Deaths in Custody/Police Operations Report

for the year 2022

Report by the New South Wales State Coroner

A report prepared pursuant to s 23 of the *Coroners Act 2009* (NSW)
NSW Office of the State Coroner
NSW Department of Communities and Justice
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CONTENTS

Acknowledgements	**1**
2022 Summary in brief	**2**
Statutory appointments	**4**
Introduction by the State Coroner	**5**
The coronial process	**7**
About this report	**12**
Overview of deaths in custody and police operations, 2003-2022	**13**
Reported deaths in 2022	**16**
Inquests finalised in 2022	**18**

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

28th April 2023

Dear Attorney General,

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

I attach a hard copy and an electronic copy of the 2022 report.

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

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

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

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

Inquest findings for those matters that were finalised in 2022 and are referred to in this report are available on the Coroners Court New South Wales webpage at: https://www.coroners.nsw.gov.au/coronial-findings-search.html. A register of coronial recommendations directed to, and responses by, government agencies to those recommendations which is maintained by the Department of Communities and Justice is available at: https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx

Later this year, I will be releasing a more detailed report that includes an analysis of the finalised matters referred to in this report.

In the meantime, please do not hesitate to contact me if you wish to discuss any of the matters contained in the report or would like further details of any of the matters referred to.

Yours faithfully,

Magistrate Teresa O'Sullivan
NSW State Coroner

ACKNOWLEDGEMENTS

Acknowledgement of Country

The Coroners Court NSW acknowledges Australia's First Nations peoples as the Traditional Custodians of the lands, waters and seas of Australia. We pay our respects to ancestors and Elders, past and present, and recognise the strength, resilience and diversity of First Nations peoples of this land.

Condolences

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

Content warning

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

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

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

Lifeline: 24/7 crisis support and suicide prevention services. Call: 13 11 14 Web: https://www.lifeline.org.au/about/our-services/
13YARN Crisis support for Aboriginal & Torres Strait Islander people: 24/7 confidential one-on-one over the phone yarning opportunity and support for mob who are feeling overwhelmed or having difficulty coping. Call: 13 92 76 Web: https://www13yarn.org.au
Beyond Blue: 24/7 advice, referral and support from trained mental health professionals. Call: 1300 22 4636 Web: https://www.beyondblue.org.au/
Suicide Call Back Service: 24/7 counselling and support for people at risk of suicide, carers and bereaved. Call: 1300 659 467 Web: https://www.suicidecallbackservice.org.au/
Griefline: Operates midday-3am 7 days a week. Phone and online counselling for people experiencing loss or grief. Call: 1300 845 745
Blue Knot Helpline: Operates 9am - 5pm, Monday to Friday. All Blue Knot counsellors are experienced trauma counsellors. Call: 1300 657 380 Web: https://www.beyondblue.org.au/
NSW Mental Health Line: 24/7 telephone helpline available to everyone in NSW. Call: 1800 011 511 Web: https://www.health.nsw.gov.au/mentalhealth/Pages/mental-health-line.aspx
The National Indigenous Postvention Service: 24/7 after suicide support for Aboriginal and Torres Strait Islander individuals and families impacted by suicide. Call: 1800 805 801 Web: https://thirrili.com.au/postvention-support
Free Translating and Interpreting Service (TIS): Call 13 11 44

2022 SUMMARY IN BRIEF

Deaths reported to the Coroner in 2022

- In the calendar year 2022, 49 deaths were reported to the Coroner as occurring in custody or as a result of a police operation.
  - This is an increase of 6 deaths from the Annual Report for the year 2021.
  - 34 deaths were reported as occurring in custody.
  - 15 deaths were reported as occurring as a result of a police operation.
  - 45 of the deaths reported were of male persons.

Overrepresentation of First Nations peoples

- 11 of the 49 deaths reported to the Coroner were First Nations people. This represents 22.4% of all deaths reported to have occurred in custody or as a result of a police operation, despite First Nations peoples comprising only 3.4% of the NSW population (ABS Census, 2021).

Deaths in custody in 2022

- 34 deaths were reported to the Coroner as having occurred in custody. Of these, 5 deaths (14.7%) were of First Nations peoples.
- The majority of these deaths (29) occurred in Corrective Services custody:
  - 15 of those persons who died were serving a full-time sentence, and
  - 14 of those persons who died were being held on remand.
- Of the remaining 5 deaths, 3 occurred in immigration detention, 1 occurred in police custody, and 1 occurred in forensic mental health custody.
- In most cases reported to the Coroner in 2022, information about the circumstances of the person's death, including the medical cause of death, is still under investigation. However, at the time of writing:
  - 13 deaths appear to be due to natural causes*,
  - 11 deaths appear to be a result of external causes,
  - 9 deaths are yet to be determined, and
  - In 1 case, the cause is unable to be determined.

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

Deaths as a result of a police operation in 2022

- 15 deaths were reported to the Coroner as occurring as a result of a police operation. Of these, 6 (40.0%) involved the death of a First Nations person, and
- The deaths occurred in a variety of police operations, including:
  - 6 (40.0%) which occurred in the course of an operation to contain or restrain the person,
  - 6 (40.0%) which occurred in connection with a police motor vehicle pursuit and 1 (6.7%) which occurred in connection with a police pursuit on foot, and
  - 1 (6.7%) which occurred during an operation to apprehend the person, and
  - 1 (6.7%) which occurred in circumstances that the Coroner has since determined was not as a result of a police operation.
- All deaths except one (which is under investigation) appear to be due to external causes.

Inquests finalised in 2022

In 2022, the State Coroner and Deputy State Coroners delivered findings in 46 inquests involving the death of a person in custody or as a result of a police operation. Of the 46 inquests that were finalised, 35 involved a death in custody,11 as a result of a police operation.

Overrepresentation of First Nations peoples

- 9 of the finalised inquests involving the death of a person in custody involved a First Nations person. This represents 25.7% of all finalised inquests into deaths in custody, despite First Nations peoples comprising only 3.4% of the NSW population (ABS Census, 2021).

Deaths in custody

- 35 of those inquests that were finalised involved the death of a person in custody.
  - 9 inquests (25.7%) involved the death of a First Nations person,
  - 34 inquests (97.1%) involved the death of a male person, and
  - 20 inquests (57.1%) involved the death of a person serving a full-time custodial sentence, 13 (37.1%) involved the death of a person being held on remand, and 2 (5.7%) involved people held in forensic mental health custody.

Deaths as a result of police operations

- 11 of those inquests that were finalised involved the death of a person which occurred as a result of a police operation.
  - 4 inquests (36.4%) found that the death occurred due to the discharge of a firearm by police in the course of a police operation,
  - 3 inquests (36.4%) found that the death occurred due to a motor vehicle collision in connection with a police operation, while another inquest (9.1%) found that the death occurred due to natural causes arising from medical treatment following a motor vehicle collision in the course of a police pursuit, and
  - 3 inquests (27.2%) found the death was due to intentional self-harm by the person.

STATUTORY APPOINTMENTS

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

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

NSW State Coroner

Her Honour Magistrate Teresa O'Sullivan (appointed 2019)

Deputy State Coroners

Her Honour Magistrate Joan Baptie (appointed 2021)

Her Honour Magistrate Carmel Forbes (appointed 2011)

Her Honour Magistrate Harriet Grahame (appointed 2015)

Her Honour Magistrate Carolyn Huntsman (appointed 2021)

Her Honour Magistrate Erin Kennedy (appointed 2022)

His Honour Magistrate Derek Lee (appointed 2016)

Her Honour Magistrate Elizabeth Ryan (appointed 2017)

His Honour Magistrate Brett Shields (appointed 2021)

INTRODUCTION BY THE STATE CORONER

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

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

What is a death in custody?

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

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

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

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

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

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

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

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

A 'police operation' is defined broadly to mean:

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

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

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

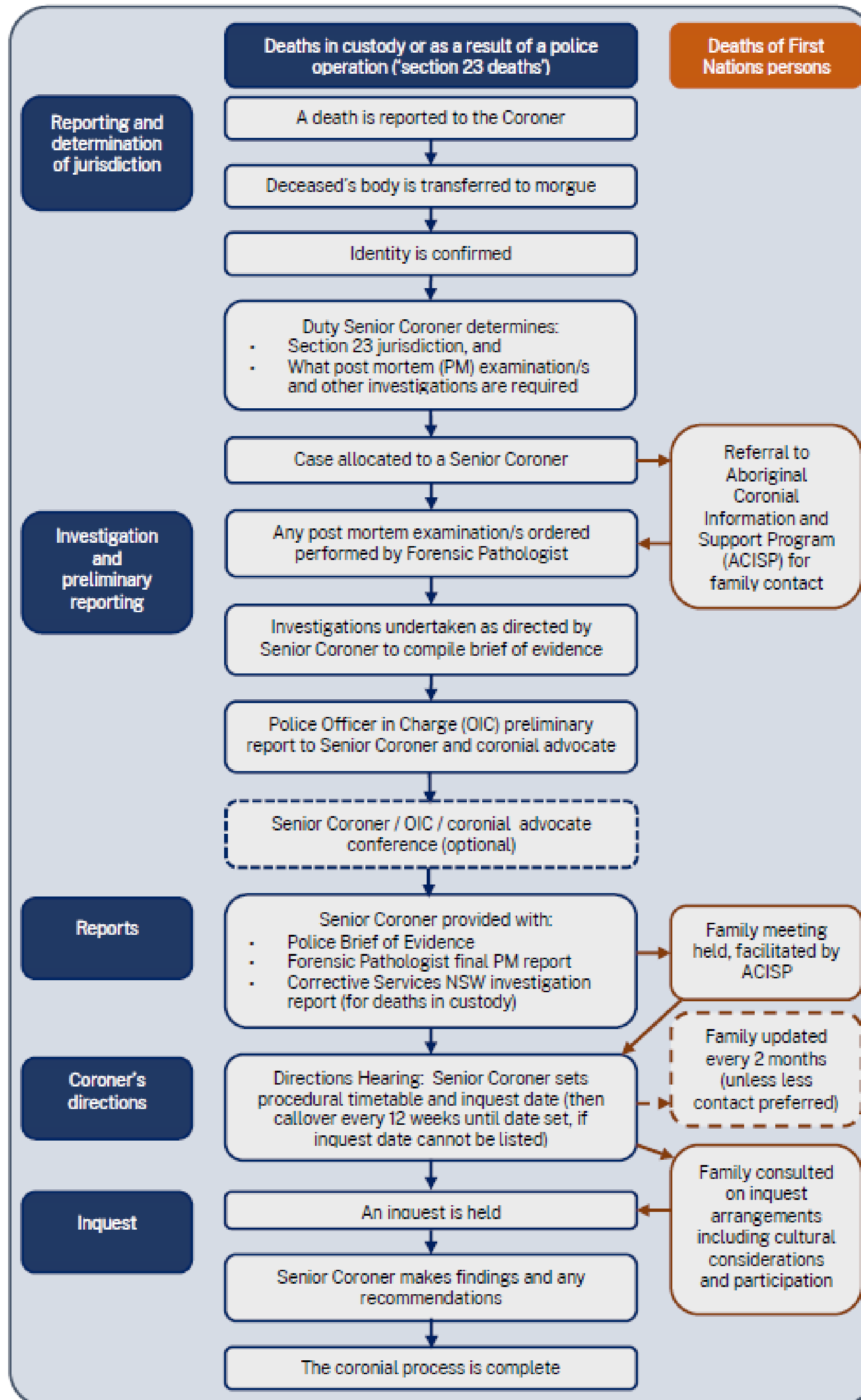
The reason for a broad approach is to enable the adequacy and appropriateness of police processes and conduct to be investigated where it appears necessary, and provide the family of the deceased, the New South Wales Police Force and the public with the opportunity to be made aware (as far as possible)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

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

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

THE CORONIAL PROCESS

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



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

Notification of deaths in custody or police operations

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

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

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

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

In cases involving the NSW Police

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

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

Case management of the coronial process

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

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

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

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

On 11 April 2022, the State Coroner issued the First Nations Protocol, which works in conjunction with Coronial Practice Note 3 of 2021, which sets out supplementary arrangements where a First Nations person has died in custody or as a result of a police operation. The aim of the Protocol is ensure that each stage of the coronial process is managed in a culturally sensitive and appropriate manner and is established in recognition that every First Nations death in custody represents the loss of a valued individual, family and community, and needs to be understood in the context of the history and harmful results of dispossession and colonisation that continue to be experienced by First Nations peoples today.

The inquest

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

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

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

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

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

Role of the Coroner

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

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

Responses to recommendations

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

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

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

Government agency responses to coronial recommendations are compiled by the Department of Communities and Justice and published at:

https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.

Timeframe for hearing of inquests

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

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

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

ABOUT THIS REPORT

This report provides information about:

- Deaths occurring in custody or as a result of police operations in NSW that were reported to the Coroner between 1 January 2022 and 31 December 2022, and
- Inquests into deaths occurring in custody or as a result of police operations in NSW that were completed by a Senior Coroner between 1 January 2022 and 31 December 2022 (regardless of the date that the death occurred and/or was reported to the Coroner).

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

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

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

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

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

OVERVIEW OF DEATHS IN CUSTODY AND POLICE OPERATIONS, 2003-2022

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

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

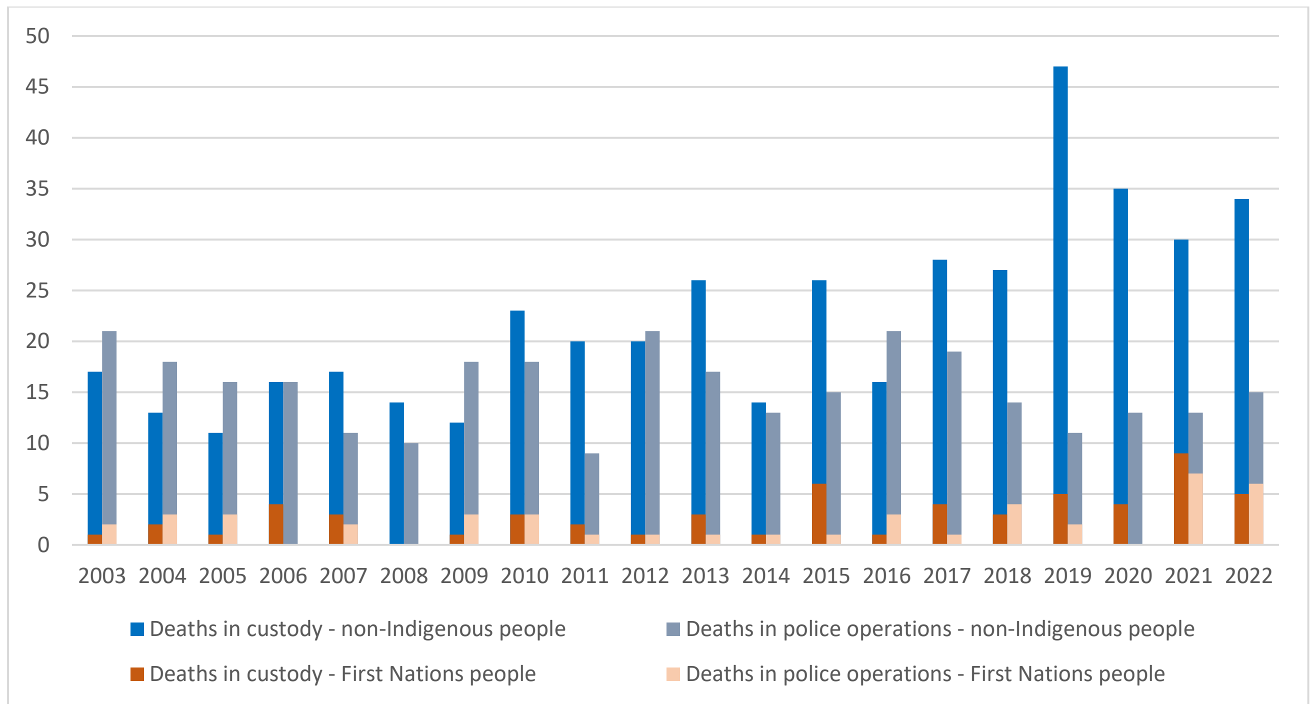


Figure 1: Deaths reported to the Coroner as occurring in custody and police operations in NSW, by First Nations status and year (2003-2022).

Deaths in custody

Year	Total	First Nations people	Non-Indigenous people
2003	17	1	16
2004	13	2	11
2005	11	1	10
2006	16	4	12
2007	17	3	14
2008	14	0	14
2009	12	1	11
2010	23	3	20
2011	20	2	18
2012	20	1	19
2013	26	3	23
2014	14	1	13
2015	26	6	20
2016	16	1	15
2017	28	4	24
2018	27	3	24
2019	47	5	42
2020	35	4	31
2021	30	9	21
2022	34	5	29
TOTAL	**446**	**59**	**387**

Figure 2: Table of deaths reported to the Coroner as occurring in custody in NSW, by First Nations status and year (2003-2022).

Deaths as a result of police operations

Year	Total	First Nations people	Non-Indigenous people
2003	21	2	19
2004	18	3	15
2005	16	3	13
2006	16	0	16
2007	11	2	9
2008	10	0	10
2009	18	3	15
2010	18	3	15
2011	9	1	8
2012	21	1	20
2013	17	1	16
2014	13	1	12
2015	15	1	14
2016	21	3	18
2017	19	1	18
2018	14	4	10
2019	11	2	9
2020	13	0	13
2021	13	7	6
2022	15	6	9
TOTAL	**309**	**44**	**265**

Figure 3: Table of deaths reported to the Coroner as occurring in police operations in NSW, by First Nations status and year (2003-2022).

REPORTED DEATHS IN 2022

This section provides information about deaths reported to a Senior Coroner in 2022 as having occurred in custody or as a result of a police operation. In most of these cases, an inquest had not yet been held at the date of this report. As a result:

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

Deaths in custody

34 deaths reported to the Coroner in 2022

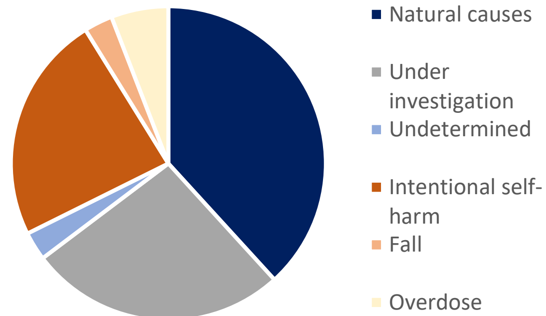
⬆ 6 deaths from 2021

30 Male

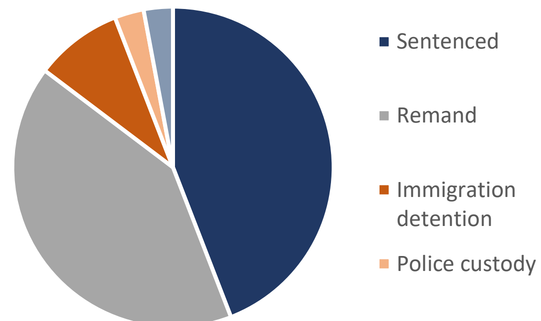
4 Female

5 First Nations persons

Manner of death		
Natural causes	13	38.2%
Under investigation	9	26.5%
Intentional self-harm	8	23.5%
Overdose	2	5.9%
Fall	1	2.9%
Undetermined	1	2.9%
TOTAL	**34**	**100.0%**



Custodial status		
Sentenced	15	44.1%
Remand	14	41.2%
Immigration detention	3	8.8%
Police custody	1	2.9%
Forensic mental health custody	1	2.9%
TOTAL	**34**	**100.0%**



Deaths as a result of police operations

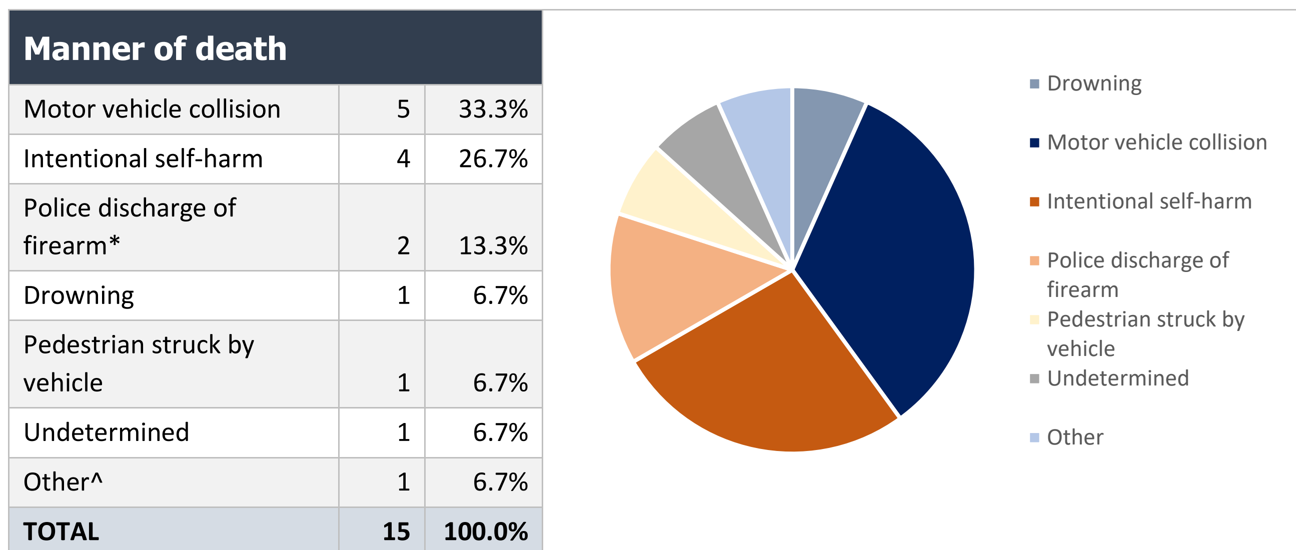
15 deaths reported to the Coroner in 2022

⬆ 2 deaths from 2021

15 Male

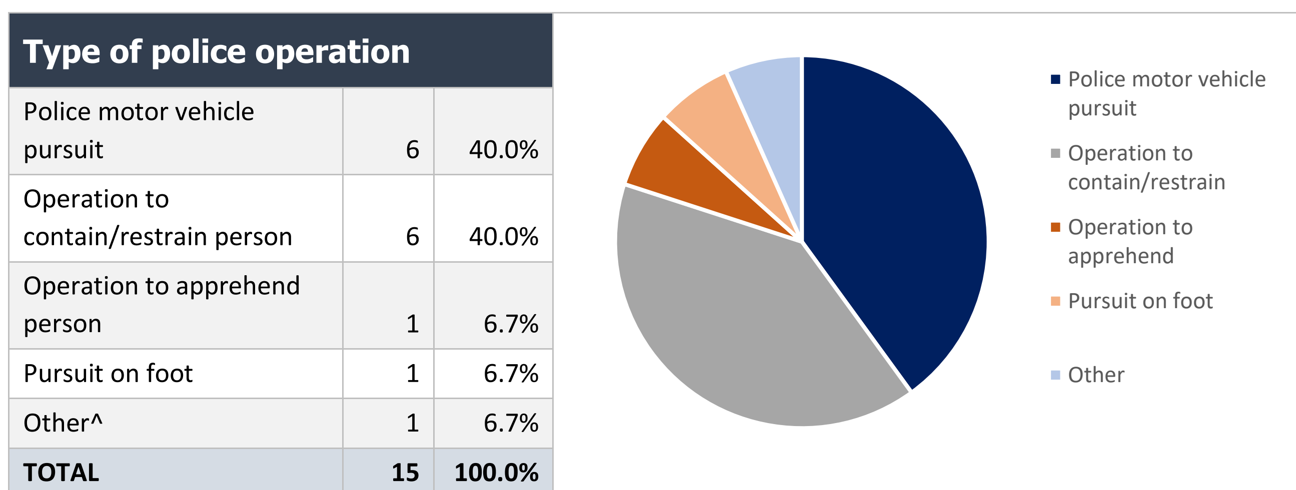
0 Female

6 First Nations persons



Manner of death		
Motor vehicle collision	5	33.3%
Intentional self-harm	4	26.7%
Police discharge of firearm*	2	13.3%
Drowning	1	6.7%
Pedestrian struck by vehicle	1	6.7%
Undetermined	1	6.7%
Other^	1	6.7%
TOTAL	**15**	**100.0%**

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



Type of police operation		
Police motor vehicle pursuit	6	40.0%
Operation to contain/restrain person	6	40.0%
Operation to apprehend person	1	6.7%
Pursuit on foot	1	6.7%
Other^	1	6.7%
TOTAL	**15**	**100.0%**

^ *Other* indicates a case that was reported to the Coroner as being a death occurring as a result of a police operation, but was subsequently determined by the Coroner not to have occurred in such circumstances. This case is therefore not counted in Inquests finalised in 2022, below.

INQUESTS FINALISED IN 2022

In 2022, 46 inquests were finalised in relation to deaths occurring in custody (35 inquests) or as a result of police operations (11 inquests).

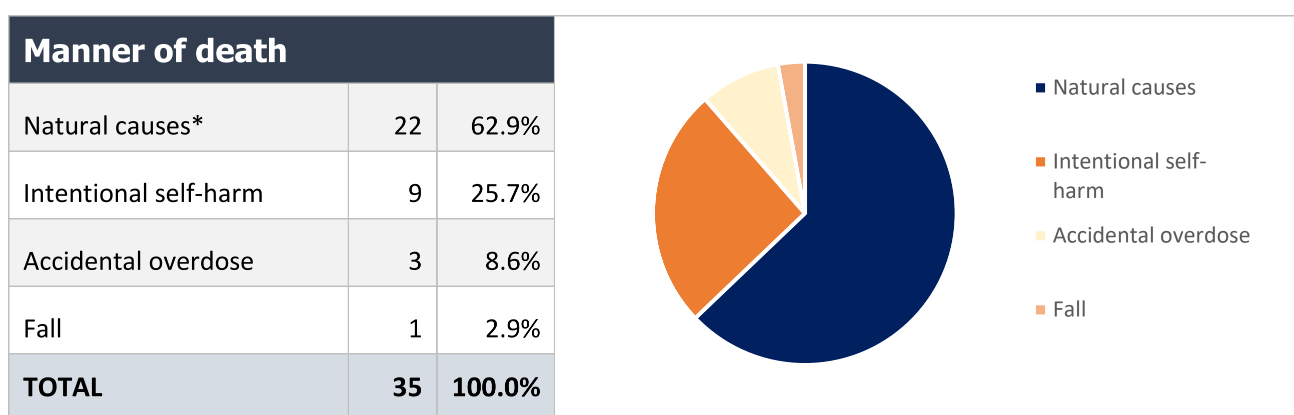
Deaths in custody

35 inquests finalised by a Senior Coroner in 2022

34 Male

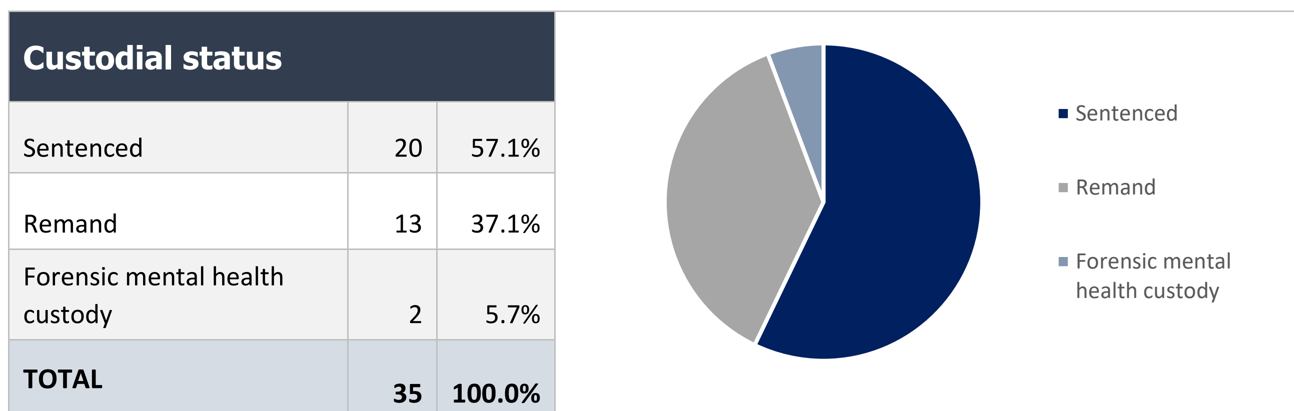
1 Female

9 First Nations persons



Manner of death		
Natural causes*	22	62.9%
Intentional self-harm	9	25.7%
Accidental overdose	3	8.6%
Fall	1	2.9%
TOTAL	**35**	**100.0%**

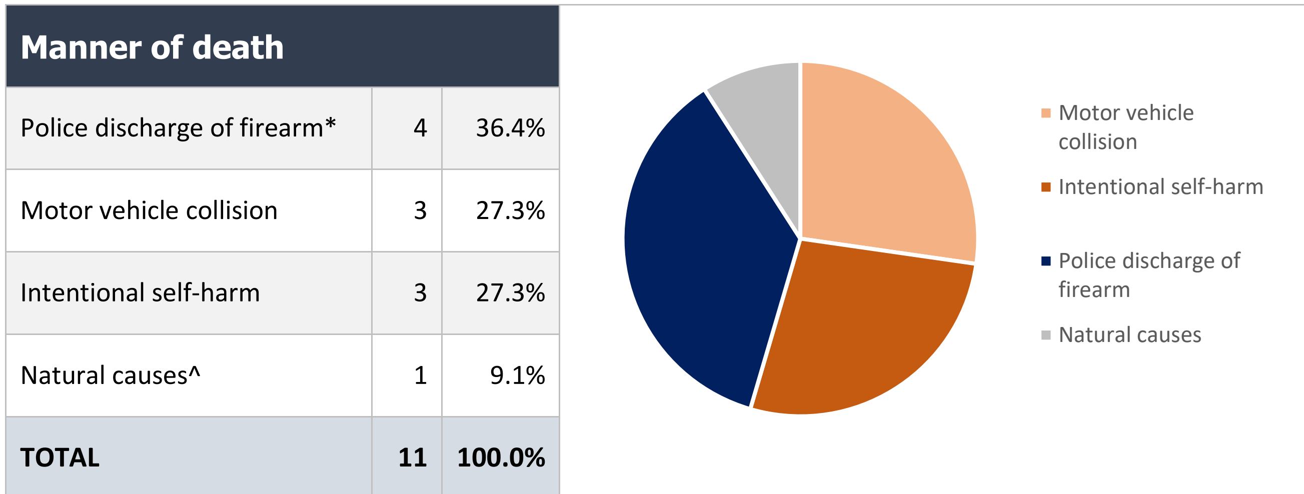
* Note: where the Coroner has found that a death was due to natural causes, they may have also identified causal or contributory issues regarding the quality of care, treatment and/or supervision of the person prior to their death that may be the subject of recommendations aimed at preventing similar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



Custodial status		
Sentenced	20	57.1%
Remand	13	37.1%
Forensic mental health custody	2	5.7%
TOTAL	**35**	**100.0%**

Deaths as a result of police operations

11 inquests finalised by a Senior Coroner in 2022 **9** Male **2** Female **0** First Nations persons

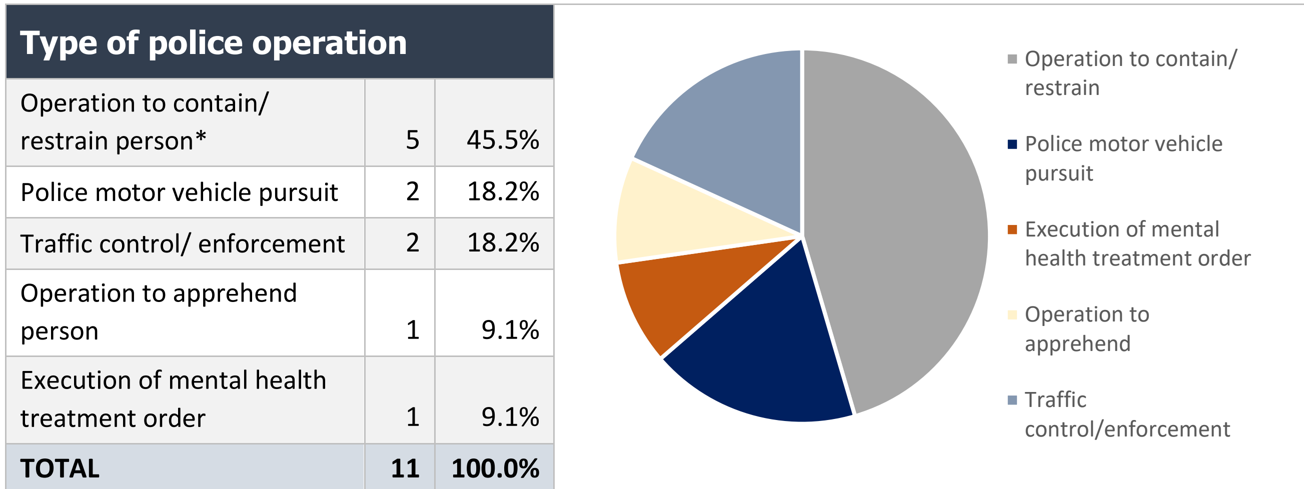


Manner of death		
Police discharge of firearm*	4	36.4%
Motor vehicle collision	3	27.3%
Intentional self-harm	3	27.3%
Natural causes^	1	9.1%
TOTAL	**11**	**100.0%**

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

- Entered the deceased's home to enforce a mental health treatment order and were confronted by the deceased, who was experiencing acute psychosis and holding a sword.
- Attempted to contain the deceased, who had attended a police station with a firearm and commenced shooting with the intention of provoking police to cause his death.
- Attempted to execute an arrest warrant for the deceased, during which he had stabbed one of the arresting officers.
- Attended the deceased's home in response to reported threats and entered the premises after observing a fire, where they were confronted by the deceased holding an axe.

^ *Natural causes*: One death was found by the Coroner to be due to a pulmonary thromboembolism that developed following medical treatment of the person for injuries caused by a self-inflicted single person motorcycle collision, occurring several weeks after the collision.



Type of police operation		
Operation to contain/ restrain person*	5	45.5%
Police motor vehicle pursuit	2	18.2%
Traffic control/ enforcement	2	18.2%
Operation to apprehend person	1	9.1%
Execution of mental health treatment order	1	9.1%
TOTAL	**11**	**100.0%**

* *Operation to contain/restrain person*: Five deaths occurred in circumstances where police responded to welfare concerns for the deceased person and/or threats of harm to others made by the deceased person.

- In all cases, the Coroner noted evidence that the deceased was experiencing a mental health condition and/or had a history of mental illness.
- In three cases in which the deceased person died by suicide, responding police had some knowledge of the deceased's mental health condition. Of these:
  - In two cases, the conduct of attending officers was commended by the Coroner. In one, the deceased died by suicide almost immediately upon the arrival of responding police, who did not have an opportunity to engage. In the other, responding police were able to engage with the deceased but were ultimately unable to take actions to prevent his death.
  - In the third case, the deceased died by suicide when attending police delayed entry to his home while awaiting the arrival of other officers, in circumstances where a prior attempt to arrest the deceased had been made and he had made threats of harm that were interpreted as threats towards police. The Coroner did not criticise the conduct of attending officers, but observed (without making formal recommendations) the need to clarify ambiguous threats of harm before internally communicating them where possible.
  - Two Coroners noted the importance of enhanced mental health training for police officers, but did not make formal recommendations as the issue was not explored in detail at inquest.

Written findings

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

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

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

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

Note that, due to the time required to complete the coronial investigation to inform the inquest process, and the impact of the COVID-19 pandemic, the substantial majority of cases in the lists below were reported to the Coroner in years prior to 2022.

Deaths in custody

	Case number	Inquest into the death of	Senior Coroner
1	201800054603	Mootijah Douglas Andrew SHILLINGSWORTH	Magistrate J Baptie
2	201800276778	LAK	Magistrate C Huntsman
3	201900120612	Kevin BUGMY	Magistrate H Grahame
4	201900120612	Kai David McEWAN	Magistrate D Lee
5	202000004795	Mervyn Douglas MORGAN	Magistrate C Forbes
6	202000245234	Jeffrey ELLINGTON	Magistrate D Lee
7	202100064779	Kerry KNIGHT	Magistrate H Grahame
8	202100306257	Jason RADFORD	Magistrate E Ryan
9	202100060334	Trevor SAMUEL	Magistrate E Ryan
10	201700099958	Gavin ELLIS	Magistrate C Forbes

	Case number	Inquest into the death of	Senior Coroner
11	201700142803	Maluovailoa TAFAU	Magistrate D Lee
12	201800279370	Ali KIZILDAG	Magistrate B Shields
13	201900010495	William EPERE	Magistrate E Kennedy
14	201900159733	Ronald REEVES	Magistrate B Shields
15	201900258876	Ricardo Damien ARQUERO	Magistrate B Shields
16	201900276007	IM	Magistrate B Shields
17	201900278264	Khaled DIB	Magistrate B Shields
18	201900281694	Jose Manuel XAVIER	Magistrate B Shields
19	201900289826	Richard NAVARRO	Magistrate C Huntsman
20	201900289835	Andrew GILBERTSON	Magistrate C Forbes
21	202000010127	Vivian David ANDERSON	Magistrate E Kennedy
22	202000026597	Ronald David TURNER	Magistrate D Lee
23	202000100722	Michael QUINN	Magistrate C Forbes
24	202000194015	Ivan CHRISTOV	Magistrate J Baptie
25	202000268433	ZA	Magistrate C Huntsman
26	202000305849	Steve FESUS	Magistrate D Lee
27	202000308509	Robert FENNELL	Magistrate E Kennedy
28	202000343056	John LITTLE	Magistrate C Huntsman
29	202100018276	David HALL	Magistrate C Forbes
30	202100063278	Edward ENGLISH	Magistrate E Ryan
31	202100081529	Chin Hung HO	Magistrate B Shields
32	202100230432	ZH	Magistrate C Huntsman
33	202100263382	WW	Magistrate C Huntsman
34	202200106226	GL	Magistrate C Forbes
35	202000020808	NG	Magistrate C Huntsman

Deaths as a result of police operations

	Case number	Inquest into the death of	Senior Coroner
1	201500007720	Tateolena TAUAIFAGA	Magistrate E Ryan
2	201500124745	WX	Magistrate C Huntsman
3	201700264782	Ian FACKENDER	Magistrate T O'Sullivan
4	201800028682	Nick NEWMAN	Magistrate E Ryan
5	201900308934	Daniel KING	Magistrate E Kennedy
6	201900345858	Jasson PEARCE	Magistrate C Huntsman
7	202000003733	Brenden MONTGOMERY	Magistrate C Forbes
8	202000094710	Dennis ELLIS	Magistrate E Kennedy
9	202000137690	MG	Magistrate E Kennedy
10	202000188420	Sky HEFFERNAN	Magistrate C Forbes
11	202100006045	RW	Magistrate E Kennedy