitation, but Mr Cameron could not be revived. At 11:55 a.m., Dr Grimsdale pronounced Mr Cameron to be life extinct. Body worn camera footage within the brief of evidence depicts this occurring. However, at 12:00 p.m., ambulance officers attended and detected a faint pulse. They recommenced CPR and prepared to transport Mr Cameron to hospital. At 12:36 p.m., while Mr Cameron was being loaded into the ambulance, ambulance officers pronounced him life extinct.

Police canvassed prisoners in neighbouring cells but none provided information that they had heard Mr Cameron give any indication of harming himself. The only reasonable hypothesis for Mr Cameron to have the plastic bag over his head is that he wished to commit self-harm. No other persons had access to him during the period that the bag was placed over his head.

Cause and Manner of Death

On 12 September 2017, pathologist Dr Pokorny conducted an external examination of Mr Cameron. Dr Pokorny's post-mortem report lists the direct cause of death as unascertained. Dr Pokorny states that while the history and circumstances are strongly suggestive of plastic bag asphyxia, there were no specific injuries or marks around Mr Cameron's neck to indicate the presence of the bag and there were no photographs of the bag in-situ.

Changes made since the death

In June 2018, CCTV camera technology was upgraded in six cells in Area 1, including Detox Cell 37, in which Mr Cameron was housed. The upgraded CCTV camera technology has the capacity to provide visibility in low light and darkness. MTC Broadspectrum now provides a mesh bag for linen when inmates are moved to an accommodation wing.

Formal Finding:

Identity
The person who died was George Cameron

Date of death
George Cameron died on 8 September 2017

Place of death
George Cameron died at Parklea Correctional Centre, New South Wales

Cause of death
The cause of George Cameron's death was plastic bag asphyxia

Manner of death
George Cameron's death was self-inflicted with the intention of ending his life.

18. 288854 of 2017

Inquest into the death of Tane Chatfield. Finding delivered down by DSC Grahame at Tamworth on the 26 August 2020.

This inquest concerns the tragic death of Tane Chatfield. Tane died surrounded by members of his loving family at Tamworth Hospital on 22 September 2017. He was 22 years of age.

Tane had been brought by ambulance to Tamworth Hospital from Tamworth Correctional Centre ("Tamworth CC") on the morning of 20 September 2017. He was unconscious and in a critical condition on arrival.

Tane was alone in his prison cell on the morning of 20 September 2017, having returned from hospital following a cluster of seizures the night before. Around 9.05 am, a fellow inmate peered through the cell peephole and saw Tane hanging from a torn prison blanket tied to an exposed pipe. Tane had been unattended for less than 46 minutes. Correctional staff were immediately notified and resuscitation attempts commenced.

Tane was a proud indigenous man of the Gamilaraay, Gumbaynggirr and Wakka Wakka people. He came from a large extended family and grew up in the Armidale area. His mother Nioka, father Colin and family continue to grieve Tane's death and search for answers. The participation by the family in this inquest was directed at seeking the truth of what occurred and prompting change for other indigenous men and women currently incarcerated. I respect and acknowledge the assistance they gave the court.

Tane is also survived by his partner, Merinda and their son Jho'Arryn. It is a profound tragedy that Jho'Arryn will grow up without his father. Merinda also attended and participated in the inquest in an attempt to affect change for others. If Jho'Arryn ever reads a transcript of these proceedings, he will know how hard his family fought to seek justice for his father. Tane is missed by all those who loved and cared for him. The court heard a powerful and moving family statement which described Tane's strengths and struggles. Family members spoke of his loving and caring personality. His mother, Nioka said that Tane would "give his shirt off his back for any stranger." One of his sisters told the court "Tane was our strength, he made our childhood bearable…he was our fun and laughter. Tane taught us how to be strong…and made our childhood memorable." His grandmother spoke of Tane's caring nature and his sporting prowess.

During the family statements, I also heard of how inter-generational trauma has affected Tane's family. Nioka spoke of Tane's father, Colin and his history of incarceration and prison beatings. Tane's sister spoke eloquently about the harm caused to Tane by his entry into juvenile detention. She explained that instead of being brought up just on his mother's love "he was also brought up by a juvenile system built on punishment, violence and drugs." Beyond the circumstances of this individual tragedy, the investigation into Tane's death raised broader questions about the general standard of medical care and support provided to inmates within our prison system.

It also demonstrated that concerns raised during the Royal Commission into Aboriginal Deaths in Custody ("RCIADIC"), thirty years ago, in relation to the placement of vulnerable indigenous prisoners in cells with obvious hanging points remain unresolved today. It shone a powerful light on the inter-generational nature of indigenous incarceration.

I am indeed encouraged to learn that Colin and Nioka Chatfield are working on a healing program to address issues that lead to incarceration and intergenerational incarceration of Aboriginal and Torres Strait islander people in this country, and especially within their local community. I sincerely hope that they find the support necessary to make their plans a success.

Background

It is necessary to place Tane's incarceration in its wider social context prior to a close examination of the particular facts surrounding his death.

According to the Australian Law Reform Commission, Aboriginal and Torres Strait Islander adults make up around 2% of the national population, however they constitute around 27% of the national prison population. In 2016, around 20 in every 1000 Aboriginal and Torres Strait Islander people were incarcerated. Tragically, over-representation appears to have grown, not decreased. Aboriginal and Torres Strait Islander incarceration rates increased 41% between 2006 and 2016 and the gap between Aboriginal and Torres Strait Islander and non-Indigenous rates widened over the decade.

Recent figures released by the Bureau of Crime Statistics and Research (BOSCAR) indicate that in NSW the total number of indigenous persons in custody as a percentage of total inmates sits consistently at around 26%, reflecting ongoing over-representation by a factor of 9 - 10. This remains the case even after a significant overall reduction of the number of people in custody during the COVID-19 period. During the inquest, the court was advised that the indigenous population at Tamworth Correctional Centre, where Tane was housed, was higher than 50 % both at the time of his death and currently.

The over-representation of Aboriginal and Torres Strait Islander people is hardly a recently discovered phenomenon. Its continued existence was accurately described in one submission to the recent Australian Law Reform Commission's Inquiry into the incarceration rate of Aboriginal and Torres Strait Islander people as a "national disgrace".

Tragically this is not the first inquest into the death of an Aboriginal man in custody that I have been called upon to preside over this year. During the *Inquest into the death of Jonathon Hogan,* I noted that as far back as 1991, the RCIADIC found that indigenous people were grossly over-represented in custody. Further, the Commissioners noted that this over-representation in both police and prison custody "provides the immediate explanation for the disturbing number of Aboriginal deaths in custody." In other words, until we do something about over-representation, we will certainly continue to record a disproportionate level of indigenous deaths in custody.

During the *Inquest into the death of Jonathon Hogan*, I noted that almost 30 years after the RCIADIC, we have failed to appropriately reduce the grossly disproportionate incarceration of indigenous people or to properly grapple with the underlying factors.

The RCIADIC identified indicators of disadvantage that contribute to disproportionate incarceration including: "the economic position of Aboriginal people, the health situation, their housing requirements, their access or non-access to an economic base including land and employment, their situation in relation to education; the part played by alcohol and other drugs - and its effects".

The Commission also identified dispossession without the benefit of treaty, agreement or compensation as a factor in over-representation in custody. Decades later, these factors remain at the forefront of our failure to reduce incarceration rates. Despite attempts to "Close the Gap", disadvantage abounds and successive governments have been unable to squarely face the effects of dispossession and move forward with 'truth telling' and with agreement with Aboriginal and Torres Strait Islander peoples.

Once again it is incumbent upon me to stress that if we are to reduce the number of Aboriginal deaths in custody we need to grapple with the underlying causes of over-representation. Quite simply, more young Aboriginal men like Tane must be diverted away from the criminal justice system if we are to reduce the number of Aboriginal deaths in custody nationally. Tane entered the system as a juvenile, and was first detained as a child around 14 years of age. At the time of his death he was only 22 years of age. He was on remand and had already spent a significant portion of his adult life in custody.

These factors form the relevant background to my specific inquiries. They are worthy of careful consideration and acknowledgement. Tane's death must be understood in its context of real social injustice, ongoing dispossession and his lived experience of inter-generational trauma.

This inquest occurred at a time when many Australians are calling for change. It raised issues well beyond my statutory task as a coroner and it may be that Tane's family are ultimately disappointed that some of the recommendations they called for, such as reform of the Bail Act, are beyond my powers in the context of this inquest. I have no doubt they will continue to work for change in other forums.

Listening to the family's expression of love and grief for Tane, I was reminded of a passage from the Uluru Statement from the Heart, quoted by State Coroner O'Sullivan in her findings in the *Inquest into the death of Eric Whittaker* earlier this year. It reads:

"Proportionally, we are the most incarcerated people on the planet. We are not innately criminal people. Our children are aliened from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.

These dimensions of our crisis tell plainly the structural nature of our problem. *This is the torment of our powerlessness."*

Tane's mother echoed this sentiment during the family statements when she told me directly that Tane was killed by the prison system. I acknowledge the truth and pain of her words.

The role of the coroner and the scope of the inquest

The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death. A coroner may also make recommendations, arising directly from the evidence, in relation to matters that have the capacity to improve public health and safety in the future. In this case there was no dispute in relation to identity of the deceased or to the date or place of death. However, the manner and circumstances of Tane's death required significant investigation.

It is clear that nobody, either within the custodial or medical system or from within Tane's family, foresaw the tragedy that occurred. Trying to understand what happened, even when it seems inexplicable, is a crucial part of preventing future death.

When a person dies in custody it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is detained in custody in NSW the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice or have their families directly assist them in this task, it is especially important that the care they are offered is of an appropriate standard and is culturally appropriate. The living conditions of inmates are similarly restricted. Correctional officers and medical staff are called upon to manage a range of inmates, taking into account their often disparate medical needs and other requirements. Considerations relating to medical care and cell placement are important and can have significant impact on an inmate's state of mind and physical well-being.

Tane had been in custody since 30 July 2015. He entered custody with a clear risk of self-harm. He was a young indigenous man who had recently been admitted to Armidale Hospital after self-harming with a razor. His initial screening indicated significant levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder. He expressed feeling a lack of family support and was known to have recently experienced suicidal ideation. He informed medical staff that he had "multiple attempts at hanging himself" and "a constant feeling of being lost." He was withdrawing from ice.

Over the next two years in custody, Tane did not receive sustained psychological care or support; drug and alcohol treatment; or meaningful assistance to strengthen his troubled relationships in the community, despite his disclosure of past abuse, his fear that his child could be removed and his request to speak with his father who was also incarcerated. Tane continued to return positive drug tests and advised the Justice Health & Forensic Mental Health Network ("JH") that he had been using "dirty fits" for months. His disciplinary record suggests that he remained unsettled on remand. His contact with any Aboriginal Support worker was minimal; the last face to face contact appears to have been in relation to his grandmother's funeral in August 2016.

This is the brief background to the despair he appears to have felt in the lead up to the medical emergency that developed in September 2017.

The pain, shock and disbelief felt by Tane's family, following his death, is profound and ongoing. His story will affect the lives of his child and his community well into the future.

Each successive indigenous death in custody shapes the story younger prisoners learn when they too are incarcerated. Tragically, the utter despair felt by Tane is most likely to have been transitory, but he was alone at this time of great need and for that I am deeply sorry. He too had heard the stories of hangings in custody and he had no reason to trust or reach out to those who were tasked to care for him.

It was clear to me that Tane's family loved him greatly and that he is missed every day. I understand that the family's participation in this inquest came with enormous pain. I acknowledge their dignity, strength and generosity in participating in these proceedings.

The evidence

The court took evidence over five hearing days. The court also received extensive documentary material, comprising six volumes. This material included witness statements, medical and custodial records, investigation reports, CCTV recordings and photographs. The court heard oral evidence from Tane's treating doctor at Tamworth Hospital, the JH Nurse Unit Manager at Tamworth CC and from involved correctional staff. The court heard from an independent neurologist, Dr Simon, who reviewed Tane's neurological care and from an independent forensic pathologist, Professor Cordner, who was present during the post mortem examination by Dr Cala. The court was also assisted by the expert evidence of Professor Matthew Large, a psychiatrist with extensive expertise in suicide, who undertook an independent review of Tane's mental health care and treatment in custody.

While I do not intend to refer specifically to all the available material in detail in these findings, it has been comprehensively reviewed and assessed.

A list of issues was prepared before the proceedings commenced. These questions directed the focus of the evidence presented in court. However, as is often the case, a hearing tends to crystallise the issues which are really at stake. For this reason, after dealing with the chronological facts, I intend to distil my reasons under a small number of broad headings.

The focus of the inquest ultimately centred on systemic challenges, rather than judging the conduct of specific individuals involved in the provision of health or custodial services. In final submissions, JH quite properly acknowledged that Tane did not receive the care that he deserved on the morning of 20 September 2020 when he was returned from Tamworth Hospital. Specifically, JH recognised that it should have recommended to CSNSW that Tane be placed in a two-out cell. This acknowledgement was in my view much more profound than any criticism of the individual decisions of particular practitioners.

Chronology

Personal Background

Tane was one of a large family and grew up in the Armidale area. He was close to his family who remained in close contact even during his incarceration. Tane had a partner, Merinda and a young son. Tane inspired great loyalty from his friends. The court heard from his co-accused who described him as like a younger brother.

A letter from another friend found in Tane's cell after his death expressed great devotion.

While Tane had some employment in the community, from his teenage years Tane also struggled with a reliance on illicit drugs, including ice. This is likely to have been the immediate trigger for his entry into the custodial system. From 2012, Tane spent various periods in juvenile detention. Records indicate that he already had a significant drug problem and had experienced symptoms of depression and anxiety. In 2012 and 2013, Tane had investigations on his brain due to findings of abnormalities in the form of a right basal ganglia cystic structure. These investigations did not result in any relevant diagnosis. Both Dr Simon, neurologist and Dr Cala, forensic pathologist were aware of this finding but expressed the view that it was unlikely to have played a role in Tane's death.

On his first entry into adult custody in July 2015 Tane was initially placed in an assessment cell which allowed for frequent observations. He was later allowed to be housed "two out". Tane was released on 20 August 2015.

After about six weeks in the community Tane was taken back into custody on 13 October 2015, where he remained until his death. The day after his entry back into custody, he was cleared for 'normal cell placement.' He was subsequently reviewed on 15 November 2016 and on 29 August 2017 and on each occasion considered suitable for 'normal cell placement.' This meant that although Tane was usually placed in a cell with another inmate, he could also be left alone.

Records indicate that Tane had some interactions with JH during 2017 in relation to dental issues. However, there is no record that he had any sustained contact with psychological or cultural support workers during his incarceration. It appears that any support he had was provided by his fellow inmates. Custodial staff described him as a "popular inmate." His cellmate on the night before his death described him as caring and helpful.

It is difficult to establish Tane's state of mind during the period leading up to his death. He is reported to have been genuinely excited about the prospect of his impending release. According to his co-accused and others, Tane clearly believed that he would be back in the community very soon. However, the court has also had the opportunity to listen to a number of telephone calls between Tane and his partner which indicate that he found the ongoing separation difficult and experienced feelings of jealousy, frustration and loneliness. An unsent letter addressed to Merinda, found after his death, suggests that the relationship could be volatile and that like many prisoners Tane found it extremely difficult to process his feelings of separation and loss. It is likely he held fears about how his relationship would survive on his release and he mourned the time he had already lost with his son.

Tane would always have had a place to return to. He was close to a number of his siblings and spoke to at least one of his sisters regularly. A number of family members attended Armidale District Court to support him during his trial. They provided him with new clothes and were excited at the prospect of him coming home.

It is clear that when his family saw him at court on 19 September 2017, they could not have foreseen what would soon occur.

Events leading up to Tane's removal from Tamworth CC on the evening of 19 September 2017

Over the years Tane spent time at a number of correctional centres. He was moved to Tamworth Correctional Centre at the end of August 2017 so that he could attend his trial at Armidale District Court.

On 2 September 2017, Tane was visited by his mother, brother and sisters. On the same day he was also found with drugs and was disciplined for having provided drugs to another inmate.

On 4 September 2017, Darren Cutmore, Tane's co-accused was moved into cell 30 with Tane. It is notable that in a number of days that followed, and during Tane's trial, Tane was regularly seen in the JH clinic. This was likely due to his ongoing dental issues. In any case, he did not raise any concerns about his mental health.

On 15, 16 and 17 September 2017, Tane made a number of calls to his partner and some friends. He tested positive for drugs on 17 September 2017 and it was on this day he made his last telephone call, which was to his partner. He was agitated and insecure. It is not clear to what extent he was affected by drugs at the time. Some of his calls during this period appear consistent with him trying to arrange drugs in prison.

On 19 September 2017, Tane attended Armidale District Court. Darren Cutmore says he gave evidence in support of Tane at the trial. There is evidence from a CSNSW officer present at court that the judge made a brief comment about the two co-accused inmates being housed together. There is no transcript of this, but it is clear that the officer contacted the manager of security who then informed the Centre and immediate arrangements were made for the inmates to be housed separately.

In the late afternoon Tane returned from court. Correctional Officer Porter who was involved with his escort reported that Tane was in "good spirits and happy with the progress of his trial." This is confirmed by Darren Cutmore who told the court Tane "was happy, he was as happy as he could be because he was beating his – like his court matter".

Tane's mood changed on return to the Tamworth Correctional Centre when he was informed that he and Darren Cutmore were to be separated. Darren Cutmore explained to the court that this distressed Tane and he became "very upset." Mr Cutmore told the court that it had been a stressful time for them both, given that their trial was in progress and this separation was unexpected. Mr Cutmore told the court that when officers informed Tane he would be separated from Mr Cutmore, Tane stated "All we've got is each other and they want to fucking take that away from us too."

There is no evidence to suggest that this decision was ever explained clearly to Tane. It is likely to have been experienced as an arbitrary and possibly punitive action. It is likely to have caused him significant distress.

Following the separation, Mr Cutmore was moved out of the shared cell and into cell 21. A new inmate, Barry Evans, was placed with Tane. Barry Evans gave evidence before this court. He explained that it was his first ever night in custody and he was extremely frightened and ill at ease.

He was struggling with his new surroundings and his head "was all over the place." Nevertheless he remembered Tane tried to "settle him down" and make him feel less uncomfortable and afraid.

At 10.12pm Tane 'knocked up' from cell 30. Mr Evans was lying on the top bunk at the time and he remembered Tane explaining the 'knock up' process and then speaking with an officer through the intercom. Mr Evans remembers Tane requesting Panadol. Mr Evans explained that his exact memory of these events was not strong as he was "in another world", only just coping with his first experience of custody. He did remember that Tane was upset and angry at being separated from Darren Cutmore. He appeared anxious, jittery, and worried. Mr Evans also said that Tane told him that he suffered from epilepsy. Officer Meznaric gave evidence that he attended the cell with other officers and spoke with Tane at this time. The officer stated that Tane told them he felt unwell. Officer Meznaric told the court that Tane said "he was feeling unwell, he knew when he got this feeling that he, and he was on his way to having a fit. That's pretty much it." The officer stated that Tane was given the opportunity to move to a safe cell. According to Officer Meznaric, Tane told the officers in clear terms that he did not want to go to a safe cell. Officer Meznaric told the court that he felt confident with the decision.

He said that as an officer he had come across "a lot of different inmates…a lot them tend to have fits…and most of them will be able to tell you straight away whether they're going to have one or not." He said he had known Tane for quite a while at that time and he felt somewhat reassured by the fact that Mr Evans could knock up if anything happened. Officer Meznaric confirmed the well-known fact that 'safe cells' with their constant bright light and ongoing surveillance are regarded as a place of last resort by inmates. To my mind it is not surprising that Tane was content to stay where he was at that time.

According to Mr Evans, Tane remained agitated in his cell. Mr Evans did not see Tane use any drugs that night; however he saw Tane doing something at the peephole in the door of the cell. At the time Mr Evans did not understand exactly what was going on, but later learned that Tane had engaged in 'fishing' from his cell peep hole. Darren Cutmore explained that fishing for drugs or other small items like lighters or food or implements for using drugs is commonplace in custody. It involves throwing a line or string, usually torn from a blanket, out of one cell so that it crosses with a line thrown from another cell. Darren Cutmore explained "we send lines out to each other and catch the line so we can pass stuff between cells…it's kind of a skill you acquire and eventually you get good at it." However, he could not remember having done it that night, and more specifically he could not remember having used drugs that night.

The CCTV tendered in these proceedings showed activity in the nature of 'fishing' from Tane's cell, between 10.27 – 10.41pm that night. It is not known what Tane was fishing for or whether he was successful. Mr Evans cannot shed any real light on what was going on in this regard or further explain his fishing attempts. However, it appears Tane was overwhelmed by anxiety and was likely affected, to some extent, by withdrawal from recent drug use. It is possible that Tane used drugs again on the night of 19 September 2017 but it seems unlikely. There were no discernible signs of recent drug use when Tane was admitted to Tamworth Hospital later that night and he told the attending doctor that he had not used for a few days.

He had no reason to lie. While some drug paraphernalia was found in Tane's cell the following morning by officers, unfortunately these items were never seized and the opportunity to inspect or test these items was lost. It is not known when they were last used or what traces they may have contained.

During the evening of 19 September 2020, Tane's condition worsened. Mr Evans told the court "Tane did mention that he suffered from epilepsy and suffered from fits, and I was like "oh yeah, rightio", and all I could think of was like, like geez man, don't do it now, eh. Don't do it while I'm here, eh. I can't handle this. Like I was, I was a mess myself, you know. And the more it progressed the more agitated he got, the more unsettled he got…and he was just standing there and next minute he hit the floor…you know that's not normal. And then just little, just like in a shake…he was having a fit of some sort."

Mr Evans, who had some first aid experience as an auxiliary fire fighter jumped down from his bunk bed and placed Tane in a recovery position. Records show that at 11.04pm Barry Evans knocked up from the cell, calling for help. Officer Meznaric and other officers attended the cell. CCTV footage shows them entering the cell and taking Tane out into the corridor. Officer Meznaric also gave evidence that he saw Tane have another fit. "He was fairly rigid and just convulsing". Officer Meznaric told the court he walked around Tane who was on the floor and tried to make sure he did not hit his head on any of the hard surfaces. Officer Meznaric was in no doubt that Tane was having a genuine seizure. He said that after the seizure Tane took a while to "get his bearings." He described Tane as disorientated as he went down the stairs and that he "still sort of hadn't come fully to himself."

Officer Meznaric was involved in taking Tane to the JH Clinic within Tamworth CC to wait for the paramedics. He and another officer witnessed a further seizure while Tane was lying on the bed. He also notified the JH after Hours Nurse Unit Manager, in Sydney about what had occurred. In my view the evidence clearly establishes that Tane had a seizure or series of short seizures of some kind. Dr Simon, an experienced neurologist and Professor Large, a psychiatrist with Emergency Department experience, both viewed the CCTV footage of Tane leaving Tamworth Correctional Centre. Both expert witnesses confirmed that his appearance as dazed and needing assistance to walk was consistent with post-ictal confusion.

Tane was taken to the hospital by ambulance. An enrolled nurse recorded that "patient had seizure when NSW Ambulance Officers and myself went to place patient onto ward trolley". The ambulance records and Emergency Department records state that Tane informed medical professionals (paramedics, nurses and the doctor) that he had epilepsy and was not compliant with medication. More specifically he told the treating doctor that he had a previous seizure at 17 years of age and another nine months ago. Despite requesting Tane's known medical records both from custody and from community sources, the court has seen no evidence of a past record of epilepsy or the prescription of epilepsy medication and no family member appeared aware of any formal diagnosis.

The Court heard from Dr Raj who was the resident medical officer who examined and assessed Tane after his initial triage at Tamworth Hospital. He told the court that Tane was initially monitored in the usual way and that his heart rate, blood pressure and oxygen saturation levels were all normal. The doctor then conducted a specific neurological examination. His records document a systematic approach of assessing Tane's cranial nerves, limbs, reflexes, sensation and coordination as well as observing his mobility.

Dr Raj came to the conclusion that it was "unlikely" Tane had suffered epileptic seizures but further investigation was required. He later recorded on the discharge summary that an EEG should be obtained. He explained his impression to the court: "Essentially on the episodes described to us it was unclear whether they were epileptic seizures.

There are lots of different types of seizures that can be caused from various different things, one of which is epilepsy. But to actually diagnose epilepsy there are particular criteria. They need to be mapped and often the diagnosis is made by a neurologist."

The records show that Tane was kept overnight and observed. It is likely that in addition to suffering from a cluster of seizures, Tane also used the opportunity to seek calming drugs while at Tamworth Hospital. It seems medical staff had suspicions that Tane engaged in "drug seeking behaviour". Tane reported that he suffered unexplained "10 out of 10 pain all over his body" but was described as clutching at his body and complaining of pain only when medical staff were present. Officer Gebadi noticed that Tane was agitated and requested "stronger medication", but that medical staff could see no clinical reason for it. Records indicate that Tane had two doses of paracetamol, two doses of ibuprofen and one dose of oxycodone during his admission.

Hospital Emergency Departments can be uncomfortable surroundings and Tane is likely to have felt tired and anxious. In my view, it is possible that Tane, who was known to have substance use issues, may have used the opportunity to attempt to access opiates. However, whether or not he engaged in drug seeking behaviour while at the Emergency Department does not change my firm view that he had experienced troubling seizures that evening. The evidence given by Dr Raj was considered and clear. Both Dr Simon and Dr Large regarded his assessment as appropriate in the context of a regional Emergency Department.

Dr Simon explained that it would be most unusual to prescribe anti-epileptic medication in the circumstances described and that Dr Raj was correct to advise specialist advice was warranted and an EEG should be obtained. I accept his view. Unfortunately, a discharge summary was not provided to the correctional officers on discharge. Dr Raj explained that an Emergency Department in a regional hospital can be very busy and there will be times where a discharge summary is not readily available at the time a patient is discharged. In this case it was completed shortly after discharge. The time stamp on the discharge summary is 8.19am. The information it contained was important and if it had been available it is likely to have affected later decisions about cell placement. The provision of a discharge summary takes on particular significance when the patient is a prisoner who has little or no control over his movements or ongoing access to supervision or medical treatment.

Tane was discharged and escorted back to Tamworth CC between 7.45am and 8am. The officers involved in his escort stated that he did not display any major signs of emotional distress. Officer Gebadi thought he was "still a bit agitated", but he was certainly cooperative. Officer Fittler explained that he was not agitated, but he was not entirely happy and was still complaining of body aches and pains. Officer Fittler told the court that while at hospital Tane mentioned that he was due to attend court that day and "was actually quite keen and enthusiastic to get back out and spend time with his partner and son."

On return to Tamworth Correctional Centre it is evident from the CCTV footage that Tane could walk unaided and was no longer obviously confused. It is difficult to assess the extent to which Tane remained in any post-ictal state. The expert evidence is that this is possible. Professor Large gave evidence that any signs of such disturbance at this time would be subtle, and likely not readily apparent to others. Before Officer Fittler escorted Tane back to his cell, he was taken to the JH clinic and seen for a brief period by the Nurse Unit Manager Janeen Adams. The CCTV footage demonstrates that this consultation must have only taken a matter of minutes.

Ms Adams explained to the court that the JH clinic provides primary health care, mental health, drug and alcohol and sexual health services. The clinic is staffed between 8am and 8.30pm on weekdays and on weekends from 9.30am to 6pm. At other hours, Corrective Services Staff can contact an after-hours Nurse Manager for advice or call Triple 000 in an emergency.

Ms Adams arrived at prison at around 7.30am on the morning of 20 September 2017 to attend to an insulin dependent diabetic inmate who required medication. She stated that it was around 8am that she first became aware of Tane. She said that Officer Fittler advised her that he was returning the patient, post discharge, from the Tamworth Hospital. She requested the discharge summary and Officer Fittler advised her that he did not have it. She said that she asked the inmate his name and went into the medical records room to retrieve his file. She told the court she looked at his current Health Problem Notification Form (HPNF). She states that she saw the HPNF dated 29 August 2020 and it was "normal cell placement." She claimed to have "flipped over to the progress notes…to see if there was a nurse entry in regard to the transfer across to hospital, which there was none."

It should be noted that according to JH policy a new HPNF form should be completed by the relevant Nurse Unit Manager whenever an inmate's clinical situation changes. Ms Adams outlined the conversation she had with Officer Fittler and with Tane himself. She told the court that Officer Fittler informed her that Tane "had some Endone which calmed him down and he was okay and he needed one of those tests on his – not his heart but his head which I added an EEG and he said, "Yes that's it"".

She did not recall Officer Fittler mentioning that Tane had suffered seizures the previous night.

She considered that the fact that Tane had been given Endone and that he required an EEG was "conflicting clinical information." Despite this apparently conflicting clinical information, Ms Adams did not make any further inquiries of Tane. Ms Adams recounted the conversation between herself and her patient. She "asked Mr Chatfield how he felt now and he said "okay" and then I asked him did he have any other issues and he said "No Miss". She told him to "knock up" if he felt unwell. This appears to have been the extent of her interaction with Tane himself. In my view this was inadequate. The failure to make inquiries about the reason for Tane's admission to hospital demonstrates a lack of clinical care and a failure to establish a rapport with the patient.

Correctional officers rely on JH to obtain the necessary information and make clinical judgments in order to inform cell placement decisions. More was required of Ms Adams in the circumstances. Ms Adams told the court that she advised Tane that she would need a discharge summary. She stated that "based on the visual observations of Mr Chatfield at the time, he was alert, he answered questions appropriately, and he appeared well, and based on the fact that the patient was been medically cleared for discharge from the hospital back to the community setting, I recommended that the patient be 'sick in cell' to rest until such time as we could get him back over to the clinic to review him."

I have considered Ms Adams's evidence carefully and find it difficult to accept. While Officer Fittler initially gave evidence that he gave Ms Adams a handover which included a reference to seizures, he was later unable be "100% certain". Officer Fittler's almost contemporaneous record notes Tane's condition as "multiple seizures" and there was an exchange in the conversation about the need for an EEG.

In my view it seems most unlikely that Officer Fittler would have failed to convey the fact that Tane had suffered from seizures to the Nurse Unit Manager, especially in the absence of a discharge summary. The interaction she describes is in my view inherently implausible.

I am not in a position to make a definitive finding as to whether or not Ms Adams was aware of the seizures at the relevant time. However, it is clear that whether or not she actually knew, she *should* have known. Ms Adams had a number of options available to her at the time. She could have called the Hospital while Tane was in the clinic. She could have made inquiries with the JH After hour's service to find out what had happened the previous evening. She could have questioned the custodial officer who had been at the Hospital for further information or she could simply have asked Tane himself.

Ms Adams was also taken to a document entitled "State-wide After Hours report of 19 September 2017." This document was emailed to the clinic on the morning of 20 September 2017, in accordance with the regular daily routine. It is not known when the document was created but the final entry on the list is reported to be at 8am. The CCTV footage shows us that by 8.01am Tane had already been taken to his cell.

This document contains a brief summary of various interventions or notifications made to the JH after Hours Nurse Manager overnight. On 20 September 2017, it reports that a patient was transferred overnight to Tamworth Hospital by CC staff. The patient is recorded to have had a history of seizures. Ms Adams stated that she did not see the document until after Tane was taken back to Hospital later that morning in a critical condition. Nevertheless, she could have checked or called for if she had wanted further information. Ms Adams told the court that she handed over responsibility for Tane's care to the other nurse, Ms Veech at around 8am.

She informed Ms Veech that Tane should be the first patient to be seen that day. Ms Adams told the court that Ms Veech contacted Tamworth Hospital Emergency Department and requested a copy of the discharge summary. Unfortunately the court could not hear from this nurse, who no longer works for JH. The discharge summary arrived at 8.20. It is not known whether Ms Veech read it, but Ms Adams said she did not see the document or discuss it with Ms Veech.

Officer Fittler was informed by Nurse Adams that Tane was to be 'sick in cell' and remain in the cell until receipt of the discharge summary. At this point he understood the plan by Ms Adams was to have Tane returned to the clinic for a compete assessment at that later point.

Ms Adams did not complete a nursing certificate for her recommendation for 'sick in cell'. It appears that the policy at the time did not require it. Fortunately this policy has been reviewed since Tane's death and CSNSW now require a medical or nursing certificate for someone to be placed "sick in cell." The completion of a nursing certificate, or a revised recommendation to CSNSW on cell placement and inmate care, was necessary. It was necessary in order for Tane to be clearly made aware of his placement situation (other than him simply being told once that he was 'sick in cell') and even more important that the officers were aware of his situation. CSNSW rely on the medical expertise of JH in order to properly make decisions about cell placement.

The court heard from Officer McPherson, who was rostered as the manager of security at Tamworth Correctional Centre on 20 September 2017. Officer McPherson spoke briefly to Ms Adams about Tane.

He told the court that Ms Adams did not inform him that Tane was "sick in cell", but just that he should stay locked in his cell until she had seen the discharge summary. Nurse Adams says that Officer McPherson asked whether Tane was "ok to be by himself'. Officer McPherson indicated that he thought it would be "like a period of an hour at the most for him to remain in cell, maybe two." He was not concerned about Tane being left alone as he knew that he had been examined by the Nurse Unit Manager. Officer McPherson was not informed, and did not ask, about the reasons Tane should remain in his cell, other than waiting for the discharge certificate.

At around 8.16am when various officers arrived on the landing for morning "Let Go" Tane was back in his cell. Darren Cutmore told the court that he saw Tane very briefly at this time and that Tane looked "upset" but they did not have the opportunity to talk. At 8.17am Officer McPherson attended cell 30 and opened the door. Tane was visible from the CCTV and there was no one else in the cell. Tane was told he would remain in the cell until the discharge summary was obtained. Barry Evans was allowed into the cell to retrieve his belongings. He said that he did not have much opportunity to speak with Tane. He said there was no one else in the cell.

Tane was angry about remaining in his cell. Darren Cutmore told the court he heard Tane say words to the effect of "Why the fuck ain't I getting out?" and that his question was ignored by the officers present. According to Darren Cutmore, Officer McPherson just ignored Tane's calls. He characterised the behaviour as "outright rude", but typical of the way officers dealt with Aboriginal prisoners at Tamworth. Officer McPherson told the court that he explained to Tane that he would have to stay in his cell until the discharge paperwork arrived from the hospital. He reported that Tane "tried on multiple occasions to change my mind, but he could not remember the exact words." He described Tane's demeanour as "mildly elevated" or "upset." Officer McPherson told the court that Tane wanted a shower. This was refused because "the nurse had asked me to leave him locked in until she had the discharge paperwork."

Barry Evans was with other inmates down in the yard when he heard Tane yelling. He gave evidence that he heard Tane swearing and angrily yelling to be let out. It is certainly clear that Tane wanted to have a shower. He expressed this to Officer McPherson. It is likely that he continued to yell out the cell window towards the exercise yard shortly afterwards. On reflection, it would have been both preferable and possible to allow an inmate such as Tane to have a shower, in circumstances where he had just returned from hospital.

Tane is discovered by the sweeper in his cell on 20 September 2017

Tane was in the cell by himself from 8.17 until 9.05am. There was continual CCTV footage of the cell door during this period and no person entered or exited the cell. During this time one can see an inmate, Brendan O'Leary, who had the job of prison sweeper, cleaning in the corridor between the rows of cells.

Brendan O'Leary told the court that he was asked by Darren Cutmore to speak to Tane through the peephole and ask him to pack Darren's stuff, given that they had now been separated. Mr O'Leary looked into the cell. He saw Tane hanging at the back of the cell, and immediately ran for help.

A number of officers attended the cell very quickly. The first was Officer Russell Smith. Officer Smith gave lengthy and considered evidence. His account was unchallenged. He said that he saw Tane hanging from the plumbing pipe. He was hanging by a torn prison blanket. Tane was not moving and he cut him down. An ambulance was called and there were extended attempts at resuscitation by correctional officers and JH staff until the paramedics arrived. There is nothing to suggest that the attempts to revive Tane were inappropriate or inefficient.

It is not clear from the photographs or oral evidence exactly how Tane's blanket was tied. However, this lack of clarity does not negate the overwhelming evidence that Tane was responsible himself for the act. The CCTV footage makes it clear that no one else entered the cell at the relevant time. Following these events, Tane was taken to Tamworth Hospital and admitted to ICU. Members of his family attended. Tragically he could not be revived. At 4.33pm on 22 September 2017, Tane was pronounced brain dead.

Findings at Autopsy

An autopsy was conducted by Dr Allan Cala on 28 September 2017 at the Department of Forensic Medicine, Newcastle. Also in attendance was Professor Cordner, an eminent forensic pathologist from Victoria who had been briefed to make an independent observation on behalf of the family.

Dr Cala recorded the direct cause of death as hypoxic ischaemic encephalopathy, caused by hanging. He noted that there was a ligature mark around the front and sides of Tane's neck. He identified a fracture of the left side of the hyoid bone which was associated with a very small amount of haemorrhage. He noted that this injury is commonly seen in self-suspension cases. Dr Cala indicated that he found no evidence of facial assault or head injury. He detected a small 8 mm pineal cyst, but thought it had no significance to the cause of death. There were no findings which indicated a focus for seizure disorder and toxicological testing showed only paracetamol and ibuprofen at low levels. Dr Cala wrote "it is my view that the death of this man did not occur as a result of foul play."

Professor Cordner was in agreement with Dr Cala in relation to the cause of death. However he noted that the existence pineal cysts can be associated with neurological problems, including seizures. He agreed that there was nothing to suggest the involvement of any other person in the immediate circumstances surrounding Tane's death. In particular there was nothing to specifically suggest that he had been assaulted around the time he was found in his cell. Professor Cordner had the opportunity to view photographs of Tane taken by family members at Tamworth Hospital and this did not change his view. He was aware of various small abrasions, some of which he thought referable to the processes of resuscitation and intubation.

Given the specific concerns raised by Tane's family prior to the hearing, Professor Cordner carefully and thoughtfully considered the possibility that Tane could have been assaulted or even murdered. He found no evidence at the autopsy to support this hypothesis. I accept his view.

Neurological Review after death

The evidence at autopsy revealed that Tane's death was caused by neck compression subsequent to hanging.

The court was concerned to discover whether the seizures Tane suffered in the evening before could have affected his cognitive function or altered his mood. This was particularly important given that Tane had recently expressed excitement about his likely impending release.

Advice was sought from an independent consultant neurologist, Dr Neil Simon. He explained that after a neurological event or *ictus*, it is not uncommon to see a collection of symptoms which may include disorientation, agitation, confusion, and some physical symptoms including gait or speech disturbance which are jointly described as indicating a "post ictal state." He viewed the CCTV footage of Tane leaving Tamworth CC on the evening of 19 September 2017 to go to Tamworth Hospital and he recognised physical symptoms which were consistent with a post ictal state.

On all the evidence available to him, Dr Simon expressed the view that Tane had experienced genuine seizure activity and the events of that evening were not feigned or manufactured. He explained that there were several possible causes of the events, including an epileptic seizure (either spontaneous or caused by drug intoxication or withdrawal) or alternatively some kind of *non*-epileptic seizure, which *could* also be related to drug intoxication or withdrawal. He explained that drug withdrawal can also sometimes include symptoms of agitation which might mimic a seizure or that stress can bring about a non-epileptic seizure by a mechanism which is incompletely understood. He doubted the relevance of the pineal cyst which was subsequently identified.

Dr Simon also specifically considered the way in which seizures can potentially contribute to suicidality. He noted that there was no evidence that Tane had developed symptoms of overt psychosis after the seizure. The most relevant possibility was related to the fact that "people with epilepsy may experience prolonged neurological disturbance following a seizure, which may include fatigue, cognitive dysfunction, psychiatric symptoms and focal neurological deficits." In his view it was "a reasonable analysis [in Tane's case] to suggest that post-ictal suicidal thoughts or altered thought processes interacted with significant existing psychological stressors with or without effects from buprenorphine or buprenorphine withdrawal." He was of the view "that this combination may have contributed to Mr Chatfield's suicide."

Psychiatric Review after death

The court was also greatly assisted by the expertise of Professor Matthew Large, a psychiatrist with extensive experience in both emergency departments and acute psychiatric settings. He has particular expertise in the study of suicide.

Professor Large had the opportunity to review Tane's health records and other documents. He observed that Tane's clearest mental health diagnosis appeared to be substance use disorder. He suggested that it is likely that Tane was "craving drugs and possibly that he was experiencing some withdrawal symptoms at the time of his death". He observed that buprenorphine withdrawal can be mild but can also have significant psychological effects. Professor Large also indicated that Tane's state of mind at the time of his death was almost certainly influenced by his long standing personality structure. There is evidence from his telephone calls and his unsent letter to his partner that indicates he was experiencing feelings of loss and separation. He had also been separated from his co-accused.

He was frustrated by being detained in his cell. All of these factors are likely to have combined and affected Tane's mental state. Professor Large was aware that Tane had expressed suicidal thoughts and had self-harmed in the past. He explained that the association between past thoughts and attempts and completed suicide is "weaker than is generally imagined." He explained in evidence that predicting who will commit suicide is extremely difficult and using past behaviour as an indicator of future suicide can be unreliable. Professor Large was aware that Tane had numerous risk factors, but cautioned against believing these operate in a straight forward or cumulative way. He reminded the Court that "the vast majority of people who can be considered to be at high risk of suicide by virtue of having multiple risk factors do not die by suicide, and that lower risk people with fewer risk factors commit about 50% of all suicides.

Professor Large told the court that *mental state*, *availability of lethal methods* and *suggestion* are sometimes considered the three main drivers of suicide. Tane had many significant factors affecting his mental state including "his substance use, interpersonal functioning, reaction to incarceration, separation from family and concerns about his legal situation." The obvious hanging point in his small cell made a lethal method immediately and obviously available.

Professor Large stated that "suggestion" may also have played a role, "because the deceased was aware of the circumstances of an earlier death in custody and had been placed in a two out cell on 28 May 2014 in the context of this bereavement." Death from hanging in a prison cell was something that formed part of his life history.

While some suicides are carefully planned, Professor Large also explained that impulsivity can play a critical role in suicidal behaviour. He referred the court to a study where more than half the subjects had considered suicide behaviours for less than 10 minutes before enacting them. Professor Large's own experience of assessing suicidal people over three decades in emergency departments was consistent with many having had surprisingly short periods of contemplation. This may also have been the case for Tane, whose family and friends were completely blindsided by his actions.

A finding of "intentionally self-inflicted death"

A finding that a death is intentionally self-inflicted should not be made lightly. The evidence must be extremely clear and cogent in relation to intention. Records indicate that Tane had a prior serious self-harm attempt for which he had been treated in Hospital. There is also evidence that he informed CSNSW that he had "multiple attempts at hanging". Nevertheless, given the shock his death caused everyone that knew him, it was necessary to consider very carefully whether any other person could have been involved in his death. Early suspicions raised by the family were seriously considered.

I am satisfied on the basis of the full autopsy conducted by Dr Cala, reviewed by an eminent independent forensic pathologist, Professor Cordner, that Tane's death was not caused by any traumatic injury from a third person.

This finding is consistent with the available CCTV footage. I have had the opportunity to thoroughly review the footage and it shows no person entered Tane's cell at the critical time. I have watched the footage of his arrival back to the Centre and he has no obvious injuries.

I have also reviewed the conduct of the first responding correctional officers, some of whom gave evidence before me. I accept that the correctional officers acted reasonably in the circumstances they faced on 20 September 2017, once they were alerted to the fact that Tane was hanging. No criticism is made of their response, which was administered within the guidelines in place. I am satisfied that Tane's death was not caused by any failure in attempts at resuscitation.

Based on the evidence before me, it is established that Tane crafted a rope from his prison blanket and hanged himself. It appears likely that this was an impulsive act which occurred at a time of great despair. He was alone and faced with an obvious hanging point. As I stated at the outset, this is not the first impulsive indigenous suicide I have been called upon to investigate this year. I remain enormously troubled by the occurrence of these events. Further consultation with Aboriginal health workers is needed to develop culturally appropriate suicide prevention strategies in custody.

The adequacy of CSNSW response to Tane's call for help on 19 September 2017

In my view, the evidence suggests that officers acted appropriately when Tane knocked up on the first occasion. I accept that although he was feeling unwell, he refused to go into an observation cell. In my view, given his classification and his physical state at that point, there was nothing to indicate to the officers that Tane needed to be removed at this time and against his will. When Barry Evans knocked up about 50 minutes later, correctional officers acted swiftly. Tane was removed from the cell and taken by ambulance to Hospital. This was the appropriate action to take following a witnessed seizure.

The adequacy of Tane's treatment at Tamworth Hospital

I have had the opportunity of reviewing the medical records made by Dr Raj on 19 - 20 September 2017 at Tamworth Hospital. They are appropriately comprehensive and indicate that he undertook the appropriate physical checks. Dr Raj gave evidence before me and impressed as a thoughtful practitioner who conducted a comprehensive examination of Tane, in an emergency setting. As set out above, his records have been reviewed by an independent neurologist, Dr Simon, who concurred with his approach.

I have no criticism of Dr Raj or of the clinical treatment Tane received on the evening and early hours of 19-20 September 2017. It is extremely unfortunate that Tane was taken back to custody without a discharge summary. While I accept that resources at regional hospitals can sometimes be stretched, a patient should not leave without a record of the care they have just received. This is even more important when the patient is a prison inmate who has no control over his ongoing health care. It is essential that the information travel with the patient, so that it can be reviewed on his arrival back in custody.

In my view it is appropriate to make a recommendation in this regard.

The adequacy of JH's response on Tane's return from Tamworth Hospital on 20 September 2017

At the conclusion of the proceedings, JH made a proper concession that the Tane did not receive the care that he deserved on the morning of 20 September 2017 when he was returned from Tamworth Hospital. Specifically, JH recognised that it should have recommended to CS NSW that Tane be placed in a two-out cell.

Ms Adams gave evidence that *had* she known of the seizures she would have taken a different approach and likely would have recommended Tane be given a two out placement. I note that she would have placed him two out because of the potential danger of having an unobserved seizure and injuring himself (and not because of any possible post-ictal risk of mood disturbance of which she was completely unaware). Nevertheless, it would have offered him some protection.

In my view Tane should have been placed 'two out' at least until a proper clinical assessment could have occurred. I note that the policy in place at the time of Tane's death listed a number of criteria that may result in an inmate requiring two out placement including: inmates at risk of self-harm; Aboriginal inmates under stress or experiencing distress; and inmates with special needs (including health issues). The current policy is even more specific and lists these three criteria only.

I accept that Dr Simon was of the view that in a community setting it would be appropriate to have discharged Tane, without the need for 24 hour supervision. He told the court that patients are routinely sent home after seizures and do not necessarily require constant supervision. The situation in my view is completely different in a custodial setting where a cell is locked, and there is little chance a seizure would be detected.

As set out in my reasons above, in my view the care Ms Adams provided to Tane was cursory and inadequate. She did not properly turn her mind to his potential risks returning from hospital. It is significant that JH has acknowledged that Tane did not receive the medical care that he should have received in the circumstances. The family have submitted through their legal representative that Ms Adams should be referred pursuant to s 151A (2) of the *Health Practitioner Regulation National Law* (NSW). I note that counsel assisting did not urge this course. I have given the matter considerable thought and careful consideration since the conclusion of evidence, paying particular attention to the interests of Ms Adams, who had the benefit of legal advice but was not represented in these proceedings.

However, I remain troubled that a nurse of her experience appeared to consider the interaction she had with her patient to be sufficient in the circumstances.

While she stated that *had* she known of the seizures she may have taken a different course, she did not appear to understand that she *should* have known. Had this lack of insight been present in a junior nurse, I might take a different view. However, she was the Nurse Unit Manager. She informed the court that she had "many, many years of experience" as an ED nurse. I have come to the conclusion that her conduct should be reviewed by her professional body.

The adequacy of specific support offered to Indigenous inmates

At the time of Tane's death, there were 88 inmates in custody at Tamworth CC, of which 45 were Aboriginal.

The court was informed that the Aboriginal Services and Programs Officer (SAPO) position was in existence at 20 September 2017, however it was vacant.

The gaol also had the assistance of a Regional Aboriginal Programs Officer (RAPO), but that person serviced a number of centres, as did a regional Deputy Manager Inmate Classification & Placement, Aboriginal Programs. Given the proportion of Aboriginal inmates this is of concern.

The Nurse Unit Manager gave evidence that JH had no targeted Aboriginal position at Tamworth CC. However, given the Aboriginal gaol population is more than 50% she agreed that employing an Aboriginal health worker would be beneficial. I am confident that input and involvement from an Aboriginal Mental Health Worker could have been an important component of improved care and support for Tane and his mental state. The provision of culturally appropriate treatment and suicide prevention work must be pursued.

The adequacy of cell architecture at Tamworth CC

The evidence of Professor Large makes it clear how difficult it is to predict who, within a prison population, will attempt suicide. Past behaviour is a less accurate indicator than one might expect. It was Professor Large's view that there was no pressing reason to place Tane in a two-out placement when he returned from Hospital, notwithstanding his past behaviour and recent seizure. However, the cell he was placed in should have been safe, because access to lethal methods can be a driver of suicide.

It follows that if one accepts the difficulties involved in predicting suicide, we must make more effort to make each cell safer by removing obvious hanging points instead of relying on correctional staff to manage risk by placing inmates in safe cells or "two out" placements.

The court was informed that although the cell in which Tane was place has been rectified to some degree, no formal audit of Tamworth Correctional Centre had taken place to provide an overall picture of the outstanding risk. Further, there is no CSNSW current proposal for an overall audit of Tamworth CC because it is an older style facility. Ms Cartright, Acting Manager of Security at Tamworth Correctional Centre, stated that *"it's very challenging for all correctional services to remove all hanging points…we have to prioritise our resources….Tamworth CC is a very old facility, heritage listed built in the 1700s (sic) and there are limitations to what you can do with changing infrastructure in some."* Leaving aside the fact that the centre cannot have been built in the 1700s, this response is in my view entirely inadequate.

The limitation of lethal means is one of the most reliable methods of reducing suicide. Professor Large referred the court to evidence which demonstrates the success of removing hanging points as a method of reducing suicide in inpatient psychiatric settings.

Coroners have been recommending the removal of hanging points for many years. The issue must be taken seriously. Thirty years on from the RCIADC it is unacceptable to suggest it would be expensive or difficult to achieve the elimination of hanging points in a "heritage listed" facility. I intend to have a copy of these findings sent to the NSW Minister with responsibility for Aboriginal Affairs for his information and review.

Outstanding concerns and the need for recommendations

Section 82 of the *Coroners Act* 2009 confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

The evidence arising during this inquest demonstrated a strong need to consider specific recommendations, particularly in relation to the management of Tane's health treatment in custody. The following recommendations I make arise directly out of the evidence before me. I acknowledge the extensive material provided to me by supporters of the Chatfield family much of which also dealt with ideas and recommendations aimed at reducing the rate of incarceration of aboriginal people. The fact that some of those suggestions have not been adopted as recommendations does not mean they have no merit.

It is also necessary to comment, in closing, that by the time I became involved in this investigation, Tane's family remained unaware of many of the important facts about his death. I understand that this lack of information, together with the delay in hearing the inquest has resulted in suspicion and has compounded their grief over Tane's death. The NSW State Coroner is currently consulting with stakeholders in relation to a practice note which will reduce delay and encourage early disclosure in cases of this nature. I am confident that this practice note will improve the coronial process for families like the Chatfield's in this court.

Formal Finding:

Identity

The person who died was Tane Chatfield.

Date of death

He died on 22 September 2017.

Place of death

He died at Tamworth Hospital, Tamworth NSW.

Cause of death

He died as a result of hypoxic ischaemic encephalopathy as a result of hanging.

Manner of death

Tane was alone when he placed a blanket rope around his neck and attached it to a prominent hanging point in his cell. His death was intentionally self-inflicted.

Recommendations pursuant to section 82 *Coroners Act 2009*

For the reasons stated above, I make the following recommendations:

To the Commissioner of Corrective Services

- That CSNSW conduct a comprehensive audit of all cell hanging points at the Tamworth Correctional Centre and undertake urgent removal of any hanging points identified.

- That CSNSW amend policy to notify the next of kin if an inmate is taken to a hospital in a medical emergency, even if that inmate is not ultimately admitted.

- That CSNSW implement a policy whereby prisoners who have been taken to hospital are not returned to prison without a discharge summary.

To the Commissioner of Corrective Services NSW and Justice Health

- That CSNSW, in consultation with Justice Health, adopt a policy whereby any inmate who has been taken to Hospital is placed either two out or in an assessment cell until a comprehensive JH review can take place. In the event that this is not considered suitable or appropriate, any other placement must be documented with reasons recorded.

- That CSNSW and JH actively recruit Aboriginal health workers at Tamworth Correctional Centre. The provision of Aboriginal health workers must include consideration of expanded culturally appropriate Drug and Alcohol and Mental Health Services and workers with expertise in suicide prevention strategies.

To Hunter New England Local Health District (HNELHD)

- That HNELHD provide a copy of a discharge summary to officer escort when a custodial patient is discharged from a HNE health service (including from the Emergency Department).

To the Chief Executive, Nursing and Midwifery Board of Australia

- I recommend that, pursuant to section 151A(2) of the *Health Practitioner Regulation National Law* (NSW) no 86a, the transcript of the evidence of Ms. Adams be forwarded to the Chief Executive, Nursing and Midwifery Board of Australia for consideration of whether the professional conduct of Ms. Adams on 20 September 2017 should be the subject of review.

19. 297414 of 2017

Inquest into the death of LP. Finding delivered by DSC Lee at Lidcombe on the 14 February 2020.

On 26 September 2017 LP was arrested and charged following an episode of interpersonal violence involving his partner, which ultimately resulted in her death. LP was subsequently taken into lawful custody and transferred to a correctional centre.

After an intake assessment identified that LP was at risk of self-harm attempts were made to assess LP on 28 September 2017 so that appropriate steps could be taken to mitigate this risk. A day later, on the morning of 29 September 2017, LP was found unresponsive in his cell bed after having apparently intentionally ingested foreign material taken from his cell and from the breakfast that he had been provided with a morning. Resuscitation attempts were initiated but were ultimately unsuccessful and LP was tragically pronounced deceased.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately.

In this context it should be recognised at the outset that the operation of the Act and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum.

Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

LP's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge Mrs Bs' life in a brief, but hopefully meaningful, way.

LP was born on 24 August 1983 to his parents, SJ and WP. LP also had a number of half-siblings from his parents' previous relationships, and by all accounts the extended family was very close knit. LP's mother describes him as a very happy and placid baby.

As a child LP loved to be active and frequently took part in soccer, trail bike riding, water skiing, and skateboarding. LP later attended St Clair High School and obtained his Year 10 School Certificate. After leaving school early, LP took on a traineeship with a motorcycle accessories business and enjoyed the work. Following this LP went to work for his uncle installing kitchens and later, building portable building. Following the closure of this business, LP started up his own business in the construction industry.

There is no doubt that LP is greatly missed by his many family members. It is distressing to know that the suddenness and unexpected nature of LP's tragic death, in already stressful circumstances following his arrest, has caused his many loved ones immeasurable grief.

Background to the events of September 2017

Sometime in around 2008 LP met and formed a relationship with DW. Between 2008 and 2011 LP and Ms W three children together, including twins. However this relationship subsequently ended. About 18 months following this LP met BD on a dating website. At the time LP was living in St Clair in Sydney. B and LP formed a relationship soon after meeting online. After about six months B decided to move in with LP at St Clair. Whilst living in Sydney B worked at a laser clinic in Wetherill Park, whilst LP continued to work in the construction industry. After some time LP and B began to experience difficulties within the relationship.

These difficulties led to B leaving the home she shared with LP and periodically staying with LP's mother and sisters. Sometime in 2015 B, LP, and members of LP's family went to Fiji for a holiday.

When they returned, B called her mother and told her that she was pregnant. B's mother noted that B seemed very happy at the time. However, in October 2015 B told her mother that she and LP had separated due to LP's illicit drug use. It appears that around this time LP had developed a dependency on methamphetamine, which resulted in a brief admission to hospital for detoxification. Subsequently, LP's family observed that he was behaving erratically due to his drug use. As a result B moved in with her grandmother at Ettalong. Whilst living there she continued to travel to Sydney for work. A month later in November 2015 B found a place of her own and to rent in Ettalong and moved in there by herself.

On 27 February 2016 B gave birth to her and LP's son at Gosford Hospital. LP was at the birth and they named their son B. After B and B were discharged from hospital after a few days LP returned to Sydney. However, LP returned to Ettalong on 10 July 2016 for B's naming day. At around this time an incident occurred at B's home which involved LP yelling and swearing and B becoming visibly upset.

On 24 August 2016 LP was evicted from his home in St Clair and subsequently moved in with his mother and stepfather. On 23 September 2016 LP, whilst apparently under the influence of illicit drugs, became involved in a violent incident with his stepfather. This resulted in LP being charged. A short time later in December 2016 LP was involved in another violent incident, this time concerning his ex-partner. This also resulted in LP being charged, and subsequently refused bail. He was later released from custody on 24 January 2017 and moved in with his aunt in the St Clair.

According to accounts from LP's family he made some changes in his life after January 2017, by ceasing his illicit drug use and focusing on work. This reportedly led to an overall improvement in his circumstances. During this period of time B travelled to Sydney and stayed at LP's sister's house so that LP could have supervised visits with B. In the same period LP also travelled to the Central Coast so that he could spend the day with B. There were no reported difficulties arising from this contact between B and LP.

Due to LP's past medical history he was referred by his GP to and outpatient mental health facility in September 2017. On assessment LP reported suicidal ideation but denied any suicidal intent and any self-harming behaviour. The psychiatrist who assessed LP formed the opinion that he had major depressive disorder, ongoing alcohol use disorder and psychosocial stressors. It was noted that LP had several historical risk factors for suicide including depression, alcohol use, and past substance use, even though he denied of suicidal intent or plans.

The weekend of 23 and 24 September 2017 and after

LP's sister, M, booked an apartment in the Mantra Hotel in Ettalong over the September school holidays so that she, her children, and her mother could visit B and B. They drove up to the Central Coast on 23 September 2017 and arrived at the hotel in the afternoon, where they met B and B. It appears that B subsequently called LP and invited him to join them. LP subsequently caught a train to the Central Coast where he was picked up by his mother. On the way back to the hotel LP's mother asked how he was feeling. LP told her that he had been feeling a bit depressed but that he had been referred to a psychiatrist and, as a result been feeling better. Upon arriving back at the hotel B, LP and LP's family had dinner together. At about 8:00pm B and LP left the Mantra to go to the nearby Ettalong hotel to watch a football match. After the match finished they returned to the Mantra and were reportedly in good spirits. A short time later B, LP and B left the Mantra and went back to B's house.

The next day, 24 September 2017, B, LP and B returned to the Mantra at about 9:00am. They were again observed to be in good spirits. It appears that they stayed at the Mantra during the morning, and after lunch B took LP to a train station so that he could catch a train back to Sydney.

On 25 September 2017 B went to work at Erina. Later that evening she met up with LP's mother and sister for dinner.

The critical events of 26 September 2017

The next morning on 26 September 2017 LP caught a train from St Marys to Woy Woy. He met up with B and B at a supermarket in Woy Woy. It appears that during the day B and LP argued about their respective locations: B was reluctant to move back to Sydney, whilst LP was equally reluctant to move to the Central Coast as he did not want to move away from his older children who were living in Sydney. At about 2:30pm that afternoon KB arrived at B's house for a beauty treatment. Ms B sensed that there was tension between B and LP and formed the belief that they had been arguing. She noticed that B was not her usual happy self.

At about 7:00pm B and LP put B to bed. Following this B started to wash up the dishes in the kitchen. On LP's version, another argument occurred over B's reluctance to move back to Sydney. At some stage B told LP that she thought he should leave, but LP told her that he was not going anywhere. According to LP, B then walked towards him holding a knife. It should be emphasised that there is no independent evidence to verify LP's version of events, given that he and B were the only two people in the kitchen at the time.

LP asked B what she was going to do with the knife. He then used both hands to grab her around the throat and squeezed until B became unconscious. It is not known how long LP was holding onto B's throat. At 7:10pm LP called Triple Zero from his mobile phone. He told the emergency operator that he needed an ambulance at B's address and said, "*I just killed my girlfriend*". When the emergency operator asked what had happened LP replied, "*She pulled a knife on me and I strangled her*".

The first responding police officers arrived at B's house at 7:15pm. They saw that LP was extremely agitated and upset, and described him as "*ranting and waving his arms around*". The police officers entered the kitchen and saw B lying on the ground, unconscious with red swelling around her face and neck. LP knelt down next to B and said, "*I've killed her, I've killed her*".

One of the police officers checked B and felt a faint pulse. The police officers moved LP away and handcuffed him so that they could attend to B. The police officers immediately commenced cardiopulmonary Resuscitation (**CPR**). NSW Ambulance paramedics arrived on the scene at about 7:27pm.

On examination B was found to be unconscious, not breathing, with nil palpable pulse and in cardiac arrest. Defibrillator pads were applied whilst the police officers continued CPR. The paramedics subsequently established an airway and took over CPR from the police officers. B was cannulated and adrenaline was administered resulting in return of spontaneous circulation.

Following the arrival of another paramedic crew B was placed into an ambulance and taken to hospital as installation continued. On arrival at Gosford Hospital emergency department hospital staff took over airway management and maintained ventilation, while stabilising B.

Once stabilised B was transferred to the intensive care unit for further monitoring and assessment, although her prognosis was poor. Subsequent investigations revealed that B remained unresponsive to external stimuli and that she had suffered an irreversible hypoxic brain injury. Life support measures were withdrawn on 28 September 2017 and B was pronounced life extinct at 5:12pm.

Police investigation concerning LP and subsequent events

LP was later arrested and taken to Gosford police station. He took part in an electronically recorded interview at 1:07am on 27 September 2017. In the interview LP told the police that he and B had an argument after B had been put to bed. LP said that after he told B that he was not going to leave she turned around with a knife in her hand. When asked by the interviewing police officers to describe what occurred next, LP became noticeably upset. However he eventually told police, "*I done it and, argh, I done it…*". When asked to explain what he had done LP said, "*I strangled her*", and indicated that he had placed both of his hands around B's neck. Due to LP's condition a decision was made to not continue with the interview. LP was charged with attempting to strangle B with intent to murder (on the information that was available to police at the time).

LP appeared at Gosford Local Court later on 27 September 2017. He was remanded into the custody of Corrective Services New South Wales, with his next court appearance on 27 October 2017. LP was subsequently transferred from Gosford to the Metropolitan Remand and Reception Centre (**MRRC**) at Silverwater.

Custodial history

On arrival at the MRRC an intake screening assessment for new inmates could not be completed due to LP being in a distressed state and unable to answer questions posed to him by a Corrective Services New South Wales (**CSNSW**) Services and Programs Officer (**SAPO**). However, it was identified that LP may be at risk of self-harm and, accordingly, he was subject to review by a Risk Intervention Team (**RIT**). LP was subsequently housed in an assessment cell within Darcy Block. The cell consists of a clear Perspex door with a steel security bars, is located near the station for Justice Health & Forensic Mental Health Network (**Justice Health**) staff, and is monitored by two CCTV cameras.

At about 8:30pm on 27 September 2017 LP was reviewed by a registered nurse from Justice Health. It was noted that LP was tearful and distressed, and that he had previously head-butted the cell doors. However physical observations of LP were normal, and LP denied any health issues.

From this assessment, a Health Problem Notification Form was completed recommending that LP be housed on his own in a camera cell (a cell monitored by CCTV cameras), for his own safety and the safety of others, until he could be reviewed by a RIT. Further it was recommended that he only be offered limited possessions, including a safety blanket.

What happened on 28 September 2017?

On the morning of 28 September 2017 a RIT consisting of Assistant Superintendent (**AS**) (as he then was) Tibo Semetka, SAPO Deborah Moffit and Registered Nurse (**RN**) Astrid Munoz reviewed LP. LP was taken from his cell to a RIT interview room. When asked whether he knew what he had been charged with, LP covered his face with his hands and began to cry inconsolably.

After some time the RIT members asked if LP was able to continue with his interview. LP only shook his head and continued crying. Accordingly the interview was terminated and LP was placed back in his cell.

The RIT members subsequently agreed that LP remained at high risk and was to stay in his assessment cell. It was noted that a further attempt to interview LP would be made on 30 September 2017.

What happened on 29 September 2017?

At about 6:27am on 29 September 2017 LP was escorted from his cell to the shower room, returning at about 6:44am. Upon his return LP collected his breakfast meal pack, and later ate it while sitting at the end of his cell bed. The meal pack contained cereal, milk, and sweetener packets in a clear plastic wrapper. In the course of eating his breakfast, LP discarded the sweetener packets onto the cell floor.

Between about 9:20am and 9:28am CCTV cameras record LP getting out of his bed, taking toilet paper from his cell toilet and soaking the paper in the toilet bowl. LP also picked up the previously discarded sweetener packets and manipulated them whilst standing in front of the toilet bowl. At about 9:28am LP returned to his bed, holding something in his hand, and lay down covering his head with the blanket. Between about 9:28am and 9:33am the CCTV cameras record LP making minor movements under the blanket. However from about 9:33am onwards no further movement under the blanket is seen.

At about 10:45am one of the investigating police officers in relation to B's death contacted the MRRC in relation to seeking LP's consent to participate in a procedure to obtain a forensic sample from him. At about 10:52am CSNSW officers attended LP's cell with the intention of speaking to him in relation to the enquiry regarding the forensic procedure.

The CSNSW officers knocked on the cell door in an attempt to gain LP's attention. However LP did not respond causing the CSNSW officers to open the cell door and enter the cell. One of the officers saw that LP's foot was protruding from beneath the blanket and touched it in an attempt to rouse him. However LP was unresponsive. One of the officers immediately notified Justice Health staff at the station near LP's cell, seeking medical assistance.

Justice Health staff arrived at the cell at about 10:53am and moved LP from his bed to the cell floor. LP was observed to be not breathing, cyanosed, and to have no detectable pulse. Initial examination revealed foreign material in LP's airway. Three pieces of torn plastic bags and a strip of five connected sweetener sachets from LP's breakfast meal packet were removed from LP's airway. Resuscitation attempts were then initiated using a defibrillator and supplemental oxygen which continued for about 20 minutes. However LP could not be resuscitated and was later pronounced life extinct at 11:11am.

What was the cause and manner of LP's death?

LP was subsequently taken to the Department of Forensic Medicine in Sydney where a post-mortem examination was performed by Dr Jennifer Pokorny, forensic pathologist, on 4 October 2017. Postmortem imaging scans revealed foreign material in the oropharynx extending to the epiglottis. Internal examination confirmed the presence of a large foreign body (measuring 110mm x 50mm x 30mm) occluding the larynx and extending to the level of the epiglottis.

The foreign body was identified as being composed of a number of pieces of compressed toilet paper. In her subsequent autopsy report dated 23 November 2017, Dr Pokorny opined that the cause of LP's death was foreign body aspiration.

The evidence relating to LP's past medical history of suicidal ideation, the events of 26 September 2017 and LP's subsequent arrest, and the circumstances in which LP was found all establish that LP died as a result of actions taken by him with the intention of ending his life. The CCTV footage shows that LP used the toilet paper from his cell and the plastic packaging from his breakfast pack to fashion an object which he later ingested. This had the consequence of occluding LP's airway resulting in his subsequent death.

It should be made clear that although LP's actions were captured by the CCTV cameras in his cell there is no suggestion that any reasonable viewing of the footage should have prompted action prior to the discovery that LP was unresponsive. The footage shows LP returning to his bed, after having soaked the toilet paper in the toilet bowl, and placing the blanket over his head. As a result LP's actions whilst his head was covered were not captured by the CCTV cameras. Even though the CCTV footage shows LP to be motionless a short time later a person viewing the footage might have reasonably believed that LP was simply asleep, rather than unresponsive.

Issues relating to the RIT review on 28 September 2017

During the course of the coronial investigation a number of issues were identified in relation to the circumstances of the RIT review conducted on 28 September 2017. In particular the proximity of the review to LP's death raised questions regarding whether or not an appropriate review was conducted in accordance with relevant policies which applied at the time, and whether appropriate arrangements were made for follow-up review. Further, the unusual circumstances in which LP inflicted his own death raises questions as to whether appropriate measures are in place to mitigate against the risk of another death in similar circumstances. These issues are dealt with individually below.

Timeframe for review of RIT Management Plans

Section 13.3.2 of the CSNSW Operations Procedures Manual (**OPM**) (which was in force at the time of Lance's death) relates to the management of inmates at risk of suicide of self-harm in correctional centres. Relevantly, section 13.3.2.7.5 of the OPM deals with assessment cell placement. It provides:

"*Placing an inmate into an assessment cell is a measure of last resort and should not be common practice. The use of assessment cells must be consistent with the approach of least restrictive care. No inmate is to stay in an assessment cell for more than 48 hours without the written approval of the General Manager.*

When an assessment cell is used the [Immediate Support Plan] must specify the length of time the inmate will stay in the cell before having the plan reviewed (this should be no more than 24 hours unless in exceptional circumstances)".

In this context, an Immediate Support Plan (**ISP**) is "*a plan to manage an inmate immediately after they have been identified as being at risk of suicide or self-harm*", and requires consideration of an inmate's cell placement options, risk of harm to or from others, assessment cell apparel, use of restraints, observations and diversionary activities.

Further, section 13.3.2.15.7 of the OPM relates to RIT Management Plans, which is a plan is designed to consider all options as detailed for an ISP, and include for consideration referrals made for an inmate, transport of an inmate, and an inmate's next RIT review date. Section 13.3.2.15.7 provides the following:

"*RIT Management Plans have a fixed timeframe for review. The review date is determined by the RIT and is dependent on the restrictive nature of the intervention. For inmate placed in an assessment cell, the RIT Management Plan should be reviewed within 24 hours (unless exceptional circumstances exist)*".

As the OPM has now been superseded, the above provisions have been replicated in the current CSNSW Custodial Operations Policy and Procedures (**COPP**) at section 4.3 (in relation to ISP cell placement options) and at section 6.4 (in relation to next review date for RIT Management Plans).

Applying these policy considerations to LP's case, it is evident that following conclusion of the incomplete RIT review on 28 September 2017 LP ought to have been the subject of another RIT review within 24 hours. This is because (in accordance with section 13.3.2.7.5 of the OPM) LP was housed within an assessment cell which mandated a review within 24 hours and also because (in accordance with, section 13.3.2.15.7 of the OPM) LP was subject to a RIT Management Plan. In both cases a review within 24 hours was not required if exceptional circumstances existed.

However, instead LP was next scheduled to be reviewed by a RIT on 30 September 2017, some 48 hours after his initial attempted review. The progress/clinical notes from the RIT review on 28 September 2017 records that LP attended the interview but was too upset to answer any questions. It was noted that he was particularly distressed. The notes then record the following: "*Due to his presentation [patient] will remain on MNF, [review] 30/8/17*".

A RIT Management Plan for LP was completed on 28 September 2017. It was signed by all three members of the RIT. Under a heading relating to "*the current presentation and situation of the inmate*", it was recorded that LP was too distressed to talk. The RIT Management Plan was completed identifying that LP was to remain in an assessment cell. Further, the next RIT Management Plan review date was recorded as being 30 September 2017. This is despite a stipulation contained in the RIT Management Plan noting that: "*A review of the RIT plan should be conducted within 24 hours for all inmates is placed in an Assessment cell*".

In a CSNSW Officer Report form dated 31 October 2017, AS Semetka noted: "*Due to very high volume of inmates assessed to be at risk of self-harm in MRRC and received as fresh custody [sic] RIT is able to review inmates remained [sic] on MNF only once in 48 hours.*

This is the reason why [LP] was to be deferred to 30/09/2017". However, in his statement AS Semetka acknowledged that there is no CSNSW policy which provides for a RIT Management Plan to be reviewed at 48 hour intervals. Similarly SAPO Moffitt said in her statement that she was also not aware of any such policy. She explained: "*I have enquired with several staff at the MRRC and apparently the policy is (I think) a local order for the MRRC*". Further, RN Munoz said in her statement that she also was not aware of any policy of this kind.

Instead, AS Semetka agreed that relevant CSNSW policies require that an inmate must be seen within 24 hours while subject to a RIT Management Plan. However AS Semetka noted: "*Ideally [inmates] should be reviewed every day after that but it is logistically impossible in MRRC due to high number of inmates*".

AS Semetka adhered to this view in his evidence during the inquest. When asked about the operation of section 13.3.2.15.7 of the OPM AS Semetka expressed the view that the 24 hour time frame for review should be complied with "*wherever possible*". He explained that because the MRRC is the busiest correctional centre in New South Wales the volume of new inmates has a direct effect on timeframes for review of RIT Management Plans.

In this context AS Semetka explained that because newly admitted inmates are required to be initially reviewed within 24 hours of admission this has an impact on the ability of a RIT to review existing inmates. Notwithstanding these considerations AS Semetka considered that it would be ideal if inmates subject to a RIT Management Plan were reviewed every 24 hours. In her evidence SAPO Moffitt said that in her experience, whilst performing duties as part of a RIT for five years, the requirement for a maximum of 24 hours between reviews had never been complied with. Instead SAPO Moffitt explained that a 48-hour interval between reviews had become the norm at the MRRC. Notwithstanding, SAPO Moffitt agreed that it would be beneficial to adhere to the current requirements of the COPP which require a maximum 24 hour interval between reviews. RN Munoz similarly agreed that in her experience the 24 hour interval requirement had never been complied with, although she considered that such compliance would be ideal.

In his statement AS Semetka said that he could not recall how many inmates were interviewed by the RIT on 28 September 2017, but estimated that on a daily basis the RIT interviews between 7 to 12 inmates. In her statement, SAPO Moffitt said that the RIT saw 9 inmates on 28 September 2017. However none of the RIT members on 28 September 2017 had a precise recollection of how many inmates were reviewed on a particular day. Notwithstanding both SAPO Moffitt and RN Munoz said in evidence that in their experience it was frequently the case that a RIT was unable to review every inmate scheduled to be reviewed on a particular day.

In evidence, Terry Murrell, the General Manager, State Wide Operations, Custodial Corrections Branch for CSNSW, was asked about the apparent inability of RIT members to comply with the requirements of the former OPM and current COPP in relation to review timeframes.

He explained that he was aware that the situation had existed for a number of years. He also explained that he was not aware of the situation existing in any other correctional centre apart from the MRRC. On this basis Mr Murrell considered the issue of review timeframes to be a local management issue. After agreeing that it would be ideal if the 24 hour interval between reviews could be complied with, Mr Murrell indicated that consideration could be given to varying local operating procedures at the MRRC in order to comply with the provisions of the COPP in this regard.

Conclusions: The decision of the RIT members to schedule the next review of LP's RIT Management Plan on 30 September 2017, 48 hours after his initial attempted review on 28 September 2017, was not in accordance with the relevant provisions of the OPM which operated at the time. These provisions required there to be only a 24 hour interval between reviews because LP was housed in an assessment cell and subject to a RIT Management Plan.

The evidence established that over a period of years it had become accepted practice at the MRRC for the relevant provisions of the OPM in relation to review timeframes to not be complied with. By way of explanation, it appears that the demands placed on a RIT as a result of increasing inmate numbers meant that reviews were occurring every 48 hours, instead of every 24 hours.

It could not be said that exceptional circumstances existed on 28 September 2017 to allow for non-compliance with the relevant provisions of the OPM in relation to review intervals. This is because the evidence established that the number of inmates to be seen by the RIT on that particular day (and the likely number of inmates that were actually reviewed) was not inordinately high but, rather, consistent with typical workload for a RIT. That is, it was common experience for an RIT to be unable to review all the inmate scheduled for review on a particular day. In this sense, and with respect to LP, 20 September 2017 was no different, meaning that exceptional circumstances did not exist.

Whilst the evidence established that in the opinion of the 28 September 2017 RIT members it would have been ideal for LP to have been reviewed within 24 hours, it should be noted that LP was still subject to the highest level of restrictive care that was available. In other words, he was housed in an assessment cell with a Perspex door and subject to CCTV monitoring. It should also be noted that it is not possible to say that if a review had been conducted within 24 hours of 28 September 2017 that this would have materially altered the eventual outcome.

Notwithstanding, having regard to the operation of sections 4.3 and 6.4 of the COPP and that the practice of conducting RIT Management Plan reviews on a 48 hour basis appears to be a practice unique to the MRRC, it would appear desirable for there to be consistent practice adopted across all correctional centres within New South Wales. Therefore, it is necessary to make the following recommendation.

Recommendation 1: I recommend that the Commissioner of Corrective Services New South Wales give consideration to the implementation or variation of relevant Local Operating Procedures at the Metropolitan Remand and Reception Centre to provide that (a) the interval for review of inmates subject to a Risk Intervention Team Management Plan and/or housed in an assessment cell is to be no longer than 24 hours; and (b) where a review of an inmate cannot be completed such a review is to be deferred to the following day, with priority to be given to review of the inmate on that subsequent day.

Outcomes of a RIT assessment interview

Section 5.3 of the COPP deals with the assessment of risk of suicide or self-harm. It identifies two outcomes of a RIT assessment interview: firstly, if an inmate is not considered by the RIT to be at risk of suicide or self-harm and does not require additional management strategies, then no RIT Management Plan is developed; alternatively,

If an inmate is considered by the RIT to be at risk of suicide or self-harm, then a RIT Management Plan should be developed which includes strategies that directly target risk factors while maintaining principles of least restrictive care. Section 13.3.2.15.3 of the OPM is couched in similar terms.

In LP's case it is plainly evident that a complete and proper assessment could not be conducted by the RIT on 28 September 2017 due to LP's level of emotional distress. This means that the RIT was unable to apply either of the two outcomes referred to above, in accordance with the equivalent provisions of the OPM.

Conclusions: Due to LP's emotional state on 26 September 2017 a complete and proper assessment in accordance with section 13.3.2.15.3 of the OPM could not be completed. As the relevant section provided for only two possible outcomes, a RIT Discharge Plan was not completed and a RIT Management plan was not developed.

It is conceivable that newly admitted inmates who are subject to a RIT protocol may not be able to be properly interviewed due to their emotional state, level of aggression, or state of intoxication from alcohol or drugs. In such circumstances it would be desirable for a RIT to be provided with guidance as to what ought to occur when a RIT assessment interview cannot be completed for these reasons. In this regard, counsel for CSNSW indicated that CSNSW was open to amending section 5.3 to provide for a third possible outcome to provide for such an eventuality. Therefore, it is necessary to make the following recommendation.

Recommendation 2: I recommend that the Commissioner of Corrective Services New South Wales give consideration to amending section 5.3 of the Custodial Operations Policy and Procedures to provide guidance to Risk Intervention Team (**RIT**) members as to what is to occur if a RIT assessment review is unable to be completed due to an inmate's emotional state, level of aggression, or intoxication due to alcohol or drug use and, as a result, the RIT is unable to determine whether a RIT Discharge Plan is to be completed or a RIT Management Plan is to be developed.

A second Risk Intervention Team

The COPP provides that for a RIT to operate the following members must be available: a RIT Coordinator, who must be a custodial officer of Senior Correctional Officer (**SCO**) rank or above; a SAPO; and Justice Health mental health nurse.

In her evidence SAPO Moffitt referred to her awareness of there being a second RIT Coordinator and SAPO being rostered on at the MRRC so that a second RIT could be formed where required. However SAPO Moffitt said that it was her understanding that a second RIT could not be formed due to the unavailability of the required Justice Health staff member.

In his evidence Mr Murrell said that he was previously unaware of the rostering of CSNSW staff to allow for the potential formation of a second RIT. As this issue was raised unexpectedly for the first time during the course of evidence in the inquest, it was agreed that both CSNSW and Justice Health would provide further information in this regard, following the conclusion of the evidence in the inquest.

That further information has now been provided by both CSNSW and Justice Health. It establishes that since 28 October 2019 an additional SCO has been rostered at the MRRC to perform the functions of a second RIT. It also establishes that the MRRC is in the process of recruiting an additional SAPO to be rostered on when a second RIT can be formed. If a second RIT cannot be formed then the rostered SCO and SAPO are to perform other duties including the interviewing and screening of new inmates.

The information provided by Justice Health establishes that the current MRRC nursing staff profile/funding only allows for one mental health nurse to be allocated to the RIT daily. However when the demand for RIT reviews is significantly high Justice Health redeploy a mental health nurse to facilitate formation of a second RIT. However in doing so, this can cause a backlog of work due to the absence of the redeployed staff member. The information provided notes that Justice Health is in the process of reviewing its policies, processes and resourcing in relation to the RIT at the MRRC.

Conclusions: It appears that appropriate consideration is being given by both CSNSW and Justice Health to the issue of staff rostering at the MRRC to provide for the formation and operation of a second RIT when the need arises. Such consideration and discussion between CSNSW and Justice Health is endorsed and encouraged. On this basis, it is neither necessary nor desirable to make any recommendation.

Method of self-harm

In evidence AS Semetka said that he only became aware for the first time at the inquest of the manner in which LP died. SAPO Moffitt said that she was aware of the way in which LP died, but said that she had not been provided with any specific training by CSNSW about the ways in which inmates could use packaging from their meal packs to potentially cause self-harm. RN Munoz said that she was also aware of the way in which LP died (as she had assisted with the resuscitation attempts on 29 September 2017), but was unaware of such packaging being a concern for the possibility of self-harm by inmates.

In his evidence Mr Murrell acknowledged that whilst there is no CSNSW policy which identifies plastic packaging from meal packs as being a potential hazard in relation to possible self-harm by inmates, he expressed the view that existing CSNSW polices are sufficiently broad to allow a RIT to put measures in place if it is thought that an inmate is at risk of self-harm. In this regard, Mr Murrell acknowledged that whilst no specific training had been provided to CSNSW staff about the potential risks associated with inmates using plastic packaging from meal packs to self-harm that LP's case might be used as an appropriate case study to warn CSNSW staff members about the potential risks associated with using plastic packaging.

Conclusions: Although some of the 28 September 2017 RIT members were aware of the way in which LP died, none were aware of the potential risks associated with plastic packaging in a self-harm attempt prior to his death. Further, since LP's death it seems that no specific training has been provided to either CSNSW or Justice Health staff members about such risks.

Given the relatively unusual circumstances surrounding the manner in which LP died it can be accepted that the possibility of such a risk may not be always recognised and considered. Raising awareness amongst CSNSW and Justice Health staff responsible for assessing an inmate's risk of self-harm about this possibility can only serve to assist in the mitigation of such a risk. It is therefore necessary to make the following recommendation.

Recommendation 3: I recommend that the Commissioner of Corrective Services New South Wales (**CSNSW**) and the Chief Executive Officer, Justice Health and Forensic Mental Health Network give consideration to the circumstances of the death of LP being used as a case study as part of training and education provided to CSNSW and Justice Health staff to raise awareness regarding the possible risks of self-harm associated with the use of plastic packaging from meal packs (with appropriate anonymization, and conditional upon consent being provided by LP's family and following appropriate consultation with them).

Findings pursuant to section 81 of the *Coroners Act 2009*

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

Identity
The person who died was LP.

Date of death
LP died on 29 September 2017.

Place of death
LP died at the Metropolitan Remand and Reception Centre, Silverwater NSW 2128.

Cause of death
The cause of LP's death was foreign body aspiration.

Manner of death
LP died as a result of actions taken by him with the intention of ending his life. At the time of his death LP was in lawful custody, on remand, at a correctional centre.

Recommendations

Recommendation 1: I recommend that the Commissioner of Corrective Services New South Wales give consideration to the implementation or variation of relevant Local Operating Procedures at the Metropolitan Remand and Reception Centre to provide that (a) the interval for review of inmates subject to a Risk Intervention Team Management Plan and/or housed in an assessment cell is to be no longer than 24 hours; and (b) where a review of an inmate cannot be completed such a review is to be deferred to the following day, with priority to be given to review of the inmate on that subsequent day.

Recommendation 2: I recommend that the Commissioner of Corrective Services New South Wales give consideration to amending section 5.3 of the Custodial Operations Policy and Procedures to provide guidance to Risk Intervention Team (**RIT**) members as to what is to occur if a RIT assessment review is unable to be completed due to an inmate's emotional state, level of aggression, or intoxication due to alcohol or drug use and, as a result, the RIT is unable to determine whether a RIT Discharge Plan is to be completed or a RIT Management Plan is to be developed.

Recommendation 3: I recommend that the Commissioner of Corrective Services New South Wales (**CSNSW**) and the Chief Executive Officer, Justice Health and Forensic Mental Health Network give consideration to the circumstances of the death of Lance Pearce being used as a case study as part of training and education provided to CSNSW and Justice Health staff to raise awareness regarding the possible risks of self-harm associated with the use of plastic packaging from meal packs (with appropriate anonymization, and conditional upon consent being provided by Lance's family and following appropriate consultation with them).

20. 311913 of 2017

Inquest into the death of Francis McCann. Finding delivered by DSC Lee at Lidcombe on the 5 February 2020.

Introduction

Francis McCann was in lawful custody serving a custodial sentence. He went to sleep in his cell on the evening of 24 September 2017. At around 10:00pm that evening Mr McCann accidentally rolled out of his cell bed and fell to the floor, suffering a serious spinal injury. Mr McCann remained on the floor, breathing and unable to move his legs, until he was discovered the following morning. He was subsequently conveyed to hospital where interventional surgery was performed. However Mr McCann's condition deteriorated and he was later pronounced deceased on 15 October 2017.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately.

Mr. McCann's personal and custodial history

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

Regrettably in this case very little is known about Mr McCann's personal history, other than he was born in Queensland on 26 February 1968. Prior to entering custody, Mr McCann had no fixed place of abode and reportedly lived a very transient lifestyle.

He had no known family members, and during his time in custody he did not make any telephone calls or receive any social visits.

Mr McCann had an extensive criminal history dating back to 1994. At the time of his death he was serving a custodial sentence after having been convicted and sentenced at Penrith Local Court on 1 March 2017. Mr McCann was serving a custodial sentence of 16 months, with a non-parole period of 10 months commencing on 15 February 2017. This meant that Mr McCann's earliest release date was 14 December 2017.

After being received into Corrective Services New South Wales (**CSNSW**) Mr McCann was housed at a number of correctional centres including Amber Laurel Correctional Centre, the Metropolitan Remand and Reception centre (**MRRC**), Junee Correctional Centre and Bathurst Correctional Centre. On 11 May 2017 Mr McCann was transferred from Bathurst to the Metropolitan Special Purpose Centre (**MSPC**).

Mr. McCann's medical history

During a reception screening assessment at the MRRC in February 2017 Mr McCann reported a history of schizophrenia, anxiety and self-harm, together with alcohol dependency. He was referred to the Risk Intervention Team (**RIT**), and to a Drug & Alcohol nurse for further assessment. Between February 2017 and March 2017 Mr McCann was assessed further on a number of occasions by the RIT following reported thoughts and threats of self-harm. By April 2017 it was noted that Mr McCann had been compliant with treatment and he was recommended for transfer to Junee Correctional Centre for single cell placement.

After brief periods at Junee and Bathurst Correctional Centres Mr McCann was referred to the Acute Screening Unit at Long Bay Correctional Complex. On 11 May 2017 Mr McCann was transferred to the MSPC and placed in the Intensive Screening Unit (**ISU**). The ISU is predominantly used to house inmates with medical needs and/or non-association alerts. It contains both assessment and stepdown cells. Mr McCann was placed in a one-out assessment cell (commonly referred to as a "safe cell") with constant electronic CCTV monitoring. Between May 2017 and September 2017 Mr McCann attended 39 separate consultations with the RIT due to his mental health issues and intermittent thoughts of self-harm.

What happened on 24 and 25 September 2017?

At about 7:25am on 24 September 2017 Mr McCann was let go from his cell so that he could access the exercise yard. He was returned to his cell at about 11:00am where he remained until a RIT review was conducted at about 1:10pm. Following the review Mr McCann was again returned to his cell sometime later that afternoon. At about 6:45pm two CSNSW officers and a Justice Health & Forensic Mental Health Network (**Justice Health**) nurse provided Mr McCann with his routine medication. Mr McCann was observed to be standing at the door of his cell, and nothing remarkable was noticed.

Later that evening Mr McCann lay down on the bed in his cell and fell asleep. The critical period occurred from about 10:00pm onwards and was recorded by the cells CCTV camera. A review of the CCTV footage establishes the following (with all times approximations based on the footage timestamps):

10:01:17pm: Mr McCann is seen to move his arms in an upward direction and begin to roll his torso towards the right side.

10:01:22pm: Mr McCann is seen to roll his body towards the right side of the bed and place his left leg out straight. At this stage his left leg and part of his lower body appears to be off the bed.

10:01:23pm: Mr McCann rolls completely off the bed, with the front of his body and face making contact with the concrete floor. Mr McCann's blanket is seen to be wrapped around his legs, and around and underneath the lower part of his body. Mr McCann is observed to roll slowly onto his left side with his head facing the bed.

At about 7:15am on 25 September 2017 CSNSW officers within the ISU were conducting routine head checks and issuing breakfast to inmates. When they opened Mr McCann's cell he was found to be lying on the floor on his blanket, with a pool of blood around his head. One of the officers called out to Mr McCann who did not respond. This was repeated and Mr McCann indicated that he could not feel his legs. An emergency radio call was made for medical assistance. Justice Health staff arrived at Mr McCann's cell at about 7:16am. A further call was made to NSW Ambulance for assistance. Mr McCann was later transported by ambulance to Prince of Wales Hospital at about 7:30am.

Imaging of the spine and facial bones at hospital showed multilevel degenerative changes, together with a 4th and 5th cervical disc spinal injury with a retropulsion and multilevel canal stenosis with cord signal changes.

On 27 September 2017 Mr McCann underwent anterior survival discectomy and fusion surgical procedure. The surgery was deemed successful with no complications noted, and Mr McCann was subsequently transferred to the Intensive Care Unit where he remained for the next few weeks. During this period Mr McCann was conscious and communicating, but his injury rendered him quadriplegic. Subsequently, on 30 September 2017, Mr McCann developed pneumonia and continued to deteriorate despite being treated with antibiotics.

Mr McCann's condition did not improve and on 14 October 2017 a guardianship discussion (because Mr McCann had no known next of kin) resulted in Mr McCann being placed on a palliative care pathway. At about 6:00pm on the same day Mr McCann went into atrial fibrillation which was treated but which resulted in respiratory failure. Mr McCann was utterly pronounced deceased at 12:30pm on 15 October 2017.

What was the cause and manner of Mr. McCann's death?

Mr McCann was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Sairita Maistry, forensic pathologist, on 17 October 2017. Dr Maistry noted that post-mortem imaging revealed evidence of a survival spine fracture fixation with no residual deformity. No acute skeletal trauma was noted. In her subsequent autopsy report Dr Maistry opined that the cause of Mr McCann's death was complications of a survival spine injury.

The investigation which followed Mr McCann's death revealed that the mattress of his bed was approximately 20 centimetres in height. Further, measurements established that the distance from the base of the mattress to the floor was approximately 50 centimetres. There is no evidence to suggest that any structural feature contributed to Mr McCann's fall from bed. Although it is not possible to precisely understand the mechanism of the fall, the CCTV footage from Mr McCann's cell appears to indicate that Mr McCann's legs and lower part of his body were entangled in his blanket. There is no evidence to suggest that Mr McCann's fall was anything other than entirely accidental and unpredictable.

Was McCann appropriately monitored?

It became evident during the course of the coronial investigation that Mr McCann was subject to both physical and electronic monitoring during the evening of 24 September 2017. As noted already, a CCTV camera recorded video footage from Mr McCann's cell. Further, CSNSW officers performed a routine cell inspection that evening. Therefore, immediate questions arise as to why Mr McCann's fall from his bed was not witnessed, and whether the observation of Mr McCann lying on the floor of his cell should have prompted some action.

Physical monitoring

First Class Correctional Officer (**FCCO**) Kymm Beer was on duty in the ISU on the evening of 24 September 2017, and performed a Wing Security Check with FCCO Jay Slifer. This type of check is conducted to ensure that cell doors are locked and secured, and to confirm that the inmate cards outside the cell is match information contained in the muster book in order to account for all the inmates.

At about 10:50pm Officer Beer looked through the window of Mr McCann's cell and saw him lying on the floor with a blanket on, and beside, him. Officer Beer specifically saw the rise and fall of Mr McCann's chest and observed that he was breathing. Officer Slifer walked past Mr McCann cell but did not look through the window into his cell. CCTV footage indicates that officers Beer and Slifer spent approximately four seconds outside of Mr McCann cell before continuing with their duties.

After completing the check, Officer Beer did not report or discuss the fact that Mr McCann was lying on the cell floor with any other correctional staff. He explained: "*It was a particularly warm night and it is very common for inmates housed in safe cells to set up beds on the floor to remain call in warmer weather as the air circulation in the ISU was quite poor*".

CCTV monitoring

Senior Correctional Officer Adam Hend was working with FCCO Anthony Van Zyl in the Complex Monitor Room (**CMR**) on the evening of 24 September 2017. Officer Hend's duties included monitoring all the security systems of the entire complex, including monitoring the perimeter security of each centre, staff duress systems, cell call systems, and the assessment cells in the ISU. As part of their duties staff in the CMR are required to manage 17 monitor screens, most of which are divided into a total of 125 Multiview image boxes. There are approximately 560 security cameras which broadcast images to these monitor screens.

Officer Hend observed Mr McCann on the monitor numerous times during the course of his shift which ended at 11:00pm. Mr McCann was seen lying on his bed for the majority of the time, and then observed to be sleeping on the floor shortly before the end of Officer Hend's shift. However Officer Hend did not consider that this to be an unusual occurrence, explaining: "*I would not have commented to other staff about [Mr McCann] appearing to be sleeping on the floor as it is common for inmates to sleep on the floor, especially on warm nights as assessment cells have poor ventilation. From my experience it is very common for inmates asleep on the floor*".

Officer Hend could not specifically recall whether it was a busy night in the CMR on 24 September 2017. However, he explained that his usual experience is that the period between 9:30pm until 11:30pm is a busy one due to shift change over and movement of staff into and out of the complex. As part of the coronial investigation, attempts were made to ascertain with more precision the number of staff moving in and out of the complex on 24 and 25 September 2017. However, due to the passage of time, that information was not available.

Officer Hend's duties concluded at about 10:30pm and he conducted a handover with the incoming officer, Senior Correctional Officer Lance Reynolds. Officer Hend could not recall whether he told Officer Reynolds that Mr McCann was sleeping on the floor, but considered that it would have been unlikely because, as already noted, this was a common occurrence. However Officer Reynolds indicated that he believed he was told that Mr McCann was sleeping on the floor. Officer Reynolds also observed Mr McCann lying on the floor during the course of his shift, but did not see any other suspicious activity.

Throughout the course of his shift in the CMR between 6:30pm on 24 September 2017 and 6:30am, Officer Van Zyl recalled seeing Mr McCann on the floor of his cell and assumed that he was sleeping. Officer Van Zyl similarly indicated that in his experience it was a common practice for inmates in assessment cells to sleep on the floor.

It should be noted that Governor of the MSPC, Patrick Aboud, also expressed the following views, consistent with those of the CMR staff working overnight on 24 and 25 September 2017: "*From my experience it is well known practice that inmates tend to sleep on the floor of their room/cell during warmer nights. It is cooler on the concrete floor and with the free airflow emitting from under the cell doors, sleeping on the floor is an optimal position for inmates throughout the warmer periods. In my time, I have seen many inmates, both male and female sleep on the floor. It is reasonable from my experience that if an inmate is lying on the floor and appears to be asleep, it may not raise any concern for correctional staff as it is a common practice amongst inmates*".

Conclusions

The evidence established that approximately 50 minutes after he fell out of his bed Mr McCann was physically seen by Officer Beer to be lying on the floor. Of course, Officer Beer did not witness the fall and assumed that Mr McCann had simply chosen to sleep on the floor. The evidence established, in the experience of both CSNSW officers and the MSPC Governor, that this was not an unusual occurrence within the ICU, particularly on warm evenings. Data collected from the Bureau of Meteorology established that 24 September 2017 "*was part of a series of unprecedented warm days*" for that time of year.

In these circumstances the assumption made by Officer Beer was not unreasonable, particularly given that there was nothing about Mr McCann's appearance or positioning which suggested that further enquiry ought to have been made. The evidence also established that Mr McCann remained on the floor of his cell for just over nine hours after falling out of bed. During this time, he was captured on video that was depicted on monitor screens in the CMR. It is also evident that Mr McCann's fall, which was approximately six seconds in duration, was recorded on video and displayed on the CMR monitor screens.

The CSNSW officers working in the CMR at the time of Mr McCann's fall did not witness it. Given the brief duration of the fall, and the multitude of other images which the officers were required to monitor as part of their duties, the failure to observe the fall is also not unreasonable. In the nine hours that followed, there is no evidence to suggest again that there was any aspect of Mr McCann's appearance or positioning on video which indicated to the officers in the CMR that anything was amiss. Similarly, it was not unreasonable for the officers in the CMR to make the assumption that Mr McCann had simply chosen to sleep on the floor. It should be noted that the pool of blood around Mr McCann's head that was observed on the morning of 25 September 2017 could not be seen from either the cell window or on the CCTV footage.

Finally, for completeness, it should be noted that once it became apparent on the morning of 25 September 2017 that something was amiss and that Mr McCann was in a potentially serious condition, the response from both CSNSW and Justice Health staff was entirely reasonable and timely. Therefore, the evidence established that no action or inaction by CSNSW or Justice Health staff contributed to Mr McCann's death.

Formal Finding:

Identity

The person who died was Francis McCann.

Date of death

Mr McCann died on 15 October 2017.

Place of death

Mr McCann died at Prince of Wales Hospital, Randwick NSW 2031.

Cause of death

The cause of Mr McCann's death was complications of a cervical spine injury.

Manner of death

Mr McCann sustained the injury following an accidental and unwitnessed fall from his bed whilst sleeping.

Mr McCann was in lawful custody, serving a custodial sentence, at the time of his death.

21. 373943 of 2017

Inquest into the death of Andrew Ngo. Finding delivered by DSC Ryan at Lidcombe on the 28 January 2020.

Introduction

Andrew Ngo was 35 years old when he died at Nepean Hospital on the night of 9 December 2017. He had been taken there by ambulance after the car he was driving collided with a tree near Lapstone, at the foot of the Blue Mountains. Mr Ngo suffered unsurvivable injuries and he died shortly afterwards.

Just prior to the fatal collision a police pursuit was underway to arrest Andrew Ngo, after he had failed to stop following a direction to do so at a Random Breath Testing site. A number of police cars were involved in the pursuit.

This is a mandatory inquest pursuant to sections 23(1) (c) and 27(1) (b) of the Act. An inquest is mandated when it appears, or there is reasonable cause to suspect, that a person has died '*as the result of police operations*'. The purpose is to ensure there is an independent and transparent investigation of the circumstances of the death, and the conduct of any involved police officers.

Andrew Tran's life

In March 2008 Andrew Ngo registered a change of name to Andrew Ngo from his birth name of Giang Dinh Tran. However his mother and sister requested that during the inquest he be referred to as Andrew Tran. Although I refer to him as Andrew Ngo in the formal findings as to date, place, cause and manner of death, I will call him Andrew Tran in the body of these findings.

Andrew Tran was born in Hong Kong on 8 November 1982. His mother Thi Lan Tran had migrated there from Vietnam on a refugee visa with her daughter Thi Lien Vu, who now uses her married name of Lien Issa. In 1984 Ms Tran left with her two children to live in Sydney. The family lived in Marrickville and then in Bossley Park.

Mr Tran left school in Year 11 and began to spend a lot of his time with friends. It was around this time that his sister Ms Issa started to suspect he was using illicit drugs. According to his friends, Mr Tran used drugs on a daily basis including Xanax, heroin and methylamphetamine. During his twenties and thirties he had periods of time in jail for offences of drug use, burglary and disqualified driving. In 2010 while driving under the influence of methylamphetamine he crashed his car, as a result of which his passenger died. He was convicted and sentenced for dangerous driving causing death.

In July 2017 while on parole, Mr Tran discussed with his sister the idea of going to rehabilitation, telling her that he was afraid of going back to prison. He had previously made attempts to remain on the methadone program. Ms Issa very much wanted to help her brother overcome his addiction problems. She commenced arrangements for him to enter a rehabilitation facility in Perth.

Unfortunately this didn't happen, and in October 2017 Mr Tran was charged with fresh offences of disqualified driving and engaging in a police pursuit. Police had been unable to serve him with Court Attendance Notices, so warrants for his arrest were current at the time of his death.

Mr Tran's mother Thi Lan Tran was emotionally unable to attend the inquest, but his sister Lien and her husband attended each day. At the close of the evidence, at Ms Issa's request Mr Ayache read to the court a loving tribute to Andrew which she had prepared on behalf of her family. She wrote of a caring brother and son, and of how she and her mother wanted to help him overcome his addictions but did not know how. It was clear that despite his struggles Andrew Tran was much loved by his family, and they grieve his loss deeply.

The issues examined at the inquest

The first four issues examined at the inquest concern the conduct of the involved police officers, and whether it complied with the provisions of the NSW Police Force's Safe Driving Policy [the SDP]. The applicable version of the SDP at the time of Mr Tran's death had come into force in December 2017. It has since received minor revisions, none of which are relevant to the issues of this inquest. I will cite only those provisions which bear directly upon these issues.

- The issues examined at the inquest were:
- Was there a proper basis to commence the pursuit?
- Should the pursuit have been terminated at an earlier stage?
- Did officers comply with the road spikes requirements of the SDP?
- Did officers comply with the 'Urgent Duty' requirements of the SDP?
- Did the pursuit cause or contribute to Mr. Tran's death?

The conduct of the pursuit was reviewed by Senior Sergeant Jennifer McWhinnie, who is appointed to perform this task within the Traffic and Highway Patrol Command Traffic Policy Unit. She provided a report and gave evidence at the inquest. Her report identified breaches of the SDP by a number of the involved officers.

As will be seen, in these findings I reach the conclusion that the evidence supports many of Senior Sgt McWhinnie's conclusions. I wish to acknowledge however that some police officers whose conduct breached pursuit policies were the first to arrive at the fatal crash site, and immediately commenced first aid in an attempt to save Mr Tran's life. Other police officers involved themselves in emergency traffic duties, ensuring that no other road users came to harm in the hours following the crash. I believe that in the inquest into the circumstances of Mr Tran's death, this capable and conscientious work on their part deserves to be acknowledged.

The cause of Mr Tran's death

The cause of Mr Tran's death is clear on the evidence. The autopsy report of forensic pathologist Dr Istvan Szentmariay found he had died as a result of multiple injuries, with a significant contributing condition of multidrug toxicity. Mr Tran had suffered fractures to his skull, ribs, sacrum and pelvis. He had also suffered haemorrhages to the brain and acutely compressed abdominal organs.

Testing of Mr Tran's blood samples showed the presence of methylamphetamine, morphine and alprazolam. The test results were examined by Dr Judith Perl, toxicologist. She provided an expert opinion that the level of methylamphetamine in Mr Tran's blood was very high.

It was very likely to have had significant impairing effects upon his psychomotor functioning, driving skills and decision-making, creating an increased risk of having a collision. In Dr Perl's opinion his ingestion of morphine, which had been recent, was likely to have contributed to the impairment.

The Random Breath Test operation

On the nights of 8 and 9 December 2017 NSW Police were conducting a Random Breath Testing [RBT] operation along the westbound length of the M4 motorway, commencing at Parramatta. A number of stationary RBT sites had been set up. One of these was located near Lapstone at the foot of the Blue Mountains, where the M4 motorway is known as the Great Western Highway.

The M4 motorway and Great Western Highway is a divided dual carriageway with three lanes westbound. Near Lapstone the three westbound lanes merge to two lanes and there is a marked turning lane allowing vehicles to exit from the Highway into Governors Drive, Lapstone ['the Governors Drive exit']. It was at this RBT site on the turning lane that the police pursuit commenced.

The lead up to the police pursuit

Mr Tran had spent the afternoon of 9 December at the house of a friend, Mr Raymond Reynolds. At Mr Tran's request, Mr Reynolds drove him to Merrylands at about 8pm. Mr Reynolds presumed this was because of Mr Tran's unlicenced status. Soon afterwards Mr Tran drove off unaccompanied in a black Mitsubishi Sedan. This car was registered in the name of his mother.

Mr Tran rang another friend to tell her he was driving to meet someone in Penrith. Then at about 9.30pm Mr Tran told Mr Reynolds by phone that he was now on the M4 and there were police at every exit. Mr Reynolds encouraged Mr Tran to pull over, leave the car and walk, but Mr Tran replied he would '*rather pull a chase than walk'*.

Soon afterwards another friend Mr Matthew Kovacik received a call from Mr Tran. According to Mr Kovacik, Mr Tran sounded panicked and told him police had blocked all the exits on the M4.

Shortly after 10pm Mr Tran was signalled by an RBT stopping officer to pull over for a random breath test at the Governors Drive exit site. Mr Tran did not pull over, but continued driving at an estimated speed of 10 - 15 kph. Senior Constable Barry Thurling then stepped forward and gave a second signal to him to pull over, at which point Mr Tran accelerated and drove away into Governors Drive at an estimated speed of 70kph. This road leads into streets within a residential area of Lapstone. It was around this time that Mr Kovacik received another phone call from Mr Tran. According to Mr Kovacik, Mr Tran said '*I'm gone, I'm gone, there's no way off*'.

Like Mr Reynolds, Mr Kovacik encouraged Mr Tran to pull over but he replied: '*No, I can't, I can't … I've turned off. I'm on the back streets, I can't talk, there's police'.* There were no further calls from Mr Tran.

SC Thurling got into his Highway Patrol car and commenced pursuit of Mr Tran. The time was 10.13pm. The ensuing pursuit took place for a period of six minutes, through suburban streets in Lapstone.

The course of the pursuit is further described below, but briefly it can be said that just after it was terminated at 10.19pm Mr Tran was once again back on the Great Western Highway, this time driving eastward in its westbound lanes. He had used the same Governors Drive exit to enter the Highway, despite this being a one-way road for traffic to exit the Highway.

On the Great Western Highway Mr Tran drove at speed for some 1.5kms before losing control of his car. It mounted the median strip and collided heavily with a tree. The impact was severe and caused his car to be broken into two parts. Mr Tran's injuries were fatal. He received first aid at the site from police officers and from an off duty nurse who had pulled over to assist. An ambulance arrived very shortly afterwards, but Mr Tran died soon after arrival at hospital. Police later found a small quantity of methylamphetamine in plastic bags inside his car.

A number of police officers were involved in the pursuit of Mr Tran's car. To assist in understanding the course of the pursuit I list their names below, with the call signs of their cars:

NWM 246	SC Barry Thurling
NWM 248	SC Natasha Crawford and Sgt Mark Falconer
NWM 247	SC Mary Louise Keating and SC Scott Andrews
NWM 203	Senior Sgt Chris Palombo and SC Douglas Roden
NWM 245	Sgt Joshua Denny
NWM 249	SC Michael Bombell
NWM 294	SC David Potter and SC Christopher Gilbey
Penrith 175	SC Kevin Hannon and SC Alison Rice
Penrith 36	SC Joshua McNally and Constable Lisa Myers
Penrith 37	SC James Cager and SC Andrew Locke.

That night the VKG police radio supervisor was Sergeant Brett Kleyn. He had been an accredited pursuit manager since 2007, and was stationed at Penrith Police Station. From his location in the radio room he was able to monitor the radio despatches of the pursuit, and to communicate instructions via the VKG radio despatcher, Steven Carter.

The Duty Operations Inspector role for the Blue Mountains region that night was Acting Inspector Michael Down. He was stationed at Blue Mountains Police Station, and monitored the pursuit using his own police radio. None of the RBT police knew Mr Tran's identity as a driver who was the subject of outstanding warrants, and his selection for a breath test was entirely random. Nor during the pursuit were any of the involved police officers aware of the warrants, or of Mr Tran's status as a disqualified driver. It was clear from their evidence at inquest that their pursuit was based on his failure to pull over at the RBT site.

The course of the pursuit

At 10.13pm SC Thurling activated the lights and sirens on his car and broadcast to VKG radio that he was in pursuit. In accordance with the NSW Police Force's Safe Driving Policy [the SDP], this signified the commencement of the pursuit. SC Thurling was the sole occupant of his police car.

The VKG despatcher responded by broadcasting that car NWM 246 was in pursuit. He directed that '*all cars stand by unless urgent'*. Car NWM 247 responded notifying it was '*about three minutes away'*. Over the next few minutes the following happened:

Mr Tran continued to drive, making circuits of the suburban streets surrounding Governors Drive
the VKG despatcher indicated on a number of occasions he wanted the radio airway kept clear for NWM 246's update reports

NWM 248 joined the pursuit, mistakenly broadcasting its car call sign as '245'. It requested and received Sgt Kleyn's permission to deploy road spikes

NWM 248 made two attempts to use the road spikes. On the first occasion the spikes were thrown out and merely contacted the headlights of Mr Tran's oncoming car. On the second occasion, Mr Tran avoided the spikes by driving his car partly onto the footpath

NWM 245 made the third attempt to deploy road spikes but Mr Tran again avoided them.

Mr Tran was by now driving back along Governors Drive in the direction of the Great Western Highway, still with NWM 246 in pursuit. Travelling at speed, Mr Tran suddenly veered his car to the right, driving onto the exit ramp which came up from the Great Western Highway. Seeing Mr Tran enter the exit ramp SC Thurling applied his own brakes, but his car collided with the concrete median strip and caught alight. He broadcast to VKG that he had '*destroyed the car'.*

At this point Mr Tran's car had just passed police cars Penrith 175 and Penrith 36. These two cars had decided to participate and were proceeding in the correct direction up the exit ramp. Mr Tran's car contacted the two police cars, causing minor damage. He continued driving eastwards past the RBT site, at an estimated speed of between 130 and 150 kph.

It was soon afterwards that Mr Tran lost control of his car and suffered the fatal collision.

I now turn to consider the issues examined at the inquest.

Was there a proper basis to commence the pursuit?

In the opinion of Senior Sgt McWhinnie, SC Thurling met the requirement imposed by Part 7.2.9 of the SDP, that an officer deciding to instigate a pursuit have reasonable cause to believe that the person has committed an offence and is attempting to evade apprehension. SC Thurling's evidence was that he decided to pursue Mr Tran because he had failed to comply with a direction to pull into the RBT site, and had accelerated away. This is an offence under Schedule 3 of the *Road Transport Act 2013.*

Sgt McWhinnie noted that in his directed interview SC Thurling had not been asked about his decision-making regarding other key aspects of commencing a pursuit. Notably, Part 7.2.1 provides that the decision: '*requires weighing the need to immediately apprehend the offender, against the degree of risk to the community and police as a result of the pursuit*'.

The conclusion I reach is that SC Thurling's decision to initiate the pursuit and his continuation of it in its early stages was reasonable having regard to the guidelines within Part 7.2.

It was submitted on behalf of Mr Tran's family that SC Thurling had other options reasonably open to him, other than commencing a police pursuit. One of these was to trace the identity of the driver by use of the car's registration plates. The driver could then have been issued with a Court Attendance Notice regarding his failure to comply at the RBT site.

At the RBT site SC Thurling did not record the registration number of the car being driven by Mr Tran. He caught sight of the registration plates only after about two minutes of pursuit, and broadcast these details. He agreed in his evidence that at that point there was an option of terminating the pursuit and attempting to trace the driver using the car's registration details. It was noted however that there were a number of potential impediments to this course. The car was not registered to Mr Tran but to his mother. It was not known, then or now, if she was in a position to name him as the driver that night. If she was not, it may not have been possible to take action against Mr Tran for the offence.

Given this I accept the submission of Counsel Assisting that SC Thurling's decision to take the option of a pursuit was neither in breach of the SDP nor unreasonable in the circumstances.

Should the pursuit have been terminated at an earlier stage?

Part 7.6 of the SDP sets out the circumstances in which a pursuit must be terminated. Once a termination has been called all vehicles must cease to pursue, stop following and return to the legal speed limit.

The pursuing officer is required to continually re-assess these factors throughout the pursuit: Part 7.2.5.

A key component of the SDP is that the overriding control of a pursuit situation rests with the Duty Operations Inspector [DOI], or the VKG Supervisor in areas where VKG radio is not controlled by a DOI. The necessity for a senior officer to coordinate the progress of a pursuit and make decisions about its termination is obvious, in the interests of police and community safety.

As noted by Senior Sgt McWhinney at paragraph 24 of her report:

'*It is imperative police involved in pursuits provide accurate and frequent information. This allows all roles as defined in the Safe Driving Policy who are monitoring and managing the pursuit to decide if the pursuit should continue or triggers have been identified to terminate the pursuit.'*

Thus to fulfil their function the DOI or VKG Supervisor relies upon frequent status reports from officers involved in the pursuit. The DOI or VKG Supervisor must also be kept updated. It is the responsibility of officers involved in the pursuit to broadcast these updates over VKG radio: Part 7.5.1.

In her report and evidence Senior Sgt McWhinnie identified numerous occasions where SC Thurling did not notify VKG of information which she considered would have been relevant to the question of whether the pursuit ought to have been terminated.

Communication is critical to the effective management of a police pursuit. This was highlighted in the evidence of Sergeant Brett Kleyn. In his directed interview he agreed that the decisions he made when supervising pursuits were based on the information he received via VKG from the pursuit vehicle or vehicles.

On the basis of the information relayed by SC Thurling, he said that he had seen no reason to terminate this pursuit at a point earlier than he did. SC Thurling was an experienced highway patrol officer. As Sgt Kleyn put it in his interview: *'that was good enough to keep it* [the pursuit] *running'*. However Sgt Kleyn's evidence at the inquest was clear that he *would* have directed termination of this pursuit had he been advised that on numerous occasions

I should note there was some controversy as to the actual speeds at which SC Thurling drove. When a police car's In Car Video is in operation, a dynamic speed is shown in one corner of the screen. In her report and evidence Senior Sgt McWhinnie used these speeds, shown in the footage derived from car NWM 246, as an indication of its actual speeds. But the court heard that this speed was not visible to the driver, who relied on the car's dashboard speedometer. The court heard further that the two methods of recording speed are known to show variances.

In response to this, Senior Sgt McWhinnie stated she was reasonably confident that the speeds shown on NWM 246's ICV were an accurate reflection of its actual speeds. She noted that on the occasions when SC Thurling had broadcast his speeds to VKG, these corresponded with the speeds shown on the ICV screen at that point. On this basis I am satisfied that the speeds of car NWM 246 referred to by Senior Sgt McWhinnie in her report may reasonably be relied upon.

It is clear from the evidence that in the course of the pursuit SC Thurling did not relay information which, on the evidence of Sgt Kleyn and Acting Inspector Down, would have been relevant to a decision whether to terminate the pursuit. That is, the information would have been relevant to the determination. As to whether in light of this information the pursuit ought to have been terminated at an earlier stage, I place weight upon the evidence of Sgt Kleyn, an experienced pursuit manager, that he would have taken this course had he known the above details of SC Thurling's manner of driving

I conclude that this pursuit should have been terminated at an earlier stage than it was, in view of the risk to community safety that SC Thurling's manner of driving posed. I also acknowledge that it is relatively easy to make judgements in hindsight about the conduct of police officers. In the midst of a dynamic situation they face unpredictable circumstances and often have to make decisions within a very short timeframe.

The pursuit was not brief and during this time it may be presumed he had opportunities to turn his mind to the risk assessment that he was required to make, and to his obligation to assist Sgt Kleyn with relevant information. It is concerning that he appears not to have done so. I conclude that he did not comply with the requirement pursuant to Part 7.5.1 of the SDP to keep the VKG supervisor sufficiently informed of relevant information about the conduct of the pursuit.

Maintaining control of his car under pursuit conditions meant that he was simply unable to keep adequately in communication with VKG. In circumstances where the driver of the primary pursuit car is its sole occupant it can readily be imagined that there could be difficulties in complying with the SDP's communication obligations. I am unable to say whether this problem is a prevalent one. If it is, it may be a matter which, I respectfully suggest, the NSW Commissioner examine further.

I accept the submission of Counsel Assisting that no criticism should attach to Sgt Kleyn or Acting Inspector Down for not terminating the pursuit at an earlier stage. The evidence establishes that they were not made aware of circumstances which would have been relevant to that decision.

Did officers comply with the road spikes requirements of the SDP?

In her report Senior Sgt McWhinnie identified instances where other police officers involved in the pursuit did not comply with the requirements of the SDP. One of these areas involved the attempts to stop Mr Tran's car with use of road spikes.

Police officers are able to deploy road spikes (officially known as 'Tyre Deflation Devices') when they are properly accredited and they receive authorisation to do so from nominated senior officers. These include DOI's and VKG supervisors. SC Crawford and Sgt Falconer in car NWM 248 sought and received permission from Sgt Kleyn to lay road spikes at a location in Governors Drive. Their two attempts were unsuccessful, as described in paragraph 26 above. Senior Sgt McWhinnie noted that neither officer communicated to VKG the outcome of their attempts. She noted further that they did not store the road spikes in the manner required by the SDP.

In my view the above breaches of the SDP were relatively minor and in the circumstances of this case did not create any significant risk to police or community safety.

In her report Senior Sgt McWhinnie had stated that Sgt Denny, who made the third attempt to stop Mr Tran with road spikes, had not obtained authorisation to do so. However she acknowledged in her evidence at the inquest that this was incorrect and that he had in fact done so.

Did officers comply with the 'Urgent Duty' requirements of the SDP?

In her report and evidence, Senior Sgt McWhinnie identified a number of police officers who had breached the SDP by involving themselves in the pursuit without notifying VKG radio that they were responding on an 'urgent duty' basis.

Part 6.2.1 of the SDP defines urgent duty as '*Duty which has become pressing or demanding prompt action'.*

Officers responding on an 'urgent duty' basis may drive in excess of the prevailing speed limit, but must comply with the 'Code Red' protocol set out in Part 8 of the SDP. This mandates that the officer activate emergency warning devices on the car and *'advise VKG and give an ETA'* [estimated time of arrival]. The officer's obligation to advise VKG of an urgent duty response is reiterated at Part 6.4 of the SDP.

In her evidence Senior Sgt McWhinnie explained that these obligations were necessary to enable those coordinating the pursuit to perform their functions. They needed accurate information about what police resources were present to assist, and whether any further resources might be needed. This was important not only for the safety of police and the community, but also for maximising the operational benefit of police resources.

These purposes are made explicit in Part 8 of the SDP, which describes the Coded System of Driving as having been designed:
' …to provide substantial safety and operational benefits to the NSW Police Force and the broader community. It provides clear parameters for police responding to urgent duty and at the same time reinforces the requirements of the Safe Driving Policy'.

Senior Sgt McWhinnie identified failures to comply with the SDP's 'urgent duty' protocol by the following officers: Officers Palombo and Roden in car NWM 203. They decided to proceed to the pursuit area, and activated their car's lights and siren. These were deactivated while they remained stationary for a period of time, before being reactivated when they went in search of Mr Tran's car once again. VKG received no notification of their involvement in the pursuit.

Officers Hannon and Rice in car Penrith 175, and officers McNally and Myers in car Penrith 36. Both cars decided to respond 'urgent duty' and proceeded to the pursuit area. However neither car advised VKG of their response.

Officers Potter and Gilbey in car NWM 294. They too decided to proceed to the pursuit area and activated their lights and siren. VKG received no notification of their involvement in the pursuit.

Officer Bombell, the sole occupant of car NWM 249. His intention was to assist with road spikes, and he proceeded to the pursuit area with lights and siren activated. VKG radio was not notified of this response.

It is apparent from the VKG transcript and from Sgt Kleyn's interview that in some cases he was entirely unaware of their presence. In his interview too, Acting Inspector Down said he had been aware of only two cars being involved in the pursuit. Their lack of awareness of these matters demonstrates the importance of officers' compliance with the SDP's communication obligations.

Yet the evidence from the involved officers highlighted practical difficulties with notifying their urgent duty response. From the outset the VKG despatcher had broadcast that car NWM 246 was in pursuit, together with the direction that '*All cars standby unless urgent'*. All officers understood this to mean that the VKG despatcher did not want them to interfere with the flow of information from car NWM 246, the primary pursuit car.

In their directed interviews and evidence a number of officers explained this was why they had not advised VKG radio of their response. Officers Palombo, Roden, Hannon, Rice, McNally and Myers all adverted either to the '*standby*' direction, or to the difficulty of being able to break in on the radio transmissions to acknowledge their cars' response.

This problem was also highlighted by Sgt Kleyn. In his directed interview he gave the following response in answer to Questions 236-238 concerning the management of VKG radio traffic:

' ..and if any other cars tried to jump on [the radio], *like a few did somehow along the way, but we tried to limit … other people getting on, saying you know, they're on their way … we try to say, remind them, North West Met 246 only.'*

In her evidence at the inquest Senior Sgt McWhinnie acknowledged these practical difficulties. However in her view priority had to be given to the SDP's communication obligations, in the interests of ensuring that pursuit coordinators had sufficient information to manage the situation. In the present case she noted that a primary and a secondary pursuit car had already responded on VKG, as well as a police car equipped with road spikes. If other police cars had decided to respond on an 'urgent duty' basis but were unable to meet their SDP notification obligations, in her opinion they should have responded on a 'Code Blue' basis.

This would mean proceeding in the direction of the pursuit area, not engaging in driving which is permitted under 'urgent duty' conditions, and not activating their lights and siren. In Senior Sgt McWhinnie's view, only when the opportunity arose to notify on VKG radio should they move to a 'Code Red' urgent duty response.

I did not hear evidence at the inquest in response to the above opinion of Senior Sgt McWhinnie, to enable me to determine whether it represents a workable solution to the practical problem which the responding officers faced. I can only conclude that it is clear the above officers were in breach of the requirement under Part 6.4 to acknowledge their response in accordance with the urgent duty protocol. However for the above reasons I do not think it would be appropriate to criticise them for it. Their dilemma again appears to highlight a problem with the practical implementation of the SDP, which the Commissioner may consider requires further examination.

Did the pursuit cause or contribute to Mr Tran's death?

The evidence establishes that in the pursuit of Mr Tran, involved officers breached the requirements of the SDP in the ways that have been described above. Can it be said that their conduct caused or contributed to his death?

On behalf of Mr Tran's family it was submitted that the failure of police to terminate the pursuit at an earlier stage did contribute to his death. Had the pursuit been terminated at an earlier and more appropriate time this may never have happened.

Mr Ayache did not dispute, nor could it be denied on the evidence, that Mr Tran was determined to avoid being arrested by police. According to his friends, he was '*panicked*' at the sight of police at the exit points of the M4. He ignored their advice to pull over, telling Mr Reynolds he'd rather *'pull a chase'.*

His intention to avoid being apprehended is borne out in his refusal to pull over at the RBT site. It must also be said also that he had many reasons to avoid police attention. He was a disqualified driver, there were warrants outstanding for his arrest, and he had a small quantity of illicit drugs in his car.

Having carefully considered the evidence however, I do not think it can be said that Mr Tran's death would have been prevented had the pursuit not been conducted, or had it been conducted in accordance with the SDP. The evidence of Dr Perl is that at the time of Mr Tran's death it was very likely that his driving ability and decision-making were significantly impaired by the effects of the methylamphetamine and possibly the morphine which he had recently ingested. In her view he had an increased risk of having a collision. I conclude therefore that due to his state of drug affectation, there remained a strong possibility of him suffering a fatal accident regardless of police involvement, and regardless of the manner in which this pursuit was conducted.

The question of recommendations

At the close of evidence submissions were made on behalf of Mr Tran's family, proposing that a number of recommendations be made. I will deal with each in turn.

Proposal 1

The first proposal was that NSW Police Force vehicles which are authorised to conduct pursuits be equipped with:

- Cameras feeding 'real time' audio and visual footage to VKG Supervisors and/or Communications Operators, to assist them in monitoring and supervising pursuit and 'urgent duty' driving.
- GPS and data tracking equipment enabling VKG Supervisors and/or Communications Operators to monitor the location and speed of police cars involved in pursuit and 'urgent duty' driving.

The clear intent of these proposals is to better assist those who are supervising pursuit and 'urgent duty' driving to assess the conditions of the pursuit. The evidence at inquest revealed practical deficiencies in the current system which relies upon VKG radio broadcasts from the individual officers involved.

In response it was submitted on behalf of the NSW Commissioner that the proposals would not be opposed, on the basis that the recommendation be that the Commissioner consider it.

At the inquest both Sgt Kleyn and Senior Sgt McWhinnie were asked whether in their opinion the above proposals would be useful, in the interests of enhancing the supervisor's understanding of the pursuit as it unfolded. Sgt Kleyn acknowledged there was room for improvement on the present system.
However he expressed doubt as to how as a practical matter, multiple and simultaneous sources of audio coming from the police cars might be managed. Senior Sgt McWhinnie was unsure whether the proposals would help or hinder the VKG supervisor.

In my view the proposal that 'real time' speed tracking devices be introduced has merit, in particular as under the current system an objective source of this information only becomes available after the pursuit, with the availability of the ICV footage.

However I am mindful of the requirement that recommendations made in an inquest be '*necessary or desirable'*. This requires evidence that the proposed measure is directed at remedying an identified problem, and that it will be effective in doing so. This evidence was not available at the inquest, nor any evidence as to the logistical factors which would be involved. (This is not a criticism of those appearing at the inquest.) For these reasons, while I think the proposal for speed tracking devices has potential, I do not think it would be appropriate to recommend it in this inquest.

Proposal 2

The second proposal was that two amendments be made the SDP. The first was to amend the wording of a section of Part 7.5.1 regarding pursuit driving, to make it consistent with a corresponding provision in Part 6.4 regarding 'urgent duty' driving. It is not clear why the two provisions differ in this respect, and whether there is any practical difference between driving**.**

I accept the submission made on behalf of the Tran family, that in the interests of providing greater clarity I should recommend that the Commissioner consider whether the wording in these two provisions ought to be aligned.

The second proposed amendment to the SDP, is that the relevant sections in its 'Urgent Duty' and 'Pursuits' parts be amended, to align with Parts 3.9 and 3.10 of the Australian Federal Police's National Guideline on Urgent Duty Driving and Pursuits [the AFP Guideline].

Parts 3.9 and 3.10 of the AFP's Guideline deal respectively with the justification criteria for commencing and continuing a pursuit, and when a pursuit must not be conducted. Significant features of the AFP Guideline's pursuit justification criteria include that:

- the police officer must believe there is an *'urgent need'* to apprehend the vehicle
- the apprehension is believed necessary to prevent '*an immediate or ongoing serious risk of public health and safety'*
- an offence has been committed or is about to be committed which involves '*serious injury to or death of a person'*
- alternative means for apprehending the vehicle's occupant are not feasible.

Also significant is the provision within Part 3.10 of the AFP Guideline, that *'in ordinary circumstances a pursuit must not be initiated for any property or traffic offences'.*

In this inquest the court did not hear evidence regarding the AFP Guideline. However it is apparent that its pursuit justification criteria are more prescriptive than those of the SDP.
In addition, pursuit is justified in a more restricted range of circumstances. It appears likely for example that if the AFP Guideline had applied in NSW at the time of Mr Tran's death, a pursuit could not lawfully have been initiated based on the facts known at the time to the pursuing police.

It is beyond the scope of this inquest to determine whether the approach to police pursuits adopted in the AFP Guideline is to be preferred to that in the SDP.

Evidence would be needed on a range of matters, including whether there are differences in the geographical features and criminal activity profiles of the ACT and of NSW which might require a different law enforcement approach. Relevant also would be evidence as to the efficacy as a law enforcement measure of the existing arrangements for police pursuits in NSW, taking into account the extent to which they achieve crime prevention and detection objectives, the resources needed to conduct them, and the safety risks for police and community. It is also evident that opinions differ as to where the balance lies in weighing the public interests in community safety and law enforcement.

I am aware that a review of the SDP is currently underway. This provides an opportunity to consider whether the more prescriptive and restrictive approach to pursuits adopted in the AFP Guideline would be of benefit to law enforcement in NSW. For this reason I will make the recommendation that the Commissioner consider doing so.

Proposal 3

The terms of the third proposal are unclear to me. In written submissions on behalf of the family Mr Ayache proposed that Clause 16(1) (a) of Schedule 3 to the *Road Transport Act 2013* be amended to impose the same penalties as an offence against clause 16(1) (b). The former is the offence of failing to submit to a breath test, and carries a fine by way of penalty. The latter is the offence of failing to submit to a breath analysis, and carries the penalty of a fine and/or imprisonment, and a period of licence disqualification.
Mr Ayache's submission was that a Clause 13(1)(a) offence should have a higher penalty in the interests of deterrence.

However the offence which initiated the pursuit of Mr Tran was one of disobeying a requirement to stop for a breath test. This is an offence pursuant to Clause 3(4) of Schedule 3. Like the Clause 16(1)(a) offence, it carries only a fine for a first offence.

Formal Finding:

Identity
The person who died is Andrew Ngo.

Date of death
Andrew Ngo died on 9 December 2017.

Place of death
Andrew Ngo died at Nepean Hospital, Penrith NSW 2750

Cause of death
Andrew Ngo died as a result of multiple injuries, with a significant contributing condition of multidrug toxicity.

Manner of death
Andrew Ngo received unsurvivable injuries when the car he was driving collided with a tree following a police pursuit.

22. 37983 of 2018

Inquest into the death of Jonathon Hogan. Finding delivered by DSC Grahame at Lidcombe on the 6 May 2020.

This inquest concerns the tragic death of Jonathon Hogan. "Jono", as he was known to his family, was 23 years of age when he died at Junee Correctional Centre ("Junee CC") on 3 February 2018.

Jonathon was a proud indigenous man of the Wiradjuri, Ngiyampaa and Murrawarri people whose lands stretch from around Canberra and up to Brewarrina. His father, Matthew Hogan, spoke during the inquest of Jonathon's love of the bush – he loved going to the river to swim or fish – and he always preferred to be outside as a child. Jonathon was also a talented artist and I was humbled to have the opportunity to display some examples of his artwork in the courtroom throughout the inquest.

Jonathon came from a large extended family including his parents and nine siblings. He is survived by his partner and their five children. He is greatly missed by all those who loved and cared for him.

Matthew Hogan represented Jonathon's extended family at the inquest each day. Mr. Hogan made it clear that Jonathon loved his family and, equally, his family loved him. He described Jonathon as a "happy-go-lucky kid, always laughing and clowning around". I thank Mr. Hogan for his attendance and patience in such sad circumstances. I am aware that other family members followed the proceedings closely, some even attending the vicinity of the court, with only their terrible sadness preventing them from entering the courtroom.

Jonathon was alone when he died. He was subsequently found by correctional staff in his cell. He was hanging by a prison blanket from a bunk bed. Although resuscitation was attempted, it was by then too late to revive him.

Jonathon had long-standing and well documented mental health issues. The evidence before this court indicates that the mental health services provided to Jonathon prior to his death were inadequate.

Beyond the circumstances of this individual tragedy, the investigation into Jonathon's death raised broader questions about the general level of care provided to inmates suffering mental illness within our prison system. It also demonstrated that many of the concerns raised during the Royal Commission into Aboriginal Deaths in Custody ("RCIADIC"), thirty years ago, remain unresolved today.

Background

It is necessary to place Jonathon's incarceration in its wider social context prior to a close examination of the particular facts of his death.

According to the Australian Law Reform Commission, Aboriginal and Torres Strait Islander adults make up around 2% of the national population, however they constitute around 27% of the national prison population. In 2016, around 20 in every 1000 Aboriginal and Torres Strait Islander people were incarcerated. Tragically, over-representation appears to have grown, not decreased.

Aboriginal and Torres Strait Islander incarceration rates increased 41% between 2006 and 2016 and the gap between Aboriginal and Torres Strait Islander and non- Indigenous rates widened over the decade.

Specifically in NSW, the Bureau of Crimes Statistics and Research ("BOSCAR") have reported that as at March 2019, 25% of the prison population across the state was identified as indigenous. During the inquest, Junee Correctional Centre also confirmed that its indigenous population sat at around 30% of its total inmate population.

The over-representation of Aboriginal and Torres Strait Islander people is hardly a recently discovered phenomenon. Its continued existence was accurately described in one submission to the recent Australian Law Reform Commission's Inquiry into the incarceration rate of Aboriginal and Torres Strait Islander people as a "national disgrace".

As far back as 1991, the RCIADIC found that Aboriginal people were grossly over- represented in custody. Further, the Commissioners noted that this over-representation in both police and prison custody "provides the immediate explanation for the disturbing number of Aboriginal deaths in custody." In other words, until we do something about over- representation, we will certainly continue to record a disproportionate level of indigenous deaths in custody.

Almost 30 years after the RCIADIC, we have failed to appropriately reduce the shockingly disproportionate incarceration of indigenous people or to properly grapple with the underlying factors. The RCIADIC identified indicators of disadvantage that contribute to disproportionate incarceration including: "the economic position of Aboriginal people, the health situation, their housing requirements, their access or non-access to an economic base including land and employment, their situation in relation to education; the part played by alcohol and other drugs - and its effects". The Commission also identified dispossession without the benefit of treaty, agreement or compensation as a factor in over-representation in custody. Decades later, these factors remain at the forefront of our failure to reduce incarceration rates. Despite attempts to "Close the Gap", disadvantage abounds and successive governments have been unable to squarely face the effects of dispossession and move forward with "truth telling" and agreement with Aboriginal and Torres Strait Islander peoples.

It is clear that if we are to reduce the number of Aboriginal deaths in custody we need to grapple with the underlying causes of over-representation. The ALRC report properly supports initiatives such as justice re-investment as one crucial strategy. While it is well beyond the scope of this inquest to suggest other strategies, it is necessary to state clearly the nature of this ongoing problem. Quite simply, more young Aboriginal citizens like Jonathon must be diverted away from the criminal justice system if we are to reduce the number of Aboriginal deaths in custody nationally.

It is also relevant to these proceedings that not only are Aboriginal and Torres Strait Islander people over-represented within the prison system, their rate of suicide attempts over a lifetime are significantly higher than those in the non-Aboriginal population. The court was informed that an estimated 33.7% of prisoners in NSW have exhibited suicidal ideation during their lifetime, of which 20.5% report suicide attempts. A significantly greater proportion of Aboriginal inmates (26.9%), compared to non-Aboriginal (18.7%) attempt suicide during their lifetime.

It is clear that indigenous prisoners are at greater risk of suicide than their non-indigenous counterparts. Jonathon's personal risk was even higher. He had been diagnosed with schizophrenia and had reported episodes of psychosis characterised by auditory hallucinations. The court heard that inmates with serious mental illnesses are potentially more vulnerable in a correctional setting and may require more assertive monitoring and treatment to ensure that their mental health needs are addressed. The rate of suicide among prisoners, as compared to the general population is high. Serious mental illness is associated with a significantly elevated risk of suicide amongst inmates.

These factors form the relevant background to my specific inquiries. They are worthy of careful consideration. Jonathon's death is not an isolated tragedy caused simply by the particular acts or omissions of any individual. His death is properly understood in its context of social injustice and dispossession.

The role of the coroner

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

In this case there is no dispute in relation to identity or to the date, place or medical cause of death. It was also readily apparent that Jonathon's death, occurring in a locked cell was self- inflicted. For this reason the inquest focused on the circumstances of Jonathon's death and on questions about whether anything could have been done to prevent it.

When a person dies in custody it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is detained in custody in NSW the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice or have their families directly assist them in this task, it is especially important that the care they are offered is of an appropriate standard and is culturally appropriate. Their living conditions are similarly restricted and prison authorities are called upon to manage an array of inmates, taking into account their often disparate medical needs and other requirements. Considerations relating to medical care and cell placement are important and can have significant impact on an inmate's state of mind and physical well-being.

Jonathon was in custody from 2 August 2017 to 3 February 2018. He entered custody with a clear risk of self-harm. He was a young indigenous man with serious mental health issues.

He had previously attempted suicide and committed self-harm on a number of occasions. As we shall see, he was actively withdrawing from drugs, had very significant relationship difficulties and his personality meant that he mostly kept to himself. One of the tasks of this inquest has been to examine what those charged with Jonathon's care ought to have known about his risk of self-harm and suicide, as well as what they actually knew. The court has carefully examined what was done to keep Jonathon safe and found aspects of the care given to him were inadequate.

The purpose of the inquest, however, is not to cast blame on specific individuals involved in his care but to identify systemic failings capable of rectification or improvement in the hope of preventing or reducing the possibility of future tragedies of this kind. The pain felt by Jonathon's family and the broader Aboriginal community is profound and ongoing. His story will affect the lives of his children and his community well into the future. Each successive Aboriginal suicide in custody shapes the story younger prisoners learn when they too are incarcerated. Tragically, the despair felt by Jonathon may well have been transitory. There needed to be stronger, culturally appropriate safeguards in place to identify his needs at an earlier time.

It was clear to me that Matthew Hogan's participation in these proceedings was directed towards more than understanding the causes of his own son's death but also to identifying opportunities for change that could assist others. I acknowledge his dignity and generosity in participating in these proceedings and I thank him for his significant contribution.

The evidence

The court took evidence over five hearing days; the court also received extensive documentary material, comprising six volumes. This material included: witness statements, medical and custodial records, investigation reports, recordings and photographs. The court heard oral evidence from doctors, nurses and correctional staff who cared for Jonathon and was assisted by the expert evidence of Dr Kerri Eagle, a forensic psychiatrist who undertook an independent review of Jonathon's mental health care and treatment in custody. While I do not intend to refer specifically to all the available material in detail in these findings, it has been comprehensively reviewed and assessed.

I should note that while the court was aware of Jonathon's contact with mental health services in the ACT just prior to his incarceration in NSW that contact was beyond the scope of this inquiry. A list of issues was prepared before the proceedings commenced. These questions directed the focus of the evidence presented in court. However as is often the case, a hearing can tend to crystallise the issues which are really at stake. For this reason, after dealing with the chronological facts, I intend to distil my reasons fairly briefly under a small number of broad headings.

The focus of the inquest ultimately centred on the systemic challenges, rather than judging the conduct of specific individuals involved in the provision of health or custodial services. At the end of the day, while no individual is singled out for particular criticism, some of the systems in place at the time of Jonoathon's death were exposed as in need of review and improvement.

Once again this court is faced with assessing care given by individuals within a system that is seriously under-resourced.

Fact finding

Those assisting me prepared a concise summary of the extensive documentary evidence obtained in relation to Jonathon's death. The summary was circulated to the interested parties during the course of the inquest for consideration and comment, prior to finalisation. The summary was a careful synopsis of the salient facts leading up to Jonathon's death. I indicated to the interested parties that I intended to adopt it as the basis of my fact finding and urged comment or correction. I was alerted to no particular controversy. In my view what follows is an accurate and useful distillation of the tendered material. I thank those assisting me for their hard work in the preparation of the following chronology.

Part two

Chronology

Personal Background

Jonathon was born in Canberra on 28 July 1994. He was the fifth of ten children.

The list of issues considered during the inquest included as follows:

The adequacy of medical screening conducted of Mr. Hogan when he entered custody at Junee Correctional Centre on 2 August 2017.

- The adequacy and timeliness of psychiatric and/or nursing reviews (including but not limited to the administration of medication) conducted of Mr. Hogan while he was incarcerated at Junee Correctional Centre.
- The adequacy and availability of Mr. Hogan's clinical documentation.
- Whether orders for Mr. Hogan's assessment under the *Mental Health (Forensic Provisions) Act 1990* were appropriately actioned by staff at Junee Correctional Centre.
- The appropriateness of Mr. Hogan's cell placement at the time of his death.
- The adequacy and appropriateness of the response by Correctional Officers following the discovery of Mr. Hogan on the evening of 3 February 2018.

Jonathon's childhood was fairly typical until around 14 years of age, when he experienced difficulties with alcohol and marijuana.

In 2008 Jonathon met whilst detained in the Quamby Youth Detention Centre in the ACT.

In 2011 Jonathon and started a relationship. They eventually had five children together; with the youngest born in November 2017 while Jonathon was in custody.

Their children were placed into the care of other family members by the Department of Family and Community Services due to substance abuse and other difficulties. By around 2010, aged about 18 years, Jonathon had commenced using methamphetamine, initially by smoking and proceeding to intravenous use by age 19.

He came into the increasing attention of police for property, drug and other offences. His offending was primarily drug related. This resulted in increasing periods of incarceration whether on remand or as a sentenced prisoner.

Mental Health History

Jonathon had a history of interaction with mental health services in NSW and the ACT.

On 22 February 2013, while on remand at the Alexander Maconochie Centre in the ACT, Jonathon swallowed a fragment of a razor blade. On 28 February 2013, Jonathon was admitted as a voluntary patient in the Adult Mental Health Unit ("AMHU") at Canberra Hospital. The Psychiatric Registrar noted the incident was Jonathon's first episode of psychosis with distressing auditory hallucinations (voices yelling and telling him to harm himself) and strong suicidal ideation. On 8 March 2013, Jonathon absconded from the AMHU after being granted bail. A discharge report noted Jonathon had been known to the Forensic Mental Health team since 2007.

On 24 August 2014, while on remand at the Wellington Correctional Centre, he attempted self-harm (cut to arm). Jonathon also reported that he had attempted to hang himself a week earlier (out of custody) but had been interrupted by a neighbour.

On 26 August 2014, Jonathon was reviewed in custody by a psychiatrist, Dr Cocks, who formed the impression he suffered from paranoid schizophrenia and polysubstance dependence.

On 28 July 2015, after entering Parklea Correctional Centre, he was noted to have a history of schizophrenia and self-harm. He had been prescribed Olanzapine (antipsychotic) medication after being released in August 2014. He reported not having seen a doctor since then and having substituted illicit substances for his medication. During the prior four months he reported using methamphetamine daily.

On 8 August 2015, Jonathon was found eligible to participate in the Drug Court program.

On 24 August 2015, Jonathon was assessed by Dr Gregory Hugh (psychiatrist), Drug Court Assessment Unit, who noted Jonathon's drug use and that he had tried buprenorphine in custody. Jonathon reported a several year history of auditory hallucinations, which included derogatory voices that told him to hurt himself (cutting or hanging).

On 2 September 2015, Jonathon was released from custody to commence the Drug Court program while residing in the community and attended regular counselling and drug screens. On 6 March 2016, Jonathon was arrested and charged with offending on During a mental health assessment on 7 March 2016 he reported himself and his partner had 'binged' on 'ice' over the preceding three days and being non-compliant with his Olanzapine medication. He returned to custody following his arrest where he remained until his release to parole on 11 November 2016.

On 29 March 2016, Jonathon's participation in the Drug Court program was terminated after he was charged with a new offence. On 27 July 2016, Jonathon reported to Correctional staff he was hearing voices. He denied thoughts of self-harm

but stated: "*I might do something silly as I can access razors in the cell"* and *"I'm stressed out*" and the voices are there most of the time. It was noted he had only recently recommenced antipsychotic medication and he was managed by the Risk Intervention Team for a period of time.

On 1 August 2016, Jonathon was reviewed by Dr Sunny Wade (psychiatrist) while he was detained for treatment in the Darcy Pod at the Metropolitan Remand and Reception Centre ("MRRC"). Dr Wade formed the impression that Jonathon was suffering from schizophrenia and substance use disorder. Dr Wade cleared Jonathon for normal cell placement.

On 23 August 2016, Jonathon reported to the medical clinic at MRRC that he had swallowed razor blades and he was hearing voices yelling to "get up". He also reported his medication wasn't working but later admitted he had been diverting his medication.

On 11 November 2016, Jonathon was released to parole. On release he was prescribed Zyprexa for treatment of his schizophrenia and an antidepressant (Alexapro) for depression.

No-contact AVO

On 19 April 2017, the Downing Centre Local Court made a 12-month no contact apprehended violence order ("AVO") against Jonathon for the protection of XX This was on the application of police and followed an alleged contravention of an earlier made on 20 March 2017.

ACT Mental Health Admission

On 28 July 2017, Jonathon was charged with additional offences and was bail refused in the ACT in relation to an outstanding warrant and other offences.

On 29 July 2017, Jonathon was transferred to Canberra Hospital for mental health assessment under an order issued by the ACT Children's Court pursuant to s. 309 of the *Crimes Act 1900* (ACT). Jonathon presented as distressed and reported that he had been experiencing auditory hallucinations since 2012. He reported '*Significant methamphetamine use*' the preceding day (about 8 points). Jonathon absconded from the hospital that evening.

Alleged offences in NSW between 31 July and 1 August 2017

On about 31 July 2017, Jonathon and X travelled to Orange, NSW.

Between 31 July 2017 and 1 August 2017, Jonathon and allegedly committed several property offences in Orange. Police allegedly pursued Jonathon in his vehicle several times before his vehicle was stopped and he and X were apprehended at about 2 pm on 1 August 2017 near Boorowa, NSW.

Jonathon was arrested, charged and bail refused at Cootamundra Police Station in relation to an outstanding breach of parole warrant and other fresh offences.

In an interview with police officers, Jonathon said he had no memory of any of the incidents or a large part of the previous five months. He stated he had not used his medication and was suffering from mental health problems. A Custody Management Record completed while he was at the police station also recorded: "*…The person is getting very agitated in the dock and is punching the dock door. States he suffers from mental illness and hallucinates."*

A parole warrant directed the parole order be treated as having been revoked on 19 April 2016. Jonathon had a balance of parole to be served of five months and 23 days, expiring on 23 January 2018.

At 1:40am on 2 August 2017, a New Inmate Identification and Observation Form was completed about Jonathon at Wagga Wagga. The Form noted that Jonathon suffered from schizophrenia but had not taken his medication "for several months". Jonathon also reported smoking cannabis the day prior and using methamphetamine two days prior.

At 11:49am on 2 August 2017, Jonathon's criminal matters were mentioned before the Registrar at Wagga Wagga Local Court. No bail application was made on Jonathon's behalf and bail was formally refused by the Registrar; with the matters adjourned and listed before Young Local Court on 8 August 2017.

Admission at Junee Correctional Centre

On 2 August 2017, Jonathon was admitted to the Junee CC in Junee, about 40 kilometres from Wagga Wagga.

Junee Correctional Centre

Junee CC is a declared correctional centre for the purposes of s. 225 of the *Crimes (Administration of Sentences) Act 1999* ("the CAS Act").

It was originally built in 1993 by the GEO Group Australia Pty Ltd ("GEO Group"). The GEO Group has operated Junee CC since its construction.

GEO Group as operator of the Junee CC was responsible for the provision and coordination of health services at Junee CC. This was under the *Management Agreement for Junee Correctional Centre* (2009) as between the Commissioner for Corrective Services NSW and the GEO Group.

As operator the GEO Group must permit the Justice Health and Forensic Mental Health Network ("Justice Health") free and unfettered access to all parts of the Junee CC and records in relation to Health Services provided in the Junee CC to all inmates. Justice Health monitors the provision of health services in managed correctional centres including the Junee CC.

The GEO Group is required, as part of its health service obligations, to provide mental health services under the protocols of the Statewide Forensic Mental Health Service and adhere to Justice Health's policies, procedures and guidelines and to ensure its policies and procedures are consistent with those of Justice Health.

That includes the Custodial Mental Health Operational Procedure Manual ("CMH manual"). The CMH manual sets out the operational framework and procedures for Custodial Mental Health. It is intended as a resource for Justice Health staff working within correctional centres.

The scheduling of medical reviews of inmates is managed by way of an electronic Patient Administration System ("PAS"). The CMH manual provides a PAS Waiting List Priority Level Protocol for mental health. This guides the prioritisation of patient booking according to their clinical needs.

As at 2017, Justice Health maintained the following records for inmate patients: an electronic records system for inmates known as the Justice Health electronic Health System ("JHeHS"). The system recorded for each inmate relevant alerts (e.g. whether a patient had self-harmed). It also allowed for reports, clinical correspondence and other medical records to be uploaded into the electronic record. Those records could then be accessed and downloaded by staff with access to the system; and patient files which contained hard copies of progress notes, reports and other records for the patient.

During the hearing a screenshot of Jonathon's JHeHS record was tendered. Dr Sarah-Jane Spencer, the Clinical Director of Custodial Mental Health and Co-Director (Clinical) Services and Programs within Justice Health, gave evidence about JHeHS during the inquest.

Dr Spencer described JHeHS as a relatively unique and evolving system that had been designed specifically for Justice Health different medical reports to be uploaded to a patient's electronic file, which could be viewed by a treating physician. Dr Spencer also confirmed that as at 3 December 2019, Justice Health was transitioning to electronic progress notes that would also be stored in JHeHS.

Junee CC medical staff, employed by GEO Group, had access to the patient files and JHeHS maintained by Justice Health for patients at Junee CC.

Mental health clinicians at the Junee CC

The Junee CC provided mental health treatment to inmates but did not contain a declared mental health facility within its grounds. Junee CC employed or contracted staff for the provision of medical treatment including:

Dr Darren Corbett as General Practitioner ("GP").

RN Alexander Tobin, a Registered Nurse ("RN") ("Tobin RN")**.**

Dr Matthew Jones (psychiatrist), a Visiting Medical Officer ("VMO"), who usually attended two consecutive days each fortnight (Wednesday-Thursday).

As at August 2017, there were two nurses at Junee CC assigned to mental health, namely: Tobin RN and RN Julie Anne Williams ("Williams RN").

Sentenced inmates considered 'mentally ill' can also be transferred in custody from Junee CC to specialist placements (declared mental health facilities) within Correctional Centres, for mental health treatment such as: Mental Health Screening Unit ("MHSU") for males in the MRRC;

Place of Detention ("POD") 17 and 18, Hamden Block within the MRRC; or the Mental Health Unit, Long Bay Hospital.

That could be done under the exercise of power pursuant s. 55 of the *Mental Health (Forensic Provision) Act 1990* ("the MHFP Act") or by other order. Management of bed availability for the POD and the Mental Health Screening Unit ("MHSU") is discussed at weekly meetings which include GEO Group staff participation.

RAPO, Aboriginal Health Worker and Cultural Advisor

Presently, the GEO Group does not employ any person in the position of Aboriginal Health Worker at Junee CC. Corrective Services NSW ("CSNSW") employs Geoffrey McAdam as a Regional Aboriginal Project Officer ("RAPO") for the south-west region of NSW. In that capacity, Mr. McAdam attends 17 correctional centres from Cooma through to Broken Hill. He typically visits each centre at least once per month.

There are four RAPOs in New South Wales. Mr. McAdam's role includes meeting with delegates of the Aboriginal Inmate Delegate Committee ("AIDC").

He also assists aboriginal inmates who are moved from one centre to another and when they are released from custody including assistance in gaining employment or training.

In 2017 and now, GEO Group employs a person in the role of Cultural Advisor based at the Junee CC. In 2017, Gerome Brodin carried out this role. Mr. Brodin previously worked as a correctional officer with GEO Group. His role involved organising cultural activities and cultural days at Junee CC including for NAIDOC week, Ramadan, Eid festival, Chinese New Year, Anzac Day, and Remembrance Day. Mr. Brodin also arranged for the provision of paints and canvases for inmates. Mr. Brodin also engaged with the AIDC, which was constituted by inmate delegates from each unit and met about twice per month to discuss any concerns raised by the Committee. Mr. Brodin's role is not principally about one to one contact with inmates, although that sometimes occurs in the course of arranging activities.

Assessment on admission to Junee CC on 2 August 2017

On 2 August 2017, a Reception Screening Assessment ("RSA") and Health Problem Notification Form ("HPNF") was completed for Jonathon by RN Tegan Aylward ("Aylward RN").

The RSA and HPNF are electronic screening tools used by Justice Health. Information captured during screening is entered into JHeHS.

Aylward RN was employed as a registered nurse by the GEO Group to work at the Junee CC.

On 2 August 2017, Aylward RN was working in the role of "intake nurse" at Junee CC. Aylward RN carried out a face to face assessment of Jonathon in a private room in the intake area. She asked him a series of questions and made observations of him. She recorded information she considered to be relevant in a handwritten progress note and also in the electronic RSA and HPNF.

Aylward RN was not medically trained or responsible for making diagnoses for patients; only to record clinical observations and nursing opinions in the RSA.

The RSA completed by Aylward RN relevantly noted: Jonathon had several existing health conditions including depression and paranoid schizophrenia (since age 17); Jonathon had previous contact with Canberra Hospital regarding mental health concerns; Jonathon had been using six-points of methamphetamine daily (IV, smoked) and smoked '10 cones' of cannabis daily before his return to custody; Clinician assessment of patient presentation: "In withdrawal"; Patient presentation (Mental Health perspective): "*pt co-operative, slightly restless, unable to sit still*"; Mental Health Condition: 'depression, schizophrenia'; Last attempted self-harm: '*many years ago'* by '*cutting'*; and Jonathon had responded "*yeah good*" when asked how he thought he would cope in prison.

The HPNF relevantly noted:

Jonathon had some mental health issues – observe for mood swings; there had been observed agitation, isolative/inappropriate behaviour; he had a history of substance abuse (was to be observed for nausea, vomiting, hallucinations, seizures); and he had 'special health needs' to be addressed by a "two-out" cell placement for two weeks (to expire on 16 August 2017) followed by a normal cell placement with contact to be made to medical if concerns arose.

The progress note completed by Aylward RN relevantly noted:

Jonathon was previously on "*meds for depression + schizophrenia*";

"*…cooperative, good eye contact…*"

"*…use ice (IV + smoked) daily – 6 points + cannabis daily. Commenced on withdrawal monitoring + nurse initiated Phenergan for 7 days*";

"*…Reports poor memory of yesterday's events, however also states he took a pill from a friend a few days ago + has felt vague since then…*" and

"*Nil current meds, no community mental health provider*".

Aylward RN referred Jonathon to the Mental Health Nurse and Drug and Alcohol Nurse for assessment.

Junee CC had a standing order that 50mg Promethazine (also known as Phenergan, antihistamine) be prescribed (night-time) for seven days to assist patients withdrawing from methamphetamine use. Jonathon was prescribed the same. During induction at Junee CC, Aylward RN had been advised that new receptions of inmates at risk of withdrawing from drugs or alcohol, or with mental health issues, were to be placed in a "two-out" cell placement for their first two weeks in custody.

The initial "two-out" cell placement permitted the inmate time to settle in the facility, undergo some detoxification and have someone else present in their cell to call for help if necessary. The expectation is that the inmate will be reviewed within that period by speciality nurses and/or the GP.

Aylward RN, as reception nurse, was not responsible for booking or managing the inmate's medical reviews. Once placed on a wait list for referral to specialised nurses, those speciality nurses made and managed their own appointments.

During Aylward RN's reception review with Jonathon, release of information consent forms were not signed by him. Such forms can obtain information from Community Health providers. The reason for this form not being signed was not documented. Aylward RN's referral to the Mental Health Nurse and Drug and Alcohol Nurse was made via the PAS. Referrals are given a priority classification by the intake nurse. Aylward RN assigned those referrals a 'category 2' classification which indicated Jonathon was to be reviewed within 14 days.

Screening during 3 August 2017

On 3 August 2017, an Intake Screening Questionnaire ("ISQ") was completed about Jonathon by Kerri Lee Walker. The ISQ relevantly noted that Jonathon was diagnosed with schizophrenia and had not been taking medication "*for about a year*". Jonathon also reported that he had no contact with his family due to his drug use and indicated that remained his only support in the community.

On 3 August 2017, a remand reception committee form was completed which noted Jonathon as being an 'un-medicated schizophrenic' and an *immediate safety concern*. On 4 August 2017, Jonathon's classification was approved as "B Medium". The approval form noted: "*Two-out cell placement 01/09/17. History of Self Harm Incident. History of Mental Illness – Schizophrenia*".

That same day Jonathon was assessed by a Drug and Alcohol Nurse. Jonathon was noted to be in withdrawal from methamphetamine and cannabis use and prescribed Phenergan.

Court ordered mental health assessment on 8 August 2017

On 8 August 2017, Jonathon appeared by audio-visual link ("AVL") before Magistrate O'Brien at Young Local Court. Magistrate O'Brien ordered Jonathon undergo a psychiatric assessment to determine if he was suffering a mental illness and whether there were reasonable grounds to believe him to be a 'mentally ill person' within the meaning of the *Mental Health Act 2007* ("the MH Act"). Jonathon's criminal matters were adjourned until 19 September 2017 to await that assessment.

By s. 3 of the MH Act, "mental illness" is defined: "***mental illness*** means a condition *that seriously impairs*, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms: delusions, hallucinations, serious disorder of thought form, a severe disturbance of mood, sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d)." (Emphasis added)

Section 14 of the MH Act provides:

14 Mentally ill persons

A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

- for the person's own protection from serious harm, or
- for the protection of others from serious harm.

In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account."

As at 2017, an employee with the Forensic Mental Health Liaison Officer, Justice Health, would email a request for a Junee CC inmate to be assessed and a report to be prepared to the Junee CC mental health team. Such emails would be sent to the Health Services Management at Junee CC, Jan Te Maru, and one or both of the Mental Health Nurses (Williams RN and Tobin RN).

Dr Jones was expected to carry out assessments and provide reports, pursuant to orders of the Court, if requested by GEO Group to do so. The reason why Dr Jones was not requested to prepare the report requested by Magistrate O'Brien with respect to Jonathon is not known.

Classification change on 17 August 2017

On 17 August 2017, Jonathon's security classification was downgraded to "B". The approval form noted Jonathon should maintain contact with psychology and the mental health team when required.

Mental health review by Tobin RN on 24 August 2017

On 24 August 2017, Jonathon was reviewed Tobin RN who documented:

Jonathon reported feeling paranoid, thought people talking about him and sought medication for symptoms ("*I think I might need medication"*);

Jonathon reported not being subject to community health interventions but thought he may have been in an inpatient unit in the ACT before coming to Junee but was "unsure what for"; he presented with normal speech flow, logical but vague in conversation, and was orientated to time; and he did not have thoughts of harm to self but reported hearing "voices" with people talking about him.

Following a discussion with the GP, Jonathon was commenced on Olanzapine 10mg (twice daily) and scheduled for review with Dr Jones the following week. He was also placed on the Metabolic Monitoring List for routine monitoring of the weight of inmates receiving antipsychotic medication. As at 28 August 2017, Jonathon was administered Olanzapine at 10 am and 3 pm under the supervision of nursing staff. Owing to the drowsy effects of the medication when taken at 3pm, Dr Corbett authorised Jonathon receiving his afternoon dose at 3pm to take at night- time (unsupervised) so as not to disrupt his sleeping pattern.

First psychiatric review by Dr Jones on 30 August 2017

On 30 August 2017, Jonathon was reviewed by Dr Jones. Dr Jones documented Jonathon: had lapses with medication before incarceration but now on Olanzapine; reported not using drugs other than small amounts of cannabis; reported hearing voices "and stuff" and symptoms worse when not on medication; reported "…been missing am Olanz dose – not getting up"; had participated in Adult Drug Court Program previously and would like to undertake drug rehabilitation now.

Dr Jones also noted that Jonathon did not talk to anyone except "*my girl (not family, not friends)*".

Based on his history and mental state examination, Dr Jones formed the impression that Jonathon had a diagnosis of schizophrenia. Dr Jones altered Jonathon's prescription of Olanzapine to a 20mg nightly dose. The documented plan was for Jonathon to be reviewed in two weeks' time (i.e. around 13 September 2017).

On 31 August 2017, Jonathon was seen by the GP, Dr Darren Corbett, to discuss his medications. During that consultation, Dr Corbett reinforced the clinical decisions of Dr Jones the previous day.

Dr Gerald Chew psychiatric review at the MRRC on 8 September 2017

Between 6 and 7 September 2017, Jonathon was transferred from Junee CC to the MRRC in Sydney. This was for the purpose of him undergoing psychiatric assessment as ordered.

On 8 September 2017, Jonathon was assessed by Dr Gerald Chew at the MRRC. Dr Chew had regard to the recent NSW Police Facts sheet (for the alleged offences on 31 July to 1 August 2017), Jonathon's criminal history and accessed records held by Justice Health which included information about Jonathon's polysubstance abuse and prior psychiatric admissions and reviews.

Transfer back to Junee CC on 10 September 2017

On 10 September 2017, Jonathon was transferred back to Junee CC via Bathurst Correctional Centre ("Bathurst CC"). That same day, on 10 September 2017, a second HPNF was completed by RN Alisha Girdlestone noting Jonathon had "nil acute medical concerns" and recommending him for normal cell placement.

On 12 September 2017, Jonathon was transferred to Wagga Wagga Police Station and charged with further offences. The Custody Management Record noted that Jonathon had schizophrenia and had not taken medication for two weeks.

Hard copy patient files

On 9 September 2017, a Transfer in and out form (Justice Health) was completed for Jonathon's transfer from MRRC. It noted regarding "All Health Record Volumes – *'Vol 1 (closed)?' and '1 x med chart* and *'3V'''.*

During the inquest, Justice Health produced a log that electronically recorded the movements of three volumes of hard copy patient records for Jonathon. In summary the log records: the files were transferred by Justice Health to the Junee CC medical clinic by 7 August 2017 (following Jonathon's placement there on 2 August 2017); the files were later transferred to the MRRC in early September 2017 for Dr Chew's assessment; and the files were transferred back to the Junee CC Clinic on or by 27 September 2017.

Dr Chew's report completed and uploaded to JHeHS on 14-15 September 2017

In a report dated 14 September 2017, Dr Chew noted Jonathon's report of auditory hallucinations that were "*much muffled"* on Olanzapine. He was oriented to time, place and person. He said his mood was "*okay*" and there were no overt signs of delusions.

Dr Chew diagnosed Jonathon with schizophrenia and opined that he remained "*acutely psychotic despite treatment with antipsychotics*" although on Jonathon's account he was much improved as compared to when he was first incarcerated. Multiple risk issues were noted in his history including self-harm attempts.

Dr Chew considered Jonathon was a "*mentally ill person"*. Dr Chew considered Jonathon could be managed in a gazetted mental health unit under s. 33 of the MHFP Act. Dr Chew's report was uploaded into the JHeHS electronic record for Jonathon on or by 15 September 2017. Other reports including those prepared by Statewide Forensic

Mental Health Services, and other records, were stored on JHeHS which was accessible to Justice Health nurses, medical officers and authorised clinicians within Junee CC. It was subsequently determined by GEO Group that a hardcopy of Dr Chew's report was not on the patient files held at Junee CC at the time of Jonathon's death.

Section 33(1) (b) order made on 19 September 2017

On 19 September 2017, Jonathon appeared by AVL before Magistrate O'Brien at Young Local Court.

Having regard to the report prepared by Dr Chew, an order was made under s. 33(1)(b) of the MHFP Act requiring Jonathon to be taken to a mental health facility.

The order was made while Jonathon's pending criminal matters were before the Court (for which he had been remanded). No reference was made to the fact of Jonathon being a sentenced prisoner serving his outstanding balance of parole. During the proceedings, mention was made about Jonathon being taken to Gissing House, a mental health unit within the Wagga Wagga Hospital, for assessment.

Section 33(1)-(1B) of the MHFP Act provided: **33 Mentally ill persons** If, at the commencement or at any time during the course of the hearing of proceedings before a Magistrate, it appears to the Magistrate that the defendant is a mentally ill person,

the Magistrate (without derogating from any other order the Magistrate may make in relation to the defendant, whether by way of adjournment, the granting of bail in accordance with the *Bail Act 2013* or otherwise): may order that the defendant be taken to, and detained in, a mental health facility for assessment, or may order that the defendant be taken to, and detained in, a mental health facility for assessment and that, if the defendant is found on assessment at the mental health facility not to be a mentally ill person or mentally disordered person, the defendant be brought back before a Magistrate or an authorised officer unless granted bail by a police officer at that facility, or may discharge the defendant, unconditionally or subject to conditions, into the care of a responsible person.

(1B) The provisions of the *Mental Health Act 2007* (other than section 51 (1) and (2)) apply to and in respect of the defendant and that order as if the order had been made by the Tribunal under that Act.

(1C) A Magistrate must, before making an order under subsection (1A), notify the Secretary of the Ministry of Health, or a person authorised by the Secretary of the Ministry of Health for the purposes of this section, of the proposed order.'

By cl 14 of the *Mental Health (Forensic Provisions) Regulation 2017,* where a defendant is on remand or serving a sentence of imprisonment (other than in a detention centre), a correctional officer or a police officer are "prescribed persons" for the purposes s. 33 who may take a defendant to or from a place.

Further, by s 55 of the MHFP Act, the Secretary of the Ministry of Health may order a person imprisoned in a correctional centre to be transferred to a mental health facility based on two certificates issued by two medical practitioners (one of whom is a psychiatrist) in the form set out in Schedule 2 to the MHFP Act. This is despite any other order made.

The order made by Magistrate O'Brien on 19 September 2017 directed:

"The defendant is to be taken by police, or a prescribed person as ordered by the Court, and detained *in the* mental health facility for assessment in accordance with the *Mental Health Act 2007*. If on assessment the accused is found *not* to be a mentally ill person or mentally disordered person within the meaning of the *Mental Health Act 2007*, he is to be brought by a prescribed person back before a Magistrate or an authorised officer". (Emphasis added)

The order was directed to the Superintendent at Gissing House (Wagga Wagga Hospital inpatient unit) rather than to any declared mental health facility.

Registry staff at Young Local Court were advised thereafter by CSNSW that it could not comply with the order because Jonathon was a "sentenced inmate" serving a balance of parole and suggesting a s. 35 order be made in substitution. The matter was raised in Court before Magistrate O'Brien who noted s. 24 of the CAS Act and declined to alter the order.

Scheduled psychiatric review on 28 September 2017

As at 28 September 2017, Jonathon had not undergone a further psychiatric review at Junee CC since that with Dr Jones on 30 August 2017. On 28 September 2017, Jonathon was included on a list of inmates to be reviewed by Dr Jones. That review did not take place possibly owing to other inmates' reviews being prioritised. Tobin RN saw Jonathon in Unit B4 the following day and told him that his review would be rescheduled. Jonathon reported he had no thoughts of harming himself or others.

Appearance before Magistrate Williams on 9 October 2017

On 9 October 2017, Jonathon appeared by AVL before Magistrate Williams at Orange Local Court. On that occasion Jonathon's legal representative referred to Dr Chew's report and submitted that his client reported still hearing voices. Another application was made under s. 33(1) (b) of the MHFP Act. Magistrate Williams granted that application.

That same day a CSNSW representative emailed Young Local Court registry drawing its attention to the s. 33(1) (b) order and stated:

"A defendant who is on remand or serving a sentence of imprisonment could not be transferred to a mental health facility on a s 33 order for the purpose of an assessment as this would effectively release them from CSNSW custody. In these instances, an order pursuant to s 35 MH (FP) Act…is the most appropriate order to be issued. Under s 35 order the defendant is assessed in CSNSW custody and transferred to Long Bay Hospital if found to be a mentally ill person."

The next day, on 10 October 2017, Jonathon again appeared by AVL before Magistrate Williams at Orange Local Court. The matter was re-listed urgently due to further concerns raised by CSNSW. Magistrate Williams maintained the s. 33(1) (b) order, although his Honour remarked that it was ultimately a discretionary matter for CSNSW as to whether Jonathon would be released to a mental health facility for assessment. The s. 33(1) (b) order was reissued containing a notation that the order did not override CSNSW's authority.

On 12 October 2017, the s. 33(1) (b) order made by Magistrate Williams the previous day was revised in chambers to an order made under s. 35 of the MHFP Act.

Section 35 of the MHFP Act provided:

"**35 Transfer from correctional centre or detention centre**

This section applies to a person who is awaiting committal for trial or trial for an offence or summary disposal of the person's case.

If it appears to a Magistrate that it may be appropriate to transfer a person to whom this section applies from a correctional centre or detention centre to a mental health facility under section 55, the Magistrate may make an order directing: that the *defendant be examined by 2 medical practitioners, one of whom is a* psychiatrist, and that, if appropriate, the relevant certificates be furnished to the Secretary of the Ministry of Health under section 55, and that the Chief Executive Officer, Justice Health or, in the case of a juvenile, the Secretary of the Department of Justice notify the Magistrate of the action, if any, taken under section 55."

Second psychiatric review by Dr Jones on 11 October 2017

On 11 October 2017, Jonathon was reviewed by Dr Jones for the second time.

Jonathon reported to Dr Jones that his prescribed Olanzapine had been ineffective and he continued to hear voices screaming and yelling at him. He also mentioned having court the previous day where mention was made of "*sending me to a + ward – left it to his gaol to do it".* Dr Jones increased Jonathon's dosage of Olanzapine to 30mg daily. The plan was for Jonathon to be reviewed again in four weeks' time.

Justice Health email to Junee CC on 8 November 2017 regarding s. 35 MHFP Act Order

On 12 October 2017, Filomena Romano, a Forensic Mental Health Liaison Officer with Justice Health, sent an email to Ms. Te Maru and Williams RN at Junee CC titled "*FW: Section 35 Court Order re: Jonathon HOGAN (MIN 545484) – detained at Junee Correctional Centre*". That email forwarded on an email sent by Justice Health earlier that day which stated:

"Please find attached the section 35 *Mental Health (Forensic Provisions) Act 1990 Court* Order for Assessment issued 12 October 2017 by the Magistrate of Young Local Court re: Jonathon HOGAN (MlN 545434) who is currently detained at Junee Correctional Centre (see below screen shot) practitioners, one of whom is a furnished to the Secretary of the Ministry of Health under s 55 of the MHFP Act 1990.

The order directs that the inmate be examined by two medical psychiatrist, and that if appropriate, the relevant certificates be Ministry of Health under section 55 of the MHFP Act 1990.

The matter has been listed for mention before the Young Local Court on 5 December 2017. Please let me know the outcome of the examinations so that I can inform the Court."

Attached to the email was the following: a two page policy document titled "*Custodial Mental Health Procedure: Orders under Section 35 of the Mental Health (Forensic Provisions) Act 1990 – Transfer from a Correctional or Detention Centre to a Mental Health facility'.* It included the instruction that "the Clinical Director Custodial Mental Health or the Deputy Clinical Director Custodial Mental Health will arrange for the person to be examined by two medical practitioners, one of whom must be a psychiatrist." a sealed copy of the s. 35 order made on 12 October 2017 in respect of Jonathon.

Third psychiatric review by Dr Jones on 8 November 2017

On 8 November 2017, Jonathon was again seen by Dr Jones at Junee CC.

Dr Jones documented: "*feeling good*" (which attributed to medication); stated his preference to be at Junee CC as it '*stabilised him*'; "*NB:? Judge request for S 35 Assessment*" some residual symptoms of schizophrenia but Jonathon insightful regarding illness and compliant with prescribed medication, weight at 72 kg with aim for 84 kg;

Jonathon prescribed Olanzapine 30 mg to be taken nightly (no side effects), no delusions, presented as calm, not neglecting his care, decrease in him hearing voices; Considered suitable for employment (sentenced until Jan 2018); and (g) "*RW – 6/52*". The noted plan was to: (1) continue the treatment and (2) review again in 6 weeks (approximately 21 December 2017).

No mental health nurse or psychiatric reviews post 8 November 2017

PAS records showed that Jonathon was booked and rescheduled for psychiatric review four times between 21 December 2017 and 1 February 2018. None of these appointments took place.

Justice Health email to Junee CC on 8 November 2017 regarding s. 35 order

At 8:28am on 8 November 2017, Ms. Romano sent another email to Junee CC concerning Jonathon's s. 35 assessment. Ms. Romano's email was sent to Williams RN, Ms. Te Maru and Tobin RN.

In that email, Ms. Romano stated: "Jonathon HOGAN was issued with a section 35 Mental Health (Forensic Provisions) Act 1990 Court Order on 12 October 2017. Are you able to confirm if Mr. Hogan has been assessed by two medical practitioners, once whom must be a psychiatrist and if so, what was the outcome of the assessments? I need to send notification to the Court of the outcome prior to his next hearing date which is currently listed for mention on 5 December 2017." The email again attached the two page policy document and s. 35 order (which had earlier been attached to Ms. Romano's email on 12 October 2017).

Tobin RN email to Justice Health on 8 November 2017 at 3:05 pm

At 3:05 pm on 8 November 2017, Tobin RN sent an email to Trevor Perry (Justice Health) copying Williams RN. The header of the email read: "*Re: Jonathon HOGAN – s35 MHFPA 1990 Court Order – Issued: 12 October 2017*" stating: "I am writing this email with Dr Jones by my side.

He has assessed Mr. Hogan today, he would not be considered a 'mentally ill person' as there are no acute risk issues and only mild current psychotic symptoms. He has not been admitted to a mental health facility and will remain under our ambulatory care."

Although reviewed by Dr Jones, a second medical practitioner did not review Jonathon as required by s. 35 of the MHFP Act.

Justice Health correspondence to the Local Court on 17 November 2017

On 17 November 2017, correspondence was sent from the Chief Executive of Justice Health to the Magistrate at Young Local Court advising that Jonathon was assessed by a psychiatrist who formed the opinion he was displaying mild psychotic symptoms and had no acute risk issues. As a result, Jonathon was found not to be a mentally ill person under the MH Act and did not require admission to a mental health facility.

Events between December 2017 and January 2018

On 5 December 2017, Jonathon appeared by AVL before Magistrate O'Brien at Young Local Court. Magistrate O'Brien noted receipt of the 17 November 2017 correspondence from the Chief Executive of Justice Health and confirmed that Jonathon did not require admission to a mental health facility. The matter was adjourned to 18 December 2017.

On 18 December 2017, Jonathon appeared by AVL before Magistrate O'Brien at Young Local Court. Jonathon's solicitor confirmed that he did not wish to disturb a 19 April 2017 conviction for contravening an AVO, which occurred in Jonathon's absence. The matter was adjourned to 5 February 2018.

Case conferences with CO Davies

On 22 December 2017, a casework interview took place between Jonathon and Correctional Officer ("CO") Harlee Davies. CO Davies noted that Jonathon "*rarely approaches staff*" and posed nil management concerns for staff. CO Davies further noted that Jonathon was recommended for participation in EQUIPS Foundation, EQUIPS Addiction and EQUIPS Aggression and encouraged to attend "*when a placement is made available*".

On 13 January 2018, a further casework interview took place between Jonathon and CO Davies. The case notes indicated the same outcome as at the 22 December 2017 interview.

Regarding CO Davies' casework interviews with Jonathon, CO Davies gave evidence that: he was not aware that Jonathon was receiving mental health treatment and this was not a topic he would have questioned Jonathon about during their conversations; the phone contact Jonathon had with his partner in the days preceding his death (discussed further below) is not a matter CO Davies would have had knowledge about unless Jonathon himself raised it with CO Davies; and Davies would only have spoken to other inmates about how Jonathon was going if he noticed any change in Jonathon's behaviour.

CO Davies' assessment of Jonathon was also informed by his general observation of him when working a shift in Jonathon's POD. On those occasions he expected he would have sighted Jonathon between 10 to 20 times each day.

Court matters as at January 2018

On 22 January 2018, Jonathon appeared by AVL before Magistrate Day at Orange Local Court. Jonathon entered pleas of guilty to four offences. The matter was adjourned to 15 March 2018, with Jonathon ordered to appear in person on the next occasion. Jonathon's criminal matters were listed for sentence on 5 February and 15 March 2018.

AVL screening

Inmates who appear in Court via AVL from Junee C are seen by a nurse in the clinic before being returned to their cell. This is typically known as an AVL screen.

These reviews typically involve a nurse asking the inmate what happened in court, what the outcome was, how they feel about the outcome and if they have any thoughts of harming themselves or others. These reviews might go no longer than a few minutes.

Completion of revoked parole on 23 January 2018

On 23 January 2018, the balance of Jonathon's parole expired. Jonathon was relocated to Unit B2 at Junee CC (a designated remand accommodation area) and assigned to cell D04 as "two-out". His classification changed to "C1_U UNS C1" owing to outstanding parole being completed and him returning to remand.

Available mental health clinicians during January 2018

During January 2018, Ms. The Maru went on unplanned leave for understandable personal reasons. Williams RN acted in the role of Health Services Manager during that period. During that period, Tobin RN was the staff member performing the Mental Health Nurse role on a full-time basis.

Medication compliance during January 2018

Medication was dispensed on an unsupervised basis to Jonathon in January 2018.

He attended the medication administration session in his accommodation unit each morning to be issued his daily medication. He would take that medication each night-time before bed. Medication charts show that between 11 and 24 January 2018 his medication chart was not signed off by nursing staff for the dispensing of Olanzapine. That concerned 11, 15, 19, 20, 23 and 24 January 2018. The absence of a staff signature on these dates likely indicates that Jonathon did not present or receive his medication on these dates. The arrangements for an inmate collecting medication, for use on an unsupervised basis, as at January 2018 consisted of medication was dispensed from the clinic which was located separate to where most inmates were housed the night before the night nurse would prepare a list identifying the inmates who were to be dispense medication the following day the list is provided to correctional officers so the movement of inmates from various units to the clinic can be managed the following day.

There would be a muster of inmates for a particular unit with that group of inmates being escorted or taken to the clinic to receive their medication. Typically if an inmate failed to attend the muster and accompany his unit's group to the clinic for the medication round, he would likely miss getting his medication on that date.

At the 'window' the medication nurses had a trolley with each inmate's medication charts. Those charts were initially positioned in a horizontal lengthwise down. When an inmate collected his medication that would be noted in the file by a nurse. The file was then placed back on the trolley in a vertical lengthwise position to indicate which inmates had collected their medication.

As at January 2018, nurses responsible for dispensing medication followed a "three-day" practice namely: if an inmate missed collecting their daily medication on a particular occasion the nurses would notify those responsible for the inmate's treatment if the nurses had immediate concerns; otherwise the nurses would notify those responsible for the inmate's treatment if an inmate missed their daily medication three days in a row.

There is no evidence of any inquiry being made by the medication nurses of correctional officers on the missed days about why Jonathon was not attending.

No notation was made in Jonathon's progress notes about the fact of his non-attendance being flagged as a possible concern by the medication nurses or between nurses or clinicians about the missed attendance, whether any inquiry was made of Jonathon about the reasons for his non-attendance when he attended on other occasions to collect his medication, or the fact of the missed medication was to be raised with the mental health treating team for their consideration.

Amendment of Apprehended Violence Order

On 29 January 2018, Jonathon appeared by AVL before Magistrate Antrum at Queanbeyan Local Court. The matter was listed for an application by X to vary an AVO in place between herself and Jonathon. Magistrate Antrum subsequently made orders deleting the non-contact condition between Jonathon and XX in the AVO. Thereafter, Jonathon made frequent calls to XX from the prison phone.

Jonathon is left "one out" on 1 February 2018

On 1 February 2018, Jonathon was housed "one-out" following the transfer of his cellmate, to cell D21. His "normal" cell classification allowed for him to be housed one-out or with others.

On the same date, Jonathon called X on 12 occasions, three of which were successfully connected. During a telephone conversation at 3:06pm, Jonathon said to X that: "*Ya wanna come see me or otherwise I'm gonna neck myself*".

Phone calls between Jonathon and X between 23 January and 3 February 2018

Successfully connected calls exchanged between Jonathon and X between 23 January and 3 February 2018 comprised as follows:

23 January 2018	
5. (9:26 am)	6. Jonathon mentions "*…But straight up, my lawyer reckons I'm going to be doin' a long time"*.
7. (3:17 pm)	8. says she will wait for him and "*…When I find out what you get I'll just come down every weekend"*. Jonathon says "*…I don't even, they're goin' to end up moving me gaols soon"* and "*…next truck for sure, it's to Bathurst*."
9. 25 January 2018	

10. (2:56 pm)	11. accuses Jonathon of lying. says: "*I'm movin' on. I don't want to be with you. I'm goin' to go find somebody else who's goin' to be actually out here, and be here for me. Out here to support me and help me when I need the fuckin' [redacted]. Where are you? You're never here for me*".
12. (3:24 pm)	13. says "*…all you know what to do is get somebody knocked up, and go to gaol all the time. That's all you know what to do*."
14. 27 January 2018	
15. (12:51 pm)	16. Jonathon says he wants "*to go back down to Sydney gaols"* and he was on

17.	18. "*BU classo again*" and due in Court in Orange.
19. 30 January 2018	
20. (12:05 pm)	21. says she just got out of the watch-house and went straight to Care and Protection to let them know. She'd moved into a new house 11 weeks ago and [redacted]olice had executed a search warrant, during which they found a stolen motor bike. She assured Jonathon her fingerprints were not on it and she knew nothing about the bike (he asked why she was lying to him).
22. (1:14 pm)	23. Jonathon asks "*who's fuckin' bike was it?*" and says she will hang up the phone. says "*I don't want to be in a relationship with somebody who doesn't trust me…*" Ends call telling him "*…I don't want anything to do with you…so seriously, don't call me*".
24. 31 January 2018	
25. (8:28 am)	26. tells Jonathon: "*I miss you. And I hope there's a visit for Saturday*' and '*…I promise you I'll be down there this weekend*'
27. 1 February 2018	
28. (3:06 pm)	29. Jonathon asks "*Are you comin' to see me this weekend?"* and replies: "*Yes I am…Sunday".* says she will catch a bus to Wagga Wagga. asks Jonathon: *"Are you excited you're goin' e to see me?"* and he replies; *"Yes, I can't wait, cunt. You…come and see me I'll just neck myself".*

Events of 3 February 2018

On 3 February 2018, Jonathon was due to be transferred to Bathurst CC the following day for an appearance at Orange Local Court on 5 February 2018.

Correctional Supervisor ("CS") Georgina Nathan was on shift. She recalled briefly seeing Jonathon during the meal muster. She did not recall noticing anything unusual or remarkable about Jonathon that day. She was not aware of the numerous attempted calls he made to throughout the day.

During the day Jonathon attempted to call X on 79 occasions. At 5:34pm, Jonathon made a final attempt to call X. He left a message on her phone that said: "*I need you to tell me what's going on…you're really fuckin' me up*".

Just before lockdown at 5:43 pm, Jonathon entered cell (D20). A later advised that he had known Jonathon since 2016. Jonathon came to his cell about five to ten minutes before lock-in for a chat. Jonathon also wanted Panadol and gave him two Panama tablets. Jonathon did not appear to be himself.

At 5:43pm, Jonathon exited cell D20 and entered cell D04 for lockdown at 5:45 pm. His cell was secured by CO Matthew Bond and CS Georgina Nathan.

At approximately 7:35pm, CO Scott Smith and CO Orisi Loco entered D Pod and commenced a security check of Unit B2. Shortly after entering, CO Loco attended cell D04 and attempted to conduct a check of Jonathon throughout the window of his cell. CO Loco observed Jonathon's cell door window covered up with a towel jammed between the door and the wall. CO Loco requested Jonathon to remove the towel but received no response. After knocking on the cell door, the towel eventually fell and CO Loco attempted to locate Jonathon with a torch.

CO Loco gave evidence that initially when he looked inside the cell it was very hard to see Jonathon "*because he wasn't in the top bunk or the bottom bunk and got my torch around, shone around and I couldn't see him"*. At CO Loco's request, CO Smith attended Jonathon's cell. This occurred at about 7:37 pm. They both looked inside through the cell window in an attempt to locate Jonathon. They both saw Jonathon on the edge of his bed with a ligature fashioned from a bed sheet hanging around his neck.

CO Loco activated a Centre Emergency Response Team 1 alert ("CERT 1 code blue") via his handheld radio. He also called for immediate medical assistance via radio.

CO Loco gave evidence that correctional officers performing cell check cannot physically unlock cell doors themselves. The doors are unlocked from within the control room. Nor do the COs performing cell checks have the authority to authorise the control room to open a cell. Only the Correctional Manager of Operations ("CMO") has that authority.

CMO Paul Errington and others made their way to the cell. On route, CMO Errington spoke with CO Loco and or CO Smith via radio.

At about 7:39pm, CO Thomas Harrison, CO Anthony Hanley and CMO Errington entered D Pod.

Approximately two and a half minutes passed between the CERT 1 code blue radio alert and CMO Errington's arrival at the cell.

At about 7:40pm, the lights in D Pod were turned on and cell D04 was opened following a direction by CMO Errington.

At about 7:41pm, RN Petrina Meffert ("Meffert RN"), RN Amanda Sheppard ("Sheppard RN") and CO Chris Dawe entered D Pod and approached cell D04. Meffert RN proceeded to check Jonathon's vital signs and directed Correctional Officers to remove Jonathon from the cell into the Day Room Area. Meffert RN and Sheppard RN then commenced resuscitation efforts.

CO Loco gave evidence that correctional officers continued resuscitation efforts, even when they considered they would not be able to revive Jonathon, because correctional officers are not authorised to cease resuscitation efforts. Resuscitation attempts must continue until someone with authority (such as a Medical Officer) can direct attempts to be ceased.

At approximately 7:45pm, Meffert RN unsuccessfully attempted defibrillation of Jonathon.

Meffert RN subsequently noted that "*on arrival to unit, cyanosed, no signs of life, fixed dilated pupils, no heart rate, incontinent or urine*." She also noted that Jonathon was in asystole during attempted defibrillation.

At approximately 7:47pm, Jonathon was placed on the Striker Trolley and escorted out of D Pod to the Medical Unit.

At approximately 7:57pm, NSW Ambulance Officers arrived at Junee CC.

At 8:12pm, Jonathon was pronounced deceased by Dr Corbett. Dr Corbett gave evidence that he was off duty but called in urgently. On arrival he assumed responsibility for control of the scene. On arrival, he saw Jonathon was asystole; meaning the defibrillator's electrocardiogram ("ECG") reading showed "a flat line" and Jonathon had a non-shockable rhythm.

At 8:38pm, NSW Police attended Junee CC and established a crime scene.

Post death investigations

On 16 February 2018, John Glasheen (Senior Investigator Officer, CSNSW) completed a Serious *Incident Report* regarding Jonathon's death. On 28 February 2018, a post-mortem toxicology analysis showed traces of non-toxic paracetamol in Jonathon's blood.

On 23 March 2018, Dr Hannah Elstub completed an autopsy report under the supervision of Dr Allan Cala. In Dr Elstub's opinion, Jonathon died due to neck compression. Abrasions and marks were seen on Jonathon's lateral right neck but no other significant injuries detected.

In April 2018, Jason White completed an investigation report into Jonathon's death for the GEO Group.

Finding of "intentionally self-inflicted death"

A finding that a death is intentionally self-inflicted should not be made lightly. The evidence must be extremely clear and cogent in relation to intention. Records indicate that Jonathon had multiple prior attempts at suicide and self-harm. We also know Jonathon was mentally ill and likely to have been experiencing auditory hallucinations to at least some degree in the lead up to his death.

There are prior records indicating that he had experienced auditory hallucinations which were derogatory and commanding in nature. However, the extent or severity of his symptoms at the time he made his physical preparations is unfortunately unknown as he had not been reviewed by a mental health practitioner for some months. While I recognise that there are complex questions in relation to his capacity to make decisions at that time, I am satisfied that his death should be recorded as intentionally self- inflicted, noting the context of mental illness. His recent phone calls indicate intention and there was some planning involved in creating the ligature. Tragically, his despair may well have been transitory in nature and it is noteworthy that his death occurred shortly after he was left alone in the cell.

I have reviewed the conduct of the first responding correctional officers, some of whom gave evidence before me. I accept that the correctional officers acted reasonably in the circumstances they faced on 3 February 2018. No criticism is made of their response which appears to have been wholly within the guidelines in place. About two and a half minutes passed between CO Loco and CO Smith discovering Jonathon in his cell and the cell door being opened. It is understandable that Jonathon's family would be concerned at any delay in the cell being opened. However, it was explained to the court that the requirement for the CMO to attend to authorise a cell opening was a policy requirement related to safety concerns for staff and other inmates. It was not further explored at this inquest.

I am satisfied, given the evidence before me, that Jonathon was likely to have been dead before the cell door was opened. CPR commenced and continued until the arrival of a doctor, in accordance with protocol rather than because there was a realistic hope of revival. The proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the Briginshaw standard (*Briginshaw* v *Briginshaw* 60 CLR 336). I note that records made by Meffert RN confirm that Jonathon was cyanosed, fixed and dilated pupils and had no signs of life when first responding in his cell. Those observations, combined with the ECG reading indicate there was no prospect of his revival.

Part three

A close examination of the chronology raises a number of concerns about the overall care and treatment provided to Jonathon right from the point of his first admission to Junee CC on 2 August 2017.

The adequacy of Jonathon's mental health screening and subsequent treatment at Junee CC

The initial screening process

I am well satisfied on the material now before me that Jonathon was experiencing psychotic symptoms related to his schizophrenia at the time he entered custody on 2 August 2017. His experience of the disease was by then longstanding. Records from his attendance at Canberra Hospital on 29 July 2017 for a mental health assessment noted his distress in the context of significant methamphetamine use. Drug use was known to trigger and exacerbate his disease. Information obtained from NSW Police indicates that he had not been taking medication for some months and he had recently been involved in extremely risky behaviour. Jonathon reported auditory hallucinations when assessed on 24 and 30 August 2017 and again when he saw Dr Jones on 11 October 2017. In my view it is most likely those hallucinations were present when he first came into custody.

It is therefore necessary to examine the initial screening to understand why his care was not escalated from the start and why it took three weeks to commence anti-psychotic medication and longer to be seen by a psychiatrist or psychiatric registrar.

Jonathon's initial intake assessment took place on 2 August 2017, when he was assessed at Junee CC by Aylward RN. She completed the RSA, the HPNF and also made a handwritten progress note about her assessment. Perhaps unsurprisingly, given the volume of inmates she saw and the time that has now passed, she had no memory of her specific interaction with Jonathon when she gave evidence, but was able to comment on her usual practice and the notes she had made contemporaneously.

She referred Jonathon to the Drug and Alcohol Nurse and the Mental Health Nurse for review. She assigned the referrals a "category 2" triage classification. This indicated that Jonathon should be reviewed within 14 days. She also recommended that he should be placed in a "two-out" cell for two weeks. It appears that this was a standard practice used for inmates entering custody who were withdrawing from methamphetamines.

A "two-out" cell placement meant another inmate would be present in Jonathon's cell during any lockdown period and could raise an alarm if he needed assistance. It was clearly an excellent idea and in my view should not have been altered without careful thought. Aylward RN told the court that while she placed him on the "two-out" for 14 days she expected that Jonathon would be reviewed by specialty nurses or the GP during that two week period when further assessment could have been undertaken.

Much of the information recorded on the RSA appears to have been auto-populated into the form that Aylward RN completed on 2 August 2017. Factors such as cannabis abuse, depression, paranoid schizophrenia and psycho-stimulant dependence would have "automatically come up" and not have been specifically entered by her. Aylward RN told the court that she would have checked the JHeHS records for any information about high risk alerts.

It is clear from the progress notes that Aylward RN was aware that Jonathon had previously been on medication for depression and schizophrenia, but was currently un-medicated.

However there appears to have been a complete lack of curiosity about the exact nature of his current symptoms. Aylward RN made no note of asking Jonathon if he was experiencing auditory or other symptoms relating to his illness. The question apparently posed to him was: "*is there anything causing you concern*?" leaving it entirely up to him to self-report the existence of such symptoms. Aylward RN agreed that had she specifically inquired about hallucinations or other symptoms, it is likely that she would have documented the answer and she did not.

Although Aylward RN knew that Jonathon had very recently attended a hospital in Canberra in relation to mental health issues, there was no real follow up about what had actually occurred there. Aylward RN told the court that she understood Jonathon had left before treatment so "*there's going to be no medical record to obtain*." Rather than pique her curiosity, this appeared to close a door to any further inquiry.

Perhaps more disturbing is the fact that there is no explanation for why Jonathon did not sign an authorisation to release information during this intake assessment. Aylward RN had no memory of an outright refusal to sign, but stated "*some people aren't forthcoming with details.*"

She gave some insight into the atmosphere that exists when these assessments take place, "*depending on what mood they're in too, it is reception screen. They've just been arrested. They can be agitated. They can be frustrated. Looking at my notes it was 8 o'clock at night….They might just want to be fed and get into a cell and want to get it over and done with as quickly as possible*."

It is easy to understand that establishing rapport in those circumstances would be challenging. On reflection I think it most unlikely that Aylward RN was able to establish any meaningful rapport with Jonathon that night. When questioned about her practice in relation to obtaining information from an inmate about how they will cope in prison, she explained she asks: "*How do you think you're going to cope?*" and records their direct answer. Jonathon apparently replied "*yeah good*" and it was left at that.

It is concerning that there is no evidence that signing the authority to release information was ever revisited with Jonathon. There is certainly no evidence indicating that requests were ever made to community or other sources. It is disturbing when one examines the wealth of material that would have been available in NSW and ACT custodial records and from community providers that Jonathon's treatment is premised almost entirely on self-report and commenced almost as though he was receiving psychiatric care for the first time.

The tenor of Aylward RN's evidence was that it is likely the interview was fairly quick and pretty unremarkable. She entered him on the system and trusted other appointments would take place in due course. We now know further appointments took longer than they should have, but even if they had taken place in a more timely manner, the failure to establish early rapport meant that crucial information was lost.

Aylward RN confirmed that there was no Aboriginal health worker available to assist in these circumstances.

This is a matter to which I will return as it appears possible that had the intake nurse had the capacity to refer Jonathon to see an Aboriginal health worker or Aboriginal mental health worker the following day, in less stressed surroundings, some kind of stronger rapport could have been established and a fuller picture of Jonathon's current symptoms and psycho-social stressors could potentially have been obtained.

As we have seen, the following day an ISQ was completed by Kerri Lee Walker. It was recorded that he had been un-medicated "*for about a year*." Jonathon disclosed that he was not in contact with his family and that his partner was his only support in the community. The subsequent remand reception committee noted that Jonathon was an "un-medicated schizophrenic" and indicated there was an "immediate safety concern." The following day Jonathon's classification was approved as "B Medium". His "two-out" cell placement was extended to 1 September 2017 and a history of self-harm was noted. He was assessed by a Drug and Alcohol nurse, noted to be in withdrawal from methamphetamine and cannabis and prescribed Phenergan.

In my view, there was a clear and urgent need to review his psychiatric medication at this point. Even without having obtained collaborative medical notes from prior providers or adequately inquiring about his symptoms, Junee CC staff knew that he was an un-medicated schizophrenic with a history of prior self-harm. I accept Dr Eagle's opinion that "*Jonathon needed to be comprehensively assessed by a person with mental health training, whether it be psychiatrist, psychiatric registrar or an experienced mental health nurse as soon as possible so that treatment could be instituted based on his mental state and symptoms. To not do that raises huge risks in terms of deterioration in his mental state, distress, also the obvious risk of suicide. But that's actually one of the rarest risks that you can encounter. Psychosis itself can cause damage to the brain as we know. So the longer you're untreated, the more difficult it can be to treat psychosis*."

Jonathon was left untreated for the following three weeks. During this time it is clear that he was unwell and that his presentation indicated increasing psychotic symptoms. The very fact that the Local Court made an order on 8 August 2017 that Jonathon undergo an assessment to determine if he was suffering a mental illness and whether there were reasonable grounds to believe him to be a mentally ill person within the meaning of the MH Act indicates that he is likely to have had symptoms that were obvious to his lawyer and indeed the court.

In my view there were deficiencies in the screening process. However, I was somewhat heartened by the evidence of Dr Spencer in relation to the potential for forthcoming change in the screening process. Dr Spencer informed the court that since Jonathon's death, Justice Health has designed a new and more sophisticated Mental Health Screening Tool. This tool is not yet in use, but subject to overcoming budgetary limitations, the court was informed that it will be converted into electronic form and rolled out to correctional facilities across NSW. I accept Dr Spencer's view that it may improve the current procedure.

Counsel for Matthew Hogan properly identified the lack of background information as a significant issue and urged recommendations that would prioritise the signing of medical release forms, streamline the transfer of information from other states and territories and from NSW Police.

I note that the solicitor appearing on behalf of the Commissioner of CSNSW advised the court that CSNSW already supply custody management records to Justice Health, and that this material formed part of the patient file in Jonathon's case. It may be that Justice Health need to review how that information is stored and accessed through its improved electronic record system.

Mental Health treatment commences

Jonathon was first seen by the Mental Health Nurse on 24 August 2017.

Jonathon told Tobin RN that he felt paranoid, thought people were talking about him and he explicitly sought medication for his symptoms. He described hearing voices. Once again he mentioned having had treatment in the ACT, but no collaborative material was sought. Nevertheless it was obvious to Tobin RN that he needed medication. After discussion with the GP, Dr Corbett, Jonathon was commenced on Olanzapine 10mg (twice daily) and scheduled for review with the psychiatrist, Dr Jones, the following week.

Tobin RN told the court that at the time this occurred it was "*a common occurrence*" that a patient such as Jonathon may be left un-medicated for three weeks. He indicated that given the high volume of referrals that were placed on the mental health review list, there would sometimes be "*delays*". Ms. Te Maru, the Health Services Manager, commented that three weeks before review in these circumstances was "*unfortunately a timely fashion*", given the triage targets then in place.

Tobin RN told the court about the difficulties practitioners faced in trying to see everyone on the list and for that reason there was a necessity "*to attend to people as quickly as possible given the circumstances*." This may in part explain the lack of any documentation indicating that Tobin RN had actually reviewed Jonathon's record on JHeHS or his patient file prior to this first consultation.

While Tobin RN indicated that it would be best practice to record the documents he had a chance to review, he accepted that there was no documentation to indicate that he was aware that Jonathon had previously been diagnosed with schizophrenia in custody, his recent methamphetamine use or his prior instances of self- harm. He agreed that his knowledge that Jonathon had been on Olanzapine appears to have come from self-report rather than collaborative documentation. He agreed that he seemed to be "*getting most of the history from him*."

In my view the delay before seeing a Mental Health Nurse, given the circumstances even as they were known at reception, was entirely unacceptable. Further it appears clear that when Jonathon saw a Mental Health Nurse three weeks after entering custody, the interaction was likely to have been rushed and suboptimal. Resource pressure meant that Tobin RN appears to have relied almost entirely on Jonathon's self-report, thereby missing the wealth of material about Jonathon which had already been collected by other health clinicians over the years.

Dr Jones's assessment and treatment

When Dr Jones first saw Jonathon on 30 August 2017, Jonathon had been in custody for almost one month. He confirmed that Jonathon was suffering schizophrenia. He altered Jonathon's prescription of Olanzapine to a nightly dose of 20mg and documented a review date of two weeks.

Once again a review of the records is somewhat troubling. It was Dr Jones' evidence that it was his practice to review patient files if they were available. He expected that he would usually make a note when he had considered information from another source. He conceded that his opportunity to review the patient file was in part dependent on the time available on a given day.

Dr Jones also conceded that the majority of the information documented in the progress note he wrote during the first patient consultation came from Jonathon's self-report, including that he had been on Olanzapine. He agreed that he did not appear to have known about other medications named in Jonathon's records, including medication for symptoms of depression.

Surprisingly, it became apparent that Dr Jones did not have access to JHeHS and would have needed to rely on a nurse to inform him of anything clinically relevant.

Dr Jones did not document a specific plan for the management of Jonathon's risk in the general prison population other than the alteration to Jonathon's medication and the scheduling of a further review. In my view there ought to have been a more explicit and documented review of Jonathon's risk. I accept that Dr Jones understood that there was some risk that Jonathon could self-harm. With the benefit of hindsight, he stated: "*He's a high risk individual by nature of a number of things, including his mental health diagnosis and his drug status, as well as his social situation, and indeed, his indigenous origin. It is a flag for awareness, given the particular natures of indigenous people being in custody; we're very sensitive to that. But may I say that he'd, he didn't stand out in that – I'm very aware of that. But that's also not an uncommon combination of risk factors*." At the time of giving evidence, Dr Jones believed he would have assessed and considered the risk factors and considered that they were not of significant concern at that time.

Once again I am concerned that Jonathon was left flying under the radar. He was by all accounts quiet, even withdrawn with those outside his immediate family. He was quite unlikely to easily share his concerns with a doctor he had never met. There may have been little outward sign of his symptoms in a short consultation, particularly when the treating doctor appears to have reviewed little or no collaborative history to help prompt a response. It is telling that in amongst the challenging caseload Dr Jones faced, Jonathon "*didn't stand out*." Again I see a clear opportunity for the intervention of an Aboriginal mental health worker who may have been able to get beyond the patient's façade.

As we have seen, Dr Jones did not see Jonathon again until 11 October 2017; some six weeks later. Dr Jones put the delay down to the "*constant challenge*" of the review list. The list, he said was "*somewhat aspirational*" and he had to be "*mindful of resources*" when making difficult decisions about who might need to be seen urgently. I have no trouble in accepting the veracity of his account of working within a very challenging environment. Nevertheless, recognition of that does not suggest the procedures were adequate or resulted in appropriate care. The problem is a systemic one rather than a professional criticism of Dr Jones.

The progress notes are brief but as we have seen they indicate that Jonathon reported that his dose of Olanzapine was ineffective to quell the voices he heard. Dr Jones increased Jonathon's dose and planned to review him in a month. It is troubling that Dr Jones was unaware of Dr Chew's assessment and opinion at this time.

Jonathon had been disrupted and required to travel a considerable distance to and from the MRRC to be assessed. Dr Chew's report was uploaded onto JHeHS by 15 September 2017. He opined that Jonathon remained "*acutely psychotic despite treatment with antipsychotics*", presented with multiple risks and met the criteria for a "mentally ill person." In hindsight, Dr Jones agreed that it would have been "*helpful and valuable*" to have had Dr Chew's report. However, he also stated that it would not have changed his management or decisions, including recommendations in relation to a "two-out" cell requirement.

Counsel for Matthew Hogan urged the court to make a recommendation that Justice Health consider reviewing the current system for transporting mentally ill inmates for court ordered reports, including the use of AVL assessments. It is certainly a pertinent issue and one would expect the use of telehealth facilities will increase. However, the inquest heard limited evidence about the utility of AVL assessments with mentally ill patients. Dr Spencer gave evidence that AVL facilities are sometimes used, particularly if a patient needs to see more than one doctor. The real problem that emerged in the facts of this case was that Jonathon was disrupted and moved a long distance for a report that was never even reviewed by his treating doctor.

The evidence before me does not clearly establish that Jonathon's mental health concerns could only have been managed in a specialised unit, rather than by a properly resourced treatment team at Junee CC at this point in his care. I note that counsel for Matthew Hogan urged me to make a recommendation that "*Justice Health and the Commissioner of Corrective Services urgently increase the number of beds available in such specialized custodial mental health facilities at Hamden or the Mental Health Screening Unit (MHSC).*" In my view the issue, although extremely important, does not arise squarely on the evidence given in this inquest. Nevertheless I note that NSW coroners (including myself) have addressed this and related issues in recent times. Similarly, while I accept that it is important to place inmates proximate to their families where reasonably practicable, the issues were not specifically examined during the inquest and I refrain from making a recommendation in relation to the issue.

Dr Jones saw Jonathon for a third and final time on 8 November 2017. Dr Jones accepted that he must have been sitting with Tobin RN when Tobin RN typed the email response regarding the s. 35 order. I accept that neither Tobin RN nor Dr Jones were familiar with orders made pursuant to s. 35 of the MHFP Act. Nevertheless, the email was completed without any attempt to properly document the decision making process which again probably indicates the speed with which they were called upon to work and treat mentally ill patients in custody.

Nevertheless, it is concerning that the procedure mandated by s. 35 of the MHFP Act was not followed. The legislature mandated that two registered practitioners separately review Jonathon. This did not occur. The information contained in Tobin RN's email was inadequate and yet it was relied upon by Justice Health when its Chief Executive advised the Local Court on 17 November 2017 that Jonathon was not assessed to be a mentally ill person under the MH Act and did not require admission to a mental health facility. That advice was in turn relied upon by the Local Court to make decisions about Jonathon's wellbeing.

The court heard that this process should now be operating in a manner to ensure adequate compliance with orders made under s. 35 of the MHFP Act. Dr Spencer told the court that there has been a substantial increase in the number of assessments ordered pursuant to section 35 MHFPA in recent times. She also outlined that in recognition of that fact Justice Health has taken steps to ensure the procedure is properly understood by relevant staff. She outlined the new and more robust oversight process. Her evidence was supplemented by the evidence of David Huskins, the Director of Statewide Administration of Sentences and Orders for CSNSW, who confirmed the substantial increase in the number of s. 35 orders issued by the Local Court.

Mr. Huskins said: "*So in - between 2016 and 2018 there were 62 section 35 orders, so that's over three years and in 2019, the 11 months to date, there's 69 section 35 orders."*

Records for the final appointment on 8 November 2017 are brief. As we have seen, Dr Jones records that Jonathon was somewhat improved, but there remained residual symptoms, even if the voices had decreased. Dr Jones noted that a further review would be scheduled for six weeks' time. Dr Jones gave evidence that Jonathon was calm and showed some insight. He appeared committed to treatment. While Dr Jones did not recall the specific consultation, he told the court Jonathon was "*doing very well and I was happy that he was, had insight and he was engaging with us and so forth, and he was getting better. That's a win, you know*".

Dr Jones presented as a genuine and caring professional working in an inherently difficult environment. He stood by his decision that Jonathon *could* be safely managed in the general prison population. I accept that as at 8 November 2017 this may have been the case. I also understand that it was Jonathon's preference at this time to remain at Junee CC. I note that Dr Eagle did not suggest he needed to be sent to a gazetted mental health facility and considered, in circumstances where Jonathon was compliant with his treatment regime and subject to regular review, that he could reasonably be managed within the general prison population. The problem, of course, was that resources did not allow regular review.

The stressors in Jonathon's life seemed to increase as the year went on including the birth of his child in November 2017, in a context where his other children had been removed from his care. There was also turbulence in his relationship with and the legal proceedings associated with their domestic situation.

When Dr Jones was asked about whether these kinds of psycho-social matters which could have been affecting his mental state should have been identified and managed, he disagreed. He described that kind of care as "*a solution that might be your private hospital situation*", explaining "*it's very hard to track psycho-social events in, 830 people's lives and put them together, collate them and realise their significance.*" Dr Jones does not appear to have understood discussion of these kinds of issues as being part of his role, even it seems as possible triggers or factors of increased risk to Jonathon's mental health. The trouble is that nobody else had that role. The court was told that Jonathon had no access to psychological services, beyond the Mental Health Nurse (Tobin RN) and he was not eligible for other psychological programs such as EQUIPS due to the proximity of his upcoming court dates. Beyond the first intervention and prescription of Phernergan, he apparently received no drug and alcohol counselling or treatment, despite the fact that his substance issues were a longstanding problem and impacted directly on his schizophrenia.

It is of grave concern that after 8 November 2017, Jonathon was never again reviewed by a psychiatrist or Mental Health Nurse. Reviews were rescheduled on four occasions before his death, but on each occasion cancelled. Tobin RN explained that it was a matter of priorities; "*there was always a high volume of people who needed to access the psychiatrist and it was challenging at that particular time of year. Christmas is always a hard time for mental health as well so it was challenging to create fair and equitable access to the psychiatrist and I do recall a heavy workload around that time and a heavy number of referrals*."

The court heard evidence from Ms. Te Maru that a "*resourcing issue"* was identified following Jonathon's death and that "*extra mental health resources have been approved moving forward".* Ultimately I found her evidence on this issue confusing and unsatisfactory. Ms. Te Maru told the court that on 4 December 2019 approval had been granted to employ an additional three full time mental health registered nurses plus one casual mental health nurse. Approval had also been given to contract a psychiatrist to provide treatment for 40 hours per fortnight, although Ms. Te Maru thought it would be difficult to recruit someone for this regional position. However, she explained that this increase in staffing also takes into consideration the 480 new beds planned in the next 12 to 24 months at Junee CC. A proportion of the new inmates would be high-risk inmates who presumably also require greater access to mental health services. I was left wondering if this actually constituted an improved position.

The court was informed that changes have also been made to reduce the numbers of referrals being made for mental health reviews. Ms. Te Maru's evidence about this was also confusing. Initially she said the wait list had essentially "tripled" and that there were 300 persons on the wait list as at 4 December 2019. Later in examination by counsel for GEO Group, Ms. Te Maru agreed that there were in fact 39 persons on the mental health waiting list as at that date.

Ms. Te Maru agreed that GEO Group's clinical coordinator, RN Melanie Bliss ("Bliss RN"), was best placed to speak to the changes which had brought about the reduction. However, in summary the strategy she described seemed to be attempting to clear the mental health list of patients that could be properly be dealt with by a primary healthcare registered nurse.

Bliss RN gave more detailed evidence about wait lists and the process that had recently been undertaken to reduce them. In about mid-October 2019 there were 160 people on the wait list to be reviewed by the Mental Health Nurse. By 5 December 2019 the numbers on the list were down to 40 persons. She explained: "*for instance, someone with no mental health, possibly a new reception who had previous mental health issue, no diagnosis, needed medication review or just wanted to have a chat. For example, that person, depending on what history we could find on them at the time, it would be more appropriate for a GP referral.*" She continued, suggesting others may be more appropriately referred to a primary nurse, psychology or the chaplaincy service.

Later when discussing triage categorisation, Bliss RN gave somewhat confusing evidence about how quickly someone with Jonathon's background would be seen now that changes had been made to the wait list process. She stated that she was confident that he would be seen within one month.

At the conclusion of the evidence on changes to the waiting list, I remained concerned that unless the under resourcing of mental health services at Junee CC was faced squarely, no administrative solution involving shifting inmates to other lists would solve the problem or ensure greater safety for inmates, particularly in circumstances where the prison population at Junee CC is about to expand substantially.

There is little doubt that the mental health care offered to Jonathon was poorly coordinated and planned. The evidence indicated that medical staff at Junee CC were seriously under resourced. As a result it appears likely that those with more dramatic presentations would be prioritised on overcrowded waiting lists.

The care offered was largely reactive and treatment plans or schedules for upcoming appointments were "*aspirational*" in nature.

I accept Dr Eagle's view that Jonathon needed closer monitoring. She stated "*the auditory hallucinations were particularly significant…in his presentation…in the individual context…Having regard to all of the other factors as well that made him particularly vulnerable, he would need to be reviewed in my view, at least by some sort of mental health person every couple of two to four weeks in order to ensure that he was…remaining stable in that environment*". She also stated that when initiating medication to someone identified as "*acutely psychotic*", "*I would have thought you needed to see them every week to two weeks.*"

Counsel for GEO Group made the submission that where Dr Eagle and Dr Jones have differing opinions on the treatment provided to Jonathon, Dr Jones should be preferred, given he had the opportunity to review the patient and Dr Eagle had "*limited clinical experience in a custodial setting*". I do not accept that submission. As was correctly identified by counsel assisting, Dr Eagle was retained by the court as an independent expert who was not directly involved in the care and treatment of Jonathon. She has extensive experience in the provision of psychiatric treatment in both community and correctional centres, including at the Forensic Hospital at Long Bay Correctional Centre. At no stage during the inquest was it put before Dr Eagle by counsel for GEO Group that she was not suitably qualified or experienced to express the opinions that she did in respect of Jonathon's care and treatment. Further, Dr Jones did not dispute the reasonableness of the views express by Dr Eagle in her report.

Dr Jones gave evidence that if he had any concerns about Jonathon's risk factors he would have communicated that through the HPNF form which is a direction to operational staff to observe Jonathon. This may well be the case and this is where part of the problem lies. Dr Jones did not see or review Jonathon in the last months of his life. He would not have known whether new risks had arisen and a new HPNF form was called for. He can add little to our knowledge of Jonathon's mental state after early November 2017. Dr Eagle was asked to review all the available records right up until Jonathon's death. I accept her opinion that Jonathon required more intensive monitoring and psychiatric care.

I remain concerned that at a number of points throughout Jonathon's time in custody there were issues in relation to the management of clinical records which impacted negatively on his care. Some information was held in hard copy files which travelled across the state. Some was placed on JHeHS, which as we have seen was not always checked by Jonathon's treating clinicians. It is difficult to judge what impact the new electronic records system will have. Dr Spencer told the court that the process had commenced as the inquest was in process. One hopes it has the desired effect of improving the efficiency of Justice Health's information flow.

Medication

Of some concern is that Jonathon missed medication on six separate dates between 11 and 24 January 2018. The court explored whether this in itself should have triggered a review of his wellbeing.

Nothing was documented in his progress notes to suggest that further inquiries were made with Jonathon or any other person about these gaps. There is nothing to suggest it was brought to the attention of his treating doctor or the mental health nurse.

Ms. Te Maru and others spoke of a practice in place at Junee CC whereby a medication review was triggered by missing medication on three or more days. Dr Jones considered the triggering of a review after missing three consecutive days as reasonable in a custodial setting.

Dr Eagle was asked to comment on the significance and possible impact on Jonathon of these missed medications. In her view it was an "*extremely important*" factor. She said: "*I think the fact that he had been reasonably compliant with his medication for a number of weeks and had actually identified that it was helping with distressing symptoms of his illness, and then had started not attending quite regularly, so up to six times…so not attending to collect his medications, that needed to be assessed because it could've been due to a variety of reasons".* She also offered the opinion that given he required a high dose of Olanzapine to stabilise his illness, the missed doses over a short period of time would likely have started to cause a deterioration of his mental health.

The court did not receive detailed evidence about Justice Health medication policies which are apparently voluminous. Instead it focussed on how this change in Jonathon's compliance may have been relevant to his treatment. The court was informed that since Jonathon's death, changes have been made which may mean that missed doses may be more easily detected and therefore reviewed.

Since his death, Junee CC has trialled satellite medication dispensing stations in each unit. Rather than requiring the inmate to attend the clinic to collect their medication, the medication nurses dispense in the unit. In Ms. Te Maru's view, there is less prospect of an inmate missing his medication because he slept in or missed the medication muster. Counsel for Matthew Hogan submitted that a review should specifically investigate the "three day rule" and the medical appropriateness of such a rule. I agree that some review of the system is required, even after hearing about the changes already made, but I am content that the more general approach urged by counsel assisting is sufficient.

The adequacy of specific support offered to Indigenous inmates

As discussed above, Junee CC had the benefit of regular visits from the south west region RAPO, who is employed by CSNSW. Mr. McAdam gave evidence that his area included 17 correctional centres from Cooma to Broken Hill. When at Junee CC he met with the AIDC, supported various art projects, assisted inmates at the time of their release, among many other duties. Mr. McAdam impressed as a highly energetic and committed man doing his level best to undertake a role that could have been shared by a number of individuals. It is clearly beyond the scope of this inquest, but I have little doubt Mr. McAdam could use extra resources over such a huge area.

Mr. McAdam gave evidence that although he did not recall meeting Jonathon, he became involved in organising a memorial service for inmates affected by Jonathon's death. I have no doubt that it was bittersweet evidence for Jonathon's family.

The fact that Jonathon was honoured and shown respect would have been balanced with sadness that they were not contacted to attend.

The court was somewhat heartened to learn of new procedures in place aimed at better family liaison after a death in custody. The solicitor acting for the Commissioner of CSNSW outlined that since February 2018, the Aboriginal Strategy and Policy Unit at CSNSW had developed specific procedures regarding Aboriginal deaths in custody. This procedure was tendered at the conclusion of the inquest. It is apparent that Junee CC did not reach out to Jonathon's family after his death. I have no doubt this compounded their grief. I urge Junee CC to ensure these new policies improve care provided to families.

The court also heard evidence from Mr. Gerome Brodin, the cultural advisor employed by GEO Group and based at Junee CC. His role involved organising a diverse range of cultural activities which included NAIDOC week and Chinese New Year among other occasions. While Mr. Brodin had intermittent contact with the AIDC, his role was not one specifically aimed at one-on-one interaction with Aboriginal inmates.

I have grappled with trying to understand what interventions, if any, could possibly have made a difference to Jonathon. He needed to be seen and heard by someone who was able to get past his quiet façade and understand the nature of his significant symptoms and concerns. He needed an advocate within an under-resourced system. In my view the evidence demonstrates a clear need for Aboriginal Mental Health Workers at Junee CC. The evidence disclosed that well intentioned non-indigenous doctors and nurses had been unable to establish any significant or consistent rapport with Jonathon or even acquire permission to seek collaborative information from community or family sources. There was nobody that had the time or that Jonathon had sufficient trust in to discuss his significant relationship and other mental health difficulties. There is no record of anyone talking with Jonathon about his family or the possibility of reconciliation and support from them. We know Jonathon faced enormously stressful situations whilst in custody, including the birth of his son against a background of prior child removals, and the tumult and breakdown in his relationship with We know he was unlikely to speak to officers about these issues. It is just possible that a skilled Aboriginal Mental Health worker could have made a positive intervention and developed a more positive therapeutic alliance. It is a strategy that deserves consideration. Counsel assisting urged the court to consider a recommendation for creating a full time Aboriginal Health Worker position at Junee CC. I note that Ms. Woods, who gave evidence as the Acting General Manager of Junee CC, indicated that GEO Group was "*absolutely*" open to the possibility of employing a dedicated Aboriginal health worker at Junee CC. Ms. Wood confirmed that CSNSW had given approval for Junee CC to commence recruitment of an Aboriginal Liaison Worker, although this appeared to coincide with the expected expansion of the prison population. Ms. Wood gave evidence that Junee CC intended to increase its proportion of Aboriginal and Torres Strait Islander employees to above 6% of the staff population; which sat at 2.7% during the inquest.

Ms. Wood said: "*We are constantly looking for ways to develop those networks and those relationships and the rapport with the local community. It will never cease. The recommendation probably will never be closed, because it should be continued to be worked on*."

In my view, the number of indigenous inmates at Junee CC would suggest that more than one Aboriginal Health Worker would be required. One isolated staff member doing that role would certainly be overwhelmed. Consideration should be given to employing a number of Aboriginal health workers, particularly with the planned expansion at Junee CC. At least one of those positions should be dedicated to mental health care and treatment.

The adequacy of other methods to reduce risk at Junee CC

Custodial staff is guided by medical staff in relation to cell placement. For almost all of his time in custody Jonathon was placed with another inmate even when his classification meant that he could have been placed alone. It is significant that his death takes place soon after being left in his cell alone.

The inquest did not examine detailed evidence in relation to the cell placement issue. At the conclusion of proceedings, Counsel for GEO Group submitted that there was no evidence that Jonathon's cell placement was inappropriate and/or in breach of any GEO Group or CSNSW policy. I accept that there was no evidence that Jonathon ever came to the attention of the High Risk Assessment Team ("HRAT") and/or Critical Incident Team ("CIT"). The question is not whether there was breach of a policy, but whether staff really had sufficient information to inform their decisions in this regard.

The matter is well addressed in the counsel assisting's reply submissions. I accept that it is the *absence* of evidence specifically in the period from 8 November 2017 to 3 February 2018 that is the critical issue. During this period there were no reviews from a psychiatrist or mental health nurse, other than the very limited AVL screens after court. Jonathon's case manager, CO Davies, was not even aware Jonathon was receiving mental health treatment and did not question him on that topic. In my view Junee CC officers had limited information on which to properly base a placement decision during this period.

Correctional staff currently take advice from medical staff about whether an inmate should be placed "two-out". It is generally accepted that inmates are less likely to hang themselves when housed with another prisoner. Not only is there the possibility that the relationship between the inmates is in itself protective, there is also the possibility that early discovery of any self-harm will avert complete disaster. In my view there were unfortunate gaps in the information medical staff were able to collect. It may be that this is an area where an Aboriginal mental health worker's input would have been of great assistance. Dr Eagle described Jonathon as a "*highly isolated and vulnerable inmate*" who could not be relied upon to articulate what was happening for him.

The court heard about various mechanisms used by Junee CC to manage risk. CO Davies was assigned as case officer for Jonathon between October 2017 and January 2018. He spoke briefly to Jonathon on 21 October 2017, 11 November 2017, 22 December 2017 and 13 January 2018 about his progress. CO Davies considered Jonathon to be "a quiet inmate" who spent the majority of his time in his cell or working out, he rarely approached staff. It should be noted that despite the expiry of the formal "two out" cell placement, Jonathon remained in a "two out" placement until 1 February 2018 when his cellmate was transferred.

Other checks such as those that occur after a court appearance were also superficial and in the circumstances unlikely to obtain useful information from an inmate such as Jonathon. Aylward RN described the process as typically involving asking the inmate a few questions about the court outcome. She said: "*We then ask how they're feeling about that. Are they upset? Do they have any thought of hurting themselves or anyone else*?" It might take a few minutes. The process may assist some inmates, but it appears unlikely to have triggered a request for help from Jonathon.

One issue that received consideration was the number of calls Jonathon made in the lead up to his death and whether closer monitoring of calls offers an opportunity to reduce risk. As we have seen Jonathon's relationship with X was in crisis in the period leading up to his death. At one point he was expecting a visit and as that possibility receded he appeared to become increasingly distressed. In the days preceding his death Jonathon spoke to or left messages for on about 13 occasions, with many more calls attempted. The calls contain declarations of love but are also at times aggressive, frustrated and full of conflict.

As we have seen, on the day of his death Jonathon made numerous attempted calls to X . He was upset at her not answering his calls and seemed unsure what was going on. His last call was made at 5.34pm about an hour and a half before cell lockdown. Recordings of the call show that he was loud and there was a level of stress in his voice.

Telephone calls are monitored in all correctional facilities for operational reasons. The inquest touched upon whether this process could be used to somehow provide a safety net in circumstances such as Jonathon's. In other words could the number of calls alert someone to the possibility that an inmate was in extreme distress.

The court was informed that CSNSW is responsible for the Offender Telephone System ("OTS") in all NSW correctional centres, including privately operated facilities such as Junee CC. The system and its functionality is operated and controlled by a third party contractor. Representatives for the Commissioner of CSNSW told the court that currently there is no function that triggers an automatic alert once a certain threshold number of calls is reached. Any change to the system or functionality would require variation to the contractual agreement between CSNSW and the third party contractor.

CSNSW did not support a recommendation to examine whether the existing telephone system could be adapted to include an alert system when an inmate makes a significant number of calls to a particular number in a short period. It was suggested that this could involve a serious cost implication. More importantly, it was suggested that it may have unintended consequences and even act as a disincentive for inmates to use the system and thereby isolate themselves from support networks in the community. An alert system may also identify inmates frequently calling a partner, where no issues exist and not identify inmates who make few but more problematic calls. It was suggested that more regularly running an existing function "Frequently Used Summary Report" for at-risk inmates could assist in identifying problematic use without changes to the contract in place.

In my view, while complex, the issue deserves further consideration.

The adequacy of cell architecture at Junee CC

Junee CC was built in 1993 by the GEO Group, who was responsible for the design, construction and operation of the Centre. Available data indicates that there have been four deaths at Junee from either suspected or confirmed suicide; the last of which was Jonathon in February 2018.

The court heard from Terry Murrell, General Manager, State Wide Services, CSNSW that Junee CC had experienced fewer suicides than some of the larger centres, both private and public.

Counsel for CSNSW submitted that CSNSW is committed to ongoing review and consideration for the removal of hanging points across NSW. There was evidence that CSNSW has undergone a program of audits which has resulted in some retrofitting in certain facilities. In determining which facilities should be subject to retrofitting, CSNSW submitted that it must "*take into account several considerations such as need, risk, cost and the existing building structure*."

CSNSW submitted that "*all deaths in custody are tragic and every effort should be made so that they do not occur. Given Junee CC experiences very few deaths in custody when compared to other centres the focus is instead on risk assessment and appropriate cell placement as opposed to costly alterations to existing structures*." Further, it was submitted that the newly built 480 bed area at Junee CC will give officers greater scope to be able to place inmates in a cell with a design "*appropriate to their risk and needs*" presumably because there will be more safe options.

As we have seen, Jonathon managed to secure a ligature around a frame positioned on the side of the top bunk. These frames were installed within the minimum security section in 2014 when an inmate rolled out of bed and injured himself. This installation was done in consultation with CSNSW. GEO Group indicated that it had more recently consulted with CSNSW and received funding from CSNSW to install different style beds in particular areas.

Ms. Wood gave evidence that the cell Jonathon died in remains as it was. However, she said there was currently a prototype being developed that would remove that kind of ligature point. She explained that the cells currently under construction at Junee CC would have the new style bed fitted and that it was a general intention to remove old and redundant bed stock and retrofit a safer option. No time frame could be given.

Both CSNSW and Junee CC appeared to accept that while prisoners are placed in cells such as the one Jonathon died in, risk exists. The primary risk mitigation strategy involves being able to identify which inmates should be placed in safer areas or in "two-out" placements. As we have seen this relies on proper resourcing of medical assessment and treatment so that reliable information can be provided to custodial staff.

Ligature points in prison cells have been an issue for decades. I accept that cell placement strategies have a place in risk mitigation, however we also need to do more about retrofitting cell furniture. Again, the issue is one of proper resourcing. Submissions made by CSNSW make this very clear. Implementing change within the area where Jonathon died "*would be cost prohibitive when weighed against other centres and units which present higher risk and need.*"

Thirty years on from the RCIADC, this is entirelyunacceptable.

Conclusions regarding medical care and custodial care

I am substantially guided by the matters set out in counsel assisting's submissions to summarise the inadequacies in the care provided to Jonathon during his final six months in custody. Specifically, there appears to have been a lack of curiosity and inadequate investigation of collaborative sources of information. This manifested itself in a number of ways including:

Treatment was principally based on Jonathon's self-reports without consideration of past records or other sources of collaborative information. No attempt was made to source information from the collaborative sources about Jonathon's prior mental health and treatment in the community and ACTcustody.

Dr Chew's report, which was uploaded to JHeHS by 15 September 2017, was never considered by clinicians at Junee CC.

The reasons underlying Jonathon missing medication in January 2018 were never explored with him.

There was no real opportunity for Jonathon to discuss some of the complex psycho- social issues he faced, such as estrangement from family and conflict in his relationship with . While custodial staff, including his case manager, checked on Jonathon at regular intervals, the contact was brief and largelysuperficial.

Dr Chew's report recommended intensive treatment. Those responsible for Jonathon's day to day care ought to have considered this recommendation in planning the frequency of Jonathon's mental health reviews. The length of time Jonathon was left untreated following his admission into custody at Junee CC is of significant concern. A person known to suffer schizophrenia should not wait three weeks for review. This is below the standard one would expect in the public health system and is unacceptable.

The frequency of mental health reviews, consisting of three reviews by a psychiatrist and one by a mental health nurse during Jonathon's six months in custody was inadequate. Jonathon required an individualised treatment plan which included regular monitoring and treatment reviews. Placing Jonathon alone in a cell with a hanging point involved substantial risk. Cell placement decisions were based largely on medical advice. The degree of risk at the time he died was not known by those involved in his medical care, because there had been no psychiatric review since November 2017.

I am satisfied that greater frequency of reviews, closer monitoring, and increased curiosity and attention to rapport building is likely to have made a difference to Jonathon's mental and emotional wellbeing as at 3 February 2018. Whether it would have been enough to save him from the despair he felt on 3 February 2018 I cannot say. The lack of medical observation of him during the months preceding his death preclude me from knowing the extent of his psychotic symptoms at that time.

I am confident that input and involvement from an Aboriginal Mental Health Worker could have been an important component of improved care which could also have impacted on Jonathon's mental state. The provision of culturally appropriate treatment and cell placement must be pursued.

In my view, Jonathon was not seen in a crowded system. As Dr Jones reported: "*he didn't stand out*." In my view his care was compromised and not sufficiently geared to his individual needs.

Outstanding concerns and the need for recommendations

Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focusses on the specific lessons that may be learnt from the circumstances of each death.

The evidence arising during this inquest demonstrated a strong need to consider specific recommendations particularly in relation to Jonathon's mental health treatment and custodial care. The following recommendations I make arise directly out of the evidence before me. Beyond these recommendations I must again draw attention to the shocking and ongoing over-representation of Aboriginal citizens in custody. The RCIADIC identified that this inequality is born from racism and dispossession. While I accept redressing such matters goes well beyond my legal task, I am nevertheless compelled to record the true contextual background of Jonathon's death.

Formal Finding:

Identity: The person who died was Jonathon Hogan.

Date of death: He died on 3 February 2018.

Place of death: Junee Correctional Centre, Junee NSW 2663.

Cause of death: He died of neck compression as a result of hanging.

Manner of death Jonathon was mentally ill at the time of his death. He was alone in his cell. I find that his death was intentionally self-inflicted in circumstances of being held in custody with inadequate mental health care in the preceding months.

Recommendations pursuant to section 82 *Coroners Act 2009*

To the Chief Executive Officer, GEO Group Australia Pty Ltd

The GEO Group Australia Pty Ltd ("GEO Group"):

Review the Junee CC's practice and procedures at the intake stage to ensure that inmates with known diagnoses for serious mental illnesses (e.g. schizophrenia) are reviewed by a suitably qualified mental health clinician in a timely manner for the purposes of: assessing the inmate's condition.

Consulting with other clinicians (if necessary) and to make recommendations about treatment (including whether the inmate requires antipsychotic medication)documenting what the inmate's risks are and how those risks are to be managed assuming the inmate is placed within the general population (including the possibility of "two-out" cell placements).

Examine the current ratio of mental health treating staff, to inmates requiring mental health reviews and treatment, and whether the staffing ratios and resources are sufficient to ensure: inmates who are suffering serious mental illnesses are reviewed by a suitably qualified mental health clinician in a timely manner after entering the Junee CC inmates who are suffering serious mental illnesses thereafter are reviewed by a psychiatrist or by another suitability qualified mental health clinician at reasonable intervals having regard to the severity of their illness, circumstances and the potential changeability of their condition. Mental health clinicians carrying out patient reviews are afforded a reasonable opportunity to review an inmate's patient file and other collaborativesources.

In consultation with Justice Health, review the Junee CC's practice and procedures as regards the provision of antipsychotic medication to ensure, in the event an inmate misses taking their daily antipsychotic medication, the mental health treating team is notified of this fact and the inmate reviewed about this issue in a timely manner (specifically taking into account the opinion expressed by Dr Kerri Eagle in these proceedings about the impact of an inmate missing Olanzapinemedication).

Consider creating at least three full-time equivalent Aboriginal Health Worker positions based at the Junee CC, at least one of whom has responsibility for the provision of mental health care and treatment to Aboriginal inmates.

To the Chief Executive Officer, GEO Group Australia Pty Ltd and the Commissioner of Corrective Services NSW

GEO Group in consultation with Corrective Services NSW ("CSNSW") urgently examines replacing or altering the bed frames of the kind used within the B2 Unit at Junee CC on 3 February 2018 to remove possible hanging points.

To the Commissioner of Corrective Services NSW

CSNSW, in consultation with other stakeholders, examine the utility of adapting the telephone system available for inmate use to include an alert system when inmates make a significant number of calls to a particular number in a short period.

23. 80723 of 2018

Inquest into the death of LS. Finding delivered by DSC Truscott at Lidcombe on the 5 November 2020.

This is an inquest pursuant to sections 21, 23 and 27 of the *Coroners Act NSW 2009* ("the Act"). At the time of his death LS was 23 years old and was a prisoner on remand at Amber Laurel Correctional Centre.

Section 81 of the Act provides for a Coroner holding an inquest to make findings as to the identification of the person, the date, place, cause and manner of death.

Section 82 of the Act, provides for a coroner to make recommendations if they consider it desirable or necessary in relation to matters arising out of a death.

The officer in charge of the investigation into LS's death, Detective Sergeant Michael Cambridge prepared a brief of evidence which was tendered in the inquest.

Background

LS was born 28 September 1994. He had a very difficult childhood and he was placed in out-of-home care at the age of 10 but it was not until he was 14 years of age that he achieved some stability after being placed into the care of D and V. LS regarded them as his parents and had no contact with his biological family. When he was an adolescent he spent some time in a psychiatric unit and was placed on anti-psychotic medication.

LS completed a life skills certificate at Plumpton Behavioural School, and then travelled overseas with his family where he attended bibles studies. He returned to Sydney and worked in a number of jobs including formwork.

In 2015 LS commenced work as a forklift driver for Sunbeam Australia. He also began a relationship with KA, and in 2017 moved into KA's family home to live with her and her parents.

D and V reported that they noticed that in the months leading up to LS death, his behaviour had changed and they learned that he had commenced ingesting the drug 'ice', gambling and drinking alcohol.

Arrest and Custody

On Friday 9 March 2018, LS was arrested and charged with serious offences by Campbelltown Detectives. Due to the serious nature of the charges the police did not release him on bail. This was the first time LS had been in custody.

The police custody management records do not indicate any concerns for LS's wellbeing. I note that while he was in police custody he received a visit from KA and from V. He also made a number of phone calls to KA.

In the early hours of 10 March 2018 LS was transferred to Amber Laurel Correctional Centre, "an intake and transient facility" at Emu Plains which manages newly arrested or charged inmates as well as those who have been refused bail and are facing court. The facility accommodates up to 56 inmates. The centre is operated by the NSW Corrections Service.

LS entered Amber Laurel at 2.20 am. A "New Inmate Lodgement and Special Instruction Sheet" was completed at 2.25 am. Questions in relation to Mr Snowden's health and safety were answered and he denied having any medical issues, or having ever tried to hurt himself or end his life. It was identified it was his first time in custody. LS denied ever being charged for an offence as a juvenile. The investigation indicates that he had been charged and sentenced as a juvenile on four occasions. LS also denied drug or substance use, or having any medical issues.

Corrective Services classed LS as "special management" due to the nature of the charges against him and he was placed in a single person cell in the Flinders Wing, an area for inmates awaiting their court appearance.

LS appeared in the Parramatta Local Court by Audio Visual Link at 9.30 am. His case was adjourned to Campbelltown Local Court for mention to 2 May 2018. He was refused bail by the court.

LS was assessed by a registered nurse in the employ of the Justice Health and Mental Health Network ("Justice Health"). At 9.51 am a Health Problem Notification Form was completed. It indicated that Mr Snowden was asked numerous questions and he denied having any medical, mental health, drug or alcohol issues. He denied any self-harm issues. He was cleared medically for a normal cell placement.

A form completed by Justice Health entitled "Penrith and Parramatta Police Cells Assessment Criteria Checklist" was completed at 10.00 am on 10 March 2018. It indicted that LS answered "No" to questions about whether he required regular medication, was on opioid substitution treatment, had any allergies, or any primary health issues, or drug and alcohol issues or mental health issues, or had had recent surgery or had any current injuries or wounds requiring daily treatment.

Upon the completion of his court appearance, LS was placed in a different wing. He was placed in cell 6, Oxley Wing and he was awaiting transfer to a Reception Prison. Due to his "special management" classification and Justice Health medical clearance, he again assessed for normal cell placement and was placed in a one person cell.

The cell has one entry and exit point, with an individual sliding bolt mechanism with lockable padlock. The cell is furnished with two mattresses, a long metal bench, toilet and television. The cell has a duress button called a "knock up" which enables the occupant to call for assistance if required.

The records indicate that the "knock up" facility was operational and that LS utilised this once. That was at 5.07 pm on 10 March 2018. Unfortunately, the purpose of the call is unknown as these calls were not then recorded – the system has now been upgraded so that all "knock up" calls are recorded. Detective Cambridge said that from his enquiries LS requested a phone call and though this was facilitated there was no record of it being successful, as records were not kept at that time.

LS may not have made any telephone calls after his court appearance on 10 March 2018. That opportunity is generally not available until the prisoner is transferred to a reception prison. When that transfer would occur was dependent on the reception prison's capacity.

The Serious Incident Report indicates that the process where an inmate requests an outgoing telephone call is that a staff member will take the information from the inmate and make the phone call on their behalf with this information being logged in the Phone Call Register. LS did receive a message from a staff member that his grandmother (V's mother) had called him and she wanted him to call her on a provided number when he was transferred to a reception prison.

The evidence shows that LS's grandmother called the centre during the day Sunday 11 March 2018. This message was written down and given to Mr Snowden at about midnight when the officer left his shift. It was not recorded in the telephone log book but photographs show the message on the counter of LS cell.

The records of the 6 am handover of 11 March 2018 indicate "all inmates showered and fed". Separate records relating to each inmate are not kept in relation to this schedule.

The records indicate that at 6pm on the 11 March 2018, Mr Snowden was reviewed by a Registered Nurse who was performing clinic rounds. Mr Snowden complained that he had been complaining of dental pain. He was administered 1 gram paracetamol. He was asked questions by the nurse and he again denied any mental or other medical health issues.

Meals are delivered to inmates in their cells through a hatch of the door of the cell. Photographs of Mr Snowden's cell showed meal packaging and the remains of an eaten meal – presumably dinner from 11 March 2018.

At about 6:20 am on 12 March 2018, a corrections officer attended LS's cell and provided him with hot water for a coffee and breakfast which LS took from the hutch into his cell. The officer asked LS if he would like a shower which LS declined. This was the last time LS was seen alive. D and V told Detective Cambridge that this was notable as LS was fastidious about his personal hygiene. They also commented that he did not like confined spaces.

About 12:20pm, correctional officers attended LS's cell to provide him lunch. They opened the hutch of the door and the officer placed a coffee on the hutch and when LS did not retrieve it she leant down and looked into the cell. She saw that LS was seated in a strange position.

The officers immediately unlocked and entered the cell and observed that LS was cold to touch and unresponsive. He had a ligature around his neck which had been made out of a torn bedsheet. This sheet was anchored on a small screw in the right-hand side of the window frame.

The officers cut the ligature and placed LS on the bed and though he was deceased they called Justice Health staff who attended by 12.26 pm. A registered nurse confirmed that Mr Snowden was deceased (CPR was not performed as there were no signs of life was present) – there was no carotid pulse, no heart sounds or breath sounds for thirty seconds, there was no response to centralised stimuli and his pupils were fixed and dilated. Mr Snowden had deep and distinct ligature marks around his neck.

LS was declared life extinct at 12.46 pm 12 March 2018.

Investigation

On 14 March 2018, Pathologist Szentmariay performed an external post mortem examination. Dr Szentmariay identified that the cause of death was hanging.

The Brief of Evidence contains a Serious Incident Report as well as statements from the relevant persons who had contact with Mr Snowden whilst he was at Amber Laurel. The completed screening forms and health documents are included in the brief.

As a result of LS's death, a review was conducted to determine whether there were similar potential hanging points within the cells at Amber Laurel Correctional Centre.

This review resulted in all window frames being replaced and clear Perspex windows are now installed throughout the facility. This was completed in February 2019. Additionally, all cells are now fitted with closed circuit television cameras to more easily maintain observations of inmates.

CCTV's located outside the cell area had footage which was reviewed and established that no person entered LS's cell other than the officers who found him deceased.

After LS's placement in the Oxley Wing cell, he apparently did not have any contact with family members other than receiving the message from his grandmother.

A review of the Corrective Services and Justice health reveals that LS appeared not to have provided honest answers when he denied having a juvenile and mental health history during the screening process no issues. According to the records he at no time alerted any staff member from CSNSW or Justice Health that he was considering or was at risk of self-harm.

LS did not leave any note about his intention to end his life, but he did leave a message written in butter on the Perspex over the television screen. It said "I love K any family". Sadly, Mr Snowden did not call for support or assistance when he must have been in a distressed and despairing state of mind during the morning of 12 March 2018.

CCTV cameras now placed inside the cells at Amber Laurel will hopefully mean that prisoners in such situations will receive assistance to prevent self-harm even if they do no ask for help or indicate the need for such intervention.

The evidence allows for the making of formal findings including LS self-harm was intentional.

Given the review and action taken by NSW Corrections in relation to addressing the potential hanging points and the installation of CCTV in the cells at Amber Laurel, there are no further matters about which I would make recommendations.

Formal Finding:

Identity of deceased: LS

Date of death: 12 March 2018

Place of death: Amber Laurel Correctional Centre, Emu Plains, NSW 2750.

Cause of death: Hanging

Manner of death: Suicide

24. 194750 of 2018

Inquest into the death of Richard Willett. Finding delivered by DSC Truscott at Lidcombe on the 10 December 2020.

This is an inquest into the death of Richard Willett pursuant to sections 23 and 27 of the *Coroners Act 2009. (*Act) Mr Willett died whilst in NSW Corrective Services custody on 23 September 2018. At the time of his death he was 86 years old.

Pursuant to s81 of the Act the Coroner is to make findings as to identity, place, date and manner of cause of death. Pursuant to s82 of the Act the coroner may also make necessary or desirable recommendation. Mr Willett was born on 1 July 1931. He spent his adult life in south western New South Wales predominately within the Corowa area. He is estranged from his family.

On 21 April 2015 Mr Willett was charged with numerous historical offences. He was convicted of those offences and was refused bail by the District Court on 7 April 2017. He entered corrective services custody and was transferred to Junee Correctional Centre. On 12 April 2018 Mr Willett was sentenced to an aggregate term of 9 years imprisonment with a non-parole period of 4 years and 6 months. He was eligible for parole on 5 May 2021.

Richard Willetts health and treatment in custody

On 7 April 2017 Mr Willett completed a Corrective Services NSW and Justice Health & Forensic Mental Health Network reception screening assessments. Mr Willett reported that he had a previous diagnosis of hypertension, constipation, gastroesophageal reflux disease (GORD), melanoma, high cholesterol, spinal degeneration, a physical disability and he used reading glasses. An on-call doctor prescribed his regular medications and arranged for a medical review. Following that review on 10 April 2017 he attended 12 appointments between 11 April 2017 and 15 May 2017. On 11 May 2017 he underwent contrast CT scans at Wagga Wagga Hospital. On 15 May 2017 he was advised that he had a diagnosis of metastatic descending colon cancer, with liver and lymph node metastasis. He was referred to Prince of Wales hospital for oncology review.

Mr Willett was transferred to MSPC Long Bay Correctional Centre and attended admitted Prince of Wales Hospital on 22 and 24 May 2017. He underwent various tests and a treatment plan was established and implemented. On 9 June 2017 he underwent a stent procedure and commenced on chemotherapy.

On 26 June 2017 Mr Willett commenced palliative chemotherapy. However, on 5 September the chemotherapy was discontinued due to the toxic effects on Mr Willett. On 26 September 2017 in consultation with his managing oncology team a decision was made to stop treatment. Mr Willett was referred to the palliative care team and he attended numerous appointments at Prince of Wales for treatment. On 14 June 2018 Mr Willett attended an appointment with Nelune Comprehensive Cancer Centre Prince of Wales Hospital where his illness was discussed with him and he was advised that ne was no longer suitable for ongoing treatment and it was agreed that he would commence end of life care.

Mr Willett was discharged to the Medical Surgical Unit at Long Bay hospital to facilitate comfort measures. He died at 8.42am on Saturday 23 June 2018. Mr Willett was in custody at the time of his death, as a result NSW Police conducted an investigation. His death was not considered to be suspicious. No issues were identified with the medical care and treatment Mr Willet received while in custody. A post mortem examination was performed by forensic pathologist Alexandra Kullen. The examination by direction of the coroner was limited to an external examination including review of medical records and post-mortem imaging. The cause of death was identified as complications of metastatic colorectal adenocarcinoma.

Mr Willet died of natural causes whilst in lawful custody. His identity was confirmed by Correctional officer Roger Morris.

Formal Finding

Identity Richard Willett

Date of Death 23 June 2018

Place of Death Long Bay Hospital, Malabar NSW

Cause of death Complication of metastatic colorectal adenocarcinoma

Manner of death Richard Willet died of natural causes whilst in the lawful Custody of Corrective Services NSW

25. 199143 of 2018

Inquest into the death of Neville Towner. Finding delivered by DSC Truscott at Lidcombe on the 4 February 2020.

Neville Towner was a 52 year old man serving a life sentence at Long Bay Correctional Complex at the time of his death; an inquest is mandatory pursuant to Sections 23 and 27 of the *Coroners Act 2009.* Mr Towner's mother, Jacqueline Smith suffers advanced dementia; she resides in the Beechworth Health Services Home, Beechworth, Victoria. Mr Towner's only other known relative is an Aunt, Daphne Brunnne of a Blacktown address. They have been advised of this inquest, however did not attend.

The officer in charge Senior Constable Stuart Highfield prepared the Brief of evidence and appeared by Audio Visual Link from Ballina Police Station. Mr Towner was born on the 21 December 1965. Prior to his incarceration, in 1989 he had been residing at the Nepean River Caravan Park, 91/95 Mackellar St, Emu Plains NSW 2750. He had never married and apparently did not have any children.

On 18 May 1989 On 19 May 1989 Mr Towner was entered into custody at Parramatta Correctional Centre. During his screening assessment it was identified that he suffered Alcohol abuse, and was a smoker of a packet of cigarette daily for over 40 years. Mr Towner was serving a life imprisonment with a non-parole period of 20 years.

He was transferred between numerous correctional centres including Goulburn, Cooma, Berrima, Lithgow, Maitland and Long Bay where he spent remainder of his sentence. Mr Towner's final placement was within the Metropolitan Special Programs Centre Area 3, Wing, and Cell 35 at Long Bay Correctional Centre. Mr Towner was placed in this area due to the category of his offences.

During his period of incarceration Mr Towner received treatment for many medical conditions including ischaemic heart diseases, anxiety disorder and back pain. On 20 January 2012 Mr Towner underwent a quadruple bypass surgery at Prince of Wales Hospital; following this he continued regular appointments with the medical officer, nurse and specialists. On 9 May 2018, Mr Towner reported pain in the left leg, he presented as sweaty and with mild tremors, he was transferred to Prince of Wales Hospital Emergency department. He had an elevated temperature and increased white cell count indicating an infection of unknown origins.

Mr Towner discharged himself against medical treatment. The following day, , Mr Towner was reviewed by a registered nurse at Long Bay Correctional Centre, he denied experiencing any pain stating he felt ok. On 18 May 2018, Mr Towner was reviewed by a general practitioner, discussing his blood results and continued on his current treatment**.**

On the 15 June 2018 Mr Towner attended a consultation with the nurse at Long Bay Correctional Centre reporting difficulty breathing, standing, walking and a dry cough. During his medical assessment Mr Towner was noted to be experiencing low oxygen saturation. Accordingly, he was placed on supplementary oxygen and transferred to the Prince of Wales Hospital emergency department by ambulance.

He was admitted to the respiratory ward, and treatment commenced with high flow nasal prongs which were initially tolerated.

However, his condition deteriorated and on 19 June 2018, Mr Towner was intubated, he was treated with regular antibiotics for severe community acquired pneumonia, however there was no improvement in his condition. He was started on a high dose of methylprednisolone 1500mg for 3 days in addition to the high ventilator support.

On 27 June 2018, Mr Towner suffered an acute deterioration becoming increasingly tachychardic and tachyponeic. A chest x-ray and ultrasound did not show any acute change to account for his deterioration and it was determined that he was suffering acute respiratory distress syndrome and that all therapeutic options had been exhausted. Management changed from active treatment to comfort care. At 4.46pm he was pronounced deceased.

Mr Towner was provided appropriate medical care, there are no suspicious circumstances surrounding his death. His progression to death could not be stopped despite multiple antibiotics and high dose of methylprednisolone.

Formal Finding:

Identity: Neville Towner

Date of Death: 27 June 2018

Place of Death: Prince of Wales Hospital, 320-346 Barker St, Randwick, New South Wales

Cause of Death: Acute respiratory distress syndrome

Manner of Death: Natural causes

26. 206773 of 2018

Inquest into the death of William Laird. Finding delivered down by State Coroner O'Sullivan at Lidcombe on the 30 January 2020.

Mr Laird was born in 1949. At the time of his death he was serving a custodial sentence and had been transferred from Long Bay Hospital to Prince of Wales Hospital due to deteriorating health. He had a lengthy medical history and was known to have significant and chronic health problems. No issues have been raised in relation to his care or treatment.

William Laird was in the lawful custody of Corrective Services NSW ("CSNSW") at the time of his death. Accordingly, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act 2009.

The role of a Coroner and purpose of this inquest

Under s81 of the Act a Coroner, is to make findings as to:

The identity of the deceased;
The date and place of the person's death;
The physical or medical cause of death; and
The manner of death, in other words, the circumstances surrounding the death.

Pursuant to s 82 of the Act a Coroner is empowered to make recommendations concerning matters such as public health or safety issues arising out of the death in question.

There is no controversy in this case as to William Laird's identity, the date or place of his death. No outstanding questions have been raised in relation to the medical cause or death or in relation to the circumstances surrounding Mr Laird's death.

Evidence at Inquest

A short inquest was held on 30 January 2020. The only witness called in the inquest was Constable Rianna Malvern who is the Officer in Charge of the investigation. The brief of evidence compiled by Constable Malvern was tendered.

Background

William Laird was born on 17 of June 1949. He lived in the suburb of Inverell in New South Wales for most of his life. Mr Laid has no siblings or children. Mr Laird played in a band and participated in a radio club. He worked as a Telecom technician and then later at a computer and electronics store. Mr Laird later went on a pension and resided in an Aged Care Facility prior to his arrest.

Medical History

At the time of Mr Laird being taken into custody he required 24 hour-a-day use of an oxygen tank to assist with his breathing. Mr Laird had been previously diagnosed with diabetes Mellitus, anxiety disorder and polycythaemia.

In 2005 he was diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and it was noted in his medical records that he had been a heavy smoker since age 25 and smoked 60 cigarettes a day. A spirometry was performed in 2005 that returned a reading of 64%. In 2009 Mr Laird was diagnosed with Bilateral Osteoarthritis of the knee, in 2010 with Hypertension and Hypercholesterolaemia, faecal and urinary incontinence and in 2016 with adjustment disorder with mixed anxiety and depressed mood.

Criminal History

Mr Laird was not known to police prior to his arrest and charge in 2017 at the age of 68. He was arrested and charged on 5 May 2017 with five offences under Section 91H (2) of the Crimes Act 1900 (NSW). Mr Laird pleaded guilty to all offences and was sentenced to 18 months imprisonment from 19 October 2017 to 18 April 2019 with a non-parole period of twelve months expiring on 19 October 2018. He was lawfully in custody pursuant to sentence warrant 2017/135991.

Medical Treatment in Custody

Mr Laird was received into Moree Court Cells on 20 October 2017. This was his first time in custody. He was transferred to Cessnock Correctional Centre where a Justice Health & Forensic Mental Health Network (JH&FMHN) Reception Screening Assessment was completed. A subsequent JH&FMHN report shows that Mr Laird had a history of Chronic Obstructive Pulmonary Disease (COPD), Hypercholesterolemia, Hypertension, Osteoarthritis, Gout, Anxiety Disorder and Incontinence of faeces and urine.

On 21 October 2017 Mr Laird was taken to Cessnock Hospital and assessed for fitness to travel to Sydney. He was transferred the same day by Ambulance to Long Bay Hospital (LBH) Medical-Surgical Unit (MSU). From that time onwards, Mr Laird remained under the care of medical personnel at LBH's MSU, Aged Care Rehabilitation Unit (ACRU), Prince of Wales Hospital public wards and the Secure Ward Annex (POWH annex).

On 22 October 2017 Mr Laird was reviewed by the attending medical officer in MSU. It was noted that Mr Laird appeared short of breath, requiring oxygen therapy at two litres per minute and presented as anxious and depressed. On 27 October 2017 Mr Laird was assessed by two Psychiatric Registrars who noted anxiety disorder symptoms with some panic symptoms and social anxiety.

NSW Department of Corrective Services case notes show that Mr Laird was generally compliant however on 11 December 2017 it was noted that Mr Laird's behaviour was argumentative, and he was under the impression that Justice Health and Correctives staff had a sinister agenda and were stealing his oxygen.

A referral was made for Mr Laird to see a psychologist. Mr Laird was seen by a Forensic Psychologist on five occasions during his time in custody to assist with the management of anxiety.

On 21 December 2017 Mr Laird completed Resuscitation Plan paperwork that confirmed that in the event of cardiopulmonary arrest, Mr Laird was not for CPR or Intensive Care Unit admission. On 27 December 2017 Mr Laird also completed an Advance Care Directive where he indicated that he was not for CPR or intensive care treatments.

On 7 June 2018 Mr Laird was admitted to Prince of Wales Hospital after presenting to the chest clinic in acute respiratory distress, with tachypnoea, low oxygen saturation and agitation.

He was seen and co-managed by the Respiratory, Palliative Care and Mental Health teams during this admission. The discharge summary from Prince of Wales Hospital noted that Mr Laird's end-stage COPD was evident, and that Mr Laird was accepting of this fact. On 21 June 2018 Mr Laird was discharged back to Long Bay Hospital – ACRU. Mr Laird's discharge plan was for palliative care follow up and psychiatric follow up. On 23 June 2018 Mr Laird was admitted to Prince of Wales Hospital and transferred to the Respiratory Ward for an acute exacerbation of his end-stage COPD. He was trialled on 72 hours of Bi-level Positive Airway Pressure (Bi-PAP) therapy. This stabilised his oxygen saturation at rest, but he desaturated (low Sp02) on minimal exertion.

On 27 June 2018 a report was made in which Mr Laird's deteriorating health was noted and the relevant paperwork was completed as his life expectancy was due to expire. The Next of Kin was notified of Mr Laird's location and contact details of officers and nursing staff provided. Mr Laird was transferred to the POWH Annex and housed in Room 1. Mr Laird remained on palliative care and was receiving morphine for comfort measures, lorazepam and clonazepam.

Events leading up to the death of Mr Laird

On 4 July 2018 the Corrective Services Night Senior was informed of the deterioration of Mr Laird and gave approval for his cell door to remain open as requested by nursing staff. About 11.40pm on 4 July 2018 Correctional Officers accompanied a NSW Health staff member to Mr Laird's room for a routine check. Mr Laird was observed to have no signs of life. At 11.58pm Doctor Hugh Carter declared life extinct. The room was secured, and the appropriate parties were notified.

Investigation following Mr Laird's death

About 12.07am on 5 July 2018 police attended POWH Annex Room 1. A Crime Scene was established and maintained. CCTV Footage was later obtained and reviewed and was in accordance with the accounts of Corrective Services and Police Officers. Photographs were taken, and Mr Laird's body was transferred to the Department of Forensic Medicine, Glebe Morgue. A limited autopsy was performed by Doctor Isabella Brouwer on 6 July 2018. Doctor Brouwer concluded that the direct cause of death was most likely due to complications of chronic obstructive pulmonary disease (COPD). The post mortem CT scan confirmed the presence of advanced COPD changes with changes suggestive of aspiration pneumonia. There was also evidence of atherosclerotic disease with calcification of the coronary arteries and an unruptured infrarenal abdominal aorta aneurysm.

Formal Finding:

Identity: The person who died was William Laird

Date of death: William Laird died on 4 July 2018.

Place of death: William Laird died at Prince of Wales Hospital, Randwick NSW.

Cause of death: The cause of William Laird's death was complications of chronic obstructive pulmonary disease.

Manner of death: William Laird died of natural causes whilst in custody.

27. 283647 of 2018

Inquest into the death of Peter Simpson. Finding delivered by DSC Forbes at Lidcombe on the 21 February 2020.

This is an inquest into the death of Peter Simpson who died at Long Bay Hospital on 15 September 2018. The role of the Coroner is to determine;

- The identity of the person who has died,
- The time of that person's death,
- The location of their death,
- And, the manner and cause of the person's death.

Section 23 of the *Coroners Act 2009* makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that the care of that person was appropriate and adequate.

Peter Simpson

Peter Simpson was born on 13 April 1950. He was the middle child of three sons, born and raised in Launceston Tasmania.

On 5 June 2007, Mr Simpson was arrested and charged with offences under Section 61N (1), 61O (1), 66C (1) and (3) of the Crimes Act 1900 (NSW). On 12 September 2008 he was sentenced to a cumulative sentence of 17 years and six months prison, which was reduced on appeal to 14 years and six months prison. On 15 July 2016, whilst still serving his sentence, Mr Simpson was charged with six counts of similar offences, and bail refused on these matters. These offences were still before the court at the time of Mr Simpson's death.

Medical History

While he was in custody Mr Simpson was diagnosed and treated for acute and chronic medical problems including arthritis, chronic obstructive pulmonary disease and Hypertension.

In 2014 a basal cell carcinoma was identified and treated. In January 2015, Mr Simpson was diagnosed with facial sarcomas and treated with radiotherapy.

In May 2015, Mr Simpson was diagnosed with mantle cell lymphoma and kept under active surveillance. A lymphocyte cell surface marker analysis was completed on Mr Simpson, along with numerous investigations including a core biopsy of his lymph nodes. Throughout 2015, Mr Simpson attended the Prince of Wales Hospital eight times for surgical procedures and routine checks. In January 2016 he began chemotherapy.

Throughout 2016 and 2017, there were clear features of progression of his mantle cell lymphoma. In January 2017, Mr Simpson had a right hemicolectomy due to adenocarcinoma. This was followed up by the consultants at Prince of Wales Hospital and by Justice Health Network staff.

In November 2017, Mr Simpson had multiple facial squamous cell carcinomas, requiring extensive excision and skin grafting. He also experienced a relapse of mantle cell lymphoma with a poor prognosis. In December 2017, Mr Simpson signed an advance care life directive stating he was not for cardiopulmonary resuscitation.

On 26 August 2018, Mr Simpson was transferred to Long Bay Hospital Medical Sub-Acute Unit. Mr Simpson was reviewed by the palliative care team on 31 August 2018 and it was noted that terminal care for a deteriorating patient was planned. Mr Simpson again confirmed the previously signed advance care directive that he was not for cardiopulmonary resuscitation.

On 12 September 2018, Mr Simpson was reviewed by the palliative care team who continued with his palliative care plan, including morphine for pain.

At 10am on Saturday 15th September 2018, Mr Simpson was last seen alive by Registered Nurse Dimity Brannon who was one of his primary carers. About 10.15am, Nurse Brannon returned to Mr Simpson's room and found him unresponsive. Nurse Brannon checked Mr Simpson for a pulse and breath sounds using a stethoscope, life extinct was declared at 10.15am.

Investigation following the death of Mr Simpson

About 11:10am on 15 September 2018 police attended Long Bay Correctional Centre. A Crime Scene was established and maintained. CCTV Footage was later obtained and reviewed and was in accordance with the accounts of Corrective Services and Police Officers. Photographs were taken, and Mr Simpson's body was transferred to the Department of Forensic Medicine, Glebe Morgue. Mr Simpson's family did not raise any issues about the medical care and treatment he received whilst in custody.

A limited autopsy was performed by Doctor Istvan Szentmariay on 20 September 2018. Doctor Szentmariay concluded that the direct cause of death was determined to be terminal lymphoma.

Formal Finding

The identity of the deceased: The deceased person was Peter Simpson

Date of death: Died on 15 September 2018

Place of death: Died at Long Bay Hospital, Malabar, NSW

Cause of death: The death was caused by terminal lymphoma

Manner of death: Natural causes

28. 334938 of 2018

Inquest into the death of Kerry Curtis. Finding delivered by State Coroner O'Sullivan at Lidcombe on the 25 February 2020.

Introduction

Mr Curtis died at Prince of Wales Hospital, Randwick at the age of 78 years. At that time, he was a sentenced prisoner and had been housed in the Long Bay Hospital Aged Care Rehabilitation Unit.

The role of the Coroner

When a person's death is reported to the Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what was the cause and manner of their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009* (NSW) makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases, the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death to ensure that the State discharges its responsibility appropriately and adequately. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

The Inquest

A short inquest was held on 25 February 2020. The officer in charge of the investigation, Detective Senior Constable Luke McNaughton gave evidence and the court considered numerous statements, medical records, photographs and reports.

The Evidence

Background:

Kerry Curtis was born on the 26 February 1940 in Hamilton, New South Wales. He was the second eldest of four siblings. Mr Curtis was married between 1963 and 1975, together they shared two daughters.

In 1992 Mr Curtis commenced a de-facto relationship, which continued until his death. Mr Curtis's daughters and partner were advised of today's inquest, however did not attend.

There is no dispute that Mr Curtis was in custody lawfully. He was convicted on 25 August 2017 for three commonwealth offences of obtain financial advantage by deception.

He was sentenced at the Newcastle District Court to three years and nine months imprisonment, commencing on the 25 August 2017 and to conclude on 24 May 2021. His earliest release date was 25 August 2019.

Mr Curtis was born with the medical condition pyloric stenosis; he was also diagnosed with asthma, eczema and insufficient adrenaline production requiring prescribed medication. Mr Curtis suffered many chronic and complex medical conditions including:

Asthma

Eczema

Bipolar effective disorder

Hyper-cholesterol

Corticosteroid induced osteoporosis

Osteoarthritis in the hips, spine and knees

Hypertension un-stability

Sinus arrhythmia

Atrial flutter

Congestive pulmonary disease

Fibrosis of the lung

Postural hypotension

Bladder cancer

Chronic obstructive pulmonary disease

In 2013 Mr Curtis was diagnosed with low grade transitional cell carcinoma in the bladder, following this diagnosis he had three monthly cystoscopies until November 2016, with no reported recurrence of the cancer. During his incarceration Mr Curtis had multiple falls with no significant injuries, these were secondary to regular complaints of dizziness. Mr Curtis had multiple hospital transfers to external hospitals for cardiac related episodes. He was subsequently transferred to the Long Bay Hospital Aged Care Rehabilitation Unit to manage his chronic and complex health issues. Mr Curtis attended regular consultations with the clinical director of Aged Care, physiotherapist, nursing staff and psychiatrists. His medication needs were strictly adhered to by Justice Health.

In June 2018 Mr Curtis had a cystoscopy identifying an invasive carcinoma on the left bladder wall. Between this diagnosis and October 2018, he was scheduled for chemotherapy for stage two bladder cancer with a scheduled surgery date of the 8 November 2018; he attended regular consultations with the oncology consultant and aged care clinical director.

The Fatal Incident:

On the 2 October 2018 Mr Curtis attended Prince of Wales Hospital Cancer Care centre to receive chemotherapy, he was described as frail, fatigued, neutropenic and considered unsuitable for chemotherapy.

Mr Curtis was admitted and received a transfusion of packed red blood cells. Mr Curtis received ongoing intravenous antibiotics, pain relief and oxygen assistance. His admission became complicated due to a right internal capsule ischaemic infarct.

On 30 October 2018 Mr Curtis' family advised the treating team of their wish to stop active treatment. At 10pm on 30 October 2018 Mr Curtis became symptomatically distressed and very short of breath, although he was given hourly intervention, there was minimal effect and at 4:50am on the 31 October 2018 Mr Curtis died.

Autopsy:

A post mortem examination was performed on 2 November 2018 by Dr Sairita Maistry at the Department of Forensic Medicine, Lidcombe. Dr Maistry found evidence of bilateral pleural effusions, pulmonary opacification suggestive of lower respiratory tract infection, cardiomegaly, coronary calcification and peripheral vascular disease. Therefore the cause of death was due to multi-lobar pneumonia and pleural effusions on a background of urothelial carcinoma and its treatment, chronic obstructive pulmonary disease and ischaemic cardiovascular disease.

CSNSW Investigation:
Mr Curtis's death resulted in an investigation conducted by senior investigation Officer, John P Gleeson of NSW Corrective Services. This investigation concluded that Mr Curtis was managed appropriately whilst in Corrective Services custody at each centre he was housed.

Formal Finding:
Identity:

The person who died was Kerry Curtis

Date of death:

He died on 31 October 2018

Place of death:

He died at Prince of Wales Hospital, 320-345 Barker Street, Randwick NSW

Cause of death:

He died as a result of multi-lobar pneumonia and pleural effusions on a background of urothelial carcinoma and its treatment, chronic obstructive pulmonary disease and ischaemic cardio-vascular disease

Manner of death:

Mr Curtis died of natural causes while he was serving a term of imprisonment

29. 369349 of 2018

Inquest into the death of AG. Finding delivered by DSC Stone at Newcastle on the 28 April 2020.

Introduction

CD died on 29 November 2018, in the course of a police operation and pursuant to sections 23(1) (c) and 27(1) (b) of the Act, this inquest is mandatory. The purpose of this type of inquest is to fully examine the circumstances of the death in which police have been involved, in order that the public, the relatives and the relevant agency can become aware of those circumstances.

The Inquest

Section 81(1) of the Act requires a coroner to make findings as to:

- the identity of the person who has died;
- the date and place of the person's death; and
- the manner and cause of the death.

In addition, under s 82 of the Act, the Coroner may make recommendations in relation to matters connected with the death, including matters that may improve public health and safety in the future.

Social History

CD was married to AB. They had two children X and Y. At the time of CD's death they were all residing together on a semi-rural property. CD was employed as an IT specialist and consistent with his job, he had particular skills in information technology, as he was responsible for installation and maintenance of specialist computer and video mediums utilised by an NSW Health facility.

During 2018, CD was the subject of an internal investigation arising out of an allegation that he had misused his position to facilitate the purchase of services and products from a company in which he had a financial interest. The allegation was serious. In its final investigation report dated 4 October 2018, the NSW Health facility determined that the allegation was substantiated and consequently, their report was submitted to the NSW Independent Commission against Corruption ("ICAC") for further investigation.

The following is a combination of agreed facts (as prepared by Counsel Assisting who I acknowledge as the author of that document) and the evidence of witnesses that were called to give evidence. There are no issues of credit. Each witness who gave evidence in my opinion did so to the best of their ability and did so to assist the inquest.

On 21 November 2018, ICAC Senior Investigator Michael Riashi obtained a search warrant permitting a search to be undertaken of CD's property. CD lived at the property with AB, and his children X and Y. Prior to executing the search warrant, ICAC Senior Investigator Riashi ascertained from the Firearm Integrated Licensing System that CD had a firearm licence and a number of firearms registered to him at the address to be searched. Consequently, arrangements were made for NSW Police Force ("NSWPF") officers to accompany the ICAC officers executing the search warrant.

Search Warrant and Events on 23 November 2018

At approximately 7.25am on 23 November 2018, the ICAC search warrant was executed at the property of CD, with ICAC Senior Investigator Riashi, ICAC Investigator Thomas, ICAC Electronic Evidence Analyst Frewen and ICAC Investigator Ionnidis in attendance. Later in the day, ICAC Technical Officer Leeson also joined them. Additionally, NSWPF officers Senior Constable Nevil and Senior Constable Proctor attended the residence and conducted an inspection and audit of CD's firearms.

After the NSWPF officers found CD's firearm safe door open, with a rifle standing outside it and one firearm in a caravan on the property, they seized CD's firearms and ammunition and informed him that his firearms licence was being suspended. The NSWPF officers departed CD's residence at approximately 9.13am, taking with them all known and accounted for firearms. At this point the ICAC Investigators began their search.

During the hearing, ICAC Senior Investigator Riashi was taken to his statement and to the transcript of the audio captured on his body worn camera, which he wore during the entire search. His statement and the transcript detail his interaction with CD and with Detective Senior Constable Walker. ICAC Senior Investigator Riashi confirmed that he held some suspicion about CD's conduct during the search, in particular once a particular mobile phone was located. Initially CD maintained that the mobile phone belonged to one of his children, however ICAC Senior Investigator Riashi described that CD displayed some reticence about unlocking this phone. It later became clear that the phone was in fact CD's and not his child's.

In the course of the search, the ICAC Investigators searched a detached shed and located a small safe which had a lock secured by a digital pin combination. CD complied with a request to open the safe and knew the combination to open it.

When CD opened the safe, he reached inside to pull items out, but was stopped by ICAC Senior Investigator Riashi. ICAC Senior Investigator Riashi then looked inside the safe and located a large, clear resealable bag with underwear in it. CD claimed that the underwear was related to a fetish his wife had. CD then quickly departed the shed.

There were a number of similar resealable bags inside the safe, each labelled with a different female Christian name. ICAC Senior Investigator Riashi reviewed the bags and noted that the underwear appeared to be very small. In the investigator's opinion, in view of the small size of the female underwear and the patterns on them, he suspected they belonged to children. He was concerned that he had located child exploitation material, which likely belonged to CD. Also within the safe was a condom, some photographs and a letter.

In his evidence at the hearing, ICAC Senior Investigator Riashi noted one photograph was of an adult woman, clothed but the picture was focused on her chest area. The other photographs were of two female children and an adult female, clothed. It appeared that they had posed for the camera. ICAC Senior Investigator Riashi thought the condom was still sealed. Some of the underwear was flattened out in the bag. Because of the names on labels attached to each bag, he had a suspicion that they were kept as "trophies". He also read the letter. The contents appeared to be a letter to a female work colleague and he saw that it was signed with CD's initials. He didn't open the plastic bags as he did not want to contaminate potential evidence.

ICAC Senior Investigator Riashi asked ICAC Investigator Thomas to locate CD. ICAC Senior Investigator Riashi telephoned his supervisor, ICAC Chief Investigator Dubois and also telephoned Detective Senior Constable Bottrell. He asked both Chief Investigator Dubois and Detective Senior Constable Bottrell to attend the premises in order to inspect the items found in the safe.

ICAC Investigator Thomas located CD in the house. He and ICAC Senior Investigator Riashi then continued their search in the shed and at approximately 11.49am, ICAC Investigator Thomas found what he suspected to be child abuse material in a plastic storage box located in the shed. They were cassette film tapes. At that point, ICAC Senior Investigator Riashi determined that the search of the box should be suspended, pending the arrival of the NSWPF officers. ICAC Investigator Thomas returned to the residence and observed that CD appeared to be unwell and was lying down on the lounge. His wife, AB, who had returned home, was comforting him.

At approximately 1.38pm, Detective Senior Constable Walker from Cessnock Police Station arrived at the premises and ICAC Senior Investigator Riashi and ICAC Investigator Thomas briefed him as to what they had discovered.

From the evidence of both Detective Senior Constable Walker and ICAC Senior Investigator Riashi, the briefing occurred as they were walking towards the shed from where Detective Senior Constable Walker parked his vehicle. They had been talking for some minutes when CD was observed to depart the house from the rear and walk with "pace" through a gate and up a hill on the property.

ICAC Senior Investigator Riashi and ICAC Investigator Thomas expressed concern regarding CD's safety to Detective Senior Constable Walker, although Detective Senior Constable Walker does not recall this conversation. Detective Senior Constable Walker asked ICAC Senior Investigator Riashi what CD was doing. ICAC Senior Investigator Riashi of course did not know.

At about the same time, AB departed the house and started running after CD. She said words to the effect that the situation had "turned" and she thought something was going to happen. ICAC Senior Investigator Riashi could not remember if he had briefed Detective Senior Constable Walker about CD's firearms. He remembers Detective Senior Constable Walker asking him if CD had access to firearms and him replying they had been taken away earlier that day. ICAC Senior Investigator Riashi called out to CD who turned around and, after apparently seeing ICAC Senior Investigator Riashi and others, started to run.

ICAC Senior Investigator Riashi and ICAC Investigator Thomas then ran after CD, who ran out of sight. Detective Senior Constable Walker saw CD take off and then joined ICAC Senior Investigator Riashi and ICAC Investigator Thomas in running after CD.

ICAC Senior Investigator Riashi's described CD's conduct as "bizarre". After initially running away, he then stopped cold, turned around and walked back towards him and the other officers chasing him, eating an apple, as if nothing had happened. ICAC Senior Investigator Riashi was concerned that CD may try to self-harm, but also that he might try to dispose of something. In his opinion, the nature of the material, the change of behaviour by CD once the contents in the safe were found in the shed and his conduct in walking and then running away concerned him.

Ultimately, when ICAC Senior Investigator Riashi, Investigator Thomas and Detective Senior Constable Walker caught up with CD, he denied that he had taken off and suggested that he "just wanted to get away, get out of the house".

At approximately 2.08pm, the ICAC Investigators found explicit child exploitation material on a hard drive. ICAC Senior Investigator Riashi informed Detective Senior Constable Walker that ICAC was not permitted to possess child exploitation material and would therefore not be able to continue with further previews or acquisitions. Detective Senior Constable Walker declared the premises a crime scene and informed CD that other NSWPF officers would be attending soon and further, that a police search warrant was being sought.

Detective Senior Constable Walker did not know who the owner of the hard drive was, and the material he briefly looked at did not depict CD. It did depict naked images of children and he determined it looked like child abuse material of some kind.

ICAC Senior Investigator Riashi was taken to his statement and he recalled having a discussion with Detective Senior Constable Walker and CD, where CD said words to the effect "no one else had access to the safe". The Detective then asked CD who put the material in the safe and he declined to answer.

At about this time, ICAC Senior Investigator Riashi said words to the effect of "I'm not prepared to leave CD because I have concerns for his welfare" to Detective Senior Constable Walker. ICAC Senior Investigator Riashi sat with CD pending the arrival of more police officers and CD said words to the effect of "I can't see farther than today". Detective Senior Constable Walker does not recall these conversations. The Detective in his evidence thought ICAC Senior Investigator Riashi was more concerned about CD having disposed of something when he ran.

Detective Senior Constable Walker determined at this point that he did not have enough evidence to hold CD, as the suspected child abuse material on the hard drive may not necessarily belong to him. Detective Senior Constable Walker and ICAC Senior Investigator Riashi informed CD that he was not under arrest and asked him why he had taken off earlier that day. They specifically questioned him as to whether he intended to harm himself. CD said that he had "nothing to harm himself with unless I ran into a tree". Under direct questioning, CD denied that he wanted to harm himself.

At approximately 3.19pm, Detective Senior Constable Sweeney, Detective Senior Constable Wilks and Senior Constable Murphy from the Cessnock Police Station arrived at the scene and Detective Senior Constable Walker briefed them.

Detective Senior Constable Walker and Senior Constable Murphy then went to Kurri Kurri Police *St*ation to seek a search warrant. A search warrant was issued by Maitland Local Court at approximately 5pm, after which time Detective Senior Constable Walker and Senior Constable Murphy returned to CD's property.

Before NSWPF officers began carrying out the search under the search warrant, CD stated that he wanted to leave. Detective Senior Constable Walker informed CD he was not under arrest and could therefore leave, but also asked that a record be made of police serving him with an Occupier's Notice. The NSWPF officers searched CD and his vehicle before he left. On the search of CD they located a small SD memory card in his wallet. He said to the officers he couldn't remember what it contained but thought it was old trail footage of wild dogs on the property.

After CD left the premises, the search was suspended pending the arrival of Chief Inspector Vromans as an "independent" officer. When Chief Inspector Vromans arrived, the search resumed and a number of exhibits were seized, as well as two firearms, which had not been located earlier by the NSWPF officers who accompanied the ICAC officers. The rifles were not on the list of known rifles owned and registered to CD. The search concluded at approximately 9pm. By that time, CD had not returned to the property.

Following the conclusion of the search, Detective Senior Constable Walker spoke to Chief Inspector Vromans and discussed CD having run away earlier in the day. Detective Senior Constable Walker suggested that it could be due to CD seeking to dispose of evidence or because he was considering self-harm. Following on from the discussion, Chief Inspector Vromans and Detective Senior Constable Walker decided that a "keep a look out" job should be created for CD and his vehicle covering the period Friday 23 November 2018 to Monday 26 November 2018.

Issue 1: The basis for the decision to charge CD on 28 November 2018 and whether there was any delay in making that decision

In the five days following the execution of the search warrant on 23 November 2018, NSWPF officers reviewed the exhibits seized, including the video and digital material. There was some delay to this review, as the material was on a variety of mediums, including old VHS tapes, and Detective Senior Constable Walker explained that he had to source suitable equipment to view the material.

On 26 November 2018, Detective Senior Constable Walker telephoned AB and enquired about CD. AB indicated that CD had been in and out of the house over the weekend. She added that she did not fear he would self-harm, though she also stated that he seemed "a little off". Detective Senior Constable Walker informed AB that she should contact triple zero if she had any concerns about CD's safety.

On 28 November 2018, and having further reviewed some of the exhibits that were seized, Detective Senior Constable Walker concluded that there was sufficient evidence of child abuse for CD to be arrested and charged. The older material, the VHS tapes, showed footage filmed covertly in public, described colloquially as "up skirting"– taking film of females under their skirts around their genital areas. However, one of the hard drives Detective Senior Constable Walker reviewed had footage that depicted CD sexually assaulting some young female children.

He then consulted with Detective Sergeant Sargent somewhere between 5.00pm and 5.30pm about the best path forward.

In his evidence at the hearing, Detective Senior Constable Walker gave sound, sensible reasons why he did not arrest CD on 23 November 2018. He concluded he did not have reasonable grounds to effect an arrest. In respect of the items in the safe, he considered those on their own would not be enough to establish a criminal offence. Similarly, the material on the hard drive located in the shed did not depict CD and there was no admission by CD that he was the owner of the hard drive.

The cassette tapes located in the separate box in the shed were unable to be viewed at the time the search warrant was executed, due to specialist equipment being required. Again Detective Senior Constable Walker was not aware as to who owned or possessed these tapes. Ultimately, Detective Senior Constable Walker gave evidence that he was not comfortable charging CD, as he had formed the view that there was not enough evidence to do so. I am satisfied with those reasons.

However, by 28 November 2018 and upon reviewing a substantial portion of the seized material, that opinion had changed, and after consultation with Detective Sergeant Sargent, a decision was made to effect the arrest of CD. Given the lateness in the day, it was determined that CD's arrest would take place the following morning on 29 November 2018. Detective Sergeant Sargent also agreed with the reasoning not to attempt an arrest on 28 November 2018. He gave evidence stating there was insufficient staff present and that by the time appropriate arrangements could be made, the arrest would occur during darkness, which was of some risk to police.

In my opinion, no criticism could be made in relation to Detective Senior Constable Walker's reasoning and his decision not to arrest CD prior to, or late on the afternoon of, 28 November 2018.

Issue 2: The arrangements made to arrest CD on 29 November 2018 and whether planning for the arrest was adequate

Issue 3: Further to Issue 2 above, whether any form of risk assessment was undertaken in respect of the planned arrest in light of the nature of the charges to be laid against CD and his behaviour on and after 23 November 2018

On 29 November 2018 at 9.30am, Detective Senior Constable Walker, Detective Sergeant Sargent, Detective Senior Constable Cooper and Detective Senior Constable Sweeney met at Kurri Kurri Police Station in order to discuss attending CD's residence and arresting him.

In his evidence at the hearing, Detective Senior Constable Walker told the inquest that the briefing of the other officers took about 20 minutes. Detective Senior Constable Walker determined that two officers would proceed to the front of CD's property and two officers would go around to the back of the property. It was not planned to inform CD of the police's intention to come out to the property to arrest him.

Prior to the briefing, Detective Senior Constable Walker undertook a location search regarding CD on the police COPS system. This was to ascertain whether there were any warnings for CD's address, whether any firearms were known to be at the address, and to ascertain who else may live at the address. The COPS system also records whether there have been any recent incidences of violence or mental health attendances by police. Detective Senior Constable Walker also conducted a search called "PerFind". This tells police about the criminal history of a person and other relevant intelligence such as their RTA details, previous and current addresses etc.

As part of the searches conducted, it appeared that CD had one old break and enter charge recorded in his criminal history from the 1980s. However nothing in the searches indicated to Detective Senior Constable Walker that CD had a propensity for violence, or that CD had any recorded offences involving violence. He had no known history of any mental health issues and no record of having either a drug or alcohol problem where he had any interaction with police. Detective Senior Constable Walker knew that firearms had been removed and his major concern was that CD may attempt to flee.

Detective Senior Constable Walker was asked in some detail about whether or not he has used the search warrant risk assessment tool. His evidence was that he had used the risk assessment tool previously in respect of a number of search warrants and found the use of the tool very time-consuming. In his opinion, having a similar risk assessment tool and guide to use for a planned arrest would delay him in going and performing that planned arrest, as this would necessitate working through a multi-page document in an attempt to factor in risks that may or may not crystallise. He added that there was already an informal process for undertaking a risk assessment.

It was difficult to understand Detective Senior Constable Walker's reasoning. On the one hand he acknowledged that the search warrant risk assessment tool had some benefit as it forced a police officer to record that a risk assessment was undertaken, the factors considered and what the conclusion was. He also acknowledged that the tool can assist in 'jogging' a police officer's memory to consider a particular risk. However on the other hand, Detective Senior Constable Walker stated that the tool did not assist in identifying risks, as attempting to identify every risk was a "*guessing game*"

He stated that overall, creating a risk assessment tool for planned arrests would not be of assistance, as a police officer would be attempting to record risks that are unable to be fully identified; it would be like "*trying to foresee the future*". This response appears somewhat illogical. Precisely because of the variability of risk, it would, in my view, be a very sensible idea to have a checklist to ensure that a police officer does consider various risks and their competing level of possibility/probability when proposing to undertake a planned arrest. However, this was not a view shared by Detective Senior Constable Walker or any of the other police officers who gave evidence at the hearing.

Detective Senior Constable Walker did not use the risk assessment tool and checklist for search warrants when he obtained his own search warrant on 23 November 2018. He said that he spoke to his superior officer and it was decided that it was not needed in view of the fact that he had already been out there, had some idea of what was going to be involved, had met CD and that all known firearms had been taken from him.

Given there is no equivalent document regarding "planned" arrests, Detective Senior Constable Walker did not formally record, nor did he need to, what risks he considered, prior to CD's arrest on the morning of 29 November 2018. However, he had already been out to the property, had already had an interaction with CD and had undertaken a variety of searches regarding CD on the COPS system. In view of these investigations, he was satisfied that he had covered all known risks. He said that he took into account his initial concern about CD running away from the home on 23 November 2018, but in view of his conversation with AB on 26 November 2018, he didn't feel at the time that self-harm was likely to be a factor.

Detective Sergeant Craig Thomas Sargent gave evidence at the inquest. He confirmed that he was Detective Senior Constable Walker's supervising officer and confirmed that they had discussed arresting CD on the afternoon of 28 November 2018 after Detective Senior Constable Walker had determined, of his own volition, that an arrest would take place. Detective Sergeant Sargent agreed with the decision to arrest and charge CD, and he then had a discussion with Detective Senior Constable Walker about the logistics of undertaking the arrest. Given it was already quite late in the afternoon; there were insufficient staff present to effect an arrest of CD.

By the time additional staff could be summoned, there was a heightened risk to any attending police officers, as it would then be dark. A plan was reached to arrest CD on the morning of 29 November 2018.

Detective Sergeant Sargent also recalled various searches that he and Detective Senior Constable Walker conducted on the afternoon of 28 November 2018, which included searches on the COPS system, a "PerFind" search, as well as a location search. They also discussed the layout of the property and any potential hazards that may be there for police. They also accessed Google Maps to work out the best point of entry to CD's property.

Detective Sergeant Sargent also remembered that he discussed CD's firearms with Detective Senior Constable Walker. They spoke about CD's firearms being removed during the execution of the search warrant on 23 November 2018 and that this included two unregistered firearms. They considered the possibility of further firearms being present at the property, but concluded that there was no intelligence or information to suggest that CD had firearms at another location.

Detective Sergeant Sargent confirmed that a briefing meeting took place the following morning on 29 November 2018 and that Detective Senior Constable Cooper, Detective Senior Constable Sweeney and Detective Senior Constable Walker were present at that briefing. He confirmed that the plan to arrest CD involved using two sets of police officers; one set of police were to enter the rear of the property and one set were to enter through the front. He believed that the overall briefing that took place prior to going out to CD's property on the morning of 29 November was reasonable and sensible.

Detective Sergeant Sargent was asked his opinion in relation to the use of the search warrant risk assessment tool. He was familiar with its use and had completed the forms on many previous occasions. He did not accept that the tool has any benefit for the purposes of assessing risk, explaining that the risk factors it asks you to consider, were factors that were already being considered prior to the introduction of the tool. He was quite frank in saying, in his view, it was of significant hindrance, as it was extremely time-consuming to complete. He explained that for a simple search warrant, the risk assessment tool took at least two hours to complete, and for more complex matters, it could take four to five hours, sometimes even longer. Even if the search warrant risk assessment tool was shortened, Detective Sergeant Sargent still thought it would be of little benefit. Any potential benefit would be outweighed by the negative impact the tool has on the workload of police officers.

Detective Sergeant Sargent accepted that there was no standard checklist for a "planned" arrest, even though he conceded that the risks that might present during a search warrant and an arrest are similar, as are the risks for persons of interest, the public and known associates of the person of interest.

He maintained that there would be no particular benefit to having standardised treatment options to assess risk before undertaking an arrest, explaining that every police officer, whether formally or informally, undertakes a risk assessment prior to carrying out an arrest; police do not "*just rock up at a place and kick a door in*". His considered view was that treatment options to mitigate risk were "*common sense things that we do anyway*".

Detective Senior Constable Ashley Cooper also gave evidence and confirmed his recollection of the briefing and planning that occurred on the morning of 29 November 2018. He was informed that CD was to be arrested and that a plan was put into place about how to approach the property, i.e. two police officers to go through the front of the property and two through the back.

Detective Senior Constable Cooper also recalled a discussion about various risk factors, including the nature of the charges being laid against CD, that firearms had been seized, and general background details relating to CD. He was aware that Detective Senior Constable Walker had been investigating CD and that a search warrant had been conducted.

Detective Senior Constable Cooper was asked his opinion in relation to the search warrant risk assessment tool and he confirmed what his colleagues had said, explaining that the tool was an onerous document and time-consuming to complete. In his view, the informal risk assessment process of going through police holdings and contacting relevant agencies to get an overview or picture of the person, can be achieved in five to ten minutes. It is the formalisation of the document, or as he bluntly stated, "*regurgitate[ing] that information into a document*", that is the time consuming part. He understood why the search warrant risk assessment tool was in place, but it was only formalising a process that was occurring anyway. He reiterated that police receive adequate training so as to perform their duties, including, by inference, about how to undertake risk assessments. This applied also to junior police. He believed that "*having a tick list or a check sheet is only adding to the red tape, adding more documents that need to be completed*".

When asked about whether he saw any benefit in there being a similar standardised approach regarding "planned" arrests, unsurprisingly, he, as his colleagues before him, explained that he did not see any benefit in a similar tool being created for that purpose. He explained that planned arrests are happening all the time. He was concerned that introducing a risk assessment tool for "planned" arrests would take more time out of the a police officer's day and prevent them from doing what is required, namely "*trying to arrest people, trying to keep the community safe*".

Detective Senior Constable Nathan Sweeney gave evidence about his involvement with CD on 23 November and 29 November 2018. He confirmed he attended CD's property on 23 November 2018 at approximately 3pm and remained there until the completion of the search warrant some hours later. Over the time he was there, he observed CD as co-operative towards police and he did not display any concerning behaviour. He was asked about his recollection in relation to his attendance at CD's property on 29 November 2018. He recalled attending the property and CD not being present. He then had a discussion with one of CD's children, as well as AB, who indicated in which vehicle they thought CD was.

Overall I am satisfied and find from the evidence that the planning and arrangements made on the morning of 29 November 2018 were reasonable and adequate.

Some days had passed since 23 November 2018 and Detective Senior Constable Walker had spoken to AB on 26 November 2018. She expressed no concerns and there was no other evidence of any concerning behaviour by CD. The use of two sets of police officers, one set intending to proceed to the front of the home and the other to the rear of the home as a precautionary measure, appear adequate and reasonable.

The evidence demonstrated, and I find, that an informal risk assessment was undertaken by Detective Senior Constable Walker prior to arresting CD. There was no formal requirement to undertake a risk assessment. The involved police officers had considered information in relation to CD's possible access to firearms and on the evidence they believed all weapons had been seized. They took CD's behaviour on 23 November 2018 into account as well as AB's observations on 26 November 2018. There was no significant history of violence or propensity for violence. The officers well knew the environment they intended to approach to effect an arrest. They concluded the arrest was not of high-risk and that the arrest was, as Chief Inspector Parker described, "*a business as usual deployment*".

I find on that basis that all of the planning and risk assessments undertaken by police in preparation for the arrest of CD were reasonable and acceptable.

Issue 4: the appropriateness of the police actions to locate and arrest CD on 29 November 2018 when he was not found to be at home

On 29 November 2018, at approximately 9.30am, Detective Senior Constable Walker, Detective Sergeant Sargent, Detective Senior Constable Cooper and Detective Senior Constable Sweeney attended the house of CD. Detective Senior Constable Walker and Detective Senior Constable Cooper entered from the front of the property and Detective Senior Constable Sweeney and Detective Sergeant Sargent entered through the rear. The NSWPF officers spoke to one of CD's children, X, who at that stage was the only person at the property, and ascertained that CD was not at home. X was unsure of CD's location. X also indicated that X's mother, AB, was attending Y's school.

Detective Sergeant Sargent and Detective Senior Constable Sweeney departed CD's residence to travel to Y's school. As they were driving, they passed AB, who appeared to be driving back towards CD's property. Detective Sergeant Sargent and Detective Senior Constable Sweeney turned around and followed AB back to the property.

Detective Senior Constable Walker spoke to AB once she arrived back at the property and informed her that Police intended to arrest CD and charge him with sexual assault of a minor, indecent assault of a minor, possession of child abuse material and filming a person's private parts without consent. AB was upset by the news, but offered to contact CD via mobile phone. This request was declined. Detective Senior Constable Walker asked AB and X not to inform CD of his impending arrest.

At 10.15am, Detective Senior Constable Walker telephoned CD and requested that they meet in person without disclosing what was planned. CD suggested meeting at Cessnock Police Station in an hour's time. Detective Senior Constable Walker agreed. Detective Senior Constable Walker did not have any concern about CD's demeanour, believing that he sounded calm, with no signs of distress during the telephone conversation.

Detective Senior Constable Walker, Detective Senior Constable Cooper, Detective Senior Constable Sweeney and Detective Sergeant Sargent then departed CD's residence and returned to Cessnock Police Station. At approximately 11.15am, CD had not arrived at Cessnock Police Station. Detective Senior Constable Walker made two unsuccessful attempts to telephone him. CD then called back and told Detective Senior Constable Walker that he would arrive at the police station within 10 minutes. Detective Senior Constable Walker did not believe CD sounded distressed during the conversation. CD said he had been on the phone and held up.

In my opinion, from the evidence that I have heard, the actions of the police officers when they attended CD's residence were all reasonable and appropriate. They made enquiries of both CD's child, X, and his wife AB, and in a reasonable and considered way informed AB of the nature of the charges that they intended to lay against CD. They also made suggestions as to how to deal with CD if he was to contact her. In my opinion, they approached AB in a considered and sensitive manner.

Further, in light of the way in which CD appeared to sound over the telephone, namely that he was calm, cooperative and volunteered to turn up at the police station, there was no evidence to suggest that the police should have thought some tragedy was about to unfold.

Issue 5: Whether the police response to the information obtained from CD's friend was adequate

At approximately 11.25am, CD telephoned his long term friend EF, who was a former NSWPF detective. During that call, CD said words to the effect of "*I've fucked up big time*" and "*You won't see me again*". EF was concerned that CD may harm himself and he telephoned his local police station, where he spoke to Senior Constable Foley. At 11.35am, Senior Constable Foley telephoned Senior Constable Heymans at Cessnock Police Station, stating that CD had contacted EF to say goodbye and was possibly armed.

At 11.37am, CD telephoned another friend, GH. During the call, CD seemed to break down. He insisted to GH that he go on the hunting trip the two of them had planned and said words to the effect of "*I love you like a brother*". At 12.03pm, GH texted CD to express his concern for him. He also indicated he was coming out to see him. GH drove to CD's property, where he met CD's wife and child, AB and X. They informed him that police were looking for CD.

After Senior Constable Heymans received the call from Senior Constable Foley, he informed Detective Senior Constable Cooper and Detective Senior Constable Walker of what he had been told. The two officers then departed Cessnock Police Station in an unmarked Holden Commodore Police vehicle "*Hunter Valley 103*". Detective Senior Constable Walker gave evidence at the inquest that the focus then became a concern for welfare rather than a focus on arrest, though the intention was still to arrest CD provided he was detained and found to be uninjured.

The information they had received from Senior Constable Heymans, led Detective Senior Constable Walker to believe that "vesting-up" might be appropriate. He said that there was no significant discussion about where they would meet and put on their police vests prior to getting into their police vehicles. He remembered that this occurred as part of a conversation they had over the radio as they were travelling towards CD's property.

Detective Senior Constable Sweeney also overheard what Senior Constable Heymans had said and very soon afterwards, Detective Senior Constable Sweeney and Detective Sergeant Sargent departed Cessnock Police Station in an unmarked Hyundai Santa Fe Police vehicle "*Hunter Valley 104*".

Another Police officer, Senior Constable Garvey was present at Cessnock Police Station and recalls hearing Senior Constable Heymans say that CD was about to commit suicide. Senior Constable Garvey spoke to Senior Constable Petheram, who was a family friend of AB and CD. Senior Constable Petheram asked Senior Constable Garvey to attend CD's house. Consequently, Senior Constable Garvey departed Cessnock Police Station in a fully caged marked Police vehicle "*Cessnock 28*". She was accompanied by Senior Constable Jeanes and Senior Constable Chapple.

While the three police vehicles were en route to CD's house, it was agreed that the officers would meet at a designated intersection so that they could "vest up".

Within a few minutes of Senior Constable Heymans informing the other officers at Cessnock Police Station of the concerns Senior Constable Foley had expressed about CD's welfare, Senior Constable Heymans heard a CAD job (created by Senior Constable Foley) broadcast over police radio.

In addition to Hunter Valley 103, Hunter Valley 104 and Hunter Valley 28, the CAD job was responded to by Cessnock 12 (a police vehicle driven by Sergeant Bojkowski).

The NSWPF officers remaining at Cessnock Police Station considered whether CD's phone may be triangulated and accordingly, Senior Constable Petheram made enquiries of CD's friend EF, who had contacted his local police station after receiving a call from CD, to try and ascertain what phone CD had used. EF thought that CD had been using his wife's phone. At 11.52am, Senior Constable Heymans updated the CAD with information to the effect that CD did not have his own mobile phone and may be contactable on his wife's mobile phone.

Initially, Hunter Valley 103 proceeded with lights and sirens, though the siren was turned off after Hunter Valley 103 passed certain road works en route and neared the property of CD. As Hunter Valley 103 approached a bend on the road they were travelling, Detective Senior Constable Cooper observed a vehicle coming in the opposite direction, although he did not believe that the driver looked like CD. Detective Senior Constable Walker and Detective Senior Constable Cooper continued to drive and shortly afterwards, overheard Cessnock 28 broadcast a message to the effect that a vehicle had driven into a tree. Detective Senior Constable Walker and Detective Senior Constable Cooper stopped Hunter Valley 103 at the intersection the police officers had designated as the meeting point to put on their bullet proof vests. A further broadcast was made regarding the vehicle that had collided with a tree, querying whether a firearm was in the car. At that point, Detective Senior Constable Walker concluded that the vehicle involved in the collision was likely CD's. Hunter Valley 103 then turned around and drove towards the crash site.

When Hunter Valley 104 departed Cessnock Police Station, it initially followed Hunter Valley 103. However, at some stage Hunter Valley 104 lost contact with Hunter Valley 103. Hunter Valley 104 proceeded with dash lights on only (no siren) in order to not alert CD to the fact that police were approaching.

While Hunter Valley 104 was en route, Detective Sergeant Sargent broadcast on police radio where he was heading. As Hunter Valley 104 made its way towards CD's residence, Detective Senior Constable Sweeney observed a utility vehicle driving in the opposite direction and he observed that it was being driven by CD. Detective Senior Constable Sweeney said to Detective Sergeant Sargent "*that's him*" and after travelling a further 300 to 400 metres, Hunter Valley 104 did a U-turn and began to try and catch up to CD.

When Hunter Valley 104 first departed Cessnock Police Station, Cessnock 28 followed close behind. At some point, Cessnock 28 seems to have lost contact with Hunter Valley 104. Cessnock 28 had initially proceeded under lights and sirens, but Senior Constable Chapple turned off the siren as Cessnock 28 neared CD's property (in order to not alert CD to the Police presence).

When the police officers at the police station had conveyed to them the possibility of CD self-harming, the primary focus then was on attempting to prevent serious or even fatal injury to CD, and to ensure the safety of CD's family. There was rapid deployment from the police station. In those circumstances, I find that the response to the information obtained from CD's friend via Senior Constable Foley and Senior Constable Heymans, was appropriate and adequate.

Issue 6: Whether CD's death was self-inflicted

As Cessnock 28 came around a right-hand bend, Senior Constable Chapple who was driving noticed a vehicle coming towards them. Senior Constable Chapple observed the vehicle come around the corner and then suddenly veer across the road, directly in front of Cessnock 28, so as to collide head on with a tree. Senior Constable Chapple, doing the best she could, gave evidence that she thought CD's vehicle was doing approximately 80 km an hour. She said CD's utility vehicle did not erratically veer across the road, but rather that is was a sudden and controlled action that caused the vehicle to change direction. She also gave evidence that the vehicle appeared to speed up and travel directly towards the tree. In her opinion, it appeared to be a deliberate action. Similarly, Senior Constable Jeanes gave evidence that after the utility vehicle came around the bend towards Cessnock 28, it took a "fairly sudden" move across the road towards the tree. She was of the view that the driver "*knew where it was going and what it wanted to do*".

After witnessing the collision, Senior Constable Chapple stopped Cessnock 28 about 15 metres from the crashed vehicle and Senior Constable Jeanes called for urgent ambulance assistance via police radio.

Senior Constable Chapple and Senior Constable Garvey quickly got out of Cessnock 28 and proceeded to the crashed vehicle. Each noticed that CD was not wearing a seatbelt and that it was in a retracted position. CD was observed lying across the front seat. Senior Constable Garvey observed CD to have glassy eyes, with his mouth open and grey in colour. Senior Constable Garvey gave CD a slight shake and squeezed his upper arm in order to see if he was responsive. Senior Constable Garvey observed CD's eyes to slightly blink and he also groaned, before motioning as if he intended to get up. Senior Constable Garvey told him not to move. CD also seemed to be gasping for air.

Hunter Valley 103 and 104 also arrived at the scene. Detective Sergeant Sargent, Senior Constable Garvey, Detective Senior Constable Cooper and Detective Senior Constable Sweeney lay CD down on the roadway and began giving CPR via chest compressions. CPR continued for about 20 minutes as the NSWPF officers awaited the arrival of an ambulance. CD seemed to have a faint pulse.

A road ambulance arrived at approximately 12.23pm and the paramedics took over CD's treatment. Soon after, a Westpac Rescue helicopter landed and further paramedics and a doctor arrived and assisted in CD's treatment. At approximately 12.40pm, the paramedics informed the NSWPF officers that CD was deceased.

Chief Inspector Vromans and Chief Inspector Robinson arrived at the scene at 12.40pm. At 12.48pm, a Critical Incident was declared by Assistant Commissioner Mitchell and a Critical Incident Investigation Team created, with Detective Chief Inspector Parker appointed the Senior Critical Incident Investigator. At 3.01pm, members of the Critical Incident Investigation Team arrived at the accident site.

I am satisfied on the balance of probabilities from the evidence of police officers Chapple, Garvey and Jeanes that the utility vehicle driven by CD came around a bend approximately one hundred metres away from their approaching vehicle and then intentionally moved across the road in a controlled movement.

There is no evidence of any screeching of brakes, no marks on the road to indicate efforts to try and break the speed or momentum of the vehicle, and on inspection of the vehicle subsequently, there were no motor vehicle defects that could have provided a reason for the vehicle to move across the road as it did. There is also independent evidence from a witness who lived close to the scene of the accident and who heard the collision. This witness did not hear any screeching of brakes or anything of that nature before impact. Although of course the witness did not physically see what occurred, what he heard corresponds with the evidence given by the police officers who witnessed the collision. In light of the other evidence, including that CD was not wearing a seatbelt at the time of the accident, and the calls to his two close friends immediately prior to the collision, I am satisfied that CD made a decision, and intended to end his life. His death was self-inflicted, knowing that he was facing arrest and serious criminal charges.

Detective Chief Inspector Parker

Detective Chief Inspector Scott Anthony James Parker is a crime manager attached to Newcastle City Police District. He was appointed the Senior Critical Incident Investigator for this matter on 29 November 2018 at 12.47 pm. He was the first witness to give evidence at the hearing and the five volume brief of evidence was tendered through him as Exhibit 1.

Detective Chief Inspector Parker was asked a number of questions concerning his enquiries with the relevant police officers and their involvement in the initial investigation that took place by investigators from ICAC on 23 November 2018. He was not critical of the decision not to arrest CD on 23 November 2018. While he would have come to a different decision, he acknowledged that the decision was made with the benefit of hindsight. He outlined several factors that he took into account, which included CD admitting to the sole possession of the safe that was located in the shed a little distance from the main house, as well as CD also having knowledge of the access code to the safe. He also outlined that he perceived there to be evidence of consciousness of guilt by CD, which was evident from CD's behaviour on the day, including the evidence of flight by CD and his lies in relation to the non-existence of the safe. However, he acknowledged that this assessment was reached after sitting down to look through all of the material and in particular, he was able to review the complete audio and transcript of Senior ICAC Investigator Riashi, which assisted him greatly.

He also explained that in hindsight, it was unlikely that CD's children would have been suspects. He stated that the sealed bags containing children's underwear looked quite historical. In addition, the tapes found, being 8mm and VHS tapes, were equally historical. He considered it unlikely that CD's children would have known what they were. Other electronic material found in the house during the later execution of the search warrant suggested a level of expertise in computer peripherals, which CD had. Detective Chief Inspector Parker believed that the circumstantial evidence pointed to one person, but again acknowledged that he was able to reach his conclusion with the "benefit of a helicopter view and hindsight".

He remained of the view that even if CD had been arrested on 23 November 2018, CD most likely would have been granted bail, given the limited material uncovered by that date would not have amounted to a 'show cause' event, CD had no criminal antecedent history, there was no evidence CD had any propensity to violence, and did not suffer from any known mental health or drug and alcohol issues.

He was asked about his understanding as to police efforts to try and determine the location of CD on 29 November 2018 by way of a triangulation using what was thought to be CD's mobile number at the time. The inspector confirmed that it was not successful and believed it was because there had not been enough time between the request and CD's death.

Post Mortem

Dr Lorraine du Toit-Prinsloo, forensic pathologist, completed an autopsy on CD at the Department of Forensic Medicine, Newcastle on 3 December 2018. In her autopsy report she concluded that the direct cause of death was chest injuries, with numerous rib fractures, bilateral pneumothoraxes, and a haemothorax on the left. Further she identified a fracture dislocation between the 9th and 10th thoracic vertebra, with severing of the spinal cord. The report was tendered as part of the brief of evidence and the findings of Dr du Toit-Prinsloo were not challenged in any way. Accordingly, I am able to find the cause of death as set out in her autopsy report.

Observations

In compiling the brief of evidence and as part of an exchange of correspondence between the Crown Solicitor and the Office of General Counsel acting for the Commissioner of Police, it was identified that there was a risk assessment tool for search warrants that also contained some ancillary information regarding arrests. It became clear that there was no separate equivalent risk assessment tool for "planned" arrests, although it was accepted that there are similar risks facing police officers for both scenarios. Detective Sergeant Sargent and Detective Senior Constable Walker both gave evidence to that effect. Counsel Assisting submitted that there was no obvious basis and logic to have a risk assessment tool and guide for search warrants but not for planned arrests. I agree with that submission.

From the evidence provided by the police officers who attended the inquest, there appeared to be considerable resistance regarding the use of the search warrant risk assessment tool and any potential equivalent tool for planned arrests. Counsel Assisting acknowledged that this resistance arose out of the current form of the search warrant risk assessment tool, which is time consuming to complete and therefore takes time away from active policing duties.

This notwithstanding, Counsel Assisting submitted that the resistance put forward by various police witnesses went further than that and was better described as a form of apparent institutional resistance. Various different bases were put forward by police - other than the time consuming nature of the document - as to why a risk assessment tool for planned arrests was not required. Some of this opposition was surprising and not easy to follow. As mentioned above, as an example, Detective Senior Constable Walker stated that a document cannot assist in predicting the future about what risks are likely to take place.

However as Counsel Assisting submitted:

"the whole point of a standardised risk assessment is to try and assist those who are coming to do, carry out a particular activity, [to work] out what factors might be relevant and assist them to then work out how you might apply those factors in coming up with an [risk] assessment. I would have thought that, at a common sense level, there would be at least an acceptance that that might have some benefits…."

From my experience, I am aware that airline pilots and surgeons all use a form of checklist no matter the complexity of the situation. It is very easy to forget even the simplest of things. In their occupations, it is a standard part of the performance of their task to undertake and check a procedure before it commences to ensure that they have thought of everything. It was my view that a police officer may find a checklist to have been of some benefit, to assist that officer in keeping safe and also, perhaps, to consider associates of the person to be arrested and other members of the public.

The possibility envisaged was a simple format aimed at ensuring that a police officer had gone through a list and thought of all the possibilities including searches that should be undertaken before proceeding to an arrest. It was not thought necessary to have it completed and signed off by a senior officer. Obviously such a checklist was not proposed for instances where an immediate arrest was required, that being a situation that is unfolding before a police officer's eyes and would require immediate action.

Detective Chief Inspector Parker gave additional evidence on day two of the inquest. He was also of the view that a checklist was not needed. He was of the opinion that police officers are constantly risk assessing and that is what they are doing as part and parcel of their job on a day-to-day basis. Because of the large number of arrests that are undertaken – estimated by Counsel appearing for the Commissioner of Police to be in the hundreds of thousands in New South Wales – and because of the extensive training given to police officers, he did not consider such a checklist necessary. He indicated that they received training at college and then further field training and mentoring and then ongoing training as they progress in seniority. Detective Chief Inspector Parker has been a police officer for 24 years and is in a senior position within the police force. His evidence and opinion carry great weight.

At the conclusion of the inquest, I made particular mention to signify my appreciation to the attending police officers about the way they had attempted to help and provide aid at the scene of the accident. They were met with a scene of significant trauma. Their sense of duty came to the fore and they attempted CPR and gave other assistance to ambulance officers, paramedics and ultimately a doctor who attended the scene.

I commend the officers on the way in which they have acted throughout in this matter and in particular at the scene of the accident. The manner in which they dealt with AB showed compassion and sensitivity to her predicament.

Formal Finding:

I find CD died: On 29 November 2018
The place of death was Richmond Vale Dr, Richmond Vale NSW 2323

The cause of death was Chest Injuries

The manner of death was Chest Injuries sustained in a single motor vehicle accident, which was self-inflicted.

30. 372498 of 2018

Inquest into the death of Lawrence Hausia. Finding delivered by DSC Grahame at Lidcombe on the 3 November 2020.

Lawrence Hausia was 30 years of age at the time of his death on 3 December 2018. He was serving a custodial sentence and living at the Metropolitan Reception and Remand Centre (MRRC) at Silverwater, NSW.

Lawrence was discovered unresponsive in his cell by another inmate. CPR was commenced and an ambulance was called. Unfortunately, Lawrence could not be revived. A post mortem examination was conducted on 7 December 2018. The forensic pathologist conducting the examination recorded the cause of death as "atherosclerotic coronary artery disease.

The role of the coroner

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

In this case there is no dispute in relation to Lawrence's identity, or to the date, place or medical cause of his death.

Nevertheless, where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is detained in custody the state is responsible for his or her safety and medical treatment. It is important to review all inmate deaths, including those which appear to be have been naturally caused so that the community has confidence that each prisoner has received adequate and appropriate medical care.

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

Scope of the inquest

The inquest took place on 3 November 2020. A comprehensive police brief was tendered including police statements, photographs and CCTV footage, as well as prison and medical records. The officer in charge of the investigation, Plain Clothes Senior Constable Joel Swales was called to give brief oral evidence.

Background

Lawrence Hausia was born on 11 October 1988. He is the son of Julie and Fakataha Hausia. His father, Fakataha died as a consequence of heart disease some years ago.

Lawrence was the third youngest of seven siblings. His sister told the court that Lawrence was greatly loved. He was close to his family and enjoyed spending time with his siblings and nieces and nephews. His family members remembered his humour and kindness and were greatly affected by his sudden and tragic death.

Lawrence had been incarcerated on a number of occasions. In 2011 Lawrence had been diagnosed, with type II diabetes while in custody. He commenced monitoring and treatment for the condition. In August 2016 he was also diagnosed, monitored and treated for hypertension while in custody. It appears that when Lawrence was in the community he did not always comply with the prescribed treatment for these medical conditions.

Lawrence's entry into custody in October 2018

On the 23 October 2018, Lawrence was arrested by police. Two warrants were executed for supply prohibited drug and reckless wounding in company. He appeared before Campbelltown Local Court and was bail refused. On the 15 November 2018 he was sentenced for drug supply matters to a period of 18 months, commencing on 15 February 2018 and concluding 14 August 2019, with a non-parole period of 9 months and 2 weeks, concluding 28 November 2018. He remained bail refused in relation to the reckless wounding in company matter. His next court appearance was for Penrith local Court, on the 21 December 2018.

Lawrence entered the custody of Corrective Services New South Wales on the 23 October 2018, spending time at Amber Laurel Correctional Centre before being transferred to the Metropolitan Remand and Reception Centre. During the reception screening process Lawrence was found to be suffering from high blood pressure and non-insulin dependent diabetes. He was prescribed Metformin and Irbesartan. The health problem notification form (HPNF) indicated that he was to remain in a Darcy group placement until cleared by the primary health care nurse. On the 17 November 2018, an updated HPNF indicated that his diabetes continued to be unstable. Lawrence was to remain in group cell placement while at the MRRC however he was cleared from Darcy. Justice health records show Mr Hausia was given his prescribed medication and had his blood sugar levels taken daily.

Mr Hausia was housed in cell 127, pod 10, F block. He shared the cell with another inmate. The cell has two single beds, a toilet, shower and storage area.

Events leading up to Lawrence's death

On the morning of 3 December 2018, Lawrence played table tennis in the main area of the pod. After breakfast his blood sugar levels were taken by a nurse from Justice Health and Forensic Mental Health Network (JH) with a reading of 7.6 recorded.

Lawrence returned to his cell for lunch before entering the exercise yard about 12.53pm. In the yard he participated in various physical activities, including boxing with makeshift pads.

These activities varied in intensity and Lawrence was seen leaning on the wall and lying on the ground in between activities. About 1.50pm Lawrence made a request to a correctional officer to leave the exercise yard and return to his cell.

He advised the correctional officer that he had low blood sugar and needed to eat. He declined an offer to attend the clinic. Lawrence was allowed to enter the pod. He was perspiring from his arms and facial area, but appeared otherwise well. He walked up the stairs in his pod unaided, entered his cell and pulled the cell door closed.

Lawrence's cell mate entered and exited the cell briefly after Lawrence returned. About 1.56pm another inmate entered Lawrence's cell for linen exchange duties. He observed Mr Lawrence lying on his bed facing the wall with a fan positioned towards him. They had a brief conversation. Lawrence said, "I feel really hot and my chest is sore." The inmate asked if Lawrence needed anything to which he replied, "No, I'm fine." The inmate left. About 3.14pm another inmate entered the cell and saw Lawrence on the floor. He believed that he was sleeping.

Muster was delayed due to an unrelated incident in the pod. About 3.20pm Lawrence's cellmate returned to the cell and saw him lying down on the floor on his stomach. The cellmate moved Lawrence onto his side and called for correctional officers to assist. Lawrence's feet were facing the door, the fan was knocked over, his eyes and mouth were open, his face was blue, and his skin was cold to touch.

Correctional officers entered the cell and resuscitation attempts began. Lawrence was moved from his cell into the walkway in front of his cell to allow better access for medical staff. Other correctional officers and JH staff continued their resuscitation attempts until the arrival of NSW ambulance personnel. NSW ambulance personnel found Lawrence had no signs compatible with life and resuscitation attempts ceased. He died at 3.55pm. The resuscitation process appears to have been according to policy. No inadequacies were identified.

Police investigation

NSW Police conducted a full investigation which involved interviewing inmates and correctional staff and reviewing available CCTV footage. There were no indications that Lawrence's death was suspicious. However family members heard from other inmates about Lawrence's physical activities prior to his death and expressed some concern.

The family were worried that Lawrence may have been injured prior to returning to his cell. Plain Clothes Senior Constable Swales conducted an extensive review of the closed circuit television (CCTV) within the MRRC. The CCTV corroborates the accounts given by staff and inmates. Lawrence does not appear injured nor is he engaged in heavy conflict on that day. The family were advised of the outcome of the CCTV review and did not raise further concerns in relation to the care and treatment that Lawrence received.

The Autopsy Report

Lawrence's identity was confirmed by fingerprints. A post mortem examination was conducted by Doctor Kendall Bailey at the Department of Forensic Medicine, Glebe on the 7 December 2018. Doctor Bailey found Lawrence to be overweight with a mildly enlarged heart; significant three vessel coronary artery disease and the myocardium (heart muscle) showed widespread microscopic fibrosis (scarring), indicative of previous ischaemic damage (due to lack of blood supply). Toxicological analysis detected the presence of Metformin (diabetic medication) and Irbesartan (antihypertensive) as expected.

No other medications or illicit substances were detected. Doctor Bailey recorded the cause of death as atherosclerotic coronary artery disease. She noted that the degree of disease found in a relatively young man may suggest a genetic predisposition, which could also affect surviving first degree relatives. Lawrence's relatives were advised to seek testing. I note that toxicological testing found no drugs of addiction or illicit substances.

What was the cause and manner of Lawrence's death?

I am satisfied that Lawrence's death was due to natural causes and that he was provided with appropriate care for his pre-existing conditions whilst in custody. I did not identify any issues with the attempts made at resuscitation by correctional or medical staff.

Formal findings

The findings I make under section 81(1) of the Act are:
Identity
The person who died was Lawrence Hausia.
Date of death
He died on 3 December 2018.
Place of death
He died at Metropolitan Reception and Remand Centre (MRRC), Silverwater Correctional Centre, Silverwater, NSW.
Cause of death
He died of atherosclerotic coronary artery disease.
Manner of death
He died of natural causes.

31. 391439 of 2018

Inquest into the death of Grace Herington. Finding delivered by State Coroner O'Sullivan at Lidcombe on the 9 September 2020.

These are the findings of an inquest into the death of Grace Herington. Grace died on 19 December 2018, at Royal North Shore Hospital, following injuries she sustained in a fall from height. In the early hours of that morning, Grace fell from the Burns Bay Road off ramp, at Hunters Hill, in the context of a mental health crisis. At the time of her fall, police officers were present and NSW Ambulance paramedics were also at the scene. Grace had also attended Royal North Shore Hospital for a mental health assessment the day prior to her death.

The nature of an inquest

An inquest is a public investigation into the circumstances of death. Unlike some other proceedings, the purpose of an inquest is not to blame or punish anyone for the death. Neither does the holding of an inquest itself suggest that any party is guilty of any wrongdoing.

Pursuant to s. 27 of the *Coroners Act 2009*, an inquest is required to be held in certain circumstances, including where it appears that the person has died as a result of police operations. While this provides an opportunity to closely examine the circumstances of death, including the conduct of police, the issues considered in this inquest were not limited to police conduct.

The primary function of an inquest is to identify the circumstances in which the death occurred. At the conclusion of an inquest, the role of a coroner, as set out in s. 81 of the *Coroners Act 2009*, is to make findings where possible as to:

- The identity of the deceased person;
- The date and place of the person's death; and
- The manner and cause of death.

A secondary purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves considering whether any lessons can be learned from the death, and whether anything should or could be done to prevent a death in similar circumstances in the future.

The facts

Background

Grace was 23 years old at the time of her death. She grew up in Grafton with her parents, Bruce and Janelle, and brother Kenneth. At the time of her death, she was living with her brother in a unit on Ryde Road, Hunters Hill.

She is described by her friends and family as a beautiful, intelligent, happy young woman. She was a loyal friend, if a little introverted and sometimes socially reserved. She had, according to her aunt, a tendency to build very small things up into big things.

Grace was generally healthy and well. She practiced Wing Chun martial arts, being an instructor in that discipline, and she attended the gym and kept fit. As a result, in her younger years she was against drugs and alcohol.

She had no significant childhood issues, although she had witnessed some traumatic events.

She was very clever, being the dux of her school in Year 12, and through hard work she obtained a place at Sydney University in 2015. She initially moved from Grafton to Hunters Hill, to live with a friend of the family.

The transition to university life appears to have not been easy for Grace, who may have felt isolated from her peers. It was after moving to university that she began to experience periods of poor mental health.

In October 2015, she attended a General Practitioner, Dr Beth Lavings, at the Central Coast Peninsula Medical Centre, Umina complaining of persistent headaches. Dr Lavings concluded that these were caused by tension or position and she suggested Grace return if her symptoms persisted.

2016

In 2016, Grace moved in briefly to another family's home, and then moved into her family's holiday house at Patonga. She commuted from Patonga to university throughout 2016. This may have increased her isolation from her peers. She returned to Dr Lavings in May 2016, still complaining of headaches. A CT scan was performed, with nil result.

At the end of 2016, her family recall that she suffered a "*breakdown*". She returned to see Dr Lavings in October 2016. She was not coping well and was tearful during the consultation. She denied thoughts of self-harm and denied drug or alcohol use. She expressed anxiety about her course and had suffered a bereavement (her grandmother) in June that year. Her mother reports that Grace was also concerned about a Centrelink investigation for fraud. Dr Lavings completed a mental health plan a few days later and Grace was referred for counselling.

Grace commenced counselling with Vic Val and Melissa Turner at the Deepwater Practice, Woy Woy, on 20 October 2016. She reported no drug or alcohol use at that time. After three sessions, Grace cancelled further appointments.

During this episode, Grace sought and was given special consideration from the university for her poor exam results.

2017

In 2017, Grace's parents took out a lease for a unit at Ryde Road, Hunters Hill, and Grace moved in. The year followed a similar pattern to the previous, where Grace's mental health began to deteriorate towards the end of the year, possibly due to academic stress.

She also had difficulties with a flatmate, who was disruptive and whom she eventually had to evict.

In November 2017, she completed a second mental health plan with Dr Jonathan Pham, and he also referred her for counselling, although there is no record of Grace having taken up this referral. Grace did have one counselling session with a counsellor at the university on 2 November 2017. She denied thoughts of self-harm and reported no drug or alcohol use. She again sought special consideration for her studies.

According to a friend, Rachel Hubble, at the end of 2017 Grace also started experimenting with cannabis and LSD. This was not known to her family at the time.

2018

In 2018, Grace's brother Kenneth transferred to Sydney University to study medicine and he moved into the Hunters Hill unit.

In about March 2018, Grace met an Iranian man called Sadra Boutorabi on Tinder. They commenced a casual relationship a few weeks later. Grace's friends believe she wanted more than a casual relationship with Sadra. According to Grace's friends, Grace also began to smoke cannabis more frequently after meeting Sadra.

Grace continued to struggle with her anxiety and her studies. She attended a GP, Dr Monaghan at Lane Cove, on 27 August 2018, who completed a university certificate about Grace's capacity to study. Dr Monaghan stated that Grace was "*very severely affected*" by ongoing headaches, fatigue and a consequent inability to study. Dr Monaghan also prescribed melatonin for sleep.

The alleged sexual assault

Two days later, on 29 August 2018, Grace reportedly suffered a sexual assault. She had gone to Sadra's home and spent time with his male flatmate. They smoked cannabis and watched Netflix. Grace later reported that the flatmate tried to kiss her and also put his hand up her top, which she resisted. When he persisted, she got up and left.

Grace called her friend, Hope Landsberry, in distress shortly after this happened. She called another friend, Ms Hubble, a few days later telling her that the man had tried to have sex with her and had also digitally penetrated her. Ms Hubble advised her to go to police.

Grace attended Dr Monaghan again on 31 August 2018. There is no record that she mentioned the sexual assault to Dr Monaghan. She returned again on 24 September 2018 for a further prescription of melatonin. Grace felt improved better energy and concentration.

On 1 November 2018, Grace reported the sexual assault to Constable Marsden-Jones at Chatswood Police Station. Grace did not want the man to be charged, although she did want there to be a formal record.

Although she had not reported the sexual assault to police before this, it appears Grace continued to be preoccupied about it; she mentioned it at the time of her attendance at hospital on 18 December 2018, and also when paramedics attended the home on 19 December 2018.

Grace also referred to the sexual assault when making an application for special consideration for her studies.

The university determined that the period whole from 29 April to 20 November 2018 would be looked at favourably, and she was to be referred for assistance as a "student at academic risk".

Despite these challenging circumstances, in the final semester Grace enrolled in four units of study in an effort to complete her degree. According to Kenneth, her family advised her not to do this, in particular given how she had struggled with stress in previous years.

Taha Boutorabi

On 20 November 2018, Sadra went on a trip to Iran, where he remained until after Grace's death. He remained in frequent contact with Grace, mainly via Facebook messenger.

Following this, Grace began to spend some more time with Sadra's brother, Taha. Taha suffered from depression. Messages between Grace and Sadra show that they were concerned about Taha's mental health, and that Grace was supporting him, and in fact booked him an appointment with Ms Turner, the psychologist she had seen in Woy Woy, on 19 December 2018.

Grace's exam results

On 12 December 2018, Grace was at Patonga with her parents when she received her exam results. They were very poor, attaining 20% and 30% in two of the subjects. She had an argument with her parents about her results. Her parents then left for a road trip, leaving Grace in charge of their dog, Basil.

A couple of days later, she contacted her brother, telling him she wanted to speak to him in person about her results. When she arrived back in Sydney, he found her to be erratic and thinking rapidly, although he was not too concerned about her at that stage.

Weekend of 15 and 16 December 2018

On Saturday 15 December 2018, Grace went to Taha's home and they smoked cannabis. She stayed the night sleeping in his bed while he slept on the couch. She returned home the next day.

Grace sent Sadra messages at 12.53am on Sunday 16 December, as follows:

I think I'm hallucinating …

Weed. I coughed so much

It was really a lot

Weird day …

I took melatonin (prolonged release) about an hr before the weed.

Activity on Grace's computer shows that later that morning she also did internet searches for "*Can weed make you hallucinate"* and "*combining cannabis with prolonged release melatonin*".

Later on Sunday, Grace met up with her parents at a park in Wahroonga to return Basil to them. There was another argument, about the care of the dog. Following this, Grace drove off without saying anything further.

Monday 17 December 2018

Grace's father texted her the next morning, saying "*I apologize for last night and regret calling you a dill over such a trivial matter*", to which she replied, "*Thanks Dad :) xx".*

During the day, her brother and a friend were watching cricket on the television. Kenneth recalled that Grace sat with them and looked "*spaced out*."

At about 5pm that day, Grace sent another message to Sadra saying it was a "*weird day I feel spacey*". She felt tired and said she should take some melatonin, and then appears to have slept.

At about 7pm on Monday evening, Grace messaged Taha to the effect that one of her brother's friends was in the house and she didn't feel safe. Taha offered for her to come to his house again. When she attended, she seemed to be paranoid and not making much sense, concerned about a backpack left at her home and beer bottles lying around. Grace remained at Taha's home that night and they kept talking for several hours. Sadra was also worried about Grace due to their previous messages, and he contacted Taha about this.

At 1.02am on Tuesday, 18 December 2018, Grace messaged her brother, asking him to text her his location. He replied that he was home in bed.

The attendance at Royal North Shore Hospital
Tuesday, 18 December 2018

On the Tuesday morning, Grace appeared to Taha to be well. She went home, then went to buy coffee and returned to Taha's about 10am. Taha then went to work, leaving Grace at his home. However, she messaged him at 1.38pm, saying that she was a bit confused. He was in a meeting at the time.

At around this time, Grace made a series of bizarre calls to her parents. She told her mother she was in Iran, she was stuck in a lift, and also that she had "*stopped 9/11, but I didn't kill* [a named person]". Her parents, alarmed, went to Woy Woy Police Station to report this and then called Kenneth. Police issued a "concern for welfare" CAD message for the Chatswood area. That message refers to Grace saying she was "*responsible for 9/11 and that she should kill more Israelis"*.

Grace also tried to contact Sadra, asking for help. She spoke with him and sent him a number of messages, saying she was in "*stuck in a bad loop of thoughts and hallucinations*". She appeared to have forgotten he was in Iran. Grace was trying to find Taha's office and seemed disorientated. She also said she had smoked cannabis but had not taken any other drugs. Sadra suggested she speak to her brother. He was concerned Grace had schizophrenia, and he contacted Taha about this.

Taha messaged Grace, asking where she was, and she sent an address of in Railway Street, Chatswood. Grace also sent Taha a video message of herself turning slowly round, saying "*this is where I am*". Taha phoned her and she said she was at a branch of NAB.

Meanwhile, Kenneth had been contacted by Grace's parents and he also called Grace. At about 3pm both he and Taha located Grace at a NAB branch at Chatswood train station.

Chatswood train station

When located, Grace appeared "*spaced out*" and was behaving erratically, talking about her food being bad. Kenneth made a call to 000.

Senior Constable Albert Yang and Constable Nicola Feltham responded to that call. Part of the police interaction with Grace is captured on Body Worn Video. Grace appeared alert but subdued in the footage, although at times she became less alert, resting her head on Taha's shoulder. Police asked her about the information her mother had reported regarding 9/11; she denied saying it.

Police considered exercising power to convey Grace to hospital under s. 22 of the *Mental Health Act 2007*. However, as Grace had not made any threats, the officers agreed that using that power was "*a bit extreme*". They decided to wait for the ambulance and leave Grace in the care of paramedics.

Paramedics Byron Urbina and Ethan Hoare then attended and spoke with Grace. According to them, Grace was at first agitated and appeared to be having an anxiety attack. Grace told the paramedics that she had been hallucinating, seeing spots in front of her eyes. She was vague about the hallucinations. She denied thoughts of self-harm or harming others. She said she had spoken to her family and suggested this may have caused her to feel the way she did.

The information that Grace told her mother, that she should have stopped 9/11, was not recorded anywhere in the ambulance records, and nor was it recalled by either paramedic in statements provided to this inquest. It appears likely that they were unaware of this information.

Grace agreed to go with paramedics voluntarily to Royal North Shore Hospital (RNSH). As a result, police decided they were no longer required. Taha travelled with Grace in the ambulance.

On the way to hospital, Grace became agitated and fell off the stretcher. However, she settled down.

Grace arrives at hospital

Grace arrived at hospital at about 4.24pm. Paramedic Hoare gave an oral handover to the triage nurse, Adrienne Ling. The paramedics had not yet completed their own paperwork, and so the ambulance records were not made available to the nurse.

Nurse Ling recorded that Grace had been unwell over the last few days with anxiety and depression, had a previous mental health history of anxiety, depression and an adjustment disorder, and that Grace denied plans of self-harm. Nurse Ling observed Grace to be upset but not behaving erratically at that time. She allocated Grace to Australasian Triage Scale 4 (ATS4), which requires an assessment within 60 minutes. That allocation to ATS4 also had the result that Grace was suitable to be assessed in the Fast Track area of the hospital.

At about 4.30pm, Grace's parents and Kenneth attended the hospital. Bruce did not go into the hospital, but stayed outside. Although Kenneth and his mother wanted to see Grace, she declined to see them.

She had also provided Taha's details as her next of kin, and not her family's details, although after Kenneth and his mother raised concern about this, Grace provided her Aunt Judith's details as a second emergency contact.

Kenneth and his mother remained in the waiting room and they did not see Grace or the staff who were dealing with Grace. Significantly, that again meant that information that they knew about Grace, including the statements she made about 9/11, was not communicated to staff who were assessing Grace.

At about 6.15pm Grace's parents and Kenneth left the hospital and later returned to the Hunters Hill unit.

At some point over course of the evening, Grace was assessed by Mental Health Clinical Nurse Consultant Justin Newton. It was the only substantial assessment Grace received at the hospital.

Among other things, Grace told Nurse Newton she had received treatment for her mental health via a GP care plan. She told him about the sexual assault and said that she had family difficulties. She also said that she had used cannabis 3 days prior. She said she had experienced hallucinations. She denied feelings of self-harm or harm to others. During the assessment, Grace was at times distracted, and was speaking in a child-like manner, changing her accent, and she referred to unusual visual perceptions, such as the fact that Nurse Newton's glasses had vivid tint or colouring.

Grace also old Nurse Newton she had an appointment with her psychologist the next day and that she intended to visit her GP about her sleep. As noted, a psychologist appointment had been arranged on 19 December, but this was for Taha, not Grace.

Nurse Newton spoke with Taha, who told him that he understood Grace was failing classes at University, and also noted that Grace's behaviour had changed recently, in particular after smoking cannabis. Nurse Newton did not speak with Grace's family.

Nurse Newton concluded that Grace did not display any overt risk and, as a result, she did not require admission. He considered it possible that Grace's presentation was drug-induced, and complicated by the sexual assault. He also considered the possibility that she was mildly psychotic, with disorganised thinking and atypical visual phenomena.

He told Grace that she would always be able to return to the Emergency Department if she felt necessary if she had concerns. Grace requested a pregnancy and STD test, and Nurse Newton made arrangements for her to see a female doctor about this. Grace then returned to the Fast Track area, and Nurse Newton told her he was going to discuss her case with the psychiatrist.

Nurse Newton then spoke with Dr Zoltan Zsadanyi, the on-call psychiatrist, for about 15 minutes. The nurse relayed a summary of the assessment, including the fact that Grace had an appointment with a psychologist and denied suicidal ideation. They discussed the fact that Grace had reported seeing bright colours and possible causes for this. Overall, the psychiatrist did not consider that the reported symptoms supported a psychotic or affective disorder. He suggested a review by a medical officer but otherwise agreed Grace was appropriate for discharge.

Grace leaves hospital

It appears that Grace was seen briefly by a doctor, Dr Bowell, who organised the pregnancy test, which was negative.

However, about 7.45pm, and prior to Grace being seen by Nurse Newton regarding discharge, Grace and Taha left the hospital. Taha returned shortly afterwards to retrieve a mobile phone and then left again.

Once Nurse Newton discovered that Grace had left, he tried to contact her by phone. He then spoke again with Dr Zsadanyi. In light of the fact that Grace was a voluntary patient, did not display suicidality, wasn't aggressive or overly agitated, and had indicated she would see her psychologist the next day, it was determined that no further efforts would be made to speak with her. No contact was made with Taha or with Grace's aunt either at any stage, whose contact details were recorded by the hospital.

The circumstances of Grace's death

Events at Hunters Hill

Grace and Taha returned to the Hunters Hill unit, where her parents and Kenneth were. Her behaviour continued to be unusual. She told Taha she wanted to go out with him on the town and started dressing up. She told her mother she was going to go with Taha to his grandma's "*Golden Persian palace*". She had her passport with her, tucked it into her skirt. She went outside and started making a video call. When her father, Bruce, took her phone from her she pushed him away.

Grace then said to her father words to the effect "*there is not much to live for in this world there are a lot of bad things that happen*." He challenged her on this, saying that there was everything to live for.

Eventually, Grace agreed she would stay home, provided her parents left. They did so; leaving Grace and Kenneth at the home and giving Taha a lift back to his unit, before returning to Patonga.

After her parents and Taha left, Grace's odd behaviour continued. For example, Kenneth went outside to phone a friend and debrief, and when he returned Grace was on the sofa in her underwear.

At 10.28pm, Grace sent an image of Hanging Rock to Taha and two friends from her Wing Chun class. The meaning of that message is unknown.

At 10.50pm, Grace sent a message to Taha "*I'm so glad you're in my life Taha / I love you"* and he replied "*I love you too grace / But we really need professional help / I don't want to lose you / But you are disconnecting from reality".*

Kenneth and Grace then spent some time talking, during which Grace put on an Arabic accent. She also told him, for the first time, about the sexual assault from August. At some stage they both went to bed.

At about 2.30am, Grace came into Kenneth's room saying "*Taha, are you there?"*

At about 3.30am, Kenneth awoke and found Grace sitting on the floor with books and her diaries around her. She told him she was going to Taha's home. At this point, Kenneth called 000. He told the operator that he believed Grace was hallucinating and that she had already been at hospital the day prior. In the course of the call, when asked about weapons he said that there were knives in the kitchen. An ambulance was dispatched.

Attendance of paramedics

At 3.37am, Paramedics Evan Steinle-Davis and Jessica Rose attended. They found Grace pacing around the unit, talking to her brother. Paramedic Steinle-Davis attempted to develop rapport with Grace. She declined to comply with his assessment or even have her temperature taken. Kenneth told the paramedics that Grace may have smoked cannabis. He also told them that she had been at RNSH the day prior with similar behaviour.

Grace then went into her bedroom and left the unit through the window. The paramedics and Kenneth followed her outside, to see her walking away to the south along Ryde Road. Kenneth gave the paramedics his details and asked to be recorded as Grace's next of kin, in the event she was taken back to hospital.

The paramedics requested police assistance at 3.45am. Police categorised this request as a "concern for welfare", initially with a priority 3 non-urgent rating.

The paramedics got into the ambulance and followed behind Grace at a distance, initially without warning lights. Grace continued walking towards Gladesville Road. There is CCTV footage which shows her throwing her arms around and apparently speaking as she walked.

Grace was then seen to lie down on the ground and flail her arms and legs around, yelling and screaming. A local resident, Michael Fardoulis, also heard someone screaming around this time, saying "*leave me alone*".

Paramedic Steinle-Davis asked for an upgraded police response. This request was made at 3.46am. Police dispatchers gave the incident a priority 2 and made an all resources broadcast. Several police units responded. The first of these was Ryde 16, comprising Senior Constable Timothy Shields and Constable Harriet Fordyce (who was at that time a Probationary Constable).

Paramedic Steinle-Davis attempted to approach Grace on foot but was unable to engage her. He returned to the ambulance to draw up a syringe of droperidol, in order to sedate her. While he was doing this, Grace began running off towards the off ramp from Burns Bay Road. The ambulance followed her and broadcast her location.

Arrival at Burns Bay Road

Burns Bay Road is a dual carriageway running approximately north / south. At the relevant point it is intersected by Church Street which passes over it as a bridge. There are two on-ramps and two off-ramps running between Church Street and Burns Bay Road. Grace's death occurred at the northbound off ramp, which has three lanes.

The ambulance drove onto Burns Bay Road via the southbound on-ramp, did a U-turn across Burns Bay Road and then proceeded up the northbound off-ramp towards Grace.

Attendance of police

At about 3.54am, Senior Constable Shields and Constable Fordyce arrived at the scene. The roof bar lights of their vehicle were illuminated. They approached towards the ambulance, driving the wrong way down the off-ramp.

About halfway down the off-ramp, they saw Grace lying down in some bushes at the side of the road. Senior Constable Shields stopped the vehicle, and Grace immediately got up and started to run back up the off-ramp. Senior Constable Shields shouted "*stop*" and ran after her. Grace was said to be running in an erratic way and she started to scream.

Grace then suddenly diverted to her right and ran towards the edge of the off-ramp. She climbed over guard rail, lay down along a low cyclone fence and then tipped over the edge.

Senior Constable Shields arrived and attempted to grab at Grace, taking hold of her leg. Grace's body continued to fall over the ledge, until she was hanging from her leg. According to Senior Constable Shields, Grace then began to swing her body. He was unable to continue holding her, and she fell headfirst towards the road below, landing on her side. The fall was approximately 10 metres.

The paramedics drove down the ramp and provided assistance immediately. Police broadcast a message for further assistance, although a number of officers were already arriving at that point. Grace was transferred to RNSH for treatment, arriving at 4.27am.

Grace underwent surgery for a laceration to her liver and significant internal injuries, including a large amount of free fluid in her abdomen. Despite the efforts of medical staff, her injuries were deemed non-survivable. A decision was made to palliate her. She was pronounced deceased at about noon the same day, 19 December 2018.

An autopsy was conducted on 21 December 2018, which recorded the cause of death to be "*multiple blunt force injuries*". Toxicology recorded ketamine (administered during treatment) and Lamotrigine; it is unclear when the latter drug was administered. No illicit drugs or alcohol were detected; antemortem urinalysis taken at RNSH on 19 December 2018 was also negative for illicit drugs.

Issues for the inquest

The following issues were raised in the inquest:

- *The nature of Grace's mental health condition at the time of her death.*
- *Whether the care and treatment provided to Grace during her attendance at Royal North Shore Hospital at about 4.24pm on 18 December 2018 was adequate and appropriate in the circumstances including:*
- *Whether it was appropriate to allocate Grace to Australian Triage Scale 4;*

- *Whether it was appropriate to assess Grace within the Emergency Department Fast Track area;*
- *The adequacy of the mental health assessment, including the extent to which information from Grace's family might have affected that assessment; and*
- *The adequacy of action taken when it was discovered that Grace had left the hospital.*
- *Whether the care and treatment provided to Grace by paramedics who attended her home at about 3.37am on 19 December 2018 was adequate and appropriate in the circumstances?*
- *The action taken by the police officers who responded to the CAD incident broadcast at about 3:46am on 19 December 2018 to attend Grace's home 2018.*
- *Are any recommendations necessary or desirable arising from any matter connected with Grace's death?*

Grace's mental health condition

The inquest had the benefit of evidence from Dr Danny Sullivan, Consultant Forensic Psychiatrist and the Executive Director of Clinical Services, Forensicare, the Victorian Institute of Forensic Mental Health. He reviewed material from the brief of evidence, provided a report and gave oral evidence by video link at the inquest.

Dr Sullivan gives the opinion that Grace suffered an acute psychotic episode. Concerns about Grace's mental state commenced abruptly on the weekend prior to her death, after she smoked cannabis. Her symptoms, including disorganised and confused behaviour, disorientation, disinhibition, anxiety, unspecified persecutory ideas about her family, bizarre delusional ideas and hallucinations, were inchoate features characteristic of an acute psychosis.

Dr Sullivan notes that it appears Grace did not disclose the full nature of her condition to anyone, minimising her symptoms and being guarded during the assessment. She did not disclose the full extent of her symptoms to either her family or medical staff.

The psychotic episode arose on a background of significant stress about her studies and financial concerns. Grace also appeared preoccupied with the sexual assault, and was experiencing some conflict with her family. However, Dr Sullivan considers it unlikely that stress alone induced a psychotic state.

Dr Sullivan also considered the fact that Grace had taken melatonin. He was not aware of cannabis and melatonin having a specific interaction, but in any event, cannabis is known to have a capacity to induce psychosis. In his view cannabis is likely to have had a far larger contribution to the psychosis. Similarly, he did not consider the presence of Lamotrigine to be significant; it was unlikely to have been taken either deliberately by Grace or ingested as an adulterant, and it would not have contributed to her psychosis.

Accordingly, the most likely precipitant of the psychosis was cannabis use alone. A cannabis-induced psychotic episode is generally short-lived (from hours to days) and will settle with the passage of time after cessation of cannabis use.

Symptoms may persist beyond the presence of cannabis in the body; this is consistent with the fact that no cannabis was detected in Grace's system at autopsy. Dr Sullivan also notes that Grace's reaction to cannabis on this occasion could not clearly have been predicted by her reported experiences when previously smoking cannabis.

Accordingly, I find that Grace suffered an acute psychotic episode that was induced by cannabis use.

Sadra and Taha Boutorabi

Both Sadra and Taha Boutorabi gave evidence to the inquest. Sadra stated he met Grace through Tinder and initially saw her about once a week. He denied smoking cannabis with Grace often, or giving her any cannabis, but said he had been out with her at weekends and had observed her smoke cannabis in a group setting ("*a few puffs from a joint"*). He did not know who supplied the cannabis to Grace. She was not a drinker and he was unaware of her taking any other drugs. This evidence is generally consistent with other evidence about Grace's drug use.

Sadra agreed he communicated with Grace quite frequently after he went to Iran. He was aware she was having some difficulties with her family, although he thought these were just "*normal family issues".* On 18 December 2018, Grace appeared paranoid and he became concerned for her. In particular, Sadra was aware that it was possible to develop mental health issues as a result of drug use. For this reason, he contacted his brother and advised that Grace should go to hospital. He had no insight into to why Grace spoke to her mother about 9/11; this was not a topic they had spoken about.

Taha did not think Grace was a regular cannabis user. He could recall 3 to 5 occasions when Grace smoked cannabis, including the weekend prior to her death. On that occasion, Grace smoked part of a joint. He and Grace were supporting each other, and she spoke to him about the sexual assault. He noted that Grace seemed "*energetic*" on the Tuesday morning, which is in contrast to the way she appeared later on. He also did not have any insight into why Grace spoke to her mother about 9/11. However, he explained that the lift in his building requires a code to be used; this may explain why she told her mother she was stuck in a lift.

My impression of both Sadra and Taha is that they were genuinely concerned for Grace. They each took appropriate steps to get her help once they realised, she was not mentally well. I accept their account about their knowledge of Grace's cannabis use. There is no evidence that Grace was coerced into using cannabis or tricked into taking anything she did not want. The evidence supports a finding that Grace was not a regular cannabis user, but that she smoked cannabis on the weekend prior to her death. The consequences of that decision were, of course, tragic.

Treatment at Royal North Shore Hospital

Dr Robert Day, the Director of the Emergency Department (ED) at RNSH, gave an overview of the operation of the ED and the manner in which mental health presentations are assessed at RNSH. Dr Day explained that there is a service-level agreement between RNSH and the North Shore Ryde Mental Health Service, which provides 24-hour mental health staff at the ED, including psychiatrists. The Fast Track area is intended to allow ambulatory patients to be dealt with more quickly. This is important, as a long wait might mean that some patients choose not to wait.

Triage and allocation to Fast Track

Grace was assessed as ATS4, which is appropriate where a patient presents with a semi-urgent mental health problem and who is at no immediate risk to self or others. The more serious ATS3 category is for patients who are "*acutely psychotic or thought disordered*" in "*situational crisis*" or "*agitated / withdrawn*".

Given Dr Sullivan's opinion that Grace was suffering an acute psychotic episode, it may have been more appropriate to allocate Grace to ATS3. However, it is unclear that this would have made any difference. The relevant RNSH policy only excludes higher risk ATS1 and 2 patients from the Fast Track. Dr Sullivan also considered the triage process and allocation to the Fast Track to be appropriate. I do not find any issue arises in these circumstances.

Dr Day also explained how the reception processes at RNSH have been improved since Grace's death, so that the ambulance record, which had not been available in Grace's case, is now kept with a patient's records and staff are advised to treat it as an important document. It is gratifying that this, and other changes, were identified and implemented by RNSH prior to the inquest having occurred.

Assessment by Nurse Newton

Mental Health Clinical Nurse Consultant Justin Newton gave evidence to the inquest. He has over 20 years' experience in mental health work. His role was to complete a mental health assessment and to discuss those requiring admission with the on-call psychiatrist, Dr Zsadanyi. He had performed that role regularly.

He spoke with Grace alone in an assessment room near the fast Track area. His assessment was substantial, taking about an hour. He used a mental health assessment template, making handwritten notes and later transferring those to the electronic record. He wanted to review the ambulance record, but it was not available; it is unlikely to have made a difference to his assessment.

Grace gave him a history, as set out above, including the conflict with her family and the sexual assault, which appeared to him to be a significant part of her presentation that day. His primary impression was that Grace's condition was drug-induced, although his differential impression was that she was mildly psychotic. They discussed her plan to see a psychologist the following day, and that she could return to the ED if she had concerns.

Grace did not give Nurse Newton permission to talk to her family, but agreed he could talk to Taha. Nurse Newton agreed that obtaining collateral information was an important part of his assessment. The fact that Grace declined to let him speak to her family did not itself cause concern, given the family conflict she had described.

Nurse Newton also said that, at some stage, he went into the waiting room to see if Grace's family were present, but they were not. It is unclear when this might have occurred, given Grace had asked him not to speak with them. In any event, Nurse Newton did not think he could go against Grace's wishes and never in fact spoke with her family.

As I have noted, a consequence of this was that Nurse Newton did not become aware of the information known to Grace's family, about some of her more bizarre delusions. Dr Sullivan agreed that this information might have demonstrated more clearly that Grace was thought disordered and psychotic. Nurse Newton said that, if he had been told the information Grace's family knew, he would have discussed it with the psychiatrist.

However, his impression was that Grace engaged well in the assessment, had participated in treatment planning and appeared to be making good decisions about her health. He therefore said it was questionable whether the outcome would have been any different.

Overall, Dr Sullivan considered Nurse Newton's assessment to be of good quality, by an appropriately skilled and experienced mental health specialist. Grace was guarded about her symptoms and wanted to appear in control, which presented a problem for Nurse Newton's assessment. Dr Sullivan stated that, while it is important to obtain collateral information about a patient, it is a challenge for clinicians where a patient who has capacity to make decisions expresses clear wishes not to involve her family in treatment. In Grace's case, she presented voluntarily and appeared to be competent. Mental health legislation and policy supports a patient's rights to make decisions about their treatment.

Dr Day indicated that Northern Sydney Local Health District is in the process of preparing a policy which will provide further guidance to treating staff about this issue, where patients refuse consent to obtain information or discuss treatment with family members. Again, it is pleasing to see that issues identified in relation to Grace's death are under active consideration. In these circumstances, it is unnecessary to make a recommendation about this issue.

The outcome of the assessment by Nurse Newton was that Grace was not considered to be at acute risk, and less intrusive care was available, namely discharging her home with Taha and allowing her to present to her GP and (it was believed) a psychologist the next day. Dr Sullivan does not criticise this decision, and notes that the hospital would not have had power to hold Grace there involuntarily under the *Mental Health Act 2007* in these circumstances in any event.

Steps taken after it was discovered Grace had left

Once Nurse Newton realised Grace had absconded, he appropriately escalated the issue to the psychiatrist. However, when he was unable to contact Grace, he did not seek to make contact with Taha or Grace's aunt, whose contact details were available. Nurse Newton said that he did not hold concerns about Grace, so he did not try to contact Taha; and also, he did not feel he had Grace's permission to contact Judith, absent there being concerns about her safety.

Dr Sullivan considered this decision "*understandable*" in circumstances where Grace had actually left with Taha. Ideally, contact would have been made with Grace to complete the discharge planning process, including providing Grace the contact details for the mental health helpline.

Of course, even if Nurse Newton had contacted Taha or Grace's aunt, it would have been discovered that Grace had returned to the Hunters Hill unit, with her family and Taha present. It is therefore unclear that making such contact would have had any impact on the events that followed.

Since Grace's death, RNSH has provided updated guidance to its staff in relation to patients who do not wait. This policy requires ED staff to inform mental health staff, and, where safety concerns exist, to make attempts to call the patient's phone, contact relatives and if required to contact police. In light of that revised guidance, no recommendation is necessary.

Action taken by the paramedics

Paramedic Steinle-Davis gave evidence to the inquest. He impressed as a careful, thoughtful witness. He spent some time trying to develop rapport with Grace, but she did not interact with him. He wanted to assess her competency and capacity and wanted to encourage her to return to the hospital voluntarily.

He believed Grace had gone into her room to obtain some belongings. When he realised, she had absconded through the window, he requested routine police assistance (a "*slow response"*). At that stage, he was not concerned as neither Grace nor anyone else appeared in danger.

Paramedic Steinle-Davis and his colleague then followed Grace along the road. He instructed his colleague not to use the warning lights; this was part of his usual practice, as "*the last thing we want to do is spook someone who may be having a psychotic episode*." Grace then became more disorderly, flailing her arms around and at one stage lying on the ground. As a result, Paramedic Steinle-Davis upgraded the request for police to an urgent "*R1*" response. He formed the view that Grace would need to be scheduled.

After unsuccessfully trying to engage Grace on foot, he also believed she may need to be sedated, and he returned to the ambulance to draw up the droperidol. He explained that this would be used only as a "*last resort*", in circumstances where a patient was being scheduled. It would also only be used if police were present, as it would be physically difficult to administer.

Dr Sullivan was not specifically asked to consider the paramedic response. However, he considered their actions were appropriate. In his view, there was no opportunity to use coercive powers to prevent Grace from leaving the apartment. Once she did so, they escalated their response appropriately, including by contacting police and preparing sedative medication.

I find that the paramedics took all appropriate steps in the circumstances.

Action taken by the police

Constable Harriet Fordyce gave evidence to the inquest. At the time of these events, she was a probationary constable with about 8 month's experience. She told the inquest she had received some training in mental health issues at the Academy. She was also aware of the Memorandum of Understanding between NSW Police Force and NSW Health ("MOU").

She recalled first becoming aware of the incident via a CAD message or radio broadcast. She understood that she would be responding to the incident and assisting paramedics by helping to detain Grace.

She confirmed that the initial CAD message made reference to Grace having access to a knife, which was of some concern to her. She did not recall a further incident broadcast to the effect that the paramedics had said Grace did not in fact have a knife.

She also made further enquiries via the Mobile Data Terminal inside the police vehicle while en route, although did not recall what information she obtained. When she and her colleague arrived at Burns Bay Road, she says the police vehicle's siren was deactivated but the warning lights remained on. She understood this was because Senior Constable Shields was driving the wrong way down a major road, with traffic heading in the opposite direction. The sirens were also appropriate because they were responding to an "*urgent duty*".

When they saw Grace, there was no time for any discussion about what they would do. Her colleague said, "*there she is*" and she saw Grace get up and start running. Constable Fordyce said she did not have time to plan a response; she left the vehicle and gave pursuit, arriving after Grace was already over the edge. Neither was there an opportunity to discuss with the paramedics what action ought to be taken.

To the extent that Constable Fordyce undertook a risk assessment, as the MOU suggests should be undertaken when attending mental health incidents, she described this as a "*swift process*", taking into account the risks to police and to Grace. Although she was aware of the fact that there was a drop off one side of the off-ramp, she did not specifically address her mind to the fact that this presented a safety risk. There was no opportunity to coordinate a plan with the paramedics in the circumstances, as Grace began running as soon as police discovered her location. I do not criticise the officers for giving pursuit, as Grace was running along a major road and clearly at risk from traffic, quite apart from the unforeseen risk posed by the height of the off-ramp.

Sadly, it appears to me likely that the arrival of police on the scene contributed to Grace's escalation in behaviour. While she had been disordered prior to that point, her immediate reaction to the police arrival was to run away and climb over the fence at the side of the off ramp. It was, however, unpredictable that she would do so. As Grace was suffering an acute psychotic episode, I do not find that she formed any intention to harm herself. Her death was therefore a tragic accident.

It is also apparent to me, after hearing from Constable Fordyce and reading the interview of Senior Constable Shields that the officers did all that possibly could have been done to prevent Grace from falling.

Formal Finding:

The identity of the deceased: The person who died was Grace Rohanne Herington.

Date of death: Grace died on 19 December 2018.

Place of death: Grace died at Royal North Shore Hospital, NSW.

Cause of death: The cause of death was multiple blunt force injuries.

Manner of death: Grace sustained fatal injuries in a fall from height in the context of an acute psychotic episode, induced by cannabis use. There is no evidence that Grace intended to end her life. The death occurred as a result of police operations.

30. 20200 of 2019

Inquest into the death of A. Finding delivered by DSC Ryan at Lidcombe on the 11 August 2020.

Introduction

A aged 74 years died on the night of 18 January 2019, at his home in Glen Innes in northern NSW. Police officers had been called to the home by A's wife B. Soon after they arrived A, who was armed with a rifle, fired a shot which injured two of the responding police officers. A then fired a round into his own head. He suffered unsurvivable injuries and died immediately.

This is a mandatory inquest pursuant to sections 23(1) (c) and 27(1) (b) of the Act. An inquest is mandated when it appears that a person has died '*as a result of police operations*'. The purpose is to ensure there is an independent and transparent investigation of the circumstances of the death, and the conduct of any involved police officers.

Detective Sergeant Jason Ronczka was appointed to lead the subsequent Critical Incident investigation and to prepare the coronial brief of evidence.

The issues examined at the inquest

The issues examined at the inquest were:

- What risk assessment did the responding police officers make prior to proceeding to A's house on 18 January 2019? Did it sufficiently take account of information that A was armed with a firearm?
- When the police officers attended A's house were their actions adequate and appropriate?
- Was the incident a high risk situation? If so what should have been done as a consequence?
- Had the police officers received adequate training regarding high risk situations?

A's life

A was born on 1 October 1944. As an adult he lived in Wollongong and worked as a plastics fabricator. He married and had two children, L and M, who are now adults. After about fifteen years the marriage came to an end. Sometime afterwards A married B, whom he had known for many years. When A retired thirteen years ago he and his wife moved to the town of Glen Innes with her adult daughter D.

Their house at 54 Church Street was a two level building with a long balcony on the upper floor which faced the street. At the rear of the house was a detached granny flat which D lived in. Church Street is the main thoroughfare running north to south through Glen Innes.

At the time of A's death his wife was working in her career as a nursing home carer. She and A shared a love of camping and hunting, and between them they owned thirteen registered firearms. These were stored in three gun safes on the ground floor of their home. Ammunition was separately stored. One of the firearms, belonging to B, was a Winchester Marlin Model .30-30 rifle. It was fitted with a magazine capable of holding seven cartridges. This was the gun which A used on the night of 18 January 2019.

A's death has had a devastating effect on many people. At the close of the evidence the court heard a tribute from his two children, who spoke of a generous and hardworking man whom they loved whole-heartedly. Following this, Mr Evenden read to the court a loving statement prepared by B. She spoke of her heartache at losing her husband and her bewilderment as to why he had taken his life that night. She remembered him as a man who loved her and her family '*beyond measure'*. She misses him deeply.

It is not only A's family who continue to suffer the effects of his death. Three police officers attended A's house on the night of 18 January 2019: Sergeant Mark Johnston, former Leading Senior Constable Helen McMurtrie, and Probationary Constable Samantha Petty. Officers Johnston and McMurtrie received gunshot wounds that night which required hospitalisation. Because of her injuries, Ms McMurtrie found herself unable to resume her career as a police officer and she retired from the service this year. While their physical wounds have healed, it is clear that she and Sgt Johnston suffer profound distress at the memory of that night. The third police officer, PC Petty, was but four weeks out of the police academy when she attended the Newman home with her fellow officers. She remains a police officer but undoubtedly will never forget these events.

The lead up to the police operation on 18 January 2019

At the inquest the court heard that the relationship between A and B was volatile at times. In 2010 B left her husband and moved to Queensland following an incident in which he had assaulted her. A undertook anger management counselling, and after about a year B returned to live with him. She told her family that his behaviour had become less aggressive. In her statement to police following A's death she denied that he had ever assaulted her after she returned to live with him.

However B's sister C presented a different picture of this aspect of their domestic life. C lived near A and B in Glen Innes and she saw her sister most days. In her statement to police she said that although she herself never saw A being violent towards her sister, on several occasions she had observed bruising on B's upper arms. B had reported to her that there was *'a lot of yelling and arguing and lots of verbal abuse',* and that she had thoughts of leaving him again.

On 27 May 2018 an ambulance was called to A's home when he fell down the stairs after drinking whiskey. He was initially aggressive to the ambulance officers and punched a hole in the wall, prompting the arrival of police.

On the night of A's death the couple was at home together. An argument broke out between them about domestic chores. At about 9.40pm B went upstairs. A followed her, grabbed her arm, and put his arm around her neck in a choke hold. After that he released her and went to another part of the house.

Fearing for her safety, B ran to the granny flat to get help from her daughter D, and they made a call to '000'. The operator said they would send an ambulance and police officers. B then rang her sister, who got in her car and collected B and D from outside their home. She drove them down the road a short distance and parked outside 39 Church St. It was here that the responding ambulance and police crew met them.

The responding officers were:

Kerry Trow, paramedic officer with NSW Ambulance
Peter Adams, paramedic officer with NSW Ambulance
Sergeant Mark Johnston
Leading Senior Constable Helen McMurtrie
Probationary Constable Samantha Petty.

On the evening of 18 January 2019 these three police officers were the only ones rostered on duty at Glen Innes Police Station. PC Petty was in the very early stages of her probation as a police officer, and LSC McMurtrie was her Field Training Officer. At that stage of her training PC Petty was required to work with two other officers at all times, which is why all three officers attended the Newman home that night in response to the triple zero call.

What risk assessment did the responding police officers make prior to proceeding to A's house on 18 January 2019? Did it sufficiently take account of information that A was armed with a firearm?

As will be seen, senior officers Johnston and McMurtrie did perform an informal risk assessment that night. This involved gathering information about what had happened and assessing what risks they faced in attempting to resolve it. A critical question is whether during this process they placed sufficient credence on information that A was physically in possession of a firearm.

NSW police officers receive training about how to respond to the wide range of incidents to which they are called. In addition to being trained in the tactical options at their disposal, police officers are taught to apply situational awareness in determining their appropriate response.

The court was assisted with an expert report and evidence from Detective Inspector Justin Waters. DI Waters had been asked to provide his opinion on the actions of the three involved officers that night in respect of planning, coordination and tactics.

DI Waters is a police instructor of more than 22 years' standing. Prior to that he had many years' operational experience as a general duties and plain clothes police officer. At the time he prepared his report he was a Senior Operations Safety Instructor with NSW Police Force's Weapons and Tactics Policy Review Unit.

In his report Detective Acting Inspector Waters described the aim of situation awareness training as to reinforce '*the dynamic nature of the decision-making process'.* [par 38]. Key elements are the gathering of all situational information, then identifying a plan and a tactical option which will best resolve the incident. Police training emphasises the need to continually monitor the effectiveness of the plan during and after implementation. Thus:

'Officers are taught to conduct a risk assessment of the situation confronting them. This risk assessment must also be reassessed on an ongoing basis to minimise the risk of danger to all involved.'(par 43).

Of direct relevance to the issues in this inquest is the feature of officer safety. The significance of officer safety was emphasised by DI Waters:

'…operational safety instructors continually reinforce with participants during training sessions the importance of maintaining their own personal safety first. In fact, it is considered paramount. If a police officer is seriously injured or killed, they are of no use to themselves or other officers present, or to those innocent bystanders whom they serve to protect.' (par 15.)

I now describe the information which the officers sought and obtained prior to their approach to A's house that night.

The Computer Aided Dispatch report.

The police radio message to which the three officers responded was one of a number of information sources to which they had access in forming their risk assessment and plan. The Computer Aided Dispatch (CAD) radio message, broadcast at 9.48pm, advised there had been an assault by a man on his wife who had suffered injury to her neck and hand. The message went on to advise that at the premises there were thirteen firearms which were '*in safe store'*, but that there were no weapons in play nor any current Apprehended Violence Orders.

B's call to triple zero was clearly the source of some of this information. The transcript of her call shows that she informed the operator of her injuries and told him their thirteen guns were locked up. In the call she made no mention of A having taken possession of one of the guns. Other evidence heard at the inquest suggests that B's information in this regard was accurate at the time of her call. At this time she was most likely inside her daughter's flat, unaware that her husband was in the process of going to the gun safe and removing her Winchester rifle. As will be seen, it is likely that by the time the police officers arrived at the scene, B had become aware of the likelihood that A was in fact armed.

The conversations outside 39 Church Street

When the ambulance and police officers arrived outside 39 Church Street at just after 10.00pm, officers Johnston and McMurtrie set about gathering information from B and her sister. Paramedic officers Adams and Trow also participated. While there are common elements to the information imparted in these conversations, it is fair to say that there were areas of inconsistency.
One of the issues explored at inquest was whether the police officers placed too much weight on these, to arrive at a conclusion that the information they received about A's possession of a gun was not fully reliable.

In his statement and evidence to the inquest, paramedic Adams said he observed that B and C were unsteady on their feet. He heard B tell paramedic Trow she had had four to six wines that night. He also heard B say that her husband had told her he was *'going to get'* the 30.30 rifle from the gun safe. Mr Adams observed that B had injuries: red marks on her neck, a bruise on her left upper arm, and a haematoma on her thumb.

The above conversations were not captured by audio or video. However once the three police officers arrived, much of the subsequent conversations were. Officers Johnston and McMurtrie each wore police-issue body-worn video cameras which they activated upon their arrival. The resulting recordings [the BWVs] reveal that while C was in the presence of officers McMurtrie and Johnston, she reported that her sister had told her the following:

- That she and her husband had both been drinking that night
- A had grabbed her by the wrist and had tried to strangle her
- A had pulled out a gun and threatened to kill her.

When asked by officer McMurtrie to confirm that this is what B had told her, C repeated that B had said that A had tried to kill her, he had broken her wrist, he was going to murder her, and that *'he's got his gun'*. C also volunteered that A had previously *'pistol-whipped'* B but she hadn't reported it, and that the couple were hunters with a safe full of guns and ammunition.

Officer McMurtrie then turned her attention to B for her account of what had happened. B was very distressed and her sister made an attempt to speak on her behalf. Officer McMurtrie rightly discouraged C from interrupting and returned her attention to B. At the inquest B told the court she had felt somewhat annoyed by this and had concluded the police did not want her help.

In the presence of Sgt Johnston, B told officer McMurtrie the following:

- she'd had '*a couple of wines'* and A had got '*a little bottle of Scotch'*
- A had put his hands around her neck and she couldn't breathe, she'd thought she was going to die
- A had mentioned a 30-30 and had said to her something like '*Oh you'll get what you want*'
- she and her daughter had hidden outside the house and she had seen A sitting on the balcony. It '*looked like'* he had her gun. She thought he was going to shoot himself.

It is to be noted that there is a discrepancy between the accounts to the police given respectively by the two sisters. According to C, B had told her that her husband had '*pulled out a gun and threatened to kill her'*. In contrast, B described A uttering an ambiguous threat while assaulting her, and that she subsequently saw him on the verandah holding what looked like a gun. It is presumably for this reason that in her evidence, officer McMurtrie expressed the view that B had not '*backed up'* C's version, and that there was reason to regard as inconsistent their accounts of the relevant circumstances.

C's visit to the house

There was a further piece of information relevant to the officers' assessment of the risks involved that night. While officer Ms McMurtrie was speaking with B, C decided to walk to A's house to see if she could find out what was happening. She ignored calls from B and the police officers to return to the group. C explained in her evidence that she had known A for many years and had always had a good relationship with him. She thought she might be able to help resolve the situation.

To the court she described going into the front yard and seeing A sitting on a bench at the northern end of the upstairs balcony. She called out to him, asking if she could come up and talk to him, but he told her to *'fuck off'*. This startled C as, she said, he had never spoken to her like that before. She saw A was holding something on his lap which was shaped like a pipe, which she assumed was a gun. Now fearful for her own safety, she returned to where the group was still gathered down the road.

There is conflicting evidence as to whether on her return C told police about her visit, and in particular about seeing A holding an object which she assumed was a gun. In her evidence to the inquest C said she definitely told her sister about it, and also that A had looked '*so angry'*. She thought that while she was saying this the police officers were standing nearby. She was clear that she did not specifically speak to the police because she was still annoyed that they had, from her point of view, ignored her earlier attempts to assist them.

Neither officers Johnston nor McMurtrie recalled hearing from C that she'd just seen A with an object that looked like a gun. On the contrary, they believed she had said that although A was upset, he was *'fine'* and she was sure he would speak to them. In her evidence however PC Petty said she *did* hear C saying A was holding an object that looked like a gun.

It is to be noted that in her evidence C denied saying to the police officers that she was sure A would talk to them. Nor is this information captured on the BWV recordings. Of itself this does not mean the words were not said: it is apparent from the recording that at times conversations were proceeding simultaneously, and that some of the participants were out of audio range. Nevertheless given C's evidence that after her encounter with A she was left feeling scared for her life, it seems unlikely she would have told the police officers that he was '*fine*' and that she was sure he would speak to them.

It appears that following these conversations, officers McMurtrie and Johnston had an informal discussion and decided on a plan to go up to the house and attempt to engage A. One of their purposes was to ascertain if he did in fact have a gun in his possession.

Why did officers Johnston and McMurtrie not believe there was sufficient evidence that A was physically armed?

In their interviews and their evidence at inquest, officers Johnston and McMurtrie were clear that when they began their approach to the house they knew A had *access* to numerous firearms. However they said they were uncertain if he was actually *in possession* of one of them. It was, they said, a possibility but they could not be sure.

This state of mind influenced not only their assessment of the risks involved in the situation, but also the plan they formed and implemented, of approaching the house to see whether he did in fact have a gun and to find out what his intentions were.

Officers Johnston and McMurtrie were questioned as to why they were uncertain whether A had a gun in hand, given the information imparted by B and C (described above at paragraphs 28 and 31). Both replied that they considered B's reliability was compromised because of her level of intoxication. Commenting that B appeared extremely distressed (an observation with which I agree, having viewed the BWV footage), Sgt Johnston also questioned her reliability on this account. As noted, both officers were also under the impression that upon her return from the house, C had reported that although A was upset he was fine and she was sure he would talk to the police.

In addition when asked about her assessment of the risk, officer McMurtrie cited what she described as confusing and '*contradictory*' information about whether A was in fact in possession of a gun. As well as the discrepancy she perceived to exist between B and C's accounts, referred to at paragraph 32 above, she cited the contents of the CAD report. This had advised that the household's guns were all stored, clearly inconsistent with B's subsequent information that she had seen A with what looked like a gun in his hand. Officer McMurtrie did not agree that this information, being later in time to the CAD report, may have accurately reflected subsequent events.

There was a further factor which Sgt Johnston said had affected his state of mind about whether A was in physical possession of a gun. During his directed interview he was played a recording of the BWV conversations. After listening to this he told the interviewing officers that he now realised he had failed to absorb a critical part of the conversation while it was taking place. This was the part where B had said that while hiding in the garden with her daughter she had seen A on the balcony holding what looked like her gun. Sgt Johnston told the interviewing officers: '*I can see I missed something very important – that she explains she thought he had the firearm already.*'

Had he picked up this information, he said, he would have been '*reasonably satisfied*' that A did have a gun. He went on to explain that the omission had reduced his perception of the risk level.
On arrival he had been under the impression from C that A had actually produced a firearm when he had assaulted B in their home.

He had found that this was not reflected in B's account of the events at the scene, according to which A had *threatened* to get a firearm when he assaulted her. Sgt Johnston told the court that had he appreciated what B had said about later seeing A on the balcony with what looked like a gun, this would have heightened his assessment of the risk level to that of 'high risk'.

Having carefully considered the evidence, the conclusion I reach is that there was sufficient information available to officers Johnston and McMurtrie to conclude that it was probable A was in physical possession of a gun. I accept the closing submission of Counsel Assisting, that although the accounts provided to the police officers were not without inconsistencies, and factors were present which potentially affected their reliability, there was credible evidence that A was probably in possession of a gun.

Viewed objectively and admittedly in hindsight, there was no real basis for officers Johnston and McMurtrie to be uncertain about this to the degree they apparently were. The very unfortunate consequence was that each underestimated the degree of risk to themselves in approaching A as they did.

Were the actions of the police officers adequate and appropriate?

The evidence enables me to establish that after forming this plan, the police officers acted as follows:

Officer McMurtrie informed B that they would go to the house, arrest A and seize all the firearms. She instructed B and C to leave the area and not to drive past the house

The officers moved their police car to a position closer to number 54. On the way officer McMurtrie attempted on two occasions to speak to A on his mobile phone. This was to try to ascertain from a safe distance where he was and what his intentions were. He did not answer.

Unbeknownst to officers McMurtrie and Johnston, C did not drive her sister and niece to her home as directed. Instead she drove around the block, then parked her car at a point diagonally opposite number 54. Soon afterwards C commenced filming the events across the road on her mobile phone.

The three officers, led by officer McMurtrie, approached the front gate of number 54 on foot. Taking on the role of the 'cover' officer, Sgt Johnston shone his torch at the verandah and the officers were able to see A sitting there. They could not see if he was holding a gun.

Adopting the role of the 'contact' officer, officer McMurtrie called out to A, introducing herself and her colleagues and telling him they needed to talk to him. She asked him to raise his hands to where she could see them. He made no response.

The three officers then entered the front yard, with officer McMurtrie at the fore and the other two officers on either side of her but remaining closer to the front fence. Officer McMurtrie continued to call out to A to raise his hands as '*we have been advised you have a firearm*'.

By this time she was standing very close to the area beneath the verandah. Sgt Johnston can be heard urging her to '*come back, come back*'.

The three officers then saw A stand up, walk to the southern end of the verandah, bend down and pick up a firearm. He yelled out something, which Sgt Johnston thought was something like: '*See what you've gone and done now'.* It is not possible to determine whom A was addressing, but a plausible theory is that he had just spotted C's car and its passengers across the road.

All three officers drew their service pistols, shouting to A '*Put it down now!*' Sgt Johnston saw A load the rifle. He shouted to his colleagues to back out of the property. As they did so officer McMurtrie noticed C's car across the road and yelled at her to '*Get in the car and drive away now!'*

At that point A discharged a round from the rifle. The bullet hit the gravel driveway and ricocheted, striking Sgt Johnston in the face and officer McMurtrie in the neck. Both fell to the ground. A second shot can faintly be heard. It was not apparent to anyone at this stage that A had fired this round to his own head.

Although injured Sgt Johnston managed to get to his feet and with PC Petty, he dragged officer McMurtrie out of the front yard and into the driveway of the neighbouring house. PC Petty called for an ambulance, while Sgt Johnston retrieved a first aid kit from the police car and radioed for police assistance. PC Petty commenced giving first aid to officer McMurtrie, with the courageous help of two occupants of 50 Church Street.

Very soon afterwards the three officers were joined by an off duty police officer, Constable Jack Chapman-Burgess. He was PC Petty's boyfriend and had learnt of the shooting via police radio. He parked his own vehicle, a ute, in front of number 54 to give some protection to the group on the ground administering first aid to officer McMurtrie.

Uncertain whether A had been shot, Sgt Johnston and Constable Chapman-Burgess put on the police car's only two ballistic vests. Edging closer to the house they were able to see A slumped over on the verandah. He was not moving and the gun was positioned between his legs.

When an ambulance arrived and collected officers McMurtrie and Petty, Sgt Johnston refused to go to hospital until reinforcing police officers were on the scene. These arrived shortly afterwards and he briefed them, before being taken to hospital in the returning ambulance.

The newly arrived police officers cautiously entered the house and found A on the upstairs verandah, deceased. He had a large gunshot wound to his head.

<u>The injuries to the involved officers</u>

Officer McMurtrie received serious injuries from the shrapnel which entered her neck. She was placed in an induced coma in Gold Coast Hospital's Intensive Care Unit, then onto a ward.

Remaining in her neck are pieces of shrapnel which cannot be removed without unacceptable risk. The consequence is that a knock to her neck would pose a serious risk of injury to her spine, meaning that she is unable to perform police operational duties. She was medically discharged from the NSW Police Force this year.

A large bullet fragment entered Sgt Johnston's left cheek and struck his jawbone. He underwent surgery and remained off work for twelve weeks. A scar of approximately ten centimetres is visible on his cheek.

PC Petty received a graze to her head from one of the bullet fragments, and required four weeks off work. At the inquest, reliving the experience of being shot that night was very painful for these three people. At the close of the evidence their ordeal was acknowledged by A's children and by B who each expressed their regret at what the police officers had endured. I join them in expressing the hope that in time they will be able to put behind them the harm that they suffered.

The cause of A's death

The cause of A's death is clear on the evidence. The autopsy report of forensic pathologist Dr Allan Cala found A had died as a result of a perforating high velocity gunshot wound to the head. Dr Cala reported that the single round had entered A's head in the area under his chin, and that it had caused severe destruction to his face, skull and brain. In his opinion, the anatomical site of the entry wound was indicative of a self-inflicted wound.

Testing of A's post mortem blood samples showed a high level of alcohol, at 0.164g/100mL. Dr Cala opined that based on the blood alcohol level recorded, it was likely A's judgement, co-ordination, reflexes and cognition were '*significantly impaired*'. I turn now to consider the remaining issues for examination at this inquest.

Was the incident a high risk situation? If so what should have been done?

In his expert report DI Waters identified errors, these primarily arising from the two senior officers' underestimation of the danger signs inherent in the information provided to them, in particular about A being in possession of a gun. I have addressed this issue above. DI Waters also opined that as the senior officer, Sgt Johnston ought to have identified the incident as 'high risk', and requested specialist resources such as police negotiators or Tactical Operations police. At the least he ought to have contacted the duty officer or DOI on duty that night.

A 'high risk' situation is defined in the NSW Police Force's Operations Manual as one where the essential judgment is:

- *'whether the real or impending violence or threat to be countered is such that the degree of force that could be applied by the police is fully justified'.*
- *The Manual advises that one or more of the following criteria may be used to define a situation as 'high risk':*
- *the seriousness of the offence committed by the person*

- *an expressed intention by the person to use lethal force*
- *reasonable grounds to believe that the person:*
- *may use lethal force*
- *has or may cause injury or death*
- *has issued threats to kill or injure any persons*
- *the person has a prior history of violence, or is currently exhibiting violence*
- *there is involvement of participants such as hostages or bystanders.*

In his report DI Waters commented that on the information provided to the involved officers, a number of these features were present. B and C had advised of a serious assault committed that night by A and of threats by him to use lethal force. In addition there was credible information that he was currently armed with a firearm.

Before giving his evidence at the inquest DI Waters had the benefit of hearing the witness evidence, including that of the senior officers McMurtrie and Johnston. This included their evidence as to what matters they took into account when assessing the risk level of the situation. Although in some respects this caused DI Waters to moderate the opinions he had expressed in his report, he maintained the view that this incident was a 'high risk' situation which required more extensive consultation between the two senior police officers and at the least, justified a consultation with the duty officer or Duty Operations Inspector.

DI Waters noted Sgt Johnston's evidence that he had missed a very important piece of information imparted by B. He noted further that although officer McMurtrie *had* absorbed this information, nevertheless she had only assessed the risk level as 'medium', whereas according to Sgt Johnston's evidence, with the benefit of this information he would more accurately have considered it to be 'high'. For her part it appears that unlike her fellow officers, PC Petty had picked up from C that A was in fact up on the balcony holding what C had assumed to be a gun. For these reasons, in DI Waters' opinion it would have been very important for the officers to have consulted together after speaking to B and C. The purpose would have been to ensure that they had assimilated all the available information relevant to risk.

DI Waters considered there were other points at which the two senior officers might appropriately have consulted about the risk level. These were when A did not answer officer McMurtrie's calls to his phone, and a little afterwards when he made no response to her attempts to engage him personally. In this regard it is interesting to note in Sgt Johnston's directed interview how he described his own reaction to A's non-responsiveness:

'..there was nothing from him [A] to us at all at that stage. There was no acknowledgement that we were even talking to him …at that point you realise that…the hairs on the back of your head stand up because obviously something's not quite, he's not interacting with us at all.'

According to DI Waters, by that stage at least the situation was of sufficient gravity that the senior officers ought to have strongly considered withdrawing and contacting the duty officer or the DOI to discuss their tactical options.

This discussion could have included whether specialist police resources should be called to help resolve the situation, such as police negotiators or members of the regional Tactical Operations Service.

Regarding the feasibility of deploying specialist resources to this incident, the court heard evidence from Detective Senior Sergeant Nathaniel Luck. He is the coordinator for the Western Region Scarce Resources Unit. In this role he arranges for the deployment of specialist officers to specific incidents if that action has been approved by the duty officer. DS Luck acknowledged the Western Region covers a vast area, which usually means there will be a time lag before specialist officers can arrive at a scene. Nevertheless he maintained that police negotiators and tactical operations police would be made available if requested.

When asked why he had not considered the option of canvassing specialist assistance, Sgt Johnston emphasised that he had felt a strong duty to engage with A, due to the imminent risk that he would carry out an act of self-harm or suicide.

Sgt Johnston was concerned that if he sought specialist assistance there would be delays which would compromise A's safety. It is very much to his credit that Sgt Johnston takes with great seriousness his professional duty to try to avert such tragedies. But as DI Waters emphasised in his report and evidence, notwithstanding the risk to A the safety of the attending police officers had to remain the paramount consideration in the police response that night. In his view this factor had not been given sufficient weight.

The evidence supports DI Waters' opinion that the situation facing the officers that night met the description of 'high risk'. It followed that the interests of officer safety required that there be a careful process of planning the steps to resolve the situation. The two senior officers missed opportunities to ensure they were in possession of all relevant information, by means of a more effective consultation with each other after their conversations with B and C, and following A's lack of response to their attempt to contact him and to engage him. On the basis of Sgt Johnston's evidence, it is likely that had they done so the attendant risks to themselves would have been assessed at a higher level. This may have led them to consider whether officer safety justified at the least a consultation with a superior officer as to their tactical options.

DI Waters was at pains to acknowledge that had consultation with a more senior officer taken place, this would not necessarily have altered the tragic outcome. I accept this assessment.

In his report and evidence DI Waters also commented on the extreme vulnerability of the three officers as they tried to engage A in his front yard. None was wearing a ballistic vest. They had no cover or concealment by way of buildings, vegetation or parked cars. In addition A was in an elevated position with a weapon of much greater range and accuracy than their service pistols.

The court heard that the three police officers were not wearing ballistic vests because their police car was equipped with only two.

As DI Waters acknowledged, had ballistic vests been worn on this night they would not have prevented the face and neck injuries which M and J received. Nevertheless it was reassuring to hear at the inquest that since this incident, the NSW Police Force has purchased sufficient ballistic vests to ensure that Probationary Constables are able to be issued with them.

Regarding the absence of cover and concealment, DI Waters acknowledged that the environment afforded the officers almost no options to remedy this. However one option they might have considered prior to entering the front yard was to direct PC Petty to move their police car to a position directly outside A's driveway. From this position the officers could have attempted to engage A with the benefit of at least some protection.

I accept that there were flaws in the risk assessment and in aspects of the plan which the officers attempted to execute that night. This led to the implementation of a plan which underestimated the risks confronting the officers as they approached A and tried to engage him. There is however no evidence that had they taken a different approach this would have prevented A's death. I want to endorse two further points made by DI Waters in his evidence.

The first is that the situation facing the police officers that night was volatile with high potential to escalate in unpredictable ways. An element of hindsight bias inevitably comes into play when such situations are later analysed. This reality must temper any criticism of shortcomings in the planning that took place that night.

The second point is that the three officers and in particular Sgt Johnston acted with great courage and professionalism in the terrible aftermath of the shooting. Sgt Johnston and PC Petty returned to their fellow officer and dragged her to a safer place, in circumstances where they were completely without cover and knew A was still armed. Still not knowing whether A remained an active shooter, they ensured officer McMurtrie received first aid and called for reinforcements. Until these arrived Sgt Johnston refused to leave the scene until he had briefed the new officers and ascertained with some degree of certainty that A was no longer a threat. I sincerely hope that Sgt Johnston drew comfort from hearing DI Waters commend him highly for his bravery.

Had the police officers received adequate training regarding high risk situations?

The training records of officers Johnston and McMurtrie were tendered at the inquest. These recorded that Sgt Johston had completed online training modules in Policing High Risk Situations, but officer McMurtrie had not, although she had received training in a number of related areas. As noted however she is no longer a serving police officer due to her injuries, and there is therefore no recommendation to be made in this regard.

The question of recommendations

I accept the closing submission of Counsel Assisting, that the shortcomings in the police officers' risk assessment cannot be attributed to deficiencies in the materials used to train officers in high risk situations.

I accept that the definition of a 'high risk situation' in the NSW Police Force Operational Manual cannot be prescriptive, given the wide range of incidents which police face on any given day. The Operational Manual adopts the pragmatic approach of providing a non-exhaustive list of factors which may characterise a situation as high risk, followed by explanations of what practical action is required. This instruction is augmented by face to face and online training in high risk scenarios.

On behalf of B, it was submitted by Mr Evenden that the Commissioner could consider amending the existing definition of a high risk situation, which appears at paragraph 60 above. Mr Evenden's proposal was that it be amended, such that a situation be considered high risk where the real or impending violence or threat to be countered *'is such that a degree of lethal force would be justified'*. However in my view this proposal would unduly restrict the circumstances in which a situation can be considered 'high risk'. As argued in the submissions made on behalf of the Commissioner, there may be high risk situations where the threat to be countered requires a lesser option than that of lethal force. This should not preclude the situation from receiving a 'high risk' classification and the practical responses that are appropriate to it. I have concluded that there is no basis to make any recommendations arising out of the tragic circumstances of A's death.

Formal Finding:

Identity
The person who died is A.

Date of death
A died on 18 January 2019.

Place of death
A died at Glen Innes NSW 2370.

Cause of death
A died of a gunshot wound to his head.

Manner of death
A died when he shot himself to the head while a police operation was underway.

33. 49616 of 2019

Inquest into the death of Francis Sawle. Finding delivered by DSC Grahame at Lidcombe on the 12 February 2020.

Mr Sawle was 82 years of age at the time of his death on 13 February 2019. He was serving a custodial sentence and had been transferred from Long Bay Prison Hospital to the Prince of Wales Hospital, Randwick NSW.

A post mortem examination was conducted on 18 February 2019. The forensic pathologist conducting the examination recorded the cause of death as "acute myocardial infarction", with an underlying cause of ischaemic heart disease. She noted that Mr Sawle also suffered interstitial lung disease with pneumonia. His death followed a period of worsening renal function and chest pain.

The role of the coroner

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

In this case there is no dispute in relation to the identity of Mr Sawle, or to the date, place or medical cause of his death.

Nevertheless, where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is detained in custody the state is responsible for his or her safety and medical treatment. It is important to review all inmate deaths, including those which appear to be have been naturally caused so that we have confidence that each prisoner has received adequate and appropriate medical care.

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

Scope of the inquest

The inquest took place on 12 February 2020. A two volume brief was tendered including police statements, photographs, prison and medical records. The officer in charge of the investigation, Senior Constable Victoria Stein was called to give brief oral evidence.

Background

Mr Sawle was born on 30 April 1936. On 2 March 1957 he married and the couple had six children together. For reasons I do not intend to outline, Mr Sawle was later estranged from his family. Prior to his arrest, Mr Sawle was socially isolated and reportedly living in his car or in temporary accommodation.

Mr Sawle had a long history of heavy smoking and alcohol use.

Mr. Sawle's medical history

Prior to entering custody, Mr Sawle did not visit a doctor regularly. It appears that he had not sought any medical advice for several years. Medical records indicate that in the 1980s, he underwent a coronary artery bypass grafting at St Vincent's Hospital. During his Reception Screening Assessment with Justice Health Mr Sawle reported a history of having been treated for skin cancers but was unable to remember the dates. It was known that Mr Sawle was allergic to penicillin.

Prior to his sentencing in the District Court a medical report was provided that detailed various clinical notes and documents within Mr Sawle's electronic health records and file. This report indicated that Mr Sawle suffered from; ischemic heart disease, had a history of smoking and bypass grafts, chronic renal impairment, renal mass, ECHO – mild aortic and mitral regurgitation, aorteosclerosis, cognitive impairment, generalised cerebral atrophy and moderate hippocampal atrophy, mild glaucoma, weight loss with constipation, prostatism, urinary incontinence, guard affect and general anxiety.

He later exhibited ongoing declining cognitive function.

Mr. Sawle's criminal history

On 22 September 2015 Mr Sawle was arrested and charged with six serious offences pursuant to the *Crimes Act* 1900. Mr Sawle was bail refused on these charges and remained bail refused until he was sentenced to full time custody.

On November 22, 2018 at the Downing Centre District Court, Mr Sawle was convicted of all six sequences after pleading guilty on the day that his trial was scheduled to start. He was sentenced by Acting Judge C O'Connor to an aggregate period of imprisonment of ten years, commencing on September 22, 2015 and expiring on September 21, 2025. A non-parole period of five years was set, which was due to expire on September 21, 2020.

Medical treatment in custody

On 22 September 2015 Mr Sawle was transferred to Grafton Correction Centre.

A mental health assessment was completed that showed that Mr Sawle was not at risk to himself or others but had delusional thoughts of being able to control natural disasters. He was placed in shared accommodation due to his age and frail capacity.

In November 2015, Mr Sawle was reviewed by a general practitioner (GP) in custody and was referred for a CT scan of the brain and to a geriatrician due to his cognitive deterioration. On 2 January 2016, Mr Sawle was transferred to the Long Bay Correctional Centre (LBCC) to attend a CT of his brain. That CT showed generalised mild cerebral atrophy.

On 6 January 2016 Mr Sawle was transferred to the Kevin Waller Unit (KWU) at the LBCC which is more suitable for elderly patients. While housed at the KWU, Mr Sawle was seen regularly by the Primary Care Nurse (PCN) for physical observations, which included blood pressure, pulse, temperature and weight recordings. Mr Sawle had several recurring issues during his time in custody including skin tears which were often dressed and monitored, substantial weight loss, lack of appetite and constipation.

On 4 February 2016 Mr Sawle was reviewed by a GP for high blood pressure and commenced on Perindopril to manage hypertension. He was also commenced on Risperidone to manage delusions.

On 22 March 2016 Mr Sawle was reviewed by an ophthalmologist and diagnosed with early glaucoma. He had follow-up appointments and a plan for cataract surgery was discussed.

Mr Sawle was diagnosed with chronic renal impairment and attended consultations at Prince of Wales Hospital. An ultrasound on 26 September 2018 showed a vascular mass at the base of the left kidney and this was to be further investigated at the renal clinic at Prince of Wales Hospital.

On 12 September 2017 an endocardiograph was conducted at POWH which identified mild aortic and mitral regurgitation and aortosclerosis.

On 30 January 2019 Mr Sawle was transferred to Prince of Wales Hospital for a planned CT of his upper abdomen and pelvis with contrast. This CT was completed on 31 January and showed a large left renal heterogeneous lobulated mass which is was most consistent with a renal cell carcinoma and atrophic right kidney. During his hospital stay, Mr Sawle experienced a cardiac event and was transferred to the Coronary Care Unit for cardiac monitoring. On 1 February 2019 Mr Sawle underwent an angiogram which showed that he had severe triple vessel disease. It was determined that Mr Sawle did not appear to be a candidate for surgical intervention given the triple vessel cardiac disease and likely interstitial lung disease (ILD). The diagnosis of Alzheimer's disease was also confirmed.

An Advanced Care Directive, in the form of a non-resuscitation plan, was prepared and signed by Dr Peiynan Li on 6 February 2019. Mr Sawle was not for CPR or referral to the ICU. The resuscitation plan indicated that Mr Sawle was "terminally ill suffering from a variety of medical ailments; heart and lung disease, chronic kidney disease; renal cell carcinoma and dementia."

On 8 February 2019 Mr Sawle was discharged from Prince of Wales Hospital and returned to the Kevin Waller Unit. About 5am on 9 February 2019 Mr Sawle had a sudden onset of severe respiratory distress and chest congestion. An ambulance was called to take Mr Sawle from Long Bay Hospital to Prince of Wales Hospital. He was escorted by Correctional Officers. Mr Sawle was admitted as a patient at Prince of Wales Hospital.

The palliative care team were consulted and care was provided for palliative care symptoms under the cardiology team. Comfort measures included medication, mouth care and positioning.

Events leading up to the death of Mr. Sawle on 13 February 2019

About 7am on 13 February 2019 NSW Health Nurse Cabatingan attended to Mr Sawle and observed Cheyne-Stokes breathing. Cheyne-Stokes breathing is an abnormal pattern of breathing that is sometimes associated with imminent death. About 8am Nurse Cabatingan continued palliative treatment, including medication.

On 13 February 2019 Senior Correctional Officer (SCO) Chris Daniels was working with Correctional Officer (CO) Amit Khanna at Secure Unit Cell 1 at Prince of Wales Hospital. About 8.45am the Correctional Officers were approached by NSW Health Nurse Cabatingan seeking entry to Mr Sawle's cell to observe and reassess his current condition. Upon entry Nurse Cabatingan examined Mr Sawle who was then unresponsive and appeared deceased. As there was an advanced care directive in place and Mr Sawle was not for CPR, no CPR was performed. Correctives Officer Khanna commenced a time log and secured the cell.

At 9.55am, Dr Andrew Dind pronounced life extinct and completed the Form A (Report of Death of a Patient to the Coroner). I have had the opportunity to review medical records and am satisfied the medical care and treatment offered to Mr Sawle was appropriate in all the circumstances.

Investigation following the death of Mr Sawle

About 9.50am on 13 February 2019 police attended the Prince of Wales Hospital Secure Unit Cell 1. A Crime Scene was established and maintained. A test of the knock-up alarm was conducted which was found to be in functioning order. Photographs were taken and Mr Sawle's body was transferred to the Department of Forensic Medicine at Lidcombe. CCTV was later obtained and reviewed and was in accordance with the accounts of Corrective Service Officers and NSW Police.

Mr Sawle was formally identified by way of fingerprint analysis.

A limited autopsy report was prepared by Doctor Dianne Little on 7 March 2019. Doctor Little concluded that the direct cause of death was acute myocardial infarction with an antecedent cause of ischaemic heart disease. A post mortem CT scan confirmed an enlarged heart with calcification of the coronary arteries. Also noted on the CT scan was a mass in the left kidney, in keeping with a renal cell carcinoma. No significant injuries were seen to the body, with only senile ecchymoses (bruising associated with fragile elderly skin) on the arms and legs.

There were no suspicious or unexpected findings. I am satisfied that Mr Sawle's death was due to natural causes and that he was provided with appropriate care. He had significant co-morbidities at the time of death.

Formal Finding:

Identity

The person who died was Francis Sawle

Date of death

He died on 13 February 2019

Place of death

He died at Prince of Wales Hospital, Randwick NSW

Cause of death

He died of an acute myocardial infarction caused by ischaemic heart disease.

Manner of death

He died in hospital of natural causes.

34. 53379 of 2019

Inquest into the death of Thomas Kedwell. Finding delivered by DSC Forbes at Lidcombe on the 12 June 2020.

This is an inquest into the death of Thomas Kedwell. Mr Kedwell was serving a term of imprisonment at Long Bay Correctional Centre at the time of his death. He died at Prince of Wales Hospital, Randwick on 15 February 2019 aged 66.

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

- the identity of the deceased;
- the date and place of the person's death;
- the physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

Section 23 of the *Coroners Act 2009* makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that the care of that person was appropriate and adequate.

Mr Kedwell

Thomas John Kedwell was born on 1st August 1952 in Brisbane, Queensland. Mr Kedwell divorced from his wife about thirty years ago and had eight children. During his employed life he worked as a heavy machinery operator throughout Queensland.

On 10 August 2018, Thomas Kedwell was sentenced to 3 years and 8 months imprisonment to commence from 18 November 2017 and conclude on 17 July 2021, with a non-parole period of 2 years and 3 months. His non parole period was due to expire on 17 February 2020.

Mr Kedwell had a long history of heavy drinking, smoking and intravenous drug use. On admission into custody at Grafton Correctional Centre in August 2018 he reported that he had surgery in 2017 for throat cancer which resulted in a total laryngectomy and tracheostomy followed by radiotherapy. He also reported a history of Chronic Obstructive Pulmonary Disease, hypothyroidism and angina that were managed with medication. The Justice Health and Forensic Mental Health Network report indicates that Mr Kedwell was unable to talk despite having a voice prothesis in situ and communicated by pen and paper.

Mr Kedwell also received a prescription of Suboxone as part of an opioid substitution treatment in the community which continued into custody. He was regularly assessed by a Drug and Alcohol nurse specialist and Drug and Alcohol doctor in custody.

Whilst in custody at Grafton Mr Kedwell initially refused to attend any medical appointments in Sydney as this was too far for his family to visit him. But, in November 2018 when he was referred to an oncologist and speech pathologist in Sydney he agreed to be transferred.

On 4 December 2018, Mr Kedwell was transferred to Long Bay Hospital. On 5 December 2018, Mr Kedwell attended a CT scan at Prince of Wales Hospital which indicated quite extensive and bilateral subcarinal lymphadenopathy. He was transferred to the Medical Subacute Unit at Long Bay Hospital for follow up care.

On 14 December 2018, Mr Kedwell was reviewed by an oncologist at Prince of Wales Hospital to discuss further investigations and was referred to the respiratory department for an Endobronchial Ultrasound. This was completed on 20 December 2018.

Mr Kedwell underwent a Positron Emission Tomography at the Prince of Wales Hospital on 21 December 2018, which showed the appearance of malignancy with extensive nodal involvement of the right cervical, mediastinal, bilateral pulmonary hilar regions along with several nodes below the diaphragm.

An urgent appointment was made for Mr Kedwell with the oncologist on 9 January 2019 and he was referred to the palliative care Team.

On 24 January 2019, Mr Kedwell was transferred from Long Bay Hospital to Prince of Wales Hospital for the assessment and treatment of his neuropathic pain and bilateral lower leg odema, secondary to lymphadenopathy. He was admitted to the Prince of Wales secure unit and did not return to Long Bay Hospital. Whilst at Prince of Wales Hospital he was regularly reviewed by the palliative care team.

On Monday 11 February 2019, Mr Kedwell was scheduled to undergo oesophageal dilation however due to surgical conflicts and Mr Kedwell's medical condition and health it was rescheduled for the 15th February 2019.

Between the 11th and 15th of February 2019, Mr Kedwell complained of chest pains which caused him to undergo a computed tomography scan and X-ray which revealed Mr Kedwell suffered from a collapsed lung, pneumonia and a bowel obstruction. Relevant medical treatment was prescribed and administered.

15 February 2019

About 8.30am on 15th of February 2019, Mr Kedwell was transferred to pre-operation where he was assessed by the anaesthetist. Based upon Mr Kedwell's deteriorating health and his presentation on the day, the anaesthetist decided to cancel the operation. About 9.00am, Mr Kedwell was transferred to Park East 7 Ward.

Shortly after 9.30am, nursing staff conducted laryngectomy suctioning where a moderate amount of tenacious secretions were noted. Mr Kedwell had previously signed a not for resuscitation order. Around 10am, the nursing staff administered 4mg Morphine for dyspnoea and comfort.

About 11.20am, nursing staff who were present with Mr Kedwell noted that he displayed no vital signs. About 11.30am, Doctor Khor issued a 'Verification of Death' certificate.

An autopsy was performed by Doctor Kendall Bailey on 21 February 2019. Doctor Bailey concluded that the direct cause of death was respiratory infection with the antecedent cause being complications of metastatic carcinoma.

The gaol and health records reveal Mr Kedwall's care and treatment were appropriate. No family member or associates have raised any care and treatment issues whilst he was in custody.

Formal Finding

The identity of the deceased

The deceased person was Thomas John Kedwell

Date of death

Died on 15 February 2019

Place of death

Died at Prince of Wales Hospital, Randwick, NSW

Cause of death

The death was caused by respiratory infection on a background of metastic carcinoma

Manner of death

Natural causes

35. 59022 of 2019

Inquest into the death of Michael Murphy. Finding delivered by State Coroner O'Sullivan at Lidcombe on the 30 November 2020.

This is an inquest into the death of Michael Murphy, who passed away on the 21st of February 2019 at Long Bay Correctional Centre.

Mr Murphy was born in 1952. At the time of his death he was serving a custodial sentence and had been transferred to Long Bay Hospital due to deteriorating health. He had a lengthy medical history and was in palliative care at the time of his death. No issues have been raised in relation to his care or treatment.

Michael Murphy was in the lawful custody of Corrective Services NSW ("CSNSW") at the time of his death. Accordingly, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act 2009 ("the Act").

The role of a Coroner and purpose of this inquest

Under s81 of the Act a Coroner, is to make findings as to:
The identity of the deceased;
The date and place of the person's death;
The physical or medical cause of death; and
The manner of death, in other words, the circumstances surrounding the death.

Pursuant to s 82 of the Act a Coroner is empowered to make recommendations concerning matters such as public health or safety issues arising out of the death in question.

There is no controversy in this case as to Mr Murphy's identity, the date or place of his death. No outstanding questions have been raised in relation to the medical cause or death or in relation to the circumstances surrounding Mr Murphy's death.

Evidence at Inquest

A short inquest was held on 30 November 2020. The only witness called in the inquest was Detective Senior Constable Lisa Imisides who is the Officer in Charge of the investigation. The brief of evidence compiled by Detective Imisides was tendered (Ex.1).

Background

Michael Patrick Murphy was born in Sydney on the 31st of October 1952, to Leslie Murphy and Dolcie Croft. He is the eldest of nine children, and they resided together in various suburbs of Sydney. Mr Murphy moved out of the family home when he was 18 years old and lived with his maternal grandparents in Maroubra. He began a relationship and had a child, born in 1977.

Criminal History

Mr Murphy's offending commenced in the early 1970's. He was sentenced for break and enter and stealing offences in 1972 and spent time in custody. In 1973 he was convicted for robbery and break and enter offences and was sentenced to a total term of 12 years with a non-parole period of four years. He was released on parole on the 28th of May 1976. Mr Murphy breached his parole in 1978 and was ordered to serve the rest of his sentence, expiring on the 24th of August 1985. He was also charged with additional matters and an additional 8 years was added to his sentence, making his release date not until January 1993.

Mr Murphy escaped lawful custody on the 27th of December 1985 after being approved for work release.

On the 26th of February 1986, Mr Murphy was arrested and charged for offences relating to the assault, abduction and murder of Anita Cobby on the 2nd of February 1986. On the 10th of June 1987, Mr Murphy was found guilty of all charges and on the 16th of June, was sentenced to life in prison, never to be released.

Mr Murphy was placed in protective custody during his incarceration, mostly in relation to threats that had been made against him due to the nature of his offences. He also spent time placed in segregation due to threats he had made, including threats to contaminate food and threats of physical violence towards other inmates and corrective services staff.

Whilst in custody, he was subjected to random and targeted drug testing. He failed to comply with testing on the 8th of November 2011 and 20th January 2014. He had positive results on the 4th of August 2012 with Beta Blockers detected, and the 8th of February 2014 with Mirtazapine detected.

Medical Treatment in Custody

During his incarceration, Mr Murphy received treatment for numerous health-related issues. Between 1986 and 2014, he received treatment for asthma, drug use, epigastric pain, bleeding peptic ulcer, hiatus hernia, hearing loss, Hepatitis C, anxiety, self-harm and suicidal ideation.

Whilst in custody in Goulburn between 2014 and 2017, Mr Murphy cancelled numerous ultrasound and CT scans that were booked in Sydney. Between 2017 and 2018, he was admitted to hospital for management of ascites, requiring regular percutaneous drainage at Goulburn Hospital and Prince of Wales Hospital.

On the 23rd of March 2018, Mr Murphy was reviewed in a teleconference by two liver specialists. He was advised that he had a well differentiated Hepatocellular Carcinoma with smaller ones present in the left lobe and metastatic spread. He agreed to be transferred from Goulburn to Long Bay Correctional Centre for ongoing medical oncology review.

On the 5th of April 2018, Mr Murphy was reviewed, and advised that he had decompensated liver failure with Child-Pugh B, secondary to liver cirrhosis and Hepatitis C. He understood that his prognosis was poor, and comfort measures would be provided should he deteriorate.

On the 17th of May 2018, Mr Murphy was reviewed at Prince of Wales Hospital and was advised that Transcatheter Arterial Chemoembolization (TACE) may be an option, but was not a curative treatment and only aimed at managing symptoms. He was also advised that, due to his likely poor hepatic reserve, the procedure could put him into liver failure which could potentially be fatal. Nevertheless, Mr Murphy consented to the treatment. He underwent this procedure on the 29th of May and the 12th of June 2018, with no complications.

On the 9th of August 2018, Mr Murphy was again reviewed by oncology at Prince of Wales, who advised that, given recent drainage of ascites and good disease control, the TACE procedures should cease. On the 16th of August 2018, Mr Murphy agreed that he was not for cardiopulmonary resuscitation in the event of a cardiac arrest.

Events leading up to the death of Mr Murphy

Between December 2018 and February 2019, Mr Murphy was regularly reviewed by the medical team and received comfort care and symptomatic treatment. His condition was noted to be deteriorating.

On the 21st of February at 10:45pm, Mr Murphy was reported to be agitated, distressed, unable to communicate and moaning. He was administered 2.5mg of Midazolam subcutaneously and placed on his left side. At 11:55pm, nursing staff attended his cell to administer his regular medication, but he was not responsive, not breathing and had no pulse. He was subsequently pronounced life extinct.

Investigation following Mr Murphy's death

Police from Eastern Beaches Police Area Command attended, and a crime scene was established. Photographs were taken, and Mr Murphy's body was transferred to the Department of Forensic Medicine, in Lidcombe.

A post-mortem external examination was conducted by Pathologist Dr Rebecca Irvine on the 27th of February 2019, along with a full body CT scan. Dr Irvine found the direct cause of death to be "complications of chronic viral liver disease". Dr Irvine commented that the external examination revealed a chronically ill older man with ascites and that there was no significant acute injuries or evidence of neglect or maltreatment.

Formal Finding:

Identity
The person who died was Michael Murphy

Date of death
Michael Murphy died on 21st of February 2019.

Place of death
Michael Murphy died at Long Bay Correctional Centre, 1300 Anzac Parade, Malabar NSW.

Cause of death
The cause of Michael Murphy's death was complications of chronic viral liver disease.

Manner of death
Michael Murphy died of natural causes while serving a life sentence in custody.

36. 69926 of 2019

Inquest into the death of Dat Nhieu Ha. Finding delivered by DSC Forbes at Lidcombe on the 12 June 2020.

This is an inquest into the death of Dat Nhieu Ha. Mr Ha was serving a term of imprisonment at Long Bay Correctional Centre at the time of his death. He died at Prince of Wales Hospital, Randwick on 4 March 2019 aged 45.

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

- the identity of the deceased;
- the date and place of the person's death;
- the physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

Section 23 of the *Coroners Act 2009* makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that the care of that person was appropriate and adequate.

Mr Ha was born in Vietnam on 10 April 1973. At the age of 5, during the Vietnam War, he came to Australia with his parents and younger brother.

Prior to his incarceration, Mr Ha lived with his elderly mother and adult nephew. He never married and had no children. On 21 September 2018 he was sentenced to a term of imprisonment of 3 years and 11 months, with a release date of 30 November 2021.

Mr Ha was classified as minimum security, he was transferred between Amber Laurel Correctional Centre, the Metropolitan Remand and Reception Centre, John Maroney Correctional Centre, Goulburn Correctional Centre and Long Bay prison, at each interval of his incarceration movements Mr Ha was assessed by justice health and claimed to have no health issues. Mr Ha had a long history of drug abuse; heroin, cannabis and methyl-amphetamine commencing in the late 1990's. He was also a heavy cigarette smoker.

On 11 January 2019 Mr Ha was admitted to Goulburn Hospital following a referral from Justice Health attached to Goulburn Correctional Centre. He complained of a pain to his right armpit, a 4 – 5 kilogram weight loss, a 4-week cough with white sputum, night-time sweats and shortness of breath on exertion. A chest x-ray identified a partial lung collapse on the left side. A CT scan identified a mass sized 39mm by 50mm by 52mm located adjacent to the left lung.

Mr Ha's right lung was clear, a cyst was located on Mr Ha's right kidney. He was referred to see a respiratory physician and have a bronchoscopy at The Canberra Hospital.

Mr Ha was prescribed antibiotics, Ibuprofen, Endone, Paracetamol and Clexane for treatment of likely pneumonia. Mr Ha remained at Goulburn hospital until the 16 February 2019 due to the risk he was suffering tuberculosis. He complained of minor rib pain however was eating a normal diet with fluids, was showering himself and passing urine as required.

On 16 January 2019, Mr Ha was admitted to The Canberra Hospital. On 18 January 2019, he underwent a bronchoscopy, he was diagnosed with terminal lung cancer. The cancer prognosis was described as treatable with a 1-2-year prognosis of life. He was discharged from The Canberra Hospital on 23 January 2019 and returned to Goulburn Prison. He continued treatment as an outpatient with a prescription for antibiotics, pain relief medication and steroids ahead of radiation treatment.

On 1 February 2019 an examination of Mr Ha's brain revealed multiple lesions at the grey-white matter junction, this was considered in keeping with a diagnosis of metastasis, commonly known as secondary cancer. On 4 February 2019 a further PET scan noted a pathological fracture of Mr Ha's seventh right-side rib. A pathological fracture is a fracture caused by disease, in lieu of an injury.

Mr Ha consented to semi-urgent radiotherapy and received five treatments of radiotherapy to the lesions on his lung and lower right rib.

On 7 February 2019 Mr Ha was transferred to Long Bay Correctional Centre Hospital to undergo chemotherapy for his brain cancer, this also placed him closer to his family. On 15 February 2019 Mr Ha complained to the Justice Health Nurse of abdominal pain, he had not had a bowel movement in four days prior and suffered a distended abdomen. He was given two enemas which had a minimal effect.

Mr Ha was admitted to the Prince of Wales Annexe Ward suffering a small bowel perforation related to his cancer diagnosis. He was considered unsuitable for surgery due to his advance cancer diagnosis. The bowel perforation was managed by pain relief, intravenous fluids and antibiotics. He was considered too unwell for any form of active cancer treatment. On 25 February 2019 Mr Ha was diagnosed with hospital acquired pneumonia, he was treated with antibiotics until the 1 March 2019. On 1 March 2019, Mr Ha's oxygen levels began to decrease, he was suffering shortness of breath and fluid retention in both feet. Mr Ha's treatment continued in palliative care with pain management. His nephew was advised by treating doctors of the regression in his health. On 3 March 2019, Mr Ha's health had markedly deteriorated, he was no longer conscious however appeared comfortable. His nephew was informed, and his treatment changed from active treatment to comfort care.

At 10:30pm Mr Ha was non-responsive but appeared comfortable, his breathing was shallow and laboured. At 11:15pm Mr Ha became agitated and appeared in pain, he was repositioned and administered pain relief, Mr Ha settled, his respiration remained shallow and laboured. Observations continued by medical staff with no change to his condition. At 1:25am on the 4 March 2019 he was declared deceased.

On 11 March 2019 Pathologist Rebecca Irvine completed an external examination of Mr Ha. She determined that Mr Ha died due to abdominal sepsis on a background of metastatic lung carcinoma. The gaol and health records reveal Mr Ha's care and treatment were appropriate. No family member or associate of Mr Ha have raised any care and treatment issues.

Formal Finding:

The identity of the deceased

The deceased person was Dat Nhieu HA

Date of death

Died on 4 March 2019

Place of death

Died at Prince of Wales Hospital, Randwick, NSW

Cause of death

The death was caused by abdominal sepsis on a background of metastatic lung carcinoma

Manner of death

Natural causes

37. 85457 of 2019

Inquest into the death of Dwayne Johnston. Inquest suspended and papers referred to the DPP by State Coroner O'Sullivan at Lismore on the 26 November 2020.

In accordance with *Section 78 of the Coroners Act* 2009 the Coroner, following the hearing of evidence and satisfied there is a prima facie case against a known person with a reasonable prospect of a conviction, suspended the inquest and referred the papers to the Director of Public Prosecutions

38. 106322 of 2019

Inquest into the death of Edward Carter. Inquest suspended by DSC Grahame.

Upon information that a person has been charged with an indictable offence in connection with this death the inquest was suspended by DSC Grahame in accordance with the *Coroners Act 2009.*

39. 114274 of 2019

Inquest into the death of XY. Finding delivered by DSC Grahame at Lidcombe on the 11 December 2020.

This inquest concerns the death of XY. XY was a proud Aboriginal man and only 45 years old when he was found deceased by officers from the NSW Police Force ("NSWPF") at around 4.30am on the morning of 11 April 2019 at Z Street, Broken Hill. XY's death was as a result of a self-inflicted gunshot wound. NSWPF officers had attended the Z Street property a short time prior to his death.

XY was the former de facto partner of his childhood sweetheart, E, and together they had four children: A, B, C and D.

Although the last years of XY's life were somewhat tumultuous, his sister, W generously told the court of XY's jovial nature and how he had the ability to make jokes to lighten any situation. He had a loud and infectious laugh and displayed great love for his family throughout his life. As a young man, he had shown great promise as a potential engineer in the aviation industry, but turned down opportunities in Sydney to stay with E and his family in Broken Hill. Sadly, a series of tragic events, including the death of his younger sister and his mother, isolated XY from his family as he struggled with his grief and became increasingly depressed, eventually turning to alcohol and methylamphetamine to cope. W generously shared this very private aspect of XY's struggle to underscore the need for appropriate rehabilitation services in the far west of NSW. XY had repeatedly expressed his desire to enter rehabilitation, but a lack of appropriate services close to the support network of his family was a significant barrier to seeking assistance.

XY cherished his role as a grandfather, and his granddaughters - one who was yet to be born at the time of his death - gave him great hope for the future. They were a driving force for XY to continue with his rehabilitation efforts.

I am grateful for the attendance of XY's family at the hearing, and for their generosity in sharing their loss with this court. The profound grief felt by XY's family was self-evident, however it is a testament to XY's family that amidst their own loss, they were also able to acknowledge the impact XY's death had on the attending NSWPF officers. I acknowledge their significant loss and thank them for sharing their memories of XY with this court.

The role of the coroner

The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of death. The coroner is also to address issues concerning the manner and cause of the person's death: s. 81 *Coroner's Act 2009* ("the Act").

A coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future: s. 82 the Act.

XY's death was self-inflicted and occurred during the course of a police operation. XY shot himself with a stolen 12 gauge sawn-off shotgun some minutes after the arrival of NSWPF officers, and whilst they were on-scene. Accordingly, the holding of an inquest by a senior coroner was considered mandatory pursuant to ss. 23(c) and 27 of the Act.

In part, the purpose of an inquest in such circumstances is to examine whether any lessons or improvements can be taken from a particular incident, with a view to improving police systems, policies, practice or training, even potentially preventing future deaths if at all possible.

The issues

A list of issues was prepared before the proceedings commenced and circulated to the parties (namely, the Commissioner of NSWPF). The issues explored at the inquest included:

- **Determination of the statutory findings required by s. 81 of the *Coroners Act 2009*;**
- **Whether the applicable NSW Police Force policies and procedures have been followed, including with respect to:**
- **the response of first responders to the high risk situation;**
- **the Critical Incident Guidelines; and**
- **Whether any recommendations are necessary or desirable in connection with XY's death.**

The evidence

The court took evidence over one hearing day. The court also received extensive documentary material, compiled in a two-volume brief of evidence. This material included witness statements, medical records, photographs and video recordings, as well as court records. While I do not intend to refer to all of the material in detail in these findings, it has been comprehensively reviewed and assessed.

It was of great assistance to this court that two of the involved officers utilised their body-worn video ("BWV") cameras. This provided a contemporaneous record of the events that unfolded on 11 April 2019, and it assisted greatly in confining the issues under consideration. In addition to oral evidence from the officer in charge, Detective Sergeant Gary Quilter, four witnesses were called to give oral evidence. These were the officers involved in the incident on 11 April 2019, namely Constable Thomas Fajks, Sergeant Patrick Schaefer, Constable Dimitrios Margiolis and Constable Robert James.

I was impressed with the frankness with which the involved officers reflected on the events surrounding XY's death at the hearing. The officers were still relatively new to the NSWPF on 11 April 2019, yet handled themselves commendably when faced with an uncertain, terrifying and serious situation. Sadly, the officers could not prevent XY's death, as it seems he had resolved to take his own life. However, their composure in the circumstances ensured that every effort was made to engage with XY, and that his family was able to be safely removed from the Z Street premises without harm.

Background

XY's relationship with E began in 1988. They were childhood sweethearts. The pair lived together on and off from that time up until the time of XY's death, although they never married. As mentioned earlier, the pair had four children. XY struggled with mental health issues throughout his life. Police had previously attended to XY in relation to threats of self-harm. In 2008, XY was scheduled by police under s. 22 of the *Mental Health Act 2007.*

From around 2014, XY's life was marred by a series of tragic events. As already outlined, XY had to endure the painful loss of his younger sister, and in November 2018, the passing of his mother. Although there were periods of separation between XY and E, from around August 2017, XY and E began living together again at Z Street, Broken Hill. B and C also lived at the Z Street house. The relationship between XY and E was volatile and the couple would fight regularly.

E believes that after the death of his mother, XY commenced using "heavy drugs". She noticed significant changes in his behaviour and moods, during which he would often be awake for days without sleeping. E had a number of Apprehended Domestic Violence Orders taken out against XY (all of which had expired by 11 April 2019) and by January 2019, E had asked XY to move out of Z Street permanently.

In the months prior to his death, XY was observed to be drinking heavily and regularly using methylamphetamine ("Ice"). According to his children, XY would regularly threaten to kill himself. The court heard evidence that around 25 March 2019, his daughter A's partner, F, found XY at their house crying. XY said he had tried to kill himself earlier that day and produced a shotgun. F (sensibly) took the live rounds from the gun (although XY said he had more) and managed to change XY's mood on that occasion. E had never seen XY with a gun, although XY had told her previously that he was able to get hold of one.

The events prior to the critical incident

After moving out of Z Street in January 2019, XY had called and text messaged E at semi-regular intervals, requesting to move back in. In the week before his death, the frequency of those calls and text messages increased to the point where XY was contacting E several times each day. On Sunday 7 April 2019, XY attended Z Street for ten minutes. E said he was "calm" that night. C also recalls her father visiting around this time to obtain cigarettes and engaging in a hushed conversation with E.

On the evening of 10 April 2019, police officers attended A's house (where XY was living) in order to serve a Court Attendance Notice on XY, relating to an alleged incident at the Wilcannia Golf Club that had occurred on 5 April 2019. They were unsuccessful on this occasion.

During the course of the day on 10 April 2019, XY repeatedly text messaged and called E, asking to come over. E replied telling him not to come.

Events on 11 April 2019

At approximately midnight on 11 April 2019, A saw her father in the kitchen of her home. He said to her: "I'm just having my last drink before I go to rehab". A did not think this was unusual, given that they had previously discussed XY attending rehabilitation for his drug and alcohol use. At approximately 3:30am on 11 April 2019, B awoke to the sound of someone banging on the front door at Z Street and E telling that person to "go away". E had been woken by XY poking his head through a broken window in her bedroom (which he had broken about five weeks previously) asking to be let into the house. E told him to leave and that she would call the police if he didn't. E could smell alcohol on XY's breath.

XY proceeded to smash another window in E's bedroom and gained access to her room. B, hearing the window smash, barricaded XY inside the bedroom. Around this time, E made her first call to police. B then heard another window smash in the lounge room. C and B both saw their father banging on the window, at one point aiming what looked like a double-barrelled, sawn-off shotgun at B. B told his mother and sister to hide in the bathroom and call the police. B also called '000' himself at around 3.52.30am, giving the '000' telephonist key information, including stating: "My father's there with a double-barrelled shotgun".

The critical incident

On 10 April 2019, "Team 1" were working the night shift at Broken Hill Police Station. This team included Sergeant Schaefer, the team leader and shift supervisor; Constable Thomas Fajks; Leading Senior Constable Sutton; Constable Robert James; and Constable Dimitrios Margiolis. As to the experience of those officers, Sergeant Schaefer attested from the academy on 19 December 1986 and was in his 33rd year of service. Constable Margiolis attested from the academy in August 2016; Broken Hill was his first posting – he had been there for 2 and ½ years. Constable James attested from the academy on 28 April 2017, and was then posted to Broken Hill Police Station, where he had been undertaking General Duties since. Constable Fajks attested from the academy on 22 February 2019; he was thus in his seventh week of duties at the time of the incident.

The shift of the NSWPF officers started at 6:00pm on 10 April 2019, and was scheduled to finish at 6:00am the following day. At around 3:40-3:45am on 11 April 2019, Constable James received a phone call at Broken Hill Police Station to respond to a domestic violence incident at Z Street. The female caller identified herself as XY's ex-partner (E). Constable James gave oral evidence that E was (understandably) quite frantic and was unable to provide specific details.

Eventually she became frustrated and passed the phone to a younger female (C) who said "XY is here, I have an AVO with him and he is smashing the windows". Constable James told the court that C sounded panicked and that he could hear windows smashing in the background. Constable Fajks was sitting in the station and heard the call come in, listening in (as it was on speaker phone) because not much was happening at this time and "someone was quite distressed on the other end". Constable Margiolis was passing through the front of the station and heard the job (including the tone of the caller and the smashing of windows) – he stated that as it was a domestic violence incident, they knew they had to go. Constable James submitted the CAD job, locked the computer and put on his load bearing vest. In oral evidence, both Constable James and Constable Margiolis said they knew it was an urgent job. During the call, there was no reference to any weapons.

Second call from E

Whilst the Constables were leaving the station, Sergeant Schaefer, who was the custody manager that evening, took a second call from the "same lady" at Z Street.

Sergeant Schaefer stated that there was no update provided in this call – it was just: "He's here, he's smashing the windows. He's smashing up the place". In oral evidence, Sergeant Schaefer told the Court he stayed on the phone with the woman to make sure that nothing happened until the police got there.

For her part, E said that she called the police again, recalling "I was on the phone when I heard XY smashing the front lounge room windows. The police arrived almost as that was happening. The police got to the house within 10 minutes of the first phone call. They were really quick".
BC16 heads to the job

Constables James, Margiolis and Fajks left in vehicle BC16, with Constable Fajks driving the vehicle.

There were communications with radio en route: Constable Margiolis copied the job and called for location checks at Z Street – these came through from VKG confirming an enforceable AVO against XY, with C as the person in need of protection. The ILS [Integrated Licensing Service] confirmed that there were no registered firearms at the premises. That was all the information the NSWPF officers received. Again, there was no mention of any weapons being present at the house.

According to Constable Fajks, it took less than 5 minutes to arrive at the Z Street address.

Each of the involved officers gave detailed records of interview regarding the incident on 11 April 2019. Further, and as mentioned above, two of the involved officers (Constables Margiolis and Fajks) were wearing BWV cameras, and virtually the entirety of the police operation is captured in that audio and visual footage. The availability of the BWV footage and the directed interviews in particular, assisted me greatly in ascertaining the sequence of events on the morning of 11 April 2019. In light of the availability of this contemporaneous record, there is no contest regarding any evidence of the involved officer – I accept their evidence.

On arriving at Z Street, Constable Fajks parked "… further up than the driveway" at the neighbour's house (near the fence line between the houses). As the car was pulling across the front of the premises, Constable James saw a male figure (XY) wearing a fluorescent jacket running down the side driveway of the house (visible because of the jacket).

Constable James, got out of the car (with Constable Margiolis following), and started running towards the driveway, to "keep eyes on where the potential suspect may have been running". It was a "tight squeeze" between the car and veranda, and he had to go sideways to fit through the gap. He picked up pace running up the driveway, and saw the figure turn the corner of a fence. The driveway (30 to 40 metres long) had a fence either side and at the rear, there was another boundary fence; the person was "tucked away behind that corner" and "all of a sudden he's come back out holding a firearm … a long arm or rifle." He was positioned on the corner of the fence and had the firearm resting on or above a household bin. Constable James said the gun was aimed directly at him and his colleagues.

Constable Margiolis recalls Constable James yelling out words to the effect "Stop, police"; Constable Margiolis was at that stage a few metres behind him. Then Constable James yelled out words like: "There's a weapon involved, there's a gun, he's got a gun", and he saw him draw his gun and take cover "behind … sort of like … a fence line …or some gas bottles." This was the first time there was any mention of the firearm.

Both Constables James and Margiolis immediately drew their firearms, XY said something like "Get back", which Constable James took as a command, responding "ok, we're moving back"; he looked for cover straight away. This all occurred in a matter of seconds.

Constable Margiolis thought XY was under the influence of some sort of drug; he also said that he wanted to shoot police (amongst other inaudible words), and was waving his weapon around. Constable Margiolis said the "gist" of what he was saying was to make police shoot him. I accept that the officers were trying not to aggravate XY, but to keep him talking, and try to get proper cover; Constables James and Margiolis were communicating throughout, and trying to talk with XY, but according to the attending officers "wasn't giving much back", and "not very long into it", they lost communication and sight of him.

Reflecting on the incident, Constable James stated "… if I knew he had a firearm, … I probably wouldn't have been … runnin' after him." He saw that Constables Fajks and Margiolis were "still in no man's land with [him]", and yelled a command to "get cover, get cover"; and told them "I've got cover". He could hear Constable Fajks get on the radio; calling: "Broken Hill 16, urgent … POI has a gun … it's a long arm". Constable James could then see Constable Margiolis trying to retreat to get cover behind an air conditioning unit.

From the BWV footage, it is evident that both those officers had their torches facing XY, who still had his firearm pointed at them on either side of the driveway.

Constable James tried to speak to engage him and say "XY is that you?". XY was shouting along the lines of "Get back, get back … get your torch light off me ….". Constable James said – "I'll move back, … XY is that you? Just talk [to me]", or something along those lines, trying to engage him. Constable James then yelled to Constable Fajks to get their vests. Constable James had a "really good view" of XY from where he was in the alcove. He held cover as Constable Fajks brought the vests to the front of the property; he asked Constable Margiolis if he had cover – he could see XY with his gun pointed down the driveway.

XY kept yelling about the lights or "get back", and at one point said: "You need the gas bottle" – Constable James looked to his left, saw the gas bottle and thought it was "probably not a good idea to be standing [next to it] when he's got a firearm". He then said: "All right mate, XY, I'm movin', I'm movin' back now", and moved back to the start of the driveway behind the vehicle parked there.

The lighting down the driveway was "exceptionally dark".

Evacuation of the residence

After extricating himself from the driveway, Constable James then sought to evacuate the house where E, B and C were still hiding. Initially no one responded to his call-outs, but eventually he got a muffled response. Constable James tried to "coax them out of the house", saying it was "a bit of a slow process, they didn't want to come out to start with", but they eventually did.

Constable Fajks said he could hear Constable James "pulling the family out of the house".

E, B and C were evacuated to BC16, although they didn't get into the vehicle. Constable James then took over radio communications from Constable Fajks to ensure a clear message had been sent, including that the weapon was a long-arm, and that they had evacuated the civilians from the house.

Sergeant Schaefer's arrival

Almost immediately after receiving the second call from E, Sergeant Schaefer saw the CAD message relating to B's call – a 'priority 2' job containing information that the informant's father was at Z Street with a shotgun; he almost simultaneously heard the call from BC16 "Urgent, offender has a firearm, a long arm". He could not recall the substance much beyond that but "identified that the incident had escalated", and there was an individual at the address with a firearm. This was the first time Sergeant Schaefer was aware of the firearm – the second CAD job came up simultaneously with the call from BC16 on-scene.

Upon hearing that the junior officers were confronting an armed person of interest, Sergeant Schaefer immediately sought to support them by attending the scene (arriving by 4.00am). Once at the property, Sergeant Schaefer spoke to Constables James and Margiolis.

Sergeant Schaefer determined to set up a perimeter at that point, and ensure the safety of the family (who had been evacuated by that time).

After setting up the perimeter, Sergeant Schaefer proposed that they would then try and find a point from which to observe the interior of the shed, to see if XY was still there or not.

Shotgun is fired

Soon after, the sound of a firearm was heard. Constable James described it as a "loud bang" which sounded a bit muffled, as though it could have been contained, for instance, in the back shed: it didn't sound like it was "in clear air". At that time, police didn't know if XY had self-harmed or if it was "just a shot for the sake of firing a shot".

Sergeant Schaefer stated that whilst they were discussing what steps to take next "we heard what [he] believed was a discharge of a shotgun, coming from the bottom of the yard. It appeared to come from the shed that had, that, um, my colleagues pointed out the, um, offender may have gone into."

Sergeant Schaefer got on the radio and advised that shots had been fired.

It is apparent from the contemporaneous records (both the BWV footage and the CAD/VKG records), that the shot was fired around 4:02am (some 9 minutes after police have arrived). At this point, Sergeant Schaefer then returned to the station briefly as he had "dashed out" without his firearm. In oral evidence, Sergeant Schaefer said he realised his firearm had been forgotten around the time the shot was fired – he put his hand on his holster and realised it was missing.

Sergeant Schaefer's firearm was locked up in the safe outside the custody area (a requirement when performing custody management duties). He stated both in his recorded interview, and in substance, during his oral evidence at the hearing: "It's a standard operating procedure that, um, particularly if you are custody manager, and most of the time if you have to deal with a prisoner in the charge room or in the cells, you lock your firearm in one of the four key-lock safes provided outside the charge room."

Sergeant Schaefer estimated it took "certainly less than ten minutes" for him to retrieve his firearm and return to the scene. He left instructions to the officers to maintain a perimeter – "no one goes in or out … And I'll be back very quickly".

At Broken Hill Police Station, Sergeant Schaefer obtained his firearm, and put on a ballistic vest. He also signed out a body worn video camera - but when he put on the ballistic vest, could not find anywhere to hang it (although he spent some minutes trying to do so). Because of this, the camera was then left switched off in the car. Sergeant Schaefer then quickly returned to the scene.

Upon Sergeant Schaefer's return to Z Street, the NSWPF officers discussed their unfolding plan. Sergeant Schaefer determined that Constables Fajks and Margiolis should "maintain obs" on the driveway; he and Constable James went to a nearby house with a backyard that adjoined the laneway near the "possible stronghold", and looked over the fence.

Sergeant Schaefer could see the doors of the shed it was believed the offender had retreated into (although he could not see inside the shed). Sergeant Schaefer then concluded that XY had either committed self-harm or discharged one shot and decamped the scene.

Sergeant Schaefer decided that based on the situation it was worth the risk of approaching the shed to see whether XY was still there. He directed Constable James to come with him, and for Constables Margiolis and Fajks to stay at the head of the driveway at the "outer perimeter of the crime scene". At the front of the shed, Constable James placed his torch on the ground and rolled it to illuminate the inside of the shed; Constable James soon identified that XY was deceased with a gun-shot injury to the head. Sergeant Schaefer covered XY's body. Constable James observed that the firearm was in between XY's legs.

It was Sergeant Schaefer, as the senior officer, who advised E that XY had killed himself. He did so with much empathy and grace, which speaks to his considerable experience within the NSWPF. The family was then permitted to return to the house but told not to go past the back door/into the yard. Ambulance officers subsequently attended the Z Street address and confirmed that XY was life extinct. XY was transferred to Broken Hill Base Hospital, where on the evening of 11 April 2019, Dr Andrew Oliensky verified XY's death on the basis that the injuries were incompatible with life.

Critical Incident investigation

A critical incident investigation was declared by Assistant Commissioner Geoff McKechnie at 5.29am.

As to the involved officers on scene, Sergeant Schaefer said he left about 5.15am, returning directly to the police station. He drove himself back in BC14; the other officers – Constables James, Margiolis and Fajks – came back in BC16. This joint conveyance of the involved officers, without the presence of at least an independent officer, raised concerns as to their separation (in the interests of protecting the integrity of their evidence) under NSWPF Critical Incident Guidelines (the "Guidelines").

As to whether there was any conversation regarding the incident, all officers gave evidence that they did not discuss the details of the incident on the short trip back to the station. Constables Margiolis and James gave oral evidence to the same effect. During oral evidence, Constable James was unclear as to whether any direction was given not to discuss the incident, initially stating the first direction was back at the station, but that it was possible Sergeant Schaefer may have given such a direction on scene. For his part, Sergeant Schaefer said he recalled telling the officers not to talk about the incident. He also explained there were no cars available to transport them separately.

On 11 and 12 April 2019, directed interviews were conducted with each of the involved officers (which included certain of those officers reviewing footage from the body worn cameras prior to participating). Detective Sergeant Gary Quilter, Investigations Manager of the Central North Police District, was ultimately appointed the Senior Critical Incident Investigator.

Post mortem examination and XY's cause of death

On 17 April 2019, Dr Lorraine Du Toit-Prinsloo conducted an autopsy on XY. She determined that the direct cause of death was "Shotgun wound to the head/brain".

The key findings were as follows:

A number of features of a shotgun wound, including an intra-oral entrance shotgun wound, severe destruction of the facial soft tissue with numerous lacerations, soot soiling of the tongue, and "bird shot pellets retrieved from the head".

"Post mortem radiology … shows severely comminuted and distracted open fractures and defect involving the facial bones extending into the cranial cavity. There are extensive defects and fractures involving the calvarium and base of skull.
Bullet fragments are present in the cranial cavity, subgaleal space and soft tissue of the neck. There are fractures of the hyoid bone and hyroid cartilage. Decomposition changes are present."

"Toxicology detects a blood alcohol level of 0.099 g/100ml. The vitreous humour alcohol level is 0.078 g/100mL. Methylamphetamine and its metabolite amphetamine (stimulant drugs) and delta-9-tetrahydrocannabinol and delta-9-THC acid (metabolites of cannabis) are present in the blood sample."

Were the applicable NSW Police Force policies and procedures followed?

Actions of the involved officers

In his statement, Detective Sergeant Quilter stated (at [26]):

"I am satisfied the officers involved acted appropriately in the circumstances. They all identified this incident was a contain and negotiate incident and attempted to set a perimeter as best they could with the resources they had. Attempts were made to interact with [XY] to the best of their ability. They communicated with Police Radio and provided updates and requested further resources to attend. Constable JAMES identified he needed to remove [E, B and C] from the house which he did."

In oral evidence, Detective Sergeant Quilter told the Court that the involved officers did a "great job in a stressful situation". Overall, he said that given their policing experience, they did well in the circumstances.

Sergeant Graham O'Toole (Sergeant O'Toole) of the Weapons Tactics Policy and Review ("WTPR") (within the Operational Safety and Skills Command of the NSW Police Force), provided two statements for the assistance of the coroner, based on his review of relevant NSWPF policy and procedure. Sergeant O'Toole concluded that overall, the actions of the involved officers were in accordance with NSWPF training, policy and procedure, and further, given their level of experience, the officers performed their duty in a "most professional and commendable manner".

He noted:

"[A]s soon as the officers observed XY had possession of a firearm, the incident was no longer a domestic verbal argument with malicious damage and breach of an AVO. The matter had then escalated and converted to a high- risk incident. The officers adhered to the [relevant] NSWPF policy ... They protected themselves and the public by utilising several aspects of [their training and procedures]. They evacuated the residents and obtained information to assist them in their efforts to resolve the situation and utilised safety equipment such as the ballistic vests, torches and gloves."

Having regard to the evidence, and noting the matters set out above, together with Sergeant O'Toole's review, there could certainly be no criticism of the first responders, Constables James, Margiolis, and Fajks. To the contrary, their response was impressive and commendable.

The quick actions required of the junior officers, following the confrontation with XY, who was clearly deeply distressed and volatile, were undertaken in circumstances of extreme stress.
It would have been possible – confronted with the situation of a long arm pointed down the driveway towards the officers, with poor lighting – for an exchange of gunfire to have ensued, with all the consequent potential for police and civilian casualties.

It ought also to be borne in mind that although with the benefit of hindsight, it is now known that any threat XY presented may have resolved by 4.02am when he took his own life, this was not known to police at the time. There remained the potential that XY was hiding, awaiting an opportunity to shoot a person at the location.

In that quite terrifying context, the conduct of the involved officers was clear-headed, collaborative, efficient and effective. I find that they acted appropriately in the circumstances, and in accordance with the relevant NSW Police Force policies, procedures and training.

Having regard to their composure, professionalism and skill – noting their comparative inexperience - Constables Margiolis, James and Fajks are to be commended for their response to the incident on 11 April 2019.

Additionally, Sergeant Schaefer's professional manner and significant experience was of significant value in the police response. His leadership and guidance to the junior officers was exemplary. Sergeant Schaefer was also impressively candid in his evidence about the circumstances and seriousness of forgetting his weapon.

Critical incident investigation

A critical incident is essentially one involving a member of the NSWPF which results in the death of a person arising from a police operation. The defining feature of a critical incident investigation is that it is constituted by an independent specialist investigative team, whose investigation is in turn reviewed by an independent review officer.

In conducting a critical incident investigation, the Guidelines state that the critical incident team are to conduct a full investigation of the incident, including relevant events and activities leading up to it, as well as the lawfulness of police action and the extent of police compliance with relevant guidelines, legislation, internal policy and procedures. The investigation report from the critical incident investigation should comment on these matters and include reference to any problems that have been identified.

The primary role of the senior critical incident investigator ("SCII"), who is the leader of the critical incident investigation, is to "ensure critical incidents are rigorously and thoroughly investigated".

Notably, the Guidelines emphasise the need for involved officers to be separated from other involved officers or witnesses to ensure that any evidence is not contaminated. This obligation falls upon the Duty Officer, until the SCII arrives on scene.

The requirement for separation is directed at protecting the integrity of the evidence and the scene.

It appears that Commander Paul Smith attended the scene at 6.48am, and Inspector Paul Roberts (the attending Duty Officer) may have attended around 7.16am. The actions of the involved officers following XY's death are set out above at [0] to [0]. In summary, Sergeant Schaefer left the scene around 5.15am, returning to the station in BC14 himself. It appears that Constables James, Margiolis, and Fajks also left around 5.15am, driving back to the station together in BC16.

Thus, by the time Senior Officers attended the scene, the involved officers had already left. Notably, given the critical incident investigation team were to be from a different Police Area Command (with the SCII located at Bourke Police Station), there was always going to be a significant delay until the SCII arrived. In fact, Detective Sergeant Quilter was not on scene until around 1.30pm that day. Detective Sergeant Quilter agreed that this situation was "not ideal", and that it was an "unfortunate thing" related to resourcing of regional police commands. He also noted that it occurred before the critical incident investigation team arrived. Detective Sergeant Quilter agreed it was a matter that would be included in his final critical incident investigation report.

Certainly, it was undesirable that the officers returned to the station together in the same vehicle (without at least the presence of another independent officer, as occurred subsequently at the station) and contrary to the intent of the Guidelines in preserving the integrity of their respective evidence. However, I accept the evidence of Constables Margiolis and James about the return trip, to the effect that the incident was not substantively discussed. I also note that the return trip (some 1.6km in distance) was brief. As Detective Sergeant Quilter will address this issue in his critical incident investigation report, I am content that the matter will receive appropriate consideration by the NSW Police Force in that way.

The need for recommendations

The recommendatory power outlined in s. 82 of the Act is the distillation of the coroner's death prevention role, "speaking for the dead to protect the living".

Hanging points for BWV camera on ballistic vests

As set out at [0] above, Sergeant Schaefer's evidence was that although signing out a body worn camera, when he put on the ballistic vest, he could not find anywhere to hang it and so left it turned off in the car. Sergeant Schaefer told the court that he had not heard about any clip to mount the camera to ballistics vests, and if there were such a clip – he would "absolutely" want to know about it. In oral evidence, Detective Sergeant Quilter noted that he had also previously encountered this issue.

The significant value of the BWV footage is clearly borne out in this matter – there is an entirely contemporaneous account of events from two of the involved officers, which records the nature of their interactions with XY, the steps taken and in fact, the entirely impressive manner in which the junior officers discharged their respective duties. In oral evidence, Detective Sergeant Quilter agreed that the BWV footage had been of great assistance in the matter.

In response to queries directed to Sergeant O'Toole on this issue, he noted that the NSWPF has had the current 'Overt' ballistic vests for about 10 years.

"The BWV cameras are relatively new and there were no provisions made at the time of purchase, for the securing of the BWV to these vests…. Having said that, the current BWV [camera] can be secured to the current 'Overt' ballistic vest by means of the clips which are being used by most Police Area Commands. These clips are available on 'Simple Order' through the SAP system. Whilst the securing clips for the BVW are not permanently attached to the 'Overt' vests, the clips can be used to secure the BVW to the vest if required. Constable Margiolis and Probationary Constable Fajks had BVW attached at the time of attending this incident and upon donning the 'Overt' ballistic vests, were able to secure the BVW so as to continue to record the incident. I believe this to be a simple equipment supply and education issue."

Sergeant O'Toole subsequently clarified the steps that were being taken to prepare an information package with clearer photos and instructions on how to secure the BWV to the 'Overt' ballistic vests with the supplied clips. He noted the package would then be sent out via a State-Wide NEMESIS message to all officers once complete.

On 8 December 2020, A/Inspector Michael McGowan of the Operational Safety Unit, NSW Police Force, confirmed that an instructional package advising police about the specific clip for the overt ballistics vest is to be disseminated by "Nemesis", the NSW state-wide messaging system. A/Inspector McGowan stated:

"The instructional package is designed to teach police officers how to attach BWV to overt ballistics vests using the clips and will be in written form accompanied by step-by-step photographs. It is anticipated that this instructional package will be finalised and disseminated on or before 11 December 2020."

In circumstances where the NSW Police Force are taking appropriate steps to deal with this issue by (imminently) providing relevant notification/information to operational police in the form of a State-Wide NEMESIS message, there is no requirement for a recommendation.

I am grateful to the Commissioner of NSWPF for his prompt consideration of this issue and the swift action undertaken to ensure valuable information is disseminated to all operational NSWPF officers.

Forgetting of firearm

As set out above, following the firing of a shot around 4.02am at the Z Street premises, Sergeant Schaefer realised he had forgotten his firearm. In accordance with standard operating procedures, it had been locked in a key-lock safe outside the charge room.

Such mistakes must be accepted as part of inevitable human fallibility – and no criticism is made of Sergeant Schaefer. In oral evidence Sergeant Schaefer candidly admitted that it was less than ideal that he had forgotten his weapon. He readily conceded that it "absolutely" could have been a serious issue in the circumstances.

On this matter, Sergeant O'Toole stated:

"Regarding the issue of Sergeant Schaefer leaving his firearm at the station, I am able to confirm it is standard operating procedure that armed officers remove and secure their firearms in metal key-lock safes located outside the Police station charge rooms either in the Van dock or Police station proper. No firearms are allowed in Police charge rooms. This requirement will always lead to an officer, on occasion, forgetting their firearm is secured in the safe and leaving the station without it. Particularly when an urgent job suddenly comes to their attention. Officers will enter and leave the charge room on a regular basis when processing a custody and completing required computer entries. Most often leaving their firearm secured in the safe until the process is complete.

I am not aware of any process or recommendation that would eliminate the possibility of such a circumstance recurring in the future, however I believe appropriately worded signage on the inside of the charge room doors and external doors of the station might assist in reducing the possibility of such incidents."

In oral evidence, Detective Sergeant Quilter agreed with Sergeant O'Toole's proposed recommendation, and said that such signs could assist but also noted there are "plenty of signs around", so they may not be that effective; he also suggested some sort of alarm mechanism/wrist band connected to the key to the safe, which buzzes if an officer leaves the station. For his part, Sergeant Schaefer suggested that any signage would have to be in a very prominent position (not inside the charge room door, but more likely from the internal door to the foyer) – it would need to be a large sign. He was also of the view that a reminder sticker in a vehicle might be constructive.

On 8 December 2020, Superintendent Anthony Ferguson, an officer within the Communications and Security Command of the NSWPF, confirmed that consideration would be given to appropriate "reminder signage or alternative warnings to police being placed in the charge rooms".

He indicated that "the potential utility of reminder signage being used to address the issue, and any practical impediments affecting the utility of reminder signage, are also issues forming part of that consideration".

Although I am grateful to receive an indication that the issue of reminder signage is being considered, it appears from Superintendent Ferguson's statement that consideration of this issue will be within the context of the Charge Room and Custody Management Standard Operating Procedures only. It was not apparent that the Commissioner of NSWPF proposes any broader review of potential safety 'reminder' systems. The evidence of both Sergeant Schaefer and Detective Sergeant Quilter indicates the need for a broader review by the NSW Police Force. Given the potential seriousness of this issue, I would hope that various units within the NSW Police Force with relevant expertise might usefully be involved in any such review (including conceivably, the NSW Police Force Education and Training Command (Lessons Learned Unit)).

In the circumstances, I consider that the following recommendation to the Commissioner of NSWPF is both necessary and desirable:

That the Commissioner of the NSW Police Force give consideration to a review of potential systems (including for example, signs within police stations, key tag or wrist alarm devices and/or stickers or signs in vehicles) to remind police about the retrieval of firearms from key-lock safes when undertaking custody management duties, so as to address the issue of operational police forgetting their firearms when attending urgent duties/high risk situations.

Absence of drug and alcohol rehabilitation centres in Far West NSW

It was clear from the evidence that XY struggled with drug and alcohol abuse issues for some years. He frequently talked of going into "rehab", but it is not clear what steps (if any), he took to pursue this.

As outlined above, during W's family statement, she told the Court that (as someone who works in the mental health area); no rehabilitation facilities for drug and alcohol abuse are available in the far west region of NSW. The rehabilitation centres that do exist in Western NSW (such as Dubbo); raise issues for Aboriginal people being removed from their support networks when accessing those services. Whilst there is a facility in Port Augusta (South Australia), access to that service raises cross-jurisdictional issues. W stated that having access to a rehabilitation centre in far west NSW would be beneficial for the community, and would assist the police in their dealings with persons struggling with methamphetamine addiction.

Although the Court will not make recommendations in this respect (there being no evidence on this issue and the Minister for Health having not been involved in the inquest), it is appropriate that the Minister for Health be apprised of W's statement (by provision of these findings), to consider the issue raised in the broader context of the tragic circumstances of XY's death.

Courage and bravery of B

Finally, it is important to acknowledge the heroic efforts of B in the incident on 11 April 2019. As raised earlier in these findings, when confronted with the terrifying scene of his father smashing windows and yelling aggressively, B managed to barricade XY in his mother's bedroom so as to give police a chance to attend the scene. During this time, his mother and sister were able to hide in the bathroom, and call police. B also managed to call '000', and convey the critical information that XY was armed with a double-barrelled shot-gun. In the circumstances, B's bravery and quick response should be commended. As Detective Sergeant Quilter said in oral evidence, he showed great courage and potentially saved the life of his mother and sister.

Formal Finding:

Identity
The person who died was XY.
Date of death
XY died on 11 April 2019.
Place of death
XY died at Z Street, Broken Hill in the state of New South Wales.
Cause of death
XY died due to a single gunshot wound to the head.
Manner of death
XY's death was self-inflicted with the intention of taking his own life.

Recommendations pursuant to section 82 *Coroners Act 2009*

I make the following recommendation:

To the Commissioner of Police, New South Wales Police Force

That the Commissioner of the NSW Police Force give consideration to a review of potential systems (including for example, signs within police stations, key tag or wrist alarm devices and/or stickers or signs in vehicles) to remind police about the retrieval of firearms from key-lock safes when undertaking custody management duties, so as to address the issue of operational police forgetting their firearms when attending urgent duties/high risk situations.

40. 182081 of 2019

Inquest into the death of Geoffrey Fardell.

Upon information that a person has been charged with an indictable offence in connection with this death the inquest was suspended by DSC Lee in accordance with the *Coroners Act 2009*.

41. 184669 of 2019

Inquest into the death of Ho Pan Chan.

Upon information that a person has been charged with an indictable offence in connection with this death the inquest was suspended by DSC Grahame in accordance with the *Coroners Act 2009*.

42. 221339 of 2019

Inquest into the death of Cemil Guler. Finding delivered down by DSC Lee at Lidcombe on the 17 September 2020.

Introduction

On 16 July 2019 Mr Cemil Guler was pronounced deceased at Braeside Hospital. At the time of his death Mr Guler was in lawful custody after having been found not guilty by reason of mental illness of an offence that he had been charged with, and being subsequently involuntarily detained as a forensic patient. On 9 July 2019 Mr Guler was transferred from the mental health facility where he had been detained to hospital in order to receive palliative care, following diagnosis of a terminal condition.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately.

In this particular case, it should be noted at the outset that there is no evidence to suggest that the care and treatment provided to Mr Guler during his time in custody was deficient or not appropriate in any way.

Mr. Guler's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore, it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

Mr Guler was born in Turkey in 1939. After partially completing high school Mr Guler served two years in the army before working as a clerk in a hospital. He later moved to Australia in 1971 and became an Australian citizen in 1992. Mr Guler previously worked on the railways and with BHP in Wollongong before ceasing employment in 1983.

Mr Guler married twice. His first marriage ended in 1990 and Mr Guler later re-married following a temporary return to Turkey in 1991. In total, Cemil has seven children: four from his first marriage and three from his second marriage.

There is no doubt that the decline in Mr Guler's health in the latter stages of his life has been a distressing experience for his the members of his family, and that Mr Guler is greatly loved and missed by those closest to him.

Mr. Guler's custodial history

On 11 April 2005 Mr Guler was charged with an offence of murder. He was subsequently remanded into custody and taken to the Metropolitan Remand and Reception Centre (**MRRC**). Criminal proceedings were subsequently commenced and on 11 August 2006 the Supreme Court found Mr Guler not guilty by reason of mental illness pursuant to section 38 of the *Mental Health (Forensic Provisions) Act 1990* (**the Mental Health Act**). Accordingly, Mr Guler was ordered to be detained pursuant to section 39 of the Mental Health Act. On 3 November 2016 Mr Guler was transferred to Long Bay Hospital before later being transferred to the Forensic Hospital on 24 March 2009.

During the period of his detainment Mr Guler was subject to periodic six monthly reviews by the Mental Health Review Tribunal (**the Tribunal**). A summary of the some of these reviews is set out below:

At a review in July 2010 the Tribunal heard that following psychiatric assessment a formal process had commenced for Mr Guler to be transferred to a psychogeriatric hospital.

During a review in August 2011 the Tribunal heard that Mr Guler's presentation and mental state had changed, with his treating team observing that there had been a considerable degree of deterioration in his mental function and abilities.

In August 2012 the Tribunal heard that Mr Guler continued to present with delusions of persecution and had limited insight into his illness. Mr Guler was subsequently assessed as being suitable for transfer to Lavender House at Macquarie Hospital. Following an order made by the tribunal in January 2013 Mr Guler was transferred to Macquarie hospital with access to escorted day leave.

During the September 2014 review the Tribunal heard that Mr Guler's mental state had deteriorated with a relapse of his paranoid psychosis. As a result of this deterioration and mood disturbance Mr Guler's leave was curtailed and it was noted that he had not had leave since July 2014.

By the time of the March 2015 review the Tribunal was informed that Mr Guler's previous episode of psychosis had resolved with no further persecutory delusions reported.

During the June 2017 review the Tribunal heard that Mr Guler's mental state had shown significant improvement over the previous several months, and that Mr Guler had been compliant with his medication.

However by the time of a review in December 2018 the Tribunal heard that Mr Guler had been experiencing instances of paranoid thoughts, and continued to experience chronic delusions. It was also noted that there was evidence of a mild deterioration of Mr Guler's psychiatric condition over the preceding months.

Mr. Guler's medical history

Mr Guler had previously been diagnosed with depression in 1987 and was admitted to a mental health facility in 1990. He was reportedly admitted to similar facilities on two further occasions. In March 2005 Mr Guler was admitted to hospital on a background of experiencing what had been described as hallucinations. Two days after his admission Mr Guler absconded from hospital and was later returned there by police.

Whilst in custody Mr Guler was treated for psychosis, insulin-dependent diabetes mellitus and ischaemic heart disease. In October 2006 Mr Guler underwent emergency surgery for coronary artery bypass grafts.

Following his transfer to Macquarie Hospital in 2012 Mr Guler was treated for schizophrenia. On 6 September 2018 Mr Guler was investigated at Royal North Shore Hospital (**RNSH**) for calcific pancreatitis. An abdominal CT scan on 24 September 2018 showed a lesion on the liver. A subsequent MRI in October 2018 suggested a diagnosis of hepatoma.

Mr Guler was subsequently seen by a specialist gastrointestinal surgical oncologist, Professor Thomas Hugh, on 9 November 2018 for consideration of surgical intervention. It was noted that Mr Guler's serum AFP (alpha-fetoprotein) level (a tumour marker test) was grossly elevated and that he had radiological signs of chronic liver disease consistent with his known underlying sclerosis and portal hypertension. Mr Guler's case was discussed on several occasions at multidisciplinary hepatobiliary cancer meetings. The consensus from these meetings was that Mr Guler could be offered regional therapy to his liver (trans arterial chemo embolization) but that he was not suitable for surgical intervention due to the high risk of liver dysfunction post-treatment.

Professor Hugh noted that Mr Guler's liver disease progressed relatively quickly and he later required a short admission to Ryde Hospital with gross ascites secondary to hepatic dysfunction. Following an oncology review at RNSH in April 2019 a recommendation was made to manage Mr Guler conservatively and transfer him to a palliative care pathway.

By this time Mr Guler's condition had deteriorated significantly, and he required a wheelchair in order to mobilise and nursing assistance with feeding. At the time, it was considered that chemotherapy was likely to substantially reduce Mr Guler's lifespan and quality of life.

As Mr Guler's condition continued to deteriorate an end-of-life care plan was formulated on 1 May 2019, following consultation with Mr Guler's family. The plan noted that Mr Guler was not for acute medical response or interventions and that the wishes of Mr Guler's family were for a non-invasive and dignified death.

Mr Guler was later transferred to Lavender House at Macquarie Hospital on 23 May 2019 due to his continuing deteriorating condition. Following review by the Tribunal on 20 June 2019, orders were made on 28 June 2019 for Mr Guler to remain detained at Macquarie Hospital until such time as a bed became available at either Greenwich Hospital or Braeside Hospital. In the interim Mr Guler was allowed to have escorted day leave and supervised day leave with one of his daughters.

Mr Guler was subsequently transferred to the Palliative Care Unit at Braeside Hospital on 9 July 2019 with a terminal diagnosis of liver failure secondary to hepatocellular carcinoma. On transfer it was noted that Mr Guler's condition had deteriorated over the preceding three weeks, that he had limited oral intake and that he had been sleeping for extended periods of time. Blood tests revealed mild hyponatraemia, high potassium, mild renal impairment, deranged liver function tests and mild thrombocytopenia. It was also noted that Mr Guler required maximal nursing assistance with personal care, hygiene and feeding as he was too drowsy to care for himself.

Following review by a speech pathologist Mr Guler was trialled on puree and moderately thickened fluids due to his swallowing difficulties and decreased level of consciousness. As Mr Guler was unable to swallow his prescribed oral medications they were withheld for safety reasons. Over the course of his admission Mr Guler continued to deteriorate significantly and his oral medications and insulin were ceased. Upon medical review on 15 July 2019 it was noted that Mr Guler had been minimally responsive in the previous days due to progression of his underlying disease process.

The events of 16 July 2019

At around 11:55am on 16 July 2019 Mr Guler was noted to be resting comfortably without any need for extra medications to settle any symptoms. Mr Guler was also found to be minimally responsive to voice and to have limited mobility.

At around 3:56pm Mr Guler was found to be unresponsive with no signs of life, and was subsequently pronounced life extinct.

Mr Guler's death was subsequently reported to police and to the Coroner. Arrangements were subsequently made for Mr Guler to be transferred to the Department of Forensic Medicine.

What was the cause and manner of Mr. Guler's death?

Given Mr Guler's well-documented medical history and the fact that his clinical course was typical of that of patients diagnosed with terminal carcinoma, no invasive post-mortem examination of Mr Guler was performed. This is because the cause of Mr Guler's death had been sufficiently disclosed on the available evidence. Accordingly, on 17 July 2019 a Coronial Certificate was issued with the cause of Mr Guler's death being metastatic hepatocellular carcinoma.

Having regard to Mr Guler's medical history and the absence of any evidence of any external contributor to death, it is evident that Mr Guler died from natural causes.

Formal Finding:

Identity
The person who died was Cemil Guler.
Date of death
Mr Guler died on 16 July 2019.
Place of death
Mr Guler died at Braeside Hospital, Prairiewood NSW 2176.
Cause of death
The cause of Mr Guler's death was metastatic hepatocellular carcinoma.
Manner of death
Mr Culer died from natural causes. At the time of his death Mr Guler was in lawful custody, having been involuntarily detained as a forensic patient as a result of orders made pursuant to the *Mental Health (Forensic Provisions) Act 1990*.

43. 248603 of 2019

Inquest into the death of Peter Glen. Finding delivered by DSC Ryan at Lidcombe on the 8 May 2020.

Introduction

On the evening of 9 August 2019 Peter Glen aged 52 years died in the Long Bay Correctional Hospital at Malabar in Sydney. He had been an inmate of Long Bay Correctional Centre since 26 February 2019. The following month he was diagnosed with hepatocellular carcinoma, on a background of cirrhosis, secondary to alcohol dependence and hepatitis C.

Since Mr Glen was a prison inmate at the time of his death, an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The role of the Coroner

The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Mr. Glen's life

Peter Glen was born in Melbourne on 25 June 1967. He was a partner in a lengthy de facto relationship which ended in 2013. Following this Mr. Glen became the primary carer for the two grandchildren of his former de facto partner. Mr. Glen struggled with alcohol dependence, the consequences of which led to surgery in 1994 for removal of his appendix and lower bowel. He was diagnosed with Hepatitis C in 2004 and cirrhosis of the liver in 2012.

On 25 February 2019 Mr. Glen was charged with child sexual assault offences. He was refused bail and the matters were next due in court in September 2019. Due to the nature of the charges, Mr. Glen was placed in protective custody. On 26 February 2019 Mr. Glen received an inmate medical assessment. He presented as jaundiced and suffering the effects of alcohol withdrawal. He notified medical staff of his conditions of Hepatitis C and cirrhosis. Following this Mr. Glen underwent diagnostic testing at Westmead Hospital, which showed a lesion on his liver consistent with hepatocellular carcinoma.

Thereafter Mr. Glen was referred to a hepatic specialist, and had regular clinical reviews which identified on 15 March that his cancer was at end stage. He received transarterial chemoembolization. He was admitted to Westmead Hospital on 27 June into the care of the palliative care team, and then transferred to the medical subacute unit at Long Bay Correctional Hospital on 23 July.

Here he was placed on an 'end of life' care plan, involving medications for pain relief and for relief of his various symptoms. In the final week of his life Mr. Glen's condition rapidly deteriorated. On the evening of 9 August 2019 nursing staff found him unresponsive in his bed. Shortly afterwards he was pronounced deceased. Since being incarcerated in February 2019, Mr. Glen's lifelong friend David Harvey visited him regularly. Mr. Harvey's last visit took place six days before Mr. Glen's death.

The post mortem report

An external examination of Mr. Glen's body was performed by forensic pathologist Dr Dianne Little. On the basis of her examination and the contents of a post mortem CT scan, Dr Little concluded that the cause of Mr. Glen's death was hepatic (liver) failure secondary to hepatocellular carcinoma which developed from cirrhosis of the liver, caused by chronic alcoholism and hepatitis C. Dr Little commented that one of the complications of cirrhosis is the development of primary cancer of the liver. External examination showed severe jaundice of Mr. Glen's body, and fluid in the abdomen. Dr Little found no injuries or other significant conditions.

Cause and manner of death

The cause of Mr. Glen's death is able to be established. The manner of his death is natural causes, while he was in lawful custody at Long Bay Correctional Centre.

Formal Finding:

Identity
The person who died is Peter Glen.

Date of death:
Peter Glen died on 9 August 2019.

Place of death:
Peter Glen died at Long Bay Correctional Hospital at Malabar, Sydney.

Cause of death:
The cause of Peter Glen's death is hepatic failure secondary to hepatocellular carcinoma which developed from cirrhosis of the liver, caused by chronic alcoholism and hepatitis C.

Manner of death:
Peter Glen's died from natural causes, while he was in lawful custody at Long Bay Correctional Centre.

44. 261510 of 2019

Inquest into the death of Stephen Pitty. Finding delivered by DSC Truscott at Lidcombe on the 4 September 2020.

At the time of his death, Mr Pitty was serving a term of imprisonment at Long Bay Correctional Centre, an inquest is mandatory pursuant to Sections 23 and 27 of the *Coroners Act NSW 2009* (the Act). Section 21 of the Act 2009 provides jurisdiction to a Coroner to hold an inquest into the death, or suspected death of a person, and to make findings as to the date, place, cause and manner or circumstances of death. Section 82 of the Act provides for a coronial recommendations.

Background

Stephen Pitty was born on the 16 April 1949 in Sydney, he was one of six children who grew up in the Sydney suburb of Rozelle. He was the father to four children, however has apparently not had contact with them or his siblings since about 2006.

Mr Pitty met his partner Kathleen Rollan in 2012 and they resided together at a property in Birdwood on the mid-north coast of New South Wales up until his incarceration.

Mr Pitty had a lengthy medical history and was a long-term user of methylamphetamine and cannabis. He had ischaemic heart disease and between 2003 and 2015 he received seven cardiac stents. Additionally he suffered angina, post-traumatic stress disorder, type 2 diabetes, chronic pulmonary disease and chronic lung disease, for which he took several prescribed medications.

On the 10 July 2015, Mr Pitty was arrested and charged with several historical sexual offences, he was bail refused and was sentenced on the 12 February 2016, he was sentenced to a term of imprisonment of seven years and six months, with an earliest release date of the 9 January 2023.

Mr Pitty was accommodated in a number of correctional facilities including Cessnock, Parklea, the Metropolitan Special Purpose Centre, Long Bay Correctional Centre.

During his incarceration Mr Pitty was regularly attended to by Justice Health and Forensic Mental Health Network (Justice Health) medical and nursing staff for the management of his health conditions.

On the 8 February 2019, Mr Pitty attended a planned admission to the Prince of Wales Hospital for a coronary angiogram. On the 12 February 2019 he was discharged to the Long Bay Hospital Medical Sub-Acute Unit. His discharge summary noted he was suffering chronic obstructive pulmonary disease, Type 3 pulmonary failure, pulmonary hypertension, progressive profound dyspnoea on exertion, dyslipidaemia, type 2 diabetes and coronary artery disease, it was recommended he receive constant oxygen.

On the 5 July 2019, Mr Pitty was placed in the Kevin Waller Unit, a unit which specifically accommodates aged and frail inmates in the Metropolitan Special Purpose Centre where he received ongoing medical care.

At 4:45pm on 21 August 2019, Mr Pitty was observed sitting on the toilet in his cell suffering shortness of breath, he was assisted to his bed where he utilised his oxygen tank.

At 5pm on 21 August 2019, Correctional officers were called to Mr Pitty's cell, he was seated on his bed and when spoken to he did not respond, his eyes rolled back, and he collapsed, slumping backwards towards the wall.

Justice Health nursing staff were called who observed that Mr Pitty's breathing was very shallow with a respiration rate of eight.

The nurses commenced CPR until the arrival of the NSW Ambulance service personnel at 5:11pm. They took over care and transferred Mr Pitty to the Prince of Wales Hospital, Accident and Emergency Department.

CPR and medical intervention continued en route to the Prince of Wales Hospital arriving at 6:05pm. Mr Pitty was unresponsive to medical treatment and pronounced deceased at 6:15pm by the treating accident and emergency practitioner.

The investigation into Mr Pitty's death establishes that he suffered multiple serious complex and chronic illnesses, for which he was provided appropriate care and treatment from Justice Health and was appropriately accommodation by CSNSW.

Formal Finding:

Identity	Stephen Pitty
Date	21 August 2019
Place	Prince of Wales Hospital, Randwick, NSW
Cause	Complications of Ischaemic cardiomyopathy and Chronic Obstructive Pulmonary Disease
Manner	Mr Pitty died whilst in the lawful custody of Corrective Services NSW, housed in the Kevin Waller Unit at the Metropolitan Special Purpose Centre, Long Bay NSW

45. 121160 of 2020

Inquest into the death of Michael Black. Upon information that a person has been charged in connection with this death the inquest was suspended by DSC Grahame.

Upon information that a person has been charged with an indictable offence in connection with this death, the inquest was suspended by DSC Grahame in accordance with the *Coroners Act 2009*.

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2020

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	124745/15	27/04/15	Camden	43	Police Op
2	*323811/15*	*03/11/15*	Wellington	*34*	*In Custody*
3	329568/15	09/11/15	Camperdown	25	In Custody
4	24535/16	22/01/16	Malabar	19	In Custody
5	73098/16	07/03/16	Ingleburn	33	Police Op
6	88742/16	21/03/16	Bradbury	36	Police Op
7	290240/16	27/09/16	Sth Windsor	46	Police Op
8	99958/17	02/04/17	Silverwater	32	In Custody
9	121886/17	24/04/17	Malabar	72	In Custody
10	142803/17	09/05/17	Blacktown	20	In Custody
11	157550/17	25/05/17	Goulburn	49	In Custody
12	185430/17	20/06/17	Camperdown	47	In Custody
13	188495/17	23/06/17	Goulburn	21	In Custody
14	225703/17	23/07/17	Malabar	67	In Custody
15	264782/17	30/08/17	Kelso	47	Police Op
16	371691/17	07/12/17	Parklea	37	In Custody
17	15711/18	15/01/18	Malabar	57	In Custody
18	28682/18	26/01/18	Maroubra	33	Police Op
19	46266/18	09/02/18	Westmead	55	In Custody
20	54603/18	15/02/18	Westmead	44	In Custody
21	54392/18	18/02/18	Camperdown	30	Police Op
22	60363/18	20/02/18	Goulburn	67	In Custody
23	63185/18	24/02/18	Liverpool	26	Police Op
24	114791/18	11/04/18	Collingullie	42	Police Op
25	123983/18	18/04/18	Kogarah	54	In Custody
26	136203/18	30/04/18	Randwick	44	In Custody

27	150097/18	13/05/18	Randwick	53	In Custody
28	166031/18	25/05/18	Surry Hills	48	In Custody
29	209734/18	07/07/18	Silverwater	30	In Custody
30	269824/18	01/09/18	Berkshire Park	36	In Custody
31	279370/18	11/09/18	Silverwater	48	In Custody
32	281398/18	12/09/18	Goulburn	43	In Custody
33	291962/18	23/09/18	Brocklehurst	51	Police Op
34	297261/18	27/09/18	Tweed Heads	22	Police Op
35	314209/18	12/10/18	Randwick	85	In Custody
36	328285/18	25/10/18	Berkshire Park	30	In Custody
37	338690/18	03/11/18	Ryde	26	Police Op
38	392964/18	20/12/18	Malabar	34	In Custody
39	400495/18	30/12/20	Tumbarumba	27	In Custody
40	2380/19	02/01/19	Wagga Wagga	60	In Custody
41	4700/19	04/01/19	Arncliffe	24	Police Op
42	10495/19	10/01/19	Silverwater	43	In Custody
43	28070/19	25/01/19	Villawood	33	Detention Centre
44	70710/19	04/03/19	Villawood	26	Detention Centre
45	83697/19	14/03/19	Glendale	22	Police Op
46	110322/19	08/04/19	Silverwater	39	In Custody
47	120612/19	13/04/19	Cessnock	57	In Custody
48	117552/19	14/04/19	Junee	66	In Custody
49	126969/19	21/04/19	Aldavilla	24	In Custody
50	146621/19	08/05/19	Silverwater	27	In Custody
51	154687/19	16/05/19	Randwick	28	In Custody
52	159733/19	17/05/19	Garran (ACT)	70	In Custody
53	179888/19	09/06/19	Silverwater	55	In Custody
54	181202/19	09/06/19	Cooma	45	In Custody
55	200952/19	25/06/19	Lithgow	44	In Custody

56	218076/19	12/07/19	Westmead	26	In Custody
57	221357/19	16/07/19	Randwick	53	In Custody
58	236119/19	29/07/19	Newcastle East	36	Police Op
59	239447/19	31/07/19	Taree	40	Police Op
60	248597/19	09/08/19	Parklea	59	In Custody
61	252231/19	13/08/19	Malabar	76	In Custody
62	256729/19	17/08/19	St Leonards	53	Police Op
63	258876/19	19/08/19	Glen Innes	40	In Custody
64	259359/19	19/08/19	Randwick	33	In Custody
65	269131/19	28/08/19	Malabar	33	In Custody
66	276007/19	03/09/19	Cessnock	37	In Custody
67	278264/19	05/06/19	Silverwater	42	In Custody
68	280398/19	08/09/19	Westmead	73	In Custody
69	281694/19	09/09/19	Randwick	54	In Custody
70	289826/19	16/09/19	Westmead	44	In Custody
71	289835/19	16/09/19	Malabar	42	In Custody
72	302386/19	26/09/19	Silverwater	55	In Custody
73	308628/19	01/10/19	Malabar	75	In Custody
74	308934/19	02/10/19	Penrith	33	Police Op
75	324097/19	14/10/19	Wellington	27	In Custody
76	323357/19	15/10/19	Malabar	80	In Custody
77	337389/19	27/10/19	Malabar	74	In Custody
78	345858/19	01/11/19	Erina	45	Police Op
79	351386/19	05/11/19	Gosford	20	In Custody
80	362566/19	18/11/19	Malabar	80	In Custody
81	388175/19	09/12/19	Berkshire Park	49	In Custody
82	388183/19	09/12/19	Randwick	72	In Custody
83	407715/19	28/12/19	Blacktown	60	In Custody
84	3733/20	02/01/20	Liverpool	36	Police Op

85	4795/20	05/01/20	Randwick	59	In Custody
86	7307/20	08/01/20	Newcastle	35	Police Op
87	7308/20	04/01/20	Grafton	54	Police Op
88	10127/20	10/01/20	Malabar	52	In Custody
89	22402/20	19/01/20	Cessnock	28	In Custody
90	20808/20	20/01/20	Silverwater	59	In Custody
91	26597/20	26/01/20	Randwick	81	In Custody
92	26654/20	25/01/20	Malabar	70	In Custody
93	38704/20	05/02/20	Malabar	84	In Custody
94	48323/20	12/02/20	Vaucluse	44	Police Op
95	80902/20	11/03/20	Malabar	43	In Custody
96	80909/20	12/03/20	Randwick	72	In Custody
97	90781/20	20/03/20	Watsons Bay	41	Police Op
98	91972/20	23/03/20	New Lambton Heights	70	In Custody
99	94710/20	22/03/20	Yass	39	Police Op
100	100722/20	01/04/20	Randwick	31	In Custody
101	103021/20	02/04/20	Lithgow	59	In Custody
102	103425/20	02/04/20	Malabar	87	In Custody
103	112521/20	13/04/20	Cessnock	67	In Custody
104	118749/20	20/04/20	Kogarah	51	Police Op
105	135219/20	05/05/20	Cesnnock	34	In Custody
106	137690/20	07/05/20	Berrima	51	Police Op
107	139754/20	10/05/20	Randwick	64	In Custody
108	148520/20	17/05/20	Terrigal	41	Police Op
109	188420/20	22/06/20	Marlee	17	Police Op
110	194015/20	30/06/20	Randwick	73	In Custody
111	201875/20	05/07/20	Cessnock	73	In Custody
112	225458/20	31/07/20	Darlinghurst	29	In Custody
113	231668/20	07/08/20	Watsons Bay	26	Police Op

114	232908/20	09/08/20	Silverwater	41	In Custody
115	235801/20	12/08/20	Parklea	24	In Custody
116	241740/20	17/08/20	Malabar	88	In Custody
117	245234/20	21/08/20	Malabar	32	In Custody
118	257581/20	03/09/20	Silverwater	59	In Custody
119	257665/20	03/09/20	Junee	34	In Custody
120	268433/20	14/09/20	Cessnock	34	In Custody
121	273670/20	20/09/20	Malabar	78	In Custody
122	277315/20	23/09/20	Kogarah	33	Police Op
123	277394/20	23/09/20	Silverwater	32	In Custody
124	279909/20	24/09/20	Parklea	32	In Custody
125	304043/20	22/10/20	New Lambton Heights	30	Police Op
126	305849/20	24/10/20	Randwick	50	In Custody
127	308509/20	27/10/20	Malabar	77	In Custody
128	343056/20	02/12/20	Malabar	76	In Custody
129	352738/20	12/12/20	Villawood	29	In Custody/Detention
130	2579/21	31/12/20	Bathurst	57	In Custody