Report by the NSW State Coroner

into deaths in

custody/police operations

for the year 2014.

(Coroners Act 2009, Section 23)

NSW Office of the State Coroner
NSW Department of Attorney General and Justice
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The Honourable Gabrielle Upton, MP
Attorney General and Minister for Justice
Level 31 Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

15 May 2015

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 which relate to deaths which 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. As a result you will, if you wish be able to follow a particular death from its initial report to finalisation by looking at successive annual reports.

I attach a hard copy and an electronic copy of the 2014 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, or in the course of, police operations, or while the person is in an inmate of a child detention centre or an adult correctional centre.

It is unclear whether deaths in Commonwealth detention facilities fall within this definition. In the submission I made to the review of the Coroners Act that is currently underway I suggested this should be clarified.

As you would appreciate, deaths in prisons have for centuries been recognised as sensitive matters warranting independent scrutiny. Similarly, deaths occurring in the course of police operations which include shootings by police officers, shootings of police officers, suicides and other unnatural deaths, 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 matter referred to.

Yours faithfully,

Magistrate Michael Barnes

(NSW State 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 2014

His Honour Magistrate MICHAEL BARNES

NSW State Coroner

1982- 1987	Solicitor in private practice
1987 -1990	Principal Solicitor, Aboriginal Legal Service
1990-1993	Principal Legal Officer, Criminal Justice Commission
1993-1999	Chief Officer, Complaints Section, Criminal Justice Commission
2000-2003	Head, School of Justice Studies, Queensland University of Technology
2003-2013	Appointed Queensland State Coroner
2013	Appointed NSW Magistrate
2014	Appointed NSW State Coroner

His Honour Magistrate HUGH DILLON

Deputy State Coroner

1983	Admitted as Solicitor.
1984	Legal Projects Officer, NSW Council of Social Service.
1986-1996	Worked as Lawyer in government practice, with NSW Ombudsman Office and Commonwealth Director of Public Prosecutions.
1996	Appointed as a Magistrate of the NSW Local Court.
2007	Appointed Visiting Fellow, Faculty of Law, UNSW. Appointed part time President of Chief of Defence Force Commissions of Inquiry (Defence Force Inquests).
2008	Appointed NSW 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.

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 NSW Deputy State Coroner**.**

His Honour Magistrate PAUL MACMAHON

Deputy State Coroner

1973	Admitted as a Solicitor of the Supreme Court of NSW and Barrister and Solicitor of the Supreme Court of the ACT and the High Court of Australia.
1973-79	Solicitor, employed in Government and Corporate organisations.
1979-02	Solicitor in private practice.
1993	Accredited as Specialist in Criminal Law, Law Society of NSW.
2002	Appointed a Magistrate under the *Local Court Act 1982*.
2003	Appointed Industrial Magistrate under the *Industrial Relations Act, 1996*.
2007	Appointed NSW Deputy State Coroner.

Her Honour Magistrate SHARON FREUND

Deputy State Coroner

1991	Admitted as Solicitor of the Supreme Court of NSW.
1993-97	Solicitor in private practice.
1997-2006	Litigator Partner/ Consultant Diamond Peisah Solicitors.
2003	Appointed Arbitrator of District Court of NSW.
2004	Appointed Arbitrator of Local Court of NSW.
2006	Appointed Magistrate of Local Court of NSW.
2011	Appointed NSW Deputy State Coroner.

His Honour, Magistrate IAN CHEETHAM

Deputy State Coroner (Newcastle)

1978	Admitted to practice as a Solicitor.
1978-2009	Solicitor in private practice.
1996	Certified as Accredited Specialist in Business Law.
2009	Appointed a Magistrate in NSW.
2013	Appointed NSW Deputy State Coroner.

CONTENTS

Introduction by the New South Wales State Coroner

What is a death in custody?

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

- 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.

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

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 more than twenty 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, as follows:

> *The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and it is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion, and satisfies the community that deaths in such places are properly investigated*[2]*.*

I 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*[3]*.*

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.

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

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

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 from the Crime Scene Unit (officers of the Physical Evidence Section), other relevant police and a coronial medical officer or a forensic pathologist to attend the scene of the death. The Coroner will check to 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.

Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit and the Forensic Pathologist. The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during the inquest. If the State Coroner or one of the Deputy State Coroner's is unable to attend a death in custody/police operations occurring in a country area, the State Coroner may request the local Magistrate Coroner to attend 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 may 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 the post mortem examination is conducted by experienced Forensic Pathologists at Glebe, Newcastle or Wollongong Departments of Forensic Medicine.

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 an expansion in recent years. At one time its main task was to investigate whether a suicide might have been caused by ill treatment or privation within the correctional centre. Now the Coroner will examine the system for improvements in management, or 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.

Government Responses to Coronial Recommendations

Premier's Memorandum 2009-12, ‘Responding to Coronial Recommendations’ was introduced in 2009.

It sets out the process for Ministers and Government agencies to respond to recommendations made by the Coroner. The Memorandum is there to ensure that there is consistency in reporting what agencies and Ministers are doing in response to recommendations directed at them by the Coroner.

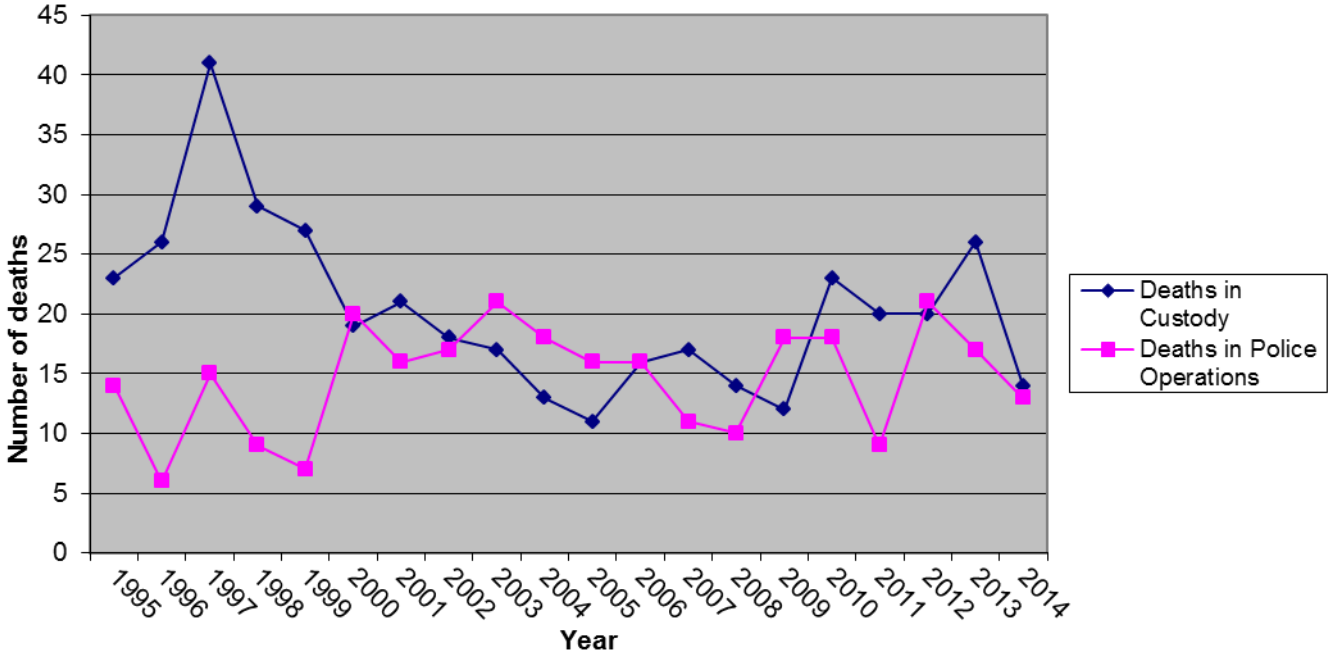
Agencies and Ministers are required to report to the Attorney General, within six months of receiving a coronial recommendation, outlining any action to be taken to implement the recommendation.

Not all inquests will result in the Coroner making recommendations. Recommendations may also be made to non-Government bodies, which are not required to report to the Attorney General.

***Section 23* Deaths Reported to the NSW State Coroner during 2014.**

<u>Table 1</u>: Deaths in Custody/Police Operations, for the period to 2014.

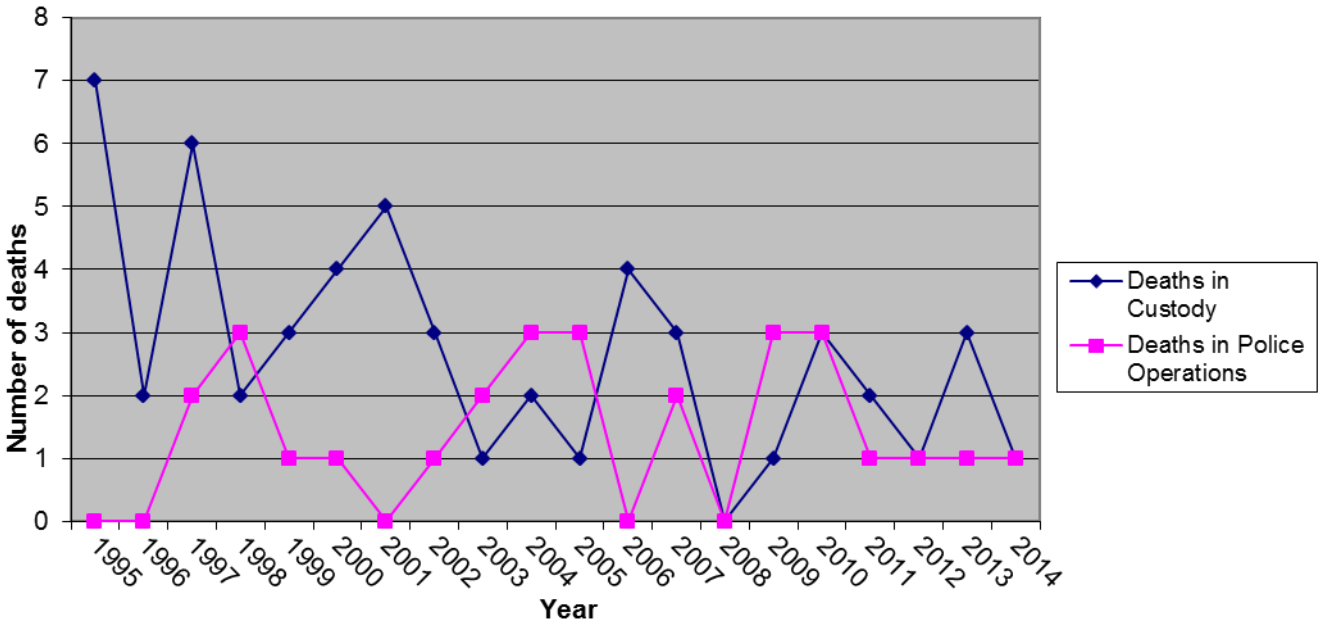
Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32
2007	17	11	28
2008	14	10	24
2009	12	18	30
2010	23	18	41
2011	20	9	29
2012	20	21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



Section 23 **Aboriginal deaths which occurred in 2014**

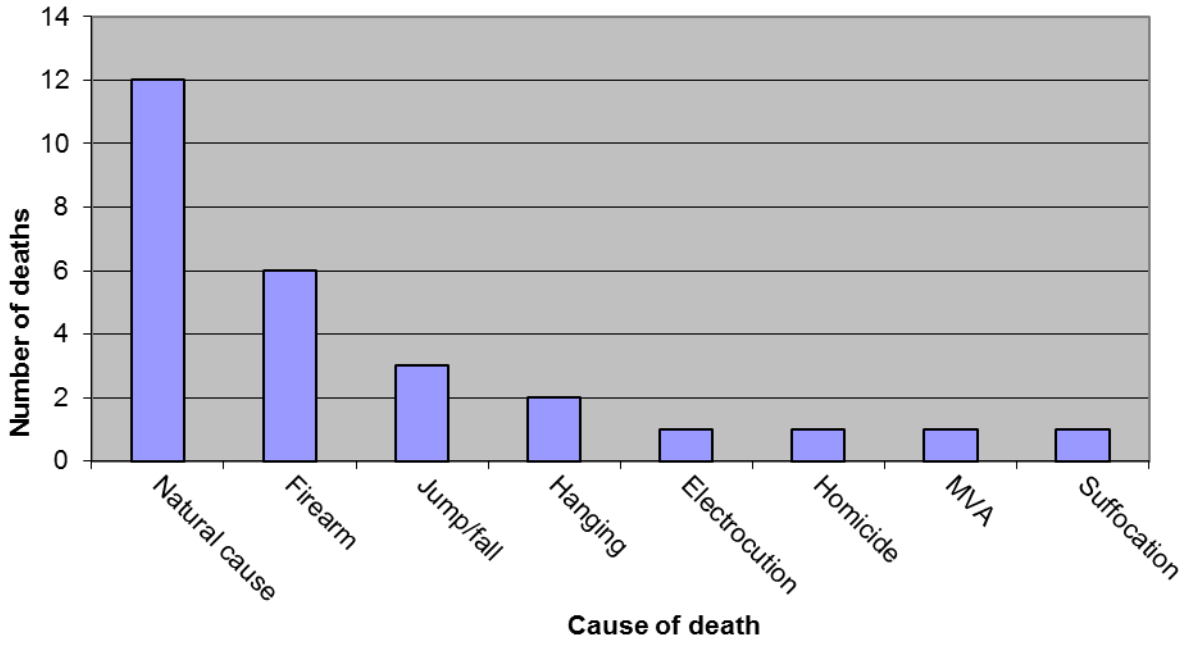
Table 2: Aboriginal deaths in custody/police operations 2014.

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



Circumstances of deaths of persons who died in Custody/Police Operations in 2014:

12 x natural causes
1 x motor vehicle accident
2 x hanging
1 x electrocution
6 x gunshot or firearm
3 x jump/fall
1x suffocation
1 x homicide



Unavoidable delays in hearing Section 23 cases

In 2014 the State Coroner and the Deputy State Coroners completed 30 inquests of deaths reportable by Section 23.

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.

Summaries of Individual Cases Completed in 2014

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 2014. 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 some cases 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 will be referred to as XX**.**

SECTION 23 INQUESTS UNDERTAKEN IN 2014

	Case No	Year	Name	Coroner
1	389375	2011	Troy O'Brien	DSC MacMahon
2	2305	2011	XX	DSC Dillon
3	388886	2011	Frederick McGregor	DSC Forbes
4	65200	2012	Ali Rahmi	DSC Forbes
5	94483	2012	Darren Neill	DSC MacMahon
6	100399	2012	Kaniappa Raju	DSC MacMahon
7	102820	2012	XX	DSC Forbes
8	259122	2012	Madaswamy Shankaranayana	DSC Dillon
9	302011	2012	William Smith	DSC Cheetham
10	314507	2012	XX	DSC Dillon
11	323452	2012	Jason Thompson	DSC MacMahon
12	349869	2012	Pat Morena	DSC Dillon
13	379032	2012	Ian Connelly	DSC Freund
14	1220	2013	John Albrecht	DSC MacMahon
15	2130	2013	Scott Pickford	DSC MacMahon
16	18658	2013	Stanley Lord	SC Barnes
17	8375	2013	Amir Chouman	DSC Forbes
18	31630	2013	Andrew McGregor	DSC Freund
19	77634	2013	Patrick Hudd	SC Barnes
20	134128	2013	Cecil Dalton	DSC Forbes
21	155396	2013	XX	DSC MacMahon
22	240615	2013	Patricia Goddard	DSC MacMahon
23	258164	2013	XX	DSC Truscott
24	265110	2013	Robert Stewart	DSC Freund
25	275420	2013	John Anderson	DSC Freund
26	316085	2013	David Marshall	DSC Freund
27	331891	2013	Leif James	DSC Forbes (s)
28	359900	2013	XX	DSC Dillon
29	366920	2013	Mark Bennett	DSC Freund
30	189899	2013	Ahmad Ali Jaferi	DSC Dillon

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1. 389375 of 2011

Inquest into the death of Troy O’Brien. Finding handed down by Deputy State Coroner MacMahon on the 10th July 2014.

This has been an inquest into the death of Troy Peter O'Brien. Mr O'Brien was born on 1 October 1979. He was the father of two children, two young children. He, however, died whilst he was an inmate at the Kirkconnell Correctional Centre and as a result of that, there are certain consequences for the coronial procedure.

Mr O'Brien was sentenced to a fixed term of imprisonment of three months, on 16 March 2011. He entered into custody at the Lismore cells that day. He was transferred to Grafton Correctional Centre the next day on 17 March 2011.

On 3 April, he was transferred to the Metropolitan Special Program Centre in Sydney and then on 7 April 2011, he was transferred to Kirkconnell Correctional Centre where he remained. His term of imprisonment was to expire on 15 June 2011. Mr O'Brien initially entered an appeal against his sentence, but subsequently sought to withdraw that appeal.

At about 11.10 on 28 April 2011, Mr O'Brien was observed slumped in a chair, being assisted by another inmate. Justice Health staff and Correctional Service staff came to his assistance. At 1.33 the same day, he was observed to have commenced a cardiac arrest and CPR was commenced. An ambulance was called which arrived ten minutes later and at that time, ambulance officers took over his care. A second ambulance arrived later.

Mr O'Brien was found to respond to the CPR at about 1.47. However, at 2 o'clock that afternoon, he was intubated, place on a gurney and moved to the ambulance and transported to Bathurst Hospital.

At 9 o'clock that night his condition was such that he was transported to the Orange Base Hospital intensive care unit. Because his condition was considered problematic, his family were advised and members of his family were able to come to Orange. At 8.45pm the next day, that is 29 April 2011, Mr O'Brien was pronounced deceased.

It is important to understand the role and function of a coroner. The relevant legislation is the Coroners Act 2009. Section 18 of that Act gives a coroner jurisdiction to hold an inquest where a death or suspected death of an individual occurs within New South Wales or the person, who has died or is suspected to have died, was ordinarily resident in New South Wales. Section 27 provides that certain deaths must be the subject of an inquest. And inquest in respect of all other deaths may be dispensed with. One such situation where an inquest is mandatory is where the jurisdiction to hold an inquest arises under s 23 of the Act.

Section 23(a) refers to a death of a person who is in the custody of a police officer or other lawful custody, and Mr O'Brien was serving a sentence of imprisonment at the time of his death, so his death therefore comes within the parameters of s 23(a) of the Coroners Act. Section 23 also requires that there are only certain coroners who are able to undertake such an inquest. Those coroners are described in the legislation as senior coroners, but in short, are the state coroner or one of the deputy state coroners.

The primary function of a coroner, when an inquest is held, is set out in s 81(1) of the Coroners Act. That section requires that at the conclusion of an inquest, the coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death, and the cause and manner thereof.

Section 82 of the Act provides that a coroner conducting an inquest may also make such recommendations as he or she considers necessary or desirable arising out of any matter with which the inquest is concerned. The making of recommendations is discretionary and usually relate to matters of public health, public safety or the conduct of services provided by public instrumentalities.

In this way, coronial proceedings can be looking forward and aiming to prevent further deaths in the future.

In this case, a number of matters are not matters of dispute. Mr O'Brien's identity was established when he was identified by his father, Cedric, at the Orange Hospital shortly after his death. The date of his death is not a matter in dispute. Dr Krishnan Pillai who was an employee of the Orange Hospital certified him to be deceased at 9.45 on 29 April 2011. The date of his death is, therefore, 29 April 2011. Mr O'Brien was admitted to Orange Hospital which is where he died. The place of his death is therefore Orange Hospital, Orange, New South Wales 2800.

The question of manner and cause of Mr O'Brien's death were matters of investigation during the course of the inquest investigation. When Mr O'Brien died, the doctor who certified his death, Dr Pillai, indicated that Mr O'Brien's cause of death was, "Cardiac arrest with prolonged period of asystole leading to end-organ ischaemic multiorgan failure". The issue of the cause of the cardiac arrest was a matter to be investigated.

Mr O'Brien was the subject of an autopsy examination at the Department of Forensic Medicine in Newcastle. The pathologist undertaking the examination was Dr Nadistan(?), supervised by Professor Tim Lyons, the Chief Forensic Pathologist in Newcastle, and the autopsy was undertaken on 3 May 2010. During the course of autopsy examination, Dr Lyons indicates that: "The symptoms described by this man are highly suggestive of a cardiac event. At autopsy there was, however, no definitive pathology in the heart to explain the symptoms".

In addition, troponin, which is an enzyme which is taken at the time of autopsy and in this case, taken on 29 April 2011 at 3 o'clock in the afternoon, Dr Lyons indicated that this was abnormally high which reflects an acute myocardial ischaemia, and Dr Lyons then opines that, "Given the clear clinical history of chest pain, on the balance of probabilities, death is considered to be consistent with ischaemic heart disease".

Other indicia, which are consistent with that conclusion, is that Mr O'Brien suffered from morbid obesity.

At death he had a BMI of 41.8, which placed him in the very high risk of sudden death, and is consistent with a person who suffers from myocardial ischaemia or commonly referred to as ischaemic heart disease.

In those circumstances, on the balance of probabilities and accepting the conclusions proffered by Dr Lyons, the cause of Mr O'Brien's death was more likely than not ischaemic heart disease which is a natural cause of death. As I indicated, two of the requirements under s 81 are that the coroner, at an inquest, is to make findings relating to the cause and manner of death of the deceased. In this case, the findings I propose to make would be that Mr O'Brien died from the condition of ischaemic heart disease, and that means that the manner of his death was a natural one.

In most cases, at that point, a coroner reviewing the evidence available would be likely to dispense with the conduct of an inquest, but as I have indicated, Mr O'Brien died whilst a prisoner in the custody of Corrective Services and it is mandatory that an inquest be conducted. The effect of that is, or the reason such inquest being mandatory is explained by the former State Coroner, Kevin Waller, when he said:

"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 the loss of liberty and 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 satisfy the community that deaths in such places are properly investigated."

As a result, it was necessary to examine the circumstances of Mr O'Brien's incarceration to determine whether or not there were any systemic failures which might have contributed to Mr O'Brien's demise. This required an examination of the medical treatment that he received and the complaints that he made whilst in custody.

And, it also required, in examining, taking into account the fact that, as I have already indicated, Mr O'Brien was transported from Grafton to Sydney by prison van, a journey of some ten hours. And then, from Sydney to Kirkconnell, a journey of some two and a bit hours and whether or not there was any contribution to his demise from those circumstances.

When Mr O'Brien entered into custody at the Lismore Court cells, he was the subject of a reception screening tool which is a normal process for persons entering into custody. That tool identified that he, at the time of entering into custody, suffered from marked swelling down the right side of his body from abdomen down right leg to ankle with blood in stools and dark dysuria. He was then transported on 17 March to Grafton and he was placed on a waiting list as assuming urgent requirement for him to be examined by a medical officer. Whilst he was at Grafton, there were two medical officer clinics on 18 March and 31 March, both for reasons that have not been able to be identified, he was not the subject of examination during those medical clinics. As I have already outlined, he was transported from Grafton to Sydney and then to Kirkconnell.

At Kirkconnell, he complained, on 8 April, to the registered nurse that he had hearing loss and painful ears. It was noted that he was suffering from poor circulation in his leg and clotted veins and he was reviewed on 11 April and then an appointment was made for him to be examined by a medical officer on 20 April 2011. During that examination, he was documented to suffer from chronic varicose veins and superficial thrombophlebitis and the recommended treatment being for those conditions being compression bandage, elevation, aspirin and Keflex. He was given further antibiotic eardrops for his bilateral ear discharge.

There was a further medical clinic on 27 April where Mr O'Brien self-referred himself saying that his, “Right leg is clotting and in pain, and I can hardly walk on it and I need to right medications.” However, before he was able to be examined, he went into the difficulties at 1.10 that I have already outlined.

Two questions arose from this. Firstly, given his diagnosis, whether or not the cause of his death was a possible pulmonary emboli, and secondly, whether or not the transportation of Mr O'Brien to Sydney and then to Kirkconnell might have been a contributing factor to his death.

As a result of that, Dr John Raftos was qualified by me to examine the treatment received by Mr O'Brien whilst in custody and to provide an opinion. Dr Raftos is a Fellow of the Australian College of Emergency Medicine and has been so since 1983. He has been a specialist in emergency medicine since that year. He is Conjoint Associate Professor of Medicine at the University of New South Wales and has been so since August 2011. Dr Raftos was provided the records of Justice Health and the autopsy report of Dr Lyons.

Dr Raftos, in his report, goes through the history which I have outlined, and then entered into a discussion of what the cause of Mr O'Brien's death might be best attributed as being, and answered a number of specific questions that were put to him on my behalf. Dr Raftos, in his discussion, records the following: "It is always difficult to attribute a cause of death where no clear anatomical cause of death is found at post-mortem examination.

In Mr O'Brien's case, there was no objective evidence at post-mortem examination that he had an acute myocardial infarction leading to his death. But the pathologist appropriately noted that the diseased entity, whose presentation most closely resembled Mr O'Brien's final illness, was acute coronary syndrome, that is, a heart attack with ventricle fibrillation, an abnormal and fatal heart rhythm that occurs with acute coronary syndrome as a mode of death.

The doctors who treated Mr O'Brien when he was critically ill before his death made a presumptive diagnosis of a pulmonary embolism because the features of Mr Brien's final illness also resembled the features of pulmonary embolism and because he had a swelling of his leg in the weeks preceding his death, suggesting the possibility of deep venous thrombosis which is a precursor to pulmonary embolism.

This was a reasonable working diagnosis in the circumstances but post-mortem examination failed to show evidence of pulmonary embolism. It would be reasonable to expect that a fatal pulmonary embolism would be the size that would make it clearly obvious at post-mortem examination, so pulmonary embolism can be reasonably discounted as the cause of Mr O'Brien's death."

Dr Raftos goes on to say:

"Atherosclerosis is an accumulation of fatty deposits in the walls of arteries throughout the body. In the coronary arteries, it causes ischaemic heart disease, which is also sometimes known as coronary artery disease. The major risk factors for the development of atherosclerosis and therefore for coronary artery disease are; a family history of coronary artery heart disease, that is a generic pre-disposition to the disease, hypocalcaemia, cigarette smoking, diabetes and high blood pressure or commonly referred to as hypertension."

Dr Raftos says:

"Atherosclerosis begins early in life with deposits of fat accumulating in the walls of affected arteries. The fat in the artery walls forms into plaques. For reasons not known, the plaques are prone to rupture through the inner wall of the artery. When the plaque rupture does occur, blood in the arteries clots and the rupture causing sudden obstruction of the coronary artery and the sudden loss of blood supply to the heart muscles which supplies the artery. This is called acute coronary syndrome which can be presented in three ways. Firstly, sudden cardiac death, secondly, acute myocardial infarction, and thirdly, unstable angina."

He then goes on to discuss the various treatments that are available and concludes:

"Whilst Mr O'Brien's obesity and his cigarette smoking were risk factors for coronary artery disease, the post-mortem examination showed that he had coronary artery atherosclerosis.

There is nothing in the medical records of Justice Health that would suggest that he had a clinical manifestation of coronary artery disease that ought to have led to suspicion of or investigation for coronary artery disease by them."

I then asked Dr Raftos a number of questions. They were:

"Having regard to the history obtained and the observations made in the RST that is the reception screening tool, on 17 March 2011, was the assessment by the medical officer of a semi-urgent basis appropriate?

Dr Raftos said, in response, in part, after having outlined what was observed on 17 March 2011:

"The concern, when a patient has swollen legs is that he may have deep vein thrombosis as opposed to superficial thrombophlebitis which affects the superficial veins. The concern with deep vein thrombosis is that it is a precursor to pulmonary embolism which is potentially fatal. Given the concern that the swelling may have been caused by deep vein thrombosis, Mr O'Brien should most probably have been seen urgently by a doctor to arrange for a venous duplex ultrasound scan of the leg to confirm or exclude the possibility of deep vein thrombosis."

So, on 17 March, Dr Raftos was of the view that Mr O'Brien should have been urgently examined by a doctor and there should have been certain tests undertaken. But quite properly, Dr Raftos, in hindsight, says, "Given the post-mortem examination, showed no evidence of pulmonary embolism. Earlier medical assessment of his swollen right leg would probably not have prevented Mr O'Brien's death." The second question was:

"Having regard to the history obtained and the observations made in the RST, was it appropriate for Mr O'Brien to be transferred from Grafton to Sydney on 2 April, a ten hour road trip, without first having been examined by a medical officer?"

The answer opined was:

"Given that there should have been concern about the possibility of deep vein thrombosis and that long distance travel is a risk factor for that deep vein thrombosis, Mr O'Brien should most probably have been assessed by a doctor regarding his swollen legs before being transported to Sydney."

The same answer was given in respect to the transport to Orange. I then asked Dr Raftos to comment on the examination of Mr O'Brien at Kirkconnell by, firstly, nursing staff and secondly the medical officer who examined him on 20 April 2011. Dr Raftos indicated that their treatment of Mr O'Brien was appropriate in the circumstances.

A question was asked of Dr Raftos as to having regard to the fact that was there any treatment which Justice Health ought to have provided which might have prevented Mr O'Brien's death on 29 April 2011. Dr Raftos indicated that:

"The pulmonary embolism having been excluded at autopsy, there was nothing in the medical records of Justice Health that would suggest that Mr O'Brien had any clinical manifestations of coronary artery disease that ought to have been led to a suspicion of, or investigation for, coronary artery disease which is the postulated cause of death."

Dr Raftos was asked to comment on the proposed cause of death, and he indicated, "Ischaemic heart disease appears to the disease that best fits the description of Mr O'Brien's final illness." But he did indicate that whilst there was no objective evidence at post-mortem examination to indicate the cause of Mr O'Brien's death, both ischaemic heart disease and pulmonary embolism would have fitted the circumstances of the death, however, pulmonary embolism was excluded by the examination at autopsy. Dr Raftos therefore supports the conclusion that Professor Lyons came to that the cause of Mr O'Brien's death was ischaemic heart disease.

The issue of Mr O'Brien's transport, whilst one which was the subject of investigation, was examined.

The exhibit 4 contains a report from Dr Suresh Badami. I do not propose to go through the details of that document other than to say that Dr Badami, having considered the material available to him, formed the view that:

"From the records, it would appear that the person completing the RST either did not consider it appropriate to place Mr O'Brien on a medical hold in accordance with the policy, or did not consider the criteria under the policy."

In short, having regard to the circumstances observed of Mr O'Brien's condition at Grafton and applying the policies of Justice Health: "It would appear not to have been appropriate for Mr O'Brien to have been transferred from Grafton to Sydney on 2 April without having been medical examined because of the medical issues recorded on the RST which ought to have been investigated."

Dr Badami then goes on to note the outcome of the examination as to the cause of Mr O'Brien's death. In short, the investigation shows that Justice Health have acknowledged that given Mr O'Brien's condition, as identified by staff at Justice Health, he should not have been transported to Sydney without having first been examined by a medical officer. However, it is likely, having regard to the conclusions of Dr Raftos, that such an examination would not have been likely to prevent Mr O'Brien's death because the examination would have sought to determine whether or not Mr O'Brien was suffering from a pulmonary emboli and the relevant examination would be likely to have excluded that as occurring, and there are no other objective medical symptoms to suggest that Mr O'Brien was suffering from ischaemic heart disease.

In those circumstances, Justice Health having acknowledged that he should have been examined by a medical officer. There is no evidence to support the contention that had he been examined by a medical officer as he should have, his death would have been prevented at the time it occurred. In those circumstances, it is unnecessary for me to make any recommendations as to any improvements in the policies and procedures of Justice Health or Corrective Services.

It is unfortunate, however, that their policies were not complied with in this case in respect of Mr O'Brien, but the non-compliance, on the evidence available, was not a contributing factor to Mr O'Brien's death.

Formal Finding:

That Troy Peter O'Brien (born 1 October 1979) died on 29 October 2011 at the Orange Base Hospital, Orange in the State of New South Wales. The cause of his death was Ischaemic Heart Disease. The manner of his death was natural.

2. 2305 0f 2011

Inquest into the death of XX. Finding handed down by Deputy State Coroner Dillon on the 21st May 2014.

Non-publication orders:

Orders have been made under s 74 of the Coroners Act Pursuant to s 75(5) I permit a report of these proceedings on condition that the deceased not be identified except by the initials "XX".

This is an inquest into the death of XX, a remand prisoner who died on the evening of 26-27 September 2011 at the Metropolitan Remand and Reception Centre after hanging himself in his cell. He had been refused bail in respect of a number of alleged offences.

Jurisdiction

His death was reported because it occurred in custody. An inquest is therefore mandatory under the provisions of s 23 of the Coroners Act.

XX was a 38 year old man who had an extensive history of drug dependency and related criminal offences. At the time of his arrest he was using "ice" and behaving in erratic fashion. It seems that he had been using and dependant on drugs from the time he was about 18 years old. He came from a loving and caring family who made genuine and regular attempts to help him rehabilitate himself.

Role of the coroner

The coroner's role is that of investigator and fact-finder. The coroner's function is to follow the evidence in an attempt to identify a deceased person, when and where that person died, the physical cause of death and how that death came about.

A coroner may also make recommendations relating to a particular death especially in relation issues of public health and safety.

Coroners have particular responsibilities under the Coroners Act to investigate deaths in custody. Prisoners are vulnerable, not only because they are deprived of their liberty and are under the power of the State, but because very many of them are mentally ill or drug-dependent or sick, sometimes all three of those things.

They have few advocates or protectors and are never likely to become popular in the wider community. The State owes them a duty of care and it is therefore necessary that Corrective Services and Justice Health be held accountable for their management of prisoners. In most cases, there will be little or no criticism but the scrutiny of an independent coronial system is a safeguard and an incentive to maintain appropriate and reasonable standards of care of those in custody.

The issues

In this case the primary issues are:

- the identity of the deceased person
- the date and place of XX's death
- the cause of his death and
- the manner or circumstances of his death.

The case has been thoroughly investigated by officers of the NSW Police Force and the Department of Corrective Services. The facts have been clearly brought out and are uncontentious. There do not appear to be any systemic issues of significance that must be addressed by the Department.

The background

XX was arrested on 12 September 2011 in Wollongong. He appeared in the Wollongong Local Court but was unable to meet bail conditions. He was then transferred to the MRRC.

He was assessed on his reception there by Justice Health staff. At that stage he was not assessed as being at risk. On 18 September he told another inmate that he wanted to kill himself. As a result, he was reassessed and placed in a 'safe cell' and was then managed for about a week by the Risk Intervention Team. He was also treated with diazepam to help calm him down as he was withdrawing from "ice". And he was prescribed methadone.

On 20 September he became involved in a violent altercation with prison staff. He was then placed on segregation as a disciplinary measure but this was postponed while he was still assessed as being 'at risk'. He was assessed again on 22 and 24 September and, as a result, remained under the management of the RIT. On 22 September he was served with a Court Attendance Notice in respect of a charge of Assault Occasioning Actual Bodily Harm in respect of the injury he had inflicted on the correctional officer on 20 September.

On 26 September XX was once again assessed by the RIT. This time he appeared co-operative and was willing to engage with the team. He appeared more settled and was remorseful for his actions when under the influence of 'ice'. He denied suicidal ideation and guaranteed his own safety. The 'RIT' order was then lifted and he was placed on segregation as he no longer appeared to be at high risk of self-harm.

He was not administered diazepam on 26 September due to an oversight by a nurse but was given his methadone dose that afternoon.

He was placed in a one-out cell.

At a little after 5 am the following morning he was discovered hanging in his cell. The officer who responded immediately, Senior Correctional Officer Kaiteli, did not follow the required protocol for dealing with attempted hangings and was not carrying the '911' tool which was supposed to have on his person for the purpose of cutting ligatures. Nevertheless, whether or not SCO Kaiteli had followed protocol would have made no difference.

XX was beyond resuscitation by that time.

I note that internal disciplinary investigation has taken place and the Professional Standards Branch of the Department of Correctional Services is considering what action to take in respect of SCO Kaiteli. A recommendation from me is unnecessary in the circumstances.

Conclusion

It is not clear why XX took his own life. He gave no obvious indication that he was planning to and appeared to regaining his mental equilibrium the day before he died. Suicide is unpredictable. A number of studies of psychiatric patients have shown that there is a low statistical correlation of 'high risk' assessment and suicidal behaviour. Suicidal ideation, of itself, is not predictive of self-harm. Some suicides are planned well in advance; others are spontaneous. XX left no notes or messages that reveal his thinking or plans to us or how he came to make his fatal decision.

The Department of Corrective Services has good protocols for managing prisoners at risk of self-harm and executed them appropriately in XX's case. So too did Justice Health. The assessments appear to have been carried out conscientiously and cautiously and, based on the evidence available to the team, were reasonable and appropriate.

As well as being tragedy of life wasted and prematurely ended, XX's death was also an agonising event for his family who continued to hope until his death that he may be able to change his life. The frustration and distress of a family who lose a young man in this way is difficult to imagine. I hope that they will accept my sincere and respectful condolences.

Formal Finding:

I find that XX died on 26 or 27 September 2011 at the Metropolitan Remand and Reception Centre, Silverwater, New South Wales by asphyxiation due to hanging himself while on remand.

3. 388886 of 2011

Inquest into the death of Frederick McGregor. Finding handed down by Deputy State Coroner Forbes on the 9th December 2014.

This inquest concerns the tragic death of Mr Frederick McGregor, who died at Liverpool Hospital on 25 February 2011, aged 69.

He died as a result of head injuries he received on 15 February 2011 when he was seriously assaulted in the cells at Liverpool Courthouse by a prisoner who was housed in the same cell. The prisoner, Mr Kaewklom, was convicted of his murder and is serving a 20-year sentence.

As the charges relating to the death have now been finally determined this Inquest has commenced pursuant to s. 79 (a) Coroner's Act 2009. Section 23 of the Coroner's Act 2009 requires an Inquest to be held into any death that occurs in custody.

"The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police (or Corrective Services...) have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82." [4]

[4] Waller's *Coronial Law & Practice in New South Wales*, 4th Edition, page 106

The role of 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.

A secondary role is that a coroner can make recommendations as are deemed necessary or desirable in relation to any matter connected with the death.

Inquests are not criminal investigations or trials, nor are they civil liability proceedings intended to determine fault or lay blame on persons involved in the incident. They are independent judicial investigations. This Inquest has been a close examination of the circumstances surrounding Mr McGregor's death and pursuant to s.37 of the Coroner's Act a summary of the details of this case will be reported to Parliament.

FREDERICK MCGREGOR

Mr McGregor was born on 14 February 1942. He had a difficult upbringing. He was the second of seven children. His father died when he was around 13 years old, and Mr McGregor and his siblings moved onto farms or did odd jobs to earn money. As a result, the sibling group became separated.

He never married or had a family of his own. In his younger life he worked as a truck driver in Melbourne, before moving to Sydney to live with his mother. Mr McGregor had a long-standing problem with alcohol. At the time of his death he had no fixed address, and he was staying in the Campbelltown area.

THE ISSUES

The question of the manner or circumstances of Mr McGregor's death raises a number of issues. Counsel Assisting, in his opening statement outlined a number of questions that go to the issues. They were as follows:

The appropriateness of housing Mr McGregor and Mr Kaewklom in the same cell at Liverpool Court House.

The circumstances which led Mr Kaewklom to believe that the deceased was a sex offender, and in particular:

Whether one or more police officers revealed to Mr Kaewklom that the deceased was a sex offender;

if so, whether that officer or officers intended Mr Kaewklom to know that the deceased was a sex offender; and
the consequences, if any, flowing from the above.

MR MCGREGOR'S CRIMINAL HISTORY

Mr McGregor had a number of criminal convictions recorded against him. Many were related to his alcoholism. They included offensive language and behaviour, assaults against police and breaches of bail.

He also had a sexual offence against a child on his record. On 12 June 2008 he was charged with Aggravated Indecent Assault and was ultimately convicted and sentenced to 10 months custody.
As a consequence of this conviction, Mr McGregor was placed on the Child Protection Register for 8 years. He was required to report any changes of address to police.

Mr McGregor was convicted for failing to comply with those reporting requirements in 2009, and was imprisoned. He was released on 29 September 2010.

Police became aware that he was not residing at the Campbelltown address that was recorded on the register.

On Friday 11 February 2011 Green Valley Police attended his sister Beverley Peachey's address in Ashcroft. Mr McGregor had actually called police himself, in relation to a dispute with a neighbour.

Police discovered that Mr McGregor was wanted for breaches of his reporting obligations. He was arrested, charged and brought before Campbelltown Local Court, where he was released on bail.

The conditions of bail are significant. They included a requirement to notify Campbelltown police of his current address within 12 hours of his release, pursuant to his reporting obligations on the Child Protection Register.

Mr McGregor entered bail at around 5pm on Sunday 13 February.

The next day, Monday 14 February 2011, was Mr McGregor's 69th birthday.

At about 7.40am he reported to Campbelltown police station. However, he did not advise police of his current address, as he was required to do.

At 3pm Detectives Dews and Adams of Green Valley police attended Ms Peachey's address. Police spoke with Ms Peachey, who said that Mr McGregor was not staying at her address, although he visited during the day, and she did not want him to stay there, due to his behaviour when he was drunk.

Police asked Mr McGregor for his address, but he refused. As a result, Mr McGregor was arrested.

POLICE CUSTODY

He was initially taken to Green Valley police station, arriving at 3.45pm. The custody management record from Green Valley states that he was well affected by alcohol. He was very aggressive and uncooperative, he refused to give his name or his next of kin, and he banged on the cell door. He was issued with a court attendance notice for breach of bail, to appear at Liverpool Local Court the following day, and was refused bail.

At about 6.30pm Mr McGregor was transferred to Cabramatta Police Station, where he was to remain overnight. He entered custody there 7.40pm.

Shortly before 11pm, Mr Kaewklom was brought into custody at Cabramatta Police Station. He had attended at the police station voluntarily regarding an allegation that he has seriously assaulted his ex-girlfriend four days earlier. He was arrested, interviewed, charged with grievous bodily harm and bail refused. He was 18 years old and it was his first time in custody.

The custody management records and police officers who have provided statements do not reveal any interaction between Mr McGregor and Mr Kaewklom during the whole time they were at Cabramatta police station. They were housed in separate cells.

The custody management records and the police officers who have provided statements describe Mr McGregor as being very disruptive during that night that he was in police custody. He was “shouting”, “swearing”, “being abusive”, “banging the cell doors”, “being annoying” and “it went on for hours”.

Mr Kaewklom was described as a model prisoner. He was very quiet.

LIVERPOOL LOCAL COURT

At 9.15am police transported the two prisoners to Liverpool Local Court.

Corrective Services Officer Lisa Barrett received them into custody. She recognised Mr McGregor because he had been in custody there before.

Mr Kaewklom was strip-searched in cell 1 and left to get dressed. Mr McGregor was stripped-searched in cell 2 and then moved to cell 1 and housed with Mr Kaewklom.

A CCTV camera recorded the events in cell 1 (without recording any sound). There is a time stamp on the recording, although it appears to show a later time than that obtained from other evidence, which suggests that the assault occurred at about 10:25am.

The recording shows Mr Kaewklom entering the cell at 9:24am. Mr McGregor was placed in the cell at around 9:29am.

Mr Kaewklom left the cell at about 9:55am for a legal visit and returned half an hour later. Mr McGregor then left the cell and returned at around 10:33am.

Mr Kaewklom can be seen on the footage at this point pacing up and down inside the cell, in an apparently agitated manner.

At 10:34:50am Mr McGregor walks slightly across Mr Kaewklom's path. Mr Kaewklom grabs Mr McGregor by the collar and throws him to the ground. He repeatedly jumps on Mr McGregor's head and body and kicks him forcefully to the head.

The assault lasts 22 seconds.

Officer Sapienza, who was in the office with most of his colleagues at the time, heard some noise and went to the cell.

The CCTV footage shows he arrived at the cell door about 5 seconds after the assault. He raised the alarm and other officers attended and 000 was called.

The response by Corrective Services was entirely appropriate. The officer in charge of the cells, Officer McIlvenny, commenced first aid on Mr McGregor and held him until the ambulance officers arrived in the cell about 11 minutes after the assault.

Mr McGregor was taken to Liverpool hospital. He had skull, rib and facial fractures, and significant bleeding to his brain. A craniotomy was performed that day. He was assessed to have a poor chance of recovery, and an EEG on 24 February confirmed this. On 25 February his family was consulted about his condition and ventilation support was withdrawn. He died in the intensive care unit at 11.46am.

An autopsy was performed on 27 February 2011 and the cause of death was determined to be a head injury.

WHY WERE THE TWO PRISONERS PLACED IN THE SAME CELL?

Corrective Services NSW informed this court that the two prisoners should not have been placed together. Policy material provided by Corrective Services NSW states that any prisoners arriving in custody should have been interviewed in order to complete the admission forms, being the "Lodgement" form and the "Inmate Identification and Observation Form" (IIO) (also called the "PDF").

The Offender Integrated Management System (OIMS) should also have been checked at this time, before a decision was made where to place the prisoners.

This procedure was not followed. If it had been, it would have been discovered that Mr McGregor was a convicted sex offender, had a number of alerts on his record and had previously been placed in protective call placements. Had this been known, he would have been placed in a separate cell.

On the day in question the decision as to how to place the prisoners was divided between Officer Barrett and Officer Slywa, who both acted independently of each other.

Officer Barrett was the Administrative officer at the front desk. She received the custody bundle from the transfer police. On the available evidence, it appears likely that this bundle included the following documents for Mr McGregor

The police Custody Management Records
The Form 7
The Transfer Note
The Property docket
A photo of the prisoner

The Application to Local Court and the facts.

Officer Barrett decided to wait until the prisoners saw Legal Aid before she completed the Lodgement, the IIO and interviewed the prisoners. She believed this would mean the prisoners would be "calmer and more cooperative".

She said that she assumed the two prisoners would be placed in separate cells until the interviews occurred. She said she didn't read the custody bundle documents, other than noting Mr McGregor was on breach of bail, and did not notice that Mr McGregor was on the Child Protection Register.

During the time that the two prisoners were in custody, she started to complete an IIO form for Mr McGregor but she did not attend to an IIO for Mr Kaewklom. By the time of the assault they had been in custody at Liverpool Local Court for an hour and ten minutes.

In her statement Officer Barrett said that during that time she didn't check the OIMS system either. However, it became apparent during the course of her giving evidence at this Inquest that she must have checked OIMS as the little information she did record on Mr McGregor's IIO form could not have been obtained elsewhere.

It is surprising and disappointing that despite having access to the custody bundle of documents and despite looking on OIMS she did not notice that Mr McGregor was on the Child Protection Register. That fact was noted throughout that material. She did not need to wait for an interview with Mr McGregor to find it out.

Officer Slywa directed the prisoners past the office and to the cell area. He directed that the two prisoners be held in cell 1 after the strip searches. He agreed that he was aware the interviews had not taken place and he had not discussed placement with Officer Barrett.

He said that he assumed that as the prisoners arrived together in the one police truck that it would be appropriate to hold them in the one cell. This assumption was misguided and ignored the prevailing policy.

I am informed that Liverpool Court cell complex has been demolished and rebuilt since this incident. I am also informed that the process for deciding how to house prisoners has been changed. The current system is that the custody bundle of documents is faxed to the court cells from the police so that these can be reviewed and the OIMS checked before the prisoner arrives.

The prisoner is then interviewed and a decision is made as to which cell a prisoner will go into before they are taken to any of the cells.

The IIO form actually requires the admission officer to confirm that they have read the Police Custody Management records.

I note that in May 2014 the Assistant Commissioners sent a memorandum to all Court Cell security staff reminding them that the IIO form must be completed on every offender who enters custody. In the memorandum it is stated:

> *"This becomes the first risk assessment completed on fresh custody inmates when they enter CSNSW and is always the first document scrutinised following incidents or deaths in custody"*

Also, I am told that the OIMS system has been changed so that a warning that a person is a sex offender remains active and does not "expire".

Accordingly, this fact should be readily apparent to any person who checks the OIMS.

The relevant Corrective Services NSW policy does not explicitly state that sex offenders should always be placed in separate cells.

There is policy which relates to the decision to place prisoners separately, although this policy does not mandate separate placement and leaves the decision to the relevant officer. Inspector Steven Murphy gave evidence during the Inquest.

He stated that he could see some benefit in a policy which requires sex offenders to be always placed separately.

However, I accept that the safe placement of sex offenders within Corrective Services NSW custody is a complex issue. The circumstances of this death do not suggest that a recommendation to that effect is required.

I accept the submission that adequate policy is now in place for this not to have occurred and that measures have been taken to address the oversight and try to ensure it doesn't happen again in the future.

Mr Katsinas, counsel for the Commissioner of Corrective Services, stated that the department takes in 30,000 prisoners per year. Since this incident there have been no similar deaths arising from cell placement.

WHAT CIRCUMSTANCES LED MR KAEKLOM TO BELIEVE MR MCGREGOR WAS A SEX OFFENDER?

Straight after the assault Mr Kaewklom was taken out of cell 1 and placed in cell 2 by Officer Sapienza. Officer Sapienza asked Mr Kaewklom: "what did you do that for?"

Mr Kaewklom replied: "He's a paedophile" Officer Sapienza said: "how do you know this?"Mr Kaewklom replied: "the boys in the cell last night said so."

Mr Kaeklom has always maintained that he was informed of this fact by police in the cells at Cabramatta Police Station. He described his night at the police station in his evidence in these proceedings. He said that he turned himself in to the police station to answer grievous bodily harm charges against his ex-girlfriend. He was interviewed and led into the cells. He said that he was aware that another prisoner was banging on the wall and that everything echoes in the cells.

The sounds were amplified and there were loud thuds, kicking and yelling. He said he didn't say anything and he didn't have much sleep as the sounds carried on and off.

He said that this was his first time he had been through the legal system, the first time he was in custody and he was frightened, angry, depressed, confused and didn't know what was going on. He was 18 years old.

He said that in the morning he was taken to the dock and placed beside Mr McGregor who was still being noisy.

He said that there was one police officer, Sergeant Dunn, who he hadn't seen before. Police were bagging out Mr McGregor and called him a "rock spider".

Mr Kaewklom said that he didn't know what that was and asked the officer and that the officer replied that it's a child molester. He said they were then taken in the truck to Liverpool Courthouse.

There are inconsistencies in Mr Kaewklom's accounts in his ERISP, in his three psychiatric assessments and in the agreed set of facts that were prepared for his sentence on the murder charge. In light of these inconsistencies, I am not able to accept Mr Kaewklom's account.

Sergeant Dunn, the custody manager at the police station, said that he had not read Mr McGregor's custody records, other than noting he was on a breach of bail, and did not know that Mr McGregor was on the Child Protection Register (at least not until he was preparing the documents for Court).

He gave evidence that he went to check the cells at about 5.45am, soon after he commenced duty. At that point Mr McGregor launched a tirade of abuse against him, and made a comment about Sergeant Dunn's children. Sergeant Dunn stated he may have said "shut up rock spider" in response. He accepted that Mr Kaewklom may have overheard him from his cell, although he appeared to be asleep at this time. I prefer this account, and that it explains how Mr Kaewklom came to believe Mr McGregor was a sex offender.

Sergeant Dunn denied having a conversation with Mr Kaewklom about what a rock spider meant.

Whilst it is surprising that Mr Kaewklom would have made up this conversation, and whilst it is understandable that a young man in custody for the first time may not know what a rock spider is, I am not in a position to make a finding that the conversation took place as Mr Kaewklom described in Court.

There are too many versions in his accounts as to when and where that conversation took place. The fact that many of those accounts were given at a time when he was being treated by psychiatrists and on medication and states that he was not in touch with reality does not assist with the reliability of any of his accounts.

Sergeant Dunn's behaviour was unprofessional and improper. It does not appear to be consistent with the NSW Police Code of Conduct and Ethics, which requires an officer to treat everyone with respect and courtesy.

WHAT CONSEQUENCES FLOWED FROM MR KAEKLOM BECOMING AWARE THAT MR MCGREGOR WAS A SEX OFFENDER?

The representatives for the NSW Police Force, the Commissioner of Corrective Services and for Officer Dunn, all submitted that Mr Kaewklom's knowledge that Mr McGregor was a paedophile played no part in his reason for attacking Mr McGregor. It was submitted that Mr Kaewklom had a short fuse, was volatile and was prepared to engage in gratuitous violence when it suited him. They submitted the real reason he attacked Mr McGregor was because he was being annoyed by him.

In this court Mr Kaewklom gave evidence that there were two reasons why he snapped and attacked Mr McGregor. He said that after he had been told that Mr McGregor was a rock spider he didn't want to know him and despised him. When they arrived at Liverpool court cells they were searched and placed in a cell together. He said there were no words between them. He said they were both taken out for Legal Aid. He said that Mr McGregor was making loud sounds and banging. He said that while he spoke to Legal Aid there were loud sounds going on and he was frustrated.

He said he had put up with it for hours and it was really getting on his nerves and he was getting angry. He said he started pacing and that was when he grabbed Mr McGregor.

Directly after the attack Mr Kaewklom expressed his dislike of Mr McGregor because he was a paedophile to both Corrective Services Officer Sapienza and later in the day in his ERISP with police. He has maintained that position ever since. He has however wavered in his opinion as to whether that was the reason he attacked Mr McGregor.

I accept his current evidence that it was a factor in his extreme reaction to Mr McGregor's annoying behaviour which I find was the predominant reason for the attack.

WHAT LESSONS CAN BE LEARNED?

Neither of the two police custody managers at Cabramatta Police Station realised that Mr McGregor was on the Child Protection Register, at least until Sergeant Dunn began preparing the documents for transfer to Court. That information was clearly available to them on the documents that arrived with Mr McGregor from Green Valley police station.

The evidence of Sergeant Chand and Sergeant Dunn was that, although they would have seen the Form 7, Application to Local Court and other documents, they did not appreciate Mr McGregor was arrested for a breach of bail which related to his obligations under the Child Protection Register. I find this evidence surprising.

I find it hard to accept the submission from Mr Spartalis that custody managers do not need to read those documents in order to discover why a person is in custody. It seems to me that the reason why prisoners are in custody is relevant to ensure their safety in custody.

It is possible that, had Sergeant Dunn known that Mr McGregor was on the Child Protection Register, he may have been more restrained in his response to Mr McGregor when facing the tirade of abuse he described. He may not have used the term “rock spider”, had he known it to be true.

Mr Spartalis suggested that the problem might be cured if I were to make a recommendation that the Commissioner of Police consider disseminating a memorandum reminding custody managers to check all warnings for persons in custody.

A document within Exhibit 5 (the COPS Person Details or “PerFind” document) demonstrates that, in this case, a check of the warnings would have revealed that Mr McGregor was wanted in relation to his obligations under the Child Protection Register.

I can see no reason why a custody manager should not be required to avail themselves of all available information on the prisoners in their care. It seems to me that there would be merit in the Police Commissioner reminding all custody managers that they must read the custody documents in full when a prisoner arrives into their custody.

FORMAL FINDING:

I find that Frederick Alfred McGregor died on 25 February 2011 at Liverpool Hospital, NSW. He died as a consequence of a head injury he sustained, while he was in custody in the Liverpool Court Cells, from a known person.

RECOMMENDATIONS: To the Commissioner of Police:

- I recommend that the Commissioner of Police give consideration to disseminating electronically a state-wide memorandum reminding custody managers;

- To read the custody management record, Form 7 and any other custody documents in full,

- To check all warnings for persons in custody, and

- To remind custody managers of the reasons why this is important.

4. 65200 of 2012

Inquest into the death of Ali Rahimi. Finding handed down by Deputy State Coroner Forbes on 19th March 2014.

This is an Inquest into the sad death of Ali Rahimi who died on 27 February 2012, aged 44 years of age. He died at Liverpool Hospital as a result of a cardiac tamponade caused by a ruptured dissecting aorta.

He had been taken to Liverpool Hospital from Villawood Immigration Detention Centre (VIDC) on 25 February 2012. VIDC detains unlawful non-citizens under the *Migration Act 1958 (Cth).*

Mr Rahimi had been held in detention at VIDC as an "irregular air arrival from Iran" since 24 April 2010. The *Coroner's Act 2009* confers jurisdiction

An inquest is intended to be an independent examination of the available evidence relating to the circumstances of a persons death. The *Coroners Act 2009* requires findings that identify the person whose death is being investigated, the date and place of the death and the cause and manner of the death.

The cause of death is the direct physical cause and the manner of death refers to the circumstances surrounding the death.

Upon Mr Rahimi's arrival at Sydney Airport on 24 April 2010 he sought asylum. He provided a history that he had been smuggled from a jail in Iran to an airport. He said he bordered a plane on 20 April 2010 arriving in Sydney four days later. He went via Thailand and the Phillipines.

His wife and two children were still in Iran and there is evidence from the workers at VIDC that he missed them dearly.

During his detention at VIDC he underwent a number of medical examinations that related to his heart.

On 24 June 2010 he was seen by a GP and an ECG was ordered. On 24 October 2010 he had a further ECG and x-ray. All results were normal. (His full medical history is in Ex 2, Vol 2, Tab 2)

Subsequent to Mr Rahimi's death, an independent expert cardiologist at Royal Prince Alfred Hospital, Professor Jeremy, reviewed Mr Rahimi's care and treatment during the time he was held at VIDC. He has reviewed the medical records from VIDC, the medical records from Bankstown Hospital, where Mr Rahimi had been taken for medical testing and the records of Liverpool Hospital where he was taken by ambulance prior to his death. (Vol 2 Tab 3).

Professor Jeremy was of the opinion that no criticisms could be made of any of the treatment and care Mr Rahimi received while he was in detention at VIDC.

He expressed the view that aortic dissection "*can occur as a sudden event, which can be catastrophic, without any antecedent signs or symptoms*"

I am satisfied from the evidence contained in the brief of evidence and from the evidence given during the course of this inquest that Mr Rahimi was given the opportunity to obtain appropriate medical treatment as needed. I accept Professor Jeremy's evidence that Mr Rahimi received treatment that was consistent with treatment that any other member of the community would receive and was in accordance with what he termed as the "usual practice".

FORMAL FINDING:

That Ali Rahimi died on 27 February 2012 at Liverpool Hospital, NSW, as a result of cardiac tamponade, the antecedent cause being a ruptured dissecting aorta. The manner of death was natural causes.

5. 94483 of 2012

Inquest into the death of Darren Neill. Finding handed down by Deputy State Coroner MacMahon on 20th January 2014.

Non-publication orders pursuant to Section 74 (1) (b) have been made in respect of the following evidence in the proceedings:

- The statement of Senior Sergeant Davis and the attachments thereto,
- The statement of Susan Mitchell,
- The statement of Inspector Ian Casha,
- The statement of Inspector Patrick Stafford,
- The photographs attached to the statement of Senior Constable Nathan Corbett,
- The NSW Police Force Domestic and Family Violence policy,
- The NSW Police Force Standard Operating Procedures contained at Tab 123, Volume 5 of Exhibit 5,
- Exhibit 4,
- Exhibit 7,
- Exhibit 8,
- Exhibit 13, and
- Exhibit 17.

These orders continue following the publication of these findings and the reasons therefore.

Findings made in accordance with Section 81(1) Coroners Act 2009:

Introduction:

Darren Edward Neill was born on 4 November 1977 (I will refer to him in these findings as 'Darren'). He was the father of two sons. Darren had a history of using illicit drugs and had a criminal record. Darren also suffered from symptoms of paranoia and delusions that were likely associated with his illicit drug use.

In 2011 his partner was Elaine Randell who was also the mother of his youngest son. There were relationship problems between Darren and Elaine Randell that involved violence and property damage on Darren's part.

At about this time Darren also told his sister-in-law Gaylynne Neill (who I will refer to as Gaylynne) that he thought he was being followed by undercover police officers.

In March 2012 the relationship between Darren and Elaine Randell dissolved with her leaving him with their son. Darren went to stay with his brother Adam and sister-in-law Gaylynne for a period of time. His sister-in-law described him at this time as being completely irrational with his moods swinging between aggression and complete sadness.

Darren's elder son had been living with him for a period of time. Because of Darren's increasing difficulties his family did not consider the arrangement good for the child. Gaylynne made arrangements for the boy to return to his mother's care in Queensland. The return of the child was to occur on 17 March 2012.

On 16 March 2012 Darren told Gaylynne that he had been out all night because unknown persons were following him. The next day whilst the child was being taken to the airport Darren called asking that the return be delayed. Later that day there was an incident outside the terminal between Darren and his brother Adam. A police officer became involved however the matter was resolved and no police action taken.

On 19 March 2012 there was a further incident between Darren and Elaine during which he assaulted her.

As can be seen from the above outline in the period up until March 2012 Daren's life was very troubled.

On 25 March 2012 a series of events occurred that ended with Darren being in the Westfield Shopping Complex at Parramatta. Whilst there a confrontation developed between him and a police officer, Inspector Toby Austin, during the course of which Inspector Austin shot Darren a number of times. The injuries Darren received led to his death. It is the purpose of this inquest to inquire into the circumstances in which Darren died.

Jurisdiction of Coroner:

It is important at this stage to set out the role and function of the coroner in respect of the death of Darren. That role and function is governed by the Coroners Act 2009 (the Act). All legislative references, unless otherwise mentioned, will be to that Act.

Section 6 defines a *"reportable death"* as including one where a person died a *"violent or unnatural death"* or under *"suspicious or unusual circumstances".*

Section 35 requires that all *reportable deaths* be reported to a coroner.

Section 18 gives a coroner jurisdiction to hold an inquest where the death, or suspected death, of an individual occurred within New South Wales or where the person who has died, or is suspected to have died, was ordinarily a resident of New South Wales.

Section 27(1) (b) provides that if it appears to a coroner that a person died, or might have died, in circumstances to which Section 23 applies then an inquest is mandatory.

Section 23 gives exclusive jurisdiction in respect of the investigation of certain deaths to Senior Coroners. Section 22 (1) defines a Senior Coroner as being the State Coroner or a Deputy State Coroner.

The exclusive jurisdiction given to senior coroners includes the investigation of deaths that that occur *as a result of or in the course of a police operation* (Section 23 (c)).

Section 81(1) sets out the primary function of the coroner when an inquest is held. That section requires, in summary that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

In addition to the matters to be determined in accordance with Section 81(1) in a case such as this where a death occurs *as a result of or in the course of a police operation* it is important that the contribution of police action, if any, to the circumstances of the death be the subject of a full and public inquiry.

The Parliament requires that inquests in such circumstances be conducted so as to provide a positive incentive to police to ensure that their actions are appropriate in all situations and to satisfy the community that those deaths that occur when police are involved are properly investigated. It is also in the interest of the police that such deaths be properly investigated so as to ensure that the officers involved, and the police in general, are not the subject of unsubstantiated or malicious allegations.

Section 82 provides that a coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned.

The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths, fires or explosions.

Death in a police operation:

I am satisfied that Darren's death was a reportable death that occurred in circumstances to which Section 23 (c) applies and, as such, an inquest examining his death is mandatory and must be conducted by either the State Coroner or a Deputy State Coroner.

Identity and Date and Place of Death:

Darren's identity and the date and place of his death were not matters of controversy.

Darren's brother, Adam David Neill, identified his body at the Department of Forensic-Medicine in Glebe on 26 March 2012. I accept that identification.

Darren was pronounced life extinct at 10:45pm on 25 March 2012 by Dr Isabella Brouwer, the on-duty forensic pathologist, who attended the scene of the confrontation between Darren and Inspector Austin. I accept that evidence and am satisfied that Darren died on 25 March 2012.

Dr Brouwer also conducted an autopsy examination of Darren's body between 26 and 29 March 2012. Dr Brouwer's autopsy report was an exhibit in the inquest and, in addition, she gave evidence at the inquest. Having undertaken that examination Dr Brouwer recommended that the cause of Darren's death was the:

Consequences of gunshot wound to the chest with injuries to heart, thoracic aorta, oesophagus and both lungs.

At the inquest the cause of death recommended by Dr Brouwer was not a matter of contention. I accept Dr Brouwer's evidence on this issue and am satisfied that the direct cause of Darren's death was as described by Dr Brouwer.

Dealing with the manner of Darren's death was a more complex matter. Because of the circumstances of the death the following issues emerged for consideration and determination. Those issues can be generally stated as follows:

- Whether Inspector Austin's actions were justified in the circumstances and whether they accorded with NSW Police Force policy and training,
- Whether the response of Senior Constable Baran to calls for assistance made by Gaylynne on 25 March 2012 was appropriate, and
- Having regard to the information available to Corrective Services NSW was any deficiency in Darren's parole supervision a factor that contributed to the circumstances of his death?

The first two issues arose as a consequence of Darren's death occurring as a result of, or in the course, of a police operation whilst the final issue arose for consideration because, at the time of his death, Darren was subject to parole supervision.

To assist in determining these matters a detailed brief of evidence that included police in-car police video recordings, police air-wing video recordings and CCTV recordings from within the Westfield Shopping complex was prepared by the officer in charge of the investigation, Detective Chief Inspector Pamela Young and, in addition, the following gave evidence at the inquest:

- Detective Chief Inspector Pamela Young,
- Gaylynne Neill,
- Senior Constable Garry Baran,
- Senior Constable Robert Collins,
- Detective Senior Constable John Lothian,
- Fifah Zratka,
- Senior Sergeant Peter Davis,
- Inspector Toby Austin,
- Carmel Kennedy,
- Sue Mitchell, and
- Dr Isabella Brouwer

I will deal with the various issues that arose in the order outlined above and make reference, in general terms, to the evidence available in respect of each issue in my consideration.

Inspector Austin's actions:

At about 3:22pm on 25 March 2012 CCTV recordings outside the Nepean Hospital at Kingswood show Darren arriving in a taxi. After that Darren attempted to rob a taxi driver using a knife. At about 3:30pm Darren attempted to enter the property at 122 Parker Street Kingswood he then jumped the fence into 120 Parker Street Kingswood and stole a blue utility. These actions resulted in a number of calls to the 000 emergency phone line.

At 3:32pm Senior Constable Glen Gribble in a highway patrol car located the vehicle driven by Darren and commenced a pursuit in an easterly direction along the M4 Expressway towards Parramatta. Police vehicle code sign *Penrith 101*, which was driven by Detective Senior Constable Marinello, subsequently replaced Senior Constable Gribble's vehicle in the pursuit. The pursuit was formally discontinued by the Penrith Duty Inspector at 3:35pm. The reason for the termination was due to the speed at which Darren was travelling which ranged between 140 and 175 kmh.

From about 3:32pm Polair commenced observation from a helicopter of the vehicle driven by Darren as police pursued it on the M4 and after the pursuit was concluded. The video recordings of the pursuit from the highway patrol vehicle and from Polair were exhibits and played during the inquest.

During the course of the pursuit Darren lost control of the vehicle he was driving and collided with another vehicle. After this Darren unsuccessfully attempted to steal one vehicle and then did steal another vehicle at knifepoint.

Having done so, Darren continued his high-speed journey towards Parramatta. The officers in the Polair helicopter recorded all this.

The actions of Darren throughout the pursuit were extremely dangerous and it is fortuitous that the only injuries suffered by other people on the M4 were the relatively minor injuries suffered by the owners of the vehicles Darren firstly attempted to steal and then did steal.

The actions of the police officers involved in the pursuit was not an issue at the inquest however nothing in the evidence available to me would suggest that such action was other than appropriate.

On 25 March 2012 Inspector Toby Austin was the St Mary's duty officer. At about 3:00 he heard what is described as a *double beeper* on the radio. This alerted him to another police officer was engaging in an urgent response situation. The detail of which he became aware was that there was *a male armed with a knife in Derby Street St Mary's.*

Inspector Austin proceeded towards that location to assist. He subsequently became aware of the police pursuit and that the incident was being monitored by Polair. He entered the M4 and then proceeded east towards Parramatta. He monitored Darren's actions from the Polair broadcasts.

At a point near Merrylands Inspector Austin became aware that Darren had left the M4 and was at a residential location. He intended to go to that location. Before he was able to do so he was advised that Darren had left the location and was driving in Church Street Parramatta and then entered the Westfield Shopping Complex. Inspector Austin by this time was also in Church Street and also entered Westfield.

On exiting his vehicle Inspector Austin proceeded through the car park in a direction that was indicated by other shoppers. He then saw a man running with no shirt on. As he was watching the man suddenly deviated from his path and then ran to and entered the shopping complex. Inspector Austin followed him into the shopping complex.

It is at about this time Inspector Austin drew his firearm. Inspector Austin explained his action in the following terms:

The reason I withdrew my firearm is because I was aware that he'd, he'd had a knife back at Penrith. I was aware that he was involved in a high-speed pursuit down the Great Western Highway. I was aware he'd hijacked a vehicle and I was aware that he used the knife during the hijacking of that, sorry, carjacking of that vehicle. So I had concerns in relation to my safety and also the safety of the people that are walking in the car park.

An altercation subsequently occurred between Darren and Inspector Austin. The evidence available suggests that Darren entered the Westfield car park at 3:52pm. NSW Ambulance officers responded an urgent job at the Westfield complex at 4:00pm. A call to the 000 emergency line between 3:53.09pm -3:59:24pm concerning the incident was made by Fiona McMillan. It is clear that the altercation had occurred very quickly and that Darren was deceased by about 4:00pm.

We are in a very good position to know what occurred in that short period of time. Apart from the evidence available from Inspector Austin there were statements form a number of lay witnesses and most importantly there were CCTV recordings of the actions of both Darren and Inspector Austin that became exhibits in the proceedings.

Dorothy Joly was working at the Goodlife Gym on 25 March 2012. She said that about 3:50pm she heard the gym doors open, heavy breathing, loud footsteps and turned to look seeing the edge of a police uniform running from the front doors to the side doors to the stairwell. She said that she heard the words *stop or I'll shoot* but did not hear or see anything else.

Anita Verma was walking from the car park to the Goodlife gym. She saw a man shirtless running away from her towards the stairwell and then saw a police officer following. She said that she heard the officer yell *stop otherwise I will shoot you*.

Fiona McMillan was walking towards the service corridor on level 5 towards the Goodlife gym. She heard gunshots as she was walking past the KFC outlet. She saw a small boy run past her as she continued down the corridor and as she rounded a corner she observed a police officer with blood on his right arm reholstering his gun.

She also saw a man on the ground covered in blood. The police officer asked her to call 000, which she did.

Inspector Austin stated that as he saw Darren in the car park he yelled out to him to stop.

Darren glanced towards the Inspector and then ran harder towards the entrance to Westfield. Inspector Austin followed him. Inspector Austin had his firearm drawn as he realised that Darren had a knife. Darren was bleeding and Inspector Austin was able to follow him by following the blood splatters he was leaving behind. The Inspector went along a corridor down a fire stairway and into another corridor. He then passed some people and came into another area.

Inspector Austin described what happened next as follows:

I came around to my left and I cleared the room. There was nothing in the room and then I noticed that there was a little door, and open area over there and I, I remember consciously slowing down and being quite afraid that this guy is going to be around this area here.

To the south there was another room that Inspector Austin thought was a garbage room. He approached the room to see if the person he was looking for was in the room. He said:

I quartered the, this wall here by looking around and glanced around. Poked my head around and then I saw him crouched down.

He had something in his right hand. I don't know what it was because it was a quick glance as I looked around the corner.

He was looking at me. He screamed something to me. I don't know what it was and started getting up, and before I knew it, he was right coming right up to me. He came around the corner and came straight at me. At one stage I thought he was going to the left and down the corridor, but he kept coming straight at me.

I retreated sort of back towards the middle of the room and tripped over. By the time I tripped over, I'm fairly confident I'd already discharged one, one maybe two rounds at that stage.

He, he sort of went to the left and then came straight at me, and by this time, I was on the ground and he was just over the top of me. He had something in his right hand and I fired, I may have fired another one or two straight at him, straight at his body, I thought, I thought he was going to stab me with the, with the knife.

In answer to questions about the number of shots Inspector Austin fired he said:

I fired two in the vicinity of the doorway when he came out at me. As I went backwards and was nearly, fairly close to being on the floor, I either fired another one or two but I'm pretty sure it was two because he was on top of me, he was coming right over –

After firing the last two shots described, Inspector Austin found Darren on top of him. Darren then made a noise and rolled off him. Inspector Austin said that he then observed a bullet wound to the bottom of Darren's ribcage area. He also saw a knife with a yellow handle on the ground to his left.

Inspector Austin described what happened next in the following terms:

I sort of realised I was covered in blood and sort of came to my senses and got up not long after, I walked towards the corridor area, because I didn't have a radio and I immediately thought I need to get help down here quickly, and there was a girl sort of standing here on a, she looked like she was on the phone, and I screamed out, get the police, I've just shot somebody, or something like that, And he might be dead, I think I probably said. I went back to him and I could see that he was taking his last breath. He, he sort of inhaled and then … and then nothing and I immediately recognised that he was, he was dying. His sort of head turned away and all the colour drained out of his face, and I just kept watching him just to make sure that he wasn't going to get back up, and I was sort of hovering around this area here, and I kept watching him and sort of realised what was, what was going on, and then I,

he kept on sort of taking these gulps of air and then it stopped. At one point I went over and checked his pulse and I couldn't feel a pulse at that stage. By this time, police had arrived.

There was a CCTV recording of the most significant of these events. Those recordings confirm, to the extent that they are able, the recollection of Inspector Austin. Importantly they confirm Inspector Austin description of falling backwards as Darren came towards him and that, at the time, Darren had a knife.

The first question that needs to be answered is whether or not Inspector Austin's actions in discharging his firearm at Darren at the time he did was appropriate. The short answer must be that it was.

I accept that after Darren saw Inspector Austin he then came at the Inspector. I am satisfied that at the time he did he had a knife. Although there is some confusion in the evidence as to whether or not Inspector Austin saw the knife at that time it was nonetheless reasonable for him to assume that he had a knife as he knew that Darren had previously that day used a knife to steal a car. I am satisfied that Inspector Austin's actions were completely justified in the circumstances and in fact necessary to protect himself from serious injury or death.

There was a second aspect of Inspector Austin's actions that was the subject of consideration at the Inquest and that was whether or not Inspector Austin provided assistance to Darren in a timely manner after the he had been shot. The CCTV recordings show that there was a period of time following the incident when Darren was lying on the ground and Inspector Austin did not check on his wellbeing or attempt CPR or other lifesaving assistance.

There is no doubt that there is a period of delay amounting to a number of minutes before Inspector Austin was shown to have checked on Darren's welfare. I do not, however, consider that Inspector Austin should be the subject of any criticism in respect of that delay. I have come to this conclusion for two reasons firstly the effectiveness of any assistance that might have been provided and secondly Inspector Austin's personal circumstances at the relevant time.

Dr Isabella Brouwer was the forensic pathologist that performed the autopsy on Darren's body following his death. Her autopsy report was an exhibit in the proceedings and Dr Brouwer gave evidence at the inquest.

In her evidence Dr Brouwer described the gunshot wounds that Darren sustained and the effect of such wounds on him. It is not necessary to go into her evidence in detail other than to note her opinion that the injuries he sustained meant that his death was both inevitable and quick. In short nothing that Inspector Austin could have done would have either saved Darren's life or extended it. I accept Dr Brouwer's evidence on this matter.

The second reason was the circumstances of Inspector Austin at the time. Inspector Austin gave evidence that at the relevant time he was in shock and confused. Dr Brouwer having viewed the relevant CCTV gave evidence that it supported such a conclusion. Indeed my own impression of that CCTV recording leads me to the same conclusion. It is apparent that, after the confrontation, Inspector Austin took some time to adjust to the significance of what had happened. He was, in effect, in no state of mind to provide assistance to Darren and as such could not be expected to do so. No criticism of him in this regard is therefore warranted.

Response of Senior Constable Baran:

Members of the Neill family had shown considerable support for Darren. They were genuinely concerned for his welfare. They were in regular contact with him. They were pragmatic about the difficulties that Darren was causing both for him and others and sought help from various authorities. Adam and Gaylynne Neill were particularly active in their attempts to support Darren.

On 22 March 2012 Darren assaulted his partner Elaine Randell after which she made a complaint at the Parramatta Police Station. This led to the granting of a Provisional Apprehended Violence Order (AVO) protecting her against Darren.

On 23 March 2012 at about 1:00pm Darren sent a SMS message to Gaylynne saying that *Elaine had gone for good and that he was thinking of ending his life.*

As a result of this Gaylynne became concerned and was in regular contact with Darren through out the rest of the day.

Gaylynne and David Neill were concerned about what Darren would do in his current state of mind and as a result David Neill contacted Darren's parole officer and informed her of the assault on Elaine Randell and that that a warrant had been issued for Darren's arrest.

At about 8:31am the next morning (24 March 2012) Darren phoned Gaylynne. He informed her that he had stolen a car at knifepoint. Gaylynne advised Darren to surrender to the police however he refused to do so at the same time claiming to be under police surveillance and having his phone tapped.

After this call Gaylynne phoned Parramatta police station at 8:55am and advised them that she had some information about the carjacking incident.

Between 11:00am and 12:00noon Darren then phoned Gaylynne again. She asked him where he was and said that she would come and get him however Darren refused to tell her where he was. At the time he once again said that his phone was tapped and that the police were following him.

In the early afternoon of 25 Mach 2012 Gaylynne returned home from shopping and was told by Adam Neill that he had heard of a carjacking at Grandville with a description like Darren's. About 3:00pm Gaylynne called Merrylands Police and spoke to Constable Haddad telling him that she had information about the carjacking. She was told that a detective would contact her.

Sometime shortly after 3:30pm Detective Baran, from Merrylands Detectives contacted Gaylynne. She outlined to him her, and the family's, concerns for Darren. She also expressed her concern were Darren, in his then emotional state, to come to the homes of any of the family members.

Not long after Gaylynne spoke to Detective Baran Darren once again phoned her. He told her that he had broken his ankle whilst being chased by police through the Marist College at Parramatta. He also expressed a depressed mood saying that *he was gone and this was it*.

He also said that he was now on the south coast of New South Wales. Gaylynne phoned Detective Baran and advised him that Darren said he was now on the south coast.

At about 4:30pm Gaylynne also phoned Constable Haddad at Merrylands Police and advised him that she thought Darren had undertaken the carjacking with knife at Merrylands. She provided him with Darren's mobile number. Constable Haddad then sent a SMS message to Darren. Darren responded with a phone call to Constable Haddad but then discontinued the call.

Later that day, at about 6:00pm, Darren took his father's work car without permission. David Neill reported this to the police. In addition Gaylynne also reported the incident to Detective Baran. During that conversation there Gaylynn's concern about Darren attending the home of family members during the night was discussed. Detective Baron agreed that he would arrange for police to patrol the areas in which their homes were located that night. This was subsequently arranged with police from the Penrith and the Hills Local Area commands.

Nothing more was heard from Darren that night however it is clear that he was in considerable distress. At about 2:00am he phoned a friend, Francine Fenton, and said to her:

This is it Fran, this is it. I'm going to end it, I can't keep going on like this…I've already made up my mind, I'm going to end up in a high speed chase.

The next morning, at about 10:30am, Darren phoned Gaylynne. He was upset. He said that he needed help. Gaylynne tried to convince him to come to her house. He was not prepared to do so. Gaylynne reported this to detective Baran.

Darren then phoned two friends, Mark Liardet and Mark Trofa, asking for assistance. They declined to assist him. At about 11:00am Darren once again phoned Gaylynne and asked her to pick him up at Penrith. This was again reported to Detective Baran.

Shortly after Darren called Gaylynne again and changed the location that he wanted to be picked up at. This time it was to be at the water fountain in Penrith. Gaylynne once again advised Detective Baran of this information however shortly after she did so Darren phoned her again and changed the address saying that he would call her later and let her know where to pick him up.

Late that morning Darren once again phoned Gaylynne. He stated that he had stolen a car. At about this time Darren is shown on CCTV recordings at the Westfield Shopping centre at Parramatta (at 11:43am and at 12:00noon).

At about 12:23pm Darren once again phoned Gaylynne and stated that he was at Dave's Fruit 'n' Veg shop on the Northern Road at Luddenham. Darren said that Gaylynne was not to bring Adam Neill with her when she came as he thought that Adam would let the police know of his location.

Gaylynne subsequently advised police where Darren said that he was located. It would seem that Darren was not at the Fruit-n-Veg store at the time he said he was however he did go there as CCTV shows him to be there at 12:52pm to 12:55pm.

Darren called Gaylynne at about 1:00pm and asked her when she was going to come to pick him up. He explained to her what he wanted to do once he was collected. Gaylynne believed him to be calm at the time. Gaylynne then advised Detective Baran of Darren's location. Following this there was a number of calls between Darren and Gaylynne during which time Darren was using the landline at Dave's Fruit 'n' Veg Shop. In a call at 1:29pm Gaylynne informed Darren that she would not come to pick him up without Adam Neill coming as well. Darren did not want this and hung up on her. During this time Gaylynne encouraged Darren to speak to Detective Baron however he refused.

Darren phoned her again at 1:40pm and confirmed that Gaylynne was not coming to pick him up. Having done so Darren hung up once again. It was Gaylynne's evidence that she phoned Detective Baron again at 1:41pm and advised him of this.

The evidence shows that at 2:03pm a taxi was booked from 278 Northern Road Luddenham for Darren and that at about 2:30pm. Darren once again called Gaylynne at about this time and informed her that he had stolen two cars, including a taxi. This was followed at about 3:00pm by a police report concerning a robbery with a knife of a taxi driver in a car park at Nepean Hospital. It was after this that events moved at a rapid pace and resulted in the police chase and confrontation at Westfield Parramatta that ended with Darren's death.

It has been important to set out these events in some detail in order to emphasise a number of matters. It is apparent that Darren's family, in particular Gaynynne Neill, remained particularly concerned as to his welfare, secondly they were in constant contact with police, in particular Detective Baron, providing information as to Darren's activities and whereabouts and thirdly to show that throughout the period leading up to his death the best description of his mental state would be that he was *out of control.* It might also be reasonably inferred that Darren's capacity to make rational decisions was, at the time, significantly compromised.

The question that needs to be answered from all of this is whether or not, on the basis of the information that was available, could the police involved, in particular Detective Baran, have reasonably taken some action that might have prevented what followed occurring and thereby prevented Darren's death. I do not think so.

I have come to this conclusion for a number of reasons firstly I am not satisfied that the time the officers had available was sufficient for them to respond in a manner that would have been effective.

I am satisfied that Darren was at Dave's Fruit ' n ' Veg store from about 12:52pm, when he was recorded on CCTV at that location, until some time after 2:03pm when he left in a taxi. He was thus there for a little over an hour.

There is some disagreement in the evidence between Adam and Gaylynne Neill on the one hand and Detectives Baran and Collins on the other as to the communication of that information. Detective Baran' recollection is that he was supplied with the address by Gaylynne and then commenced discussing with Detective Collins actions that might be taken however Gaylynne called back a short time later and informed him that Darren had left the location. As a consequence he and Detective Collins took no further action.

Gaylynne's recollection of the events on this point, supported in parts by Adam Neill, is somewhat different. She does not agree that she told Detective Baran that Darren had left the fruit store. Both Detective Baran and Gaylynne gave evidence at the inquest and confirmed their respective recollections.

Were Detective Baran's recollection to be correct he would have only a matter of minutes to respond. His evidence was that he gave consideration to the action that he might have taken but discontinued that consideration when he was informed that Darren had left the location. Detective Collins confirmed in his evidence that discussion occurred as to what action was possible action could be taken but that the discussion did not reach a conclusion.

As already mentioned both Gaylynne and Detective Baran gave evidence at the inquest. Gaylynne was an impressive witness. She showed a concern for her brother in law that was tempered by a realistic appreciation of his failings. She was precise and appeared careful in responding to questioning. Detective Baran also appeared to be careful, although more reserved, in answering questions. His recollection did not appear to be as precise. I am satisfied that it is more likely that Gayleen's recollection on this point is the more accurate.

At the same time I accept that Detective Baran believed that he had been told Darren had left the location. The evidence was that there had been a lot of communication between Detective Baran and Gaylynne during this period. It seems that on this point there was a misunderstanding. This is unfortunate.

The next question is whether had that misunderstanding not to have occurred would Detective Baran have been able to act on the information in a time frame that would have made a difference?

Assuming Detective Baran became aware of Darren's location at about 1:00pm he would have had about an hour to organise police to attend the location and, if they had the power, apprehend him. For my purposes I do not need to consider the question of power to apprehend.

Detective Baran would have been unlikely to try and deal with the matter himself as he was in Merrylands almost 40 kilometres away from Luddenham, which was also in a separate police command.

To be able to organise a response Detective Baran would need to have obtained the assistance of police from another command and comply with the various police protocols that would have been involved. It is not necessary once again for me to analyse the requirements of those protocols in this finding. While the evidence before me was ambivalent as to the time that this would have taken in the absence of an active threat to the safety or welfare of a third party, which there was not in this case, I am satisfied that it would have been a period that was longer than the time that was reasonably available in this case.

I am therefore satisfied that even if Detective Baran was aware of the location at Luddenham for the period that Darren was there any action that he took would have been unlikely to have prevented the events that followed.

Actions of Corrective Services NSW:

Darren was on parole at the relevant time. He was the subject of supervision by Corrective Services NSW through what was known as the Community Offender Services or Probation and Parole (I will refer to that organisation as Parole). Darren had been transferred to New South Wales from Queensland in accordance with the *Parole Orders (Transfer) Act 1983.*

At the relevant time Darren was on conditional liberty and subject to supervision by Parole. His supervising officer was Ms Carmel Kennedy.

At the inquest statements were tendered from Ms Kennedy as well as from the manager of the Parramatta Community Corrections office, Ms Susan Mitchell. In addition each gave evidence.

I do not propose to review the history of Darren's supervision by Parole. The evidence available showed that Darren's response to supervision was initially positive, that this changed at about the time he recommenced his involvement with illicit drugs, that Darren's father brought this change to the attention of Parole and that Ms Kennedy's response to that information, which was to commence action to revoke Darren's parole, was both timely and appropriate.

The review of the supervision file identified however that a scheduled home visit did not occur. It was asked whether had the home visit in fact occurred something might have been observed in Darren's living environment that might have led to action being taken that might have prevented Darren's subsequent mental state decline and his death.

This was really not much more than speculation as to the consequences of a lost opportunity. I do not think that the failure to conduct the home visit could be in any way a contributing factor to Darren's death.

Section 82, Coroners Act 2009 Recommendations:

It is apparent from the history outlined above that Darren's mental state at that time was severely disturbed. He was capable of responding in a violent and aggressive manner. He was a danger to both himself and others. It was necessary for Darren to be apprehended as quickly as possible in order to ensure the safety of both him and those with whom he came into contact.

Inspector Toby Austin responded to that need. Because of the circumstances he did so without the immediate assistance of other police officers.

Inspector Austin's actions on 25 March 2012 showed a high level of professionalism and considerable bravery. I propose to recommend to the Commissioner of Police that Inspector Austin's bravery be appropriately recognised.

Formal Finding:

That Darren Edward Neill (born 4 November 1977) died on 25 March 2012 at the Westfield Shopping Centre, Parramatta in the State of New South Wales. The cause of his death was gunshots wounds to the chest involving injuries to his heart, thoracic aorta, oesophagus and both lungs that he sustained when he attacked a police officer with a knife.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

To the Commissioner of Police:

That action is taken to recognise the professionalism and bravery exhibited by Inspector Toby Austin in the performance of his duties as a police officer on 25 March 2012.

6. 100399 of 2012

Inquest into the death of Kaniappa Raju. Finding handed down by Deputy State Coroner MacMahon

This has been an inquest into the death of Kaniappa Raju who was born on 12 July 1960 in the Solomon Islands. Mr Raju was an inmate under the custody of Corrective Services. He had been convicted of the murder of his wife and sentenced to a prison term of 21 years with 16 years non parole. The murder of his wife occurred between 5 May and 2 June 2002 at Wollongong. Following that event he appears to have left Australia but on 9 February 2005 he was extradited from the Solomon Islands to Australia.

In July 2011 Mr Raju was an inmate at the Wellington Correctional Centre. On 2 July 2011 he was taken to Dubbo Base Hospital and diagnosed with a preliminary diagnosis of a glioblastoma multiforme. He was then transferred to the Prince of Wales annex of the Long Bay hospital and on 14 July 2011 that diagnosis was confirmed. That diagnosis is an incurable, high grade tumour of the brain. The diagnosis was confirmed by Dr Elizabeth Hovey. Dr Hovey expressed the opinion that life span following diagnosis of that disease is something of the order of 12 to 14 months after diagnosis.

On 27 February 2012 Mr Raju was admitted to the Prince of Wales annex of the Long Bay hospital. He had, by that stage, the evidence shows, understood and accepted his diagnosis, that being that he had a terminal medical condition. He had applied for early release on the basis of that terminal medical condition and that application had been rejected. He had indicated on 14 and 15 March that he accepted the placing of a not for resuscitation order in respect of his condition should he deteriorate. He was receiving regular administration of morphine and hyoscine medications to assist him via subcutaneous injections every four hours as a result of the medical condition from which he suffered.

The evidence in the brief shows that Nurse Upton, who was a nurse conducting practice at the relevant ward, and caring for Mr Raju, on 22 March 2012 Nurse Upton indicates that Mr Raju was conscious and able to converse. At that time Nurse Upton went on a period of a break of a number of days from work and returned on 28 March 2012. At that point Nurse Upton found Mr Raju to be unconscious. On 29 March 2012 it was observed that Mr Raju's condition was deteriorating and at 2.40am that morning Dr Martin Facini, a doctor attached to the unit, pronounced him life extinct.

The matter was reported to the Coroner because Mr Raju was an inmate of the Department of Corrective Services. The jurisdiction of the Coroner is set out in s 81.1 of the Coroner's Act. That section provides, in summary that at the conclusion of an inquest the Coroner is required to establish, should sufficient evidence be available, the fact that a person has died, and the identity of that person, the date and place of their death and the cause and manner thereof. Section 82 provides that a Coroner, conducting an inquest, may also make recommendations as such as he or she considers appropriate or desirable in relation to any matter connected with the death with which the inquest is concerned. In making recommendations are discretionary and relate usually but not necessarily only to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way Coronial proceedings can be forward looking, aiming to prevent future deaths. It is not the role of a Coroner to attribute blame.

Because Mr Raju was serving a prison sentence and in the custody of the Department of Corrective Services at the time of his death s 22, 23 and 27 of the Act are also applicable to this inquest. The effect of these sections is that the inquest must be conducted into the death of a person who dies whilst in custody and such inquest must be conducted by either the State Coroner or a Deputy State Coroner. The reason why the inquest is mandatory in the case of such deaths has been explained by the former State Coroner, Magistrate Kevin Waller. He explained it in the following terms.

"The answer must be that society having effected the arrest and incarceration of persons who have seriously breached the laws owes a duty to those persons of ensuring that their punishment is restricted to the loss of liberty and is not exacerbated by ill treatment or privation whilst awaiting trial or serving their sentence. The rationale is that by making mandatory a full and public inquiry into the deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion and satisfy the community that deaths in such places are properly investigated."

In this case the identity of Mr Raju is not in issue. He was identified by Hannah Tiernan, a nurse who worked at the Prince of Wales hospital. The date of his death is not in issue. That is certificate by Dr Martin Facini as being 29 March 2012 at 2.40am. The place is not in issue that being the Long Bay correctional centre hospital, Prince of Wales annex. The cause of death is also not in issue. That being metastatic glioblastoma multiforme and the manner of death is also not in issue, that being natural cause. The cause of death was confirmed by Dr Hovey.

The direct cause of death was certified by Deputy State Coroner Dillon on the advice of forensic pathologist, Dr Matthew Ord having reviewed the medical records held by the Department of Forensic Medicine and no doubt relying on the diagnosis of Dr Hovey.

The evidence before me satisfies me that whilst in the custody of Corrective Services Mr Raju was provided appropriate medical and other care following his complaint. He was taken to Dubbo Base Hospital where a preliminary diagnosis was made as to his medical condition. That was subsequently confirmed by transfer to the Prince of Wales hospital and examination by an appropriate medical specialist. The condition from which he suffered was incurable and terminal and it would appear that whilst that following diagnosis in July 2011 Mr Raju was provided with appropriate medical care and as his condition deteriorated, and with his consent, he received appropriate palliative care for which he acknowledged. It is interesting that in the file Mr Raju has written in glowing terms as to the manner in which the medical care and nursing treatment he received was accepted by him as being more than appropriate.

In the circumstances I am satisfied that this is not a matter in which recommendations need or ought to be made in accordance with s 82 and I make the following finding in accordance with s 81.1 of the Coroner's Act

Formal Finding:

That Kaniappa Raju died on the 29th March 2012 at the Long Bay Correctional Centre Hospital, Prince of Wales Hospital in Randwick in the state of New South Wales, the cause of his death was Metastatic Glionlastoma Multiforme, and the manner of his death is natural causes.

7. 102820 of 2012

Inquest into the death of XX. Finding handed down by Deputy State Coroner Forbes on the 19th May 2014.

This is an Inquest into the death of XX who died on 30 March 2012 at Long Bay Correctional Centre. XX was found hanging in his cell and despite attempts by paramedics and correctional staff he was unable to be revived and was pronounced life extinct at about 3.30 p.m. that afternoon.

Because XX died in a correctional centre, an inquest is mandatory and must be held before a senior coroner pursuant to the combined operation of ss. 27(1) (b) and 3(d) (ii) of the Coroners Act 2009.

XX was 31 years old at the time of his death. He was single and had two younger brothers. He was born in England and lived there until the age of 10 when his family immigrated to Australia. At the age of 10 XX was diagnosed with ADHD. He had issues at school and ended up attending Boys Town in Engadine, he left school at the age of 16 to begin an apprenticeship as a chef.

According to his father, XX experimented recreationally with drugs. At about the age of 18 he overdosed, on what Mr XX Senior was told was heroin.

Unfortunately in about late 2001, things in XX's life began to spiral out of control and he began to get in trouble with police for deception offences. In about 2008, XX overdosed on tablets and was admitted to hospital overnight. Sometime after this, XX became addicted to sniffing aerosol deodorant. He had spells in and out of the psychiatric unit at Wollongong Hospital.

Mr XX Senior told investigators that in December 2011, XX was arrested for threats he had made in relation to a call centre he worked at and was imprisoned. Mr XX Senior felt that XX by this point was a very troubled person and that at this stage his father was the only one he had left to turn to.

An inquest is intended to be an independent examination of the available evidence relating to the circumstances of a person's death. The *Coroners Act 2009* requires findings that identify the person whose death is being investigated, the date and place of the death and the cause and manner of the death.

The cause of death is the direct physical cause and the manner of death refers to the circumstances surrounding the death.

In this inquest the identity, time and place of XX's passing and the direct cause of the injury leading to his death are not in issue. The real question to be considered is the manner of XX's death.

A Coroner is given power under the legislation to make recommendations in relation to matters in connection with the death that relate to public health and safety.

The relevant issues surrounding XX's death are:

Was XX appropriately received into custody?

Was XX's request for protection whilst in custody appropriately dealt with?

Was the response to the discovery of him hanging in his cell appropriate?

Those matters were considered in the context of the applicable policies and procedures with a view to identifying whether any systemic issues or matters emerge.

Was XX appropriately received into custody?

On 16 March 2012 XX was bail refused and taken to Cessnock Correctional Centre. His court matters had been adjourned to 27 April 2012.

He arrived after hours and his reception screening by Justice Health took place on 17 March 2012.

On 17 March Nurse Kerkham completed a 12 page reception screening tool document (Ex2 Tab 45D). Part of the screening addressed XX's mental health state. As a result he was booked for triage with a mental health nurse for 27 March.

No criticism is made of Nurse Kirkham in that she followed the correct protocol upon his reception. What did become clear during the course of her evidence was that she had relevant information at hand that was not considered by her. I am informed that this information would not have changed the outcome for XX's reception but it is evident that it may well have been very crucial for another inmate.

The screening undertaken by Nurse Kerkham was from information provided by XX, i.e. self reporting. She did not know that he had been recently released from custody and psychiatrically assessed in custody less than two months earlier. She did not know that there were records of previous self harm events both in and out of custody.

Risk is never an easy matter to assess; that much has been made clear in this court by numerous eminent psychiatrists over many years. However it stands to reason that the more independent information, and supporting history, and reliable sources of information, the clinician has available, the more informed their decision might be. This must be contrasted with a system where decisions are based on the clinician's interpretation of information disclosed by the inmate. The decision about cell placement is a vital one; there is no further review unless prompted by a significant event.

I note the evidence of Mr Forrest, Executive Director; Clinical Operations (Custodial Health) of Justice Health that a new state-wide Justice Health Electronic Health System is going live in June 2014 and will be rolled out over the next 3-4 years. This will enable a reception nurse to have greater access to an inmate's relevant mental health history. I also note that reception nurses generally undertake a one day training programme. I note that at the time of XX's reception the nurse had not done that course. I urge Justice Health to ensure that all of their reception nurses have undertaken the training.

On 27 March 2012 XX was transferred to Long Bay Correctional Complex. His referral to see a Mental Health nurse for triage was also transferred. He was received at Long Bay by Corrective Services Assistant Superintendent Coronel and Ms Chekhourdina, psychologist. They gave evidence that, in accordance with protocol, they relied on the Justice Health reception assessment for XX's cell placement. Mr Coronel said that when he noted on the PAS system that there had been a previous threat of self harm that he marked the papers that XX be referred to a psychologist.

At the time of his death on 30 March 2012 he had not been seen by the mental health nurse arranged for at reception on 17 March or the psychologist referred to by Officer Coronel. This lag time for someone with mental health issues and possibly needing medication is something that needs to be reviewed.

Was XX's request for protection whilst in custody appropriately dealt with?

On 30 March 2012 at 11.45 a.m. XX approached Officer Singh at the Yard Gate and said he needed to go into protection because he felt scared of some inmates in the yard. That officer took the deceased to see Officer Brannock who was told the same thing. Officer Brannock said that he would speak to a senior officer and locked the deceased alone in his cell in the interim during the lunch break. Officer Brannock then informed his superior, Senior Assistant Superintendent Cheryl Wood, who then interviewed the deceased in the presence of Assistant Superintendent Frawley at about 1.20 p.m.

XX was placed in his cell (cell 75) to come up with further information relevant to a possible assessment of him for SMAP placement or a non association order. Officers Wood and Frawley felt XX was asking for protection from a person who he felt threatened by, rather than a formal request to move into protection. Their evidence is that in accordance with Operations Procedures Manual section 14.5 XX was placed in his cell.

At the time they interviewed XX, no record was made by Officer Wood or Frawley in the wing diary/accommodation journal for the next shift as to the interview itself or the nature of XX's request or their plan to leave him in his cell to come up with further relevant information. Officer Wood said she intended to make an entry on PAS at the end of her shift but that did not occur because XX was found hanging in his cell before her shift ended. Recording of information affecting an inmate's placement is required for example 12.1 policy statements. No doubt the Department will look at that issue in light of this inquest. I have been informed by the representative of Corrective Services that the regime relating to protective custody is in the process of being reviewed.

I encourage the Department to require officers to make contemporaneous notes, in the wing diary, of such requests and also of their decisions as to the outcome, even if they are temporary decisions.

Was the response to the discovery of him his hanging in his cell appropriate?

XX was returned to his cell (cell 75) at about 1.20 p.m.by Officer Holmes. This is supported by CCTV footage. The proposal was to keep him in his cell overnight.

At about 2.20 p.m. the remaining prisoners from the Wing returned from the yard for muster. In the meantime, food was delivered to the outside of the cells and the CCTV footage shows the cell 75 door remaining closed during that time. The CCTV footage shows that Officer Moore at 2.28 pm walked towards Cell 75 and looked in the direction of the door but continued past the cell. At 2.30 pm he opened the door to cell 75 and looked into the cell briefly before closing the door and then walking up towards the further end of the Wing. It was dark in the cell and he gave evidence that he didn't notice anything untoward. About a minute later another officer, Officer Cappelleri, took Mr XX's fellow inmate, Mr Shankaranarayana, to the cell and opened the door. He saw Mr XX hanging from a bed sheet attached to the top of the window at the rear of the cell. He immediately went to get a 911 tool. The three 911 tools on the wing were down two floors in the wing office.

As of 3 January 2012, Acting Deputy Commissioner Kelaher issued a memorandum titled "Wearing and carrying the 911 Rescue Tool" noting that one of the officers in every team conducting a lock-in and the Officer in Charge of every Wing, Accommodation Unit or Pod, should carry one, as per existing policy. Officer Frawley gave evidence that he did not understand the policy to say that two officers should have a 911 tool on their person. He said that he usually did carry a 911 tool but had forgotten on this day.

Both Senior Assistant Superintendent Cheryl Wood and Assistant Superintendent Frawley gave evidence that the wording of the memo was ambiguous and that they did not understand that two 911 tools were to be carried on each wing.

Preservation of life is paramount and to that end the staffs are required to support the inmate's body weight and cut him down with a 911 tool. The detail is set out in section 13.2.1.1 of the Operations Procedures Manual at attachment 58, page 4.

Questions of safety are important and in some cases there may be potential for tension, when an emergency occurs in a prison setting, between the need to respond immediately and the need to keep control of the general prison population. In responding to a hanging, the need to preserve life is however a paramount consideration.

The CCTV footage shows Officers Moore and McIver at cell 75 while the 911 tool was being obtained. Officer Moore gave evidence in this inquest that he went into the cell and Mr XX appeared to be standing on a chair and that he noticed pressure on his neck from the ligature as Mr XX was leaning forward, but that when he moved Mr XX back against the wall of the cell the noose became loose. Officer Moore had not mentioned this in his two police interviews about the incident.

His evidence was not supported by Mr McIver's statement which said that there was "some pressure" on the ligature when he saw it after he entered the cell, which on the video was about a minute after Mr Moore.

Officer Moore conceded that he had not been aware that a person hanging and who appeared to be standing may still be in danger of asphyxiation and may not be bearing their own weight safely. He gave evidence that his academy training 2 years earlier, had not involved physical demonstrations of how to hold the weight nor any advice about how a person may hang even when standing, sitting or kneeling.

Mr McIver similarly did not recall such instruction.

The CCTV footage shows that Officer Moore was in the cell for 13 seconds before the 911 tool arrived. He candidly acknowledged that a total of 13 seconds to enter the cell, check a pulse, shout for a response from Mr XX, shake him and start to make a radio broadcast was hardly enough time to make an assessment for signs of life.

Officer McIver stayed outside the cell. He gave evidence that he had taken a stance outside the cell to ensure that the area was safe. He described threats to kill him being made by a passing inmate, something serious enough to cause him to remain outside the cell.

He did not disclose this in his interview with police less than 2 weeks after the incident. Certainly once Officer Frawley arrived he had no hesitation in following Officers Capelleri and Moore into the cell.

Officer Moore did not give evidence that safety was the reason he decided to exit the cell and remain outside until Officer Cappelleri returned with the tool.

In his statement with police, Officer Mr McIver stated that he entered the cell with Mr Moore immediately after Mr Cappelleri left to get the 911 tool, felt for a pulse, observed Mr XX standing and decided not to lift him in case the chair dislodged, *then* found Mr Cappelleri returning with officer Frawley and the 911 tool.

The CCTV footage shows that this was not the sequence of events. Officer McIver is seen to remain outside the cell the entire time until the tool arrived, for over one minute. He and Officer Moore were not only outside but they closed the cell door while Mr XX was still hanging inside.

The procedure in the policy was not followed. The evidence on any version suggests a fundamental misunderstanding of the policy that the body weight must be supported until the ligature is cut.

This scenario highlighted the importance of clearer training in the case of a hanging. It would have been far better if an officer in the immediate area had a 911 tool on them. It was important that Mr XX's body weight was supported until the tool arrived.

Further, for Officer McIver to explain that he remained outside the cell for safety reasons, when such a serious situation was present in the cell, suggests a real need for training of officers about how to assess if there is a threat and reconcile it with their duty to act to preserve life.

As a result of the evidence in this inquest I make the following recommendations.

RECOMMENDATIONS

To the Minister for Corrective Services

That the Minister for Corrective Services gives consideration to the following matters:

1. That the current guidelines relating to 911 tools be expressed in clear and unambiguous terms, to clarify that:

    a. Both the Officer in Charge of an accommodation unit, wing or pod and at least one correctional officer in every team of correctional officers conducting a let-go or lock-in, carry a 911 tool; and

    b. That the correctional officer in the team conducting a let-go or lock-in and carrying the 911 tool be physically present at all times during the procedure on the floor where the let-go or lock-in is being conducted.

2. That in addition to the 911 tools carried by the officer in charge of the accommodation unit, wing or pod and the additional correctional officer a part of the team conducting the lock-in or let-go, that a third 911 tool be available in the office of the accommodation unit, wing or pod as the case may be.

3. That the name of the officer issued the 911 tool by the Officer in Charge be recorded in the accommodation journal or wing diary and the return of the tool at the end of the shift be similarly noted.

4. That training in relation to the procedures applying to an immediate response to a hanging includes training with simulation, and training in relation to managing the safety of the inmate found hanging, alongside the safety of other inmates and officers.

5. That the OPM Policy setting out the immediate response to hanging include a clarification that an inmate found hanging should still be supported and cut down even if they appear to be supporting their own weight (such as standing, sitting or kneeling).

6. That the accommodation journal or wing diary in each accommodation unit, wing or pod also contemporaneously record a request for protection, or protection from a threat, made by an inmate, including any interim arrangements for their housing pending consideration of the request.

To the Minister responsible for Justice Health

That the Minister responsible for Justice Health give consideration to the Reception Screening Tool used for assessment of new inmates being amended to include a requirement to note that the PAS system has been checked for relevant alerts, both inactive and active, from previous periods of imprisonment.

Formal Finding:

That XX on the 30th March 2012 at Long Bay Correctional Facility at Malabar in the state of New South Wales died as a result of hanging. The manner of his death was intentional.

8. 259122 of 2012

Inquest into the death of Madaswamy Shankaranayana. Finding handed down by Deputy State Coroner Dillon on 6 June 2014.

I think, on consideration, I think it probably is best if I allow the publication of Mr Shankaranarayana's name. So I will make that direction under s 75.

This is an inquest into the death of Madaswamy Shankaranarayana who died on the night of 17 and 18 August 2012 at the Metropolitan Special Programs Centre, part of the Long Bay Correctional Centre complex by hanging himself in his cell while on remand in respect of a charge of alleged murder of his wife, Leoni Felix.

I simply note that under the Coroner's Act it is mandatory for an inquest to be conducted by a Coroner if a person dies in custody.

Mr Shankaranarayana was a 40 year old man who was born in India to a Catholic family and who migrated to Australia in 2004 with his wife Leoni Chandrika Felix and their son Dion. The marriage was arranged in the Indian custom. By January 2012 it appears that the relationship was an unhappy one.

Mr Shankaranarayana was an intelligent man of quiet and modest disposition who worked as a toolmaker. The death of his wife and his arrest for her murder shocked those who knew him because it seemed so out of character for him to act in such a violent fashion. He had, however, during the course of his marriage occasionally used physical violence towards her. On a couple of occasions police were called although no further action was taken.

Shortly after the alleged murder Mr Shankaranarayana attempted suicide by slashing his throat and wrist. For several months, before his death in custody, he was assessed and treated as a person at risk of self harm. By the time of his death however the risk of self harm had apparently dissipated.

His suicide occurred just before his son Dion was to be sent back to India to be cared for by the extended Felix family. Mr Shankaranarayana had no known history of previous mental illness.

Over the next couple of pages I have touched on the role of a Coroner and what an inquest is and the issues. On page six I also have described the background facts. I will not go through these but simply go straight to page nine where I begin to deal with the facts of the matter and I will simply summarise the answers that I have come to a conclusion and I have come to in relation to the issues.

The first issue being did any of the decisions made by Justice Health contribute to Mr Shankaranarayana's death? Suicide is unpredictable and suicide risk assessment is an uncertain science in mental health. Some suicides are impulsive, others are premeditated but take place shortly after the plan is first conceived. Still others are carefully planned over time.

In my view there were genuine and reasonable attempts made by both Justice Health and Corrective Services to protect Mr Shankaranarayana from self harm.

Mr Shankaranarayana did not leave a note or record of his reasons for taking his own life but it is clear that he was remorseful for killing his wife, Leoni Felix, intelligent enough to realise that he had no absolute defence to the charge of murder and would, at the very least, spend many years in gaol and finally, that he would very soon lose his wife's family in India perhaps never to hear from him again. He must also have realised that his son had learned or would learn that his father had killed his mother. Atonement and reconciliation would be difficult, if not impossible, in such a relationship. Mr Shankaranarayana had few real friends in gaol and was intelligent enough to foresee a long period of desolation and loneliness in prison. Against that background he took his own life.

I deal with the question was there an appropriate system of communication between Justice Health and New South Wales Department of Corrective Services.

The obvious background to this is that large numbers of prisoners are mentally ill and medically sick or both, also socially disadvantaged. It seems to me that the process for managing those prisoners, in particular their mental health, could be improved. If a system for the managing the mental health of prisoners was to be designed from the ground up it is doubtful that it would have psychiatry being practised by Justice Health and psychology by Corrective Services in respect of the same inmate.

Health records or records relevant to health assessment, including mental health, ought, it seems to me, be available to the clinicians making the relevant decisions. It is a fundamental principle of medicine that good diagnosis and good treatment starts with a good history. If relevant parts of an inmate's history are not available to, or not easily accessible by. Clinicians this creates a risk that diagnosis and treatment will not reach the optimal level.

I have moved to the question did any of the conduct of Justice Health nurses, who attended Mr Shankaranarayana when he was discovered, contribute to his death. Although it cannot be said with absolute certitude that Mr Shankaranarayana was no longer alive when he was attended by the Justice Health nurses it appears to me that it is highly likely that he was either dead or beyond resuscitation when they arrived. Nothing they did or did not do appears to have contributed to Mr Shankaranarayana's death and I go on to further discuss the nurses but I have no criticism of those particular individuals.

On page 11 I have discussed the question did the nurses have the appropriate expertise to render aid to Mr Shankaranarayana including the use of the defibrillator. The nurses have the appropriate training but no practical experience in using defibrillators to resuscitate living patients.

Although it appears that due to his inexperience Mr Baldigan(?) was initially in shock and in some difficulty performing his duties. He was able to perform his duties when prompted. Fortunately, the Correctional officers were more than capable at first aid and were able to assist him.

What I have gone on to say is that evidence was given that Justice Health nurses are given a relatively intense induction but it is probably impossible to prepare a nurse psychologically for the first time they see a hanged person in a cell.

So I move to the question did any decisions made by the New South Wales Department of Corrective Services contribute to Mr Shankaranarayana's death. I do not believe that decisions made by Corrective Services contributed to Mr Shankaranarayana's death. I am aware from this, and other inquests, that an extensive program designed to reduce risk from hanging points has been underway in New South Wales prisons for some years. I will not further comment on that subject.

The real question is whether it was reasonable to place Mr Shankaranarayana in a one out cell. In the light of the evidence available at the time the decision seems to me to have been reasonable. Mr Shankaranarayana appeared to have stabilised psychologically in prison. He reported that he was psychologically quite well although, unsurprisingly, like most prisoners he had a low level of depression. He was well regarded by staff and other inmates. He had a son whom he loved and he had been in gaol for several months without further attempts at self harm.

The prisoner who is kept two out is constantly inconvenienced by the need to be moved around cells. He or she rarely enjoys any privacy. Mr Shankaranarayana's good behaviour, his helpfulness to the staff and other inmates as an interpreter and his mental health assessment, given all of those matters, it was appropriate to grant his request for a single cell placement.

I now turn to recommendations that I believe might be made and the improvements in the system that might be made. I will read this section in full onto the public record.

Although there are arrangements or systems that theoretically enable some sharing of patient information between Corrective Services staff and Justice Health staff in practice this is not routine.

For obvious privacy reasons and perhaps for other administrative reasons information is not easily passed from one organisation to the other. Of course, not all prisoner information held by Corrective Services is relevant to Justice Health and vice versa.

It is often remarked that our prisons are the psychiatric hospitals of the 21st century so, to an onlooker, it appears strange that information relating to the mental health of prisoners is frequently obtained by Corrective Services staff psychologists but this information does not appear to be routinely shared or passed on to Justice Health.

Indeed, although there may be very good reasons for the psychologist to be employed and managed by Corrective Services it is not obvious to me what those reasons are. Given the overlap of the psychological mental health and medical disciplines if a patient or inmate is to be treated holistically it would seem to be more efficient for all these services to be managed by Justice Health.

Both Dr Gerald Chu, clinical director of the Custodial Mental Health Service in New South Wales and Dr Danny Sullivan, a forensic psychiatrist at the Victorian Institute of Forensic Medicine commented during the inquest that ideally mental health services ought to be managed in a unitary fashion. During this inquest I was informed that, together, Corrective Services and New South Wales Health are considering this issue and how best to approach the complex mental health issues involved in managing the prison population, many of whom bring with them into custody an array of psychological. Psychiatric and physical pathologies and disorders.

I recommend that this process continue with all practical speed to develop guidelines and an efficient system or method of sharing relevant patient information.

I also recommend that the working party for the two relevant departments consider the longer term issue of merging or transferring Corrective Services psychological staff into Justice Health.

Second, while I imply no criticism of the nurse involved, it does not appear appropriate to me that an enrolled nurse without specialist mental health training should be placed in the position of having to conduct mental health assessments, as happened in this case. If I do a disservice to Mr Standring, I certainly do not imply any criticism of him. He has had some mental health experience but my understanding is that he was not specifically accredited as a mental health nurse.
For such assessments to be conducted without access to all relevant patient records appears to be both poor professional practice and potentially unsafe.

I was informed that staff shortages are a chronic problem for Justice Health. This makes adoption of any recommendation I make more difficult, no doubt. The problem may be addressed by implementing in-house mental health training for Justice Health nurses or by seconding Justice Health nurses to psychiatric units for a period of training.

Third, Dr Sullivan observed in one of his independent and expert reports that it is generally preferable that a patient who is being assessed at intervals be assessed by the same psychologist or clinician over that time. This would enable the clinician to both build a therapeutic relationship with the patient but also to better comprehend any subtle but significant changes in the patient's mental status.

In conclusion, the death of Mr Shankaranarayana is, in itself, a most unfortunate event. We can only speculate about why Mr Shankaranarayana killed Leoni Felix but he had eight months to contemplate the magnitude of his crime and to consider the damage he had done to her and others, the shame he had brought on himself and his family and the long separation, perhaps for life, he would suffer from his son. It seems that he concluded that the enormity of these things was more than life was worth. It also compounds the tragedy of the death of his ex-wife, Leoni Felix. For both families these deaths have brought desolation and confusion.

Mr Shankaranarayana's death has deprived his son of a father, his parents of a son and Ms Felix's family of a trial according to law.

I now turn to my formal findings in this case and the recommendations I propose to make.

Formal Finding:

I find that Madaswamy Shankaranarayana died on or about the 17th or 18th August 2013 by taking his own life by hanging himself in his cell at the Metropolitan Special programs centre at the Long Bay Correctional Centre

RECOMMENDATIONS:

TO THE MINISTERS FOR HEALTH AND FOR CORRECTIVE SERVICES.

- I RECOMMEND THAT GIVEN THE OVERLAP OF THE PSYCHOLOGICAL MENTAL HEALTH AND MEDICAL DISCIPLINES IF A PATIENT OR INMATE IS TO BE TREATED HOLISTICALLY THESE SERVICES BE MANAGED BY JUSTICE HEALTH.

- ALTERNATIVELY, I RECOMMEND THAT THE CURRENT PROCESS OF WORKING TOWARDS DEVELOPING GUIDELINES FOR THE SHARING OF PATIENT INFORMATION AND AN EFFICIENT SYSTEM OR METHOD OF SHARING RELEVANT PATIENT INFORMATION CONTINUE WITH ALL PRACTICAL SPEED.

- I ALSO RECOMMEND THAT A WORKING PARTY OR THE TWO RELEVANT DEPARTMENTS CONSIDER THE LONGER TERM ISSUE OF MERGING OR THE TRANSFERRING CORRECTIVE SERVICES PSYCHOLOGICAL STAFF INTO JUSTICE HEALTH.

- I RECOMMEND THAT JUSTICE HEALTH NURSES BE REQUIRED TO HAVE UNDERGONE SUITABLE MENTAL HEALTH 40 TRAINING BEFORE

THEY ARE PERMITTED TO CONDUCT MENTAL HEALTH ASSESSMENTS.

- I RECOMMEND THAT DECISIONS BY JUSTICE HEALTH STAFF CONCERNING HEALTH PROBLEM NOTIFICATION FORMS RELATING TO GREEN CARDS NOT BE MADE WITHOUT ACCESS TO ALL RELEVANT PATIENT RECORDS.

- I RECOMMEND THAT, WHERE PRACTICABLE, A CUSTODIAL PATIENT WHO IS BEING ASSESSED PSYCHOLOGICALLY OR PSYCHIATRICALLY AT INTERVALS BE ASSESSED BY THE SAME CLINICIAN OVER THAT TIME TO BOTH BUILD A THERAPEUTIC RELATIONSHIP WITH THE PATIENT BUT ALSO TO BETTER COMPREHEND ANY SUBTLE BUT SIGNIFICANT CHANGES IN THE PATIENT'S MENTAL HEALTH STATUS.

So I think, on consideration, I think it probably is best if I allow the publication of Mr Shankaranarayana's name. So I will make that direction under s 75.

9. 302011 of 2012

Inquest into the death of William Smith. Finding handed down by Deputy State Coroner Cheetham on the 17th February 2014.

Introduction:

The death of Mr Smith was determined as a critical incident by an Assistant Commissioner of Police. The Coroner has been presented with an extensive Police Investigation. I am satisfied that the circumstances have been fully investigated in accordance with the requirements of the critical incident guidelines.

William Geoffrey Smith:

Mr Smith was born on 30 August 1983. He was the second child of his parents. His early childhood is described as being unsettled and his father has been described as ostensibly an active criminal. There is a lengthy history of allegations and counter-allegations between his parents including itinerant lifestyle, kidnapping and violence. His father was sent to prison in 1990. It was stated that Mr Smith's home life improved when his mother married another man in 1992.

Mr Smith met his former partner, Ms Melissa Lipinski, at school. They ended their association before commencing a full-time relationship in 2001. By that time his partner had a child from another relationship.

Mr Smith is believed to have commenced to use methamphetamine, also known as ice, in about 2001.

In 2006 Mr Smith disclosed his drug use to his mother requesting help. She arranged for him to live with her at Condoblin. After a period Ms Lipinski also came to live at Condoblin. He appeared to be overcoming his drug dependency.

In 2007 they moved to Newcastle for the birth of their first child and he again commenced using drugs.

They returned to Condoblin and purchased a house. Pressures began to affect their relationship and Ms Lipinski returned to Newcastle. He was dismissed from work at a time when his partner was expecting a second child. Their second child was born in February 2009 and they again resided in Newcastle for the birth.

Ms Lipinski learned that Mr Smith had re-commenced his drug use and this time by injection. He was dealing in the purchase and sale of drugs. His increased drug use was associated with increasing domestic violence toward Ms Lipinski.

Ms Lipinski gave birth to their third child in June 2011. Mr Smith started new work in Newcastle area in late 2011. He appeared more settled but resumed his intravenous drug use. He then became erratic in his home obligations and financial pressures again affected their relationship. Ms Lipinski said she could not cope with his life style and insufficient funds.

In June or July 2012 Ms Lipinski left and went to live with her parents at 47 Railway Parade Blackalls Park. Mr Smith moved to his brother's home. She returned to Mr Smith after a few weeks but then left again. His drug use increased and their relationship further deteriorated. He lost his job and became more paranoid and erratic and aggressive toward her. The Police became involved to assist her and arrangements were made to seek rehabilitation but it did not eventuate.

In the weeks leading up to his death he threatened self harm and harm to Ms Lipinski. He threatened to kill them both by driving his car through her parent's home. His behaviour became increasing erratic and threatening. Amongst other events he damaged her car to stop her using it, he assaulted her, and he was accusing her and then wanting her affection. He threatened to harm himself in a vehicle. He wanted her affection but then rejected it. He began to exhibit significant self-destructive behaviour and threatening self-harm.

By 27 September 2012 their relationship had continued on and off for seven years. His drug use was uncontrolled and the frequency of domestic violence was increasing. He had significant paranoia and made a number of threats to her.

What happened?

At about 9pm on 27 September 2012 Mr Smith attended the home of Ms Lipinski at 47 Railway Parade Blackalls Park. He was driving Ford sedan registration number AK78BL. She was residing with other members of her family. He began calling out to her in an aggressive manner. He demanded his son. Ms Lipinski refused and he drove off in an erratic manner. He returned shortly after and parked outside her home. Another argument developed. He was sounding his car horn and Tracey, the sister of Melissa Lipinski, called Police.

Probationary Constable Sutherland received a call at 10pm at Toronto Police Station from a person called “Kasey” alleging a person was outside 47 Railway Parade Blackalls Park revving a car engine and calling abuse. The Officer classified the call as priority 3 because he could not establish the bona fides of the caller.

Ten minutes later he received another call from a different person saying “he’s smashing up the place with something”. Two minutes later he received another call from a person he believed was the initial caller. The person was said to be hitting a car with a baseball bat and attempting to get into the house. The Police up-graded the response and a vehicle LM 32 was dispatched with another vehicle LM 205 as back-up.

Mr Smith had attended the premises and made a number of demands upon Ms Lipinski. An altercation commenced between them and he damaged her motor vehicle with a baseball bat. She had confronted him also with a weapon and damaged his car. During the heated argument she threatened to repeat damage his vehicle and he said; “go on, do it. We’re all going to be gone soon”. Police attended the location to investigate what had occurred. They observed smashed windows and extensive damage to the bodywork of her vehicle.

At about the time the Police arrived at Railway Parade Mr Smith drove off in his motor vehicle. One Officer described his demeanour as being in an extreme rage. The second Police vehicle LM 205 followed his vehicle. It was occupied by two Police Officers. The Police Vehicle activated its warning lights to signal Mr Smith to stop. Mr Smith indicated an intention to stop by use of his blinker and almost did so.

Before the Police Officer could stop his vehicle to speak to Mr Smith he performed a U-turn to travel in the direction from which he had travelled. It was toward Ms Lipinski's home. It was not possible for the Officer to complete a U-turn because of the location of his vehicle on the roadway. The Officer completed a three-point turn and followed Mr Smith's vehicle with warning lights and siren activated. Mr Smith accelerated his vehicle away followed by the Police vehicle.

The Police vehicle reached speeds of up to 120 km/hour without gaining on Mr Smith's vehicle. When approaching the home of Ms Lipinski it crossed to the right side of the road and travelled through a fence. At that time Ms Lipinski was outside the property speaking to other persons and Police who had attended to investigate the earlier incident. The first Police vehicle LM 32 was parked outside the property. The vehicle driven by Mr Smith mounted the footpath in a diagonal direction. It drove across the footpath through the front fence and struck Ms Lipinski causing serious injury to her. His vehicle continued forward striking a large tree. The impact caused multiple injuries to Mr Smith.

Police investigating the earlier complaint at the location took evasive action to avoid the path of Mr Smith's vehicle. They did not sustain injury.

The driving incident was recorded by a video from within the pursuing Police vehicle LM 205. The video confirms other evidence.

The identity of Mr Smith's vehicle was broadcast at 22.16.21 hours. Within 29 seconds Police vehicle LM 32 was attending. Within a further minute Police vehicle LM 205 was attending. At 22.19.39 hours Police were advised the vehicle was taking off.

The driver of the Police vehicle LM 205 was travelling at 53 km/h until Mr Smith's vehicle was first observed. The Police vehicle attempted to catch up to Mr Smith's vehicle and increased speed to 107 km/h. Warning devices were activated. It then reached 122 km/h. Mr Smith signalled his intention to stop and his vehicle pulled to the left hand side of the road. Any reasonable interpretation would indicate that Mr Smith intended to stop. The time was 22.19.57. He almost stopped in an area that permitted a U-turn.

The Police vehicle decreased speed an almost stopped when Mr Smith made a U-turn at 22.20.00 and increased speed. The Police Officer did not have time to completely stop his vehicle or alight from it. The Police vehicle completed a three-point turn accelerated to catch up to Mr Smith who was accelerating away. The pursuit was called at 22.20.08 hours. Within 6 seconds the Officer called an urgent pursuit. At 22.20.17 Mr Smith's vehicle crosses to incorrect side of roadway and crashes through the fence. The pursuit ended with the collision 13 seconds after it commenced.

The impact was significant. The force was such that a Scientific Police Officer described the vehicle as "wrapped around a large tree" with the engine was pushed back into the firewall. The large tree was completely in the engine bay. Photographs show the severity of this impact. Mr Smith's seatbelt was not fastened. An inspection found no mechanical defect in the vehicle. Lack of damage to the vehicle's brake light filaments is indicative that the brakes had not been applied.

A Scientific Police Officer also concluded that the major contributing factor in the collision was a deliberate act of driving by Mr Smith. Road, traffic and weather conditions are not considered to be contributing causes. There were no mechanical defects or failures within the vehicle that were contributing factors toward the collision.

The driver of the Police vehicle participated in an interview pursuant to Clause 8(1) Police Regulation 2008. It was a compulsory interview as the events had been classified as a critical incident. In that Interview he described the events depicted in the In Car Video.

He estimated the speed of Mr Smith's vehicle at the time of the pursuit at 120km/h. After the impact he immediately attempted to assist Mr Smith and requested assistance. He also assisted Ms Lipinski who was seriously injured. These actions occurred even though he was the witness to the significant impact and was likely to have suffered an emotional reaction to the events he had observed. The driver of the Police vehicle had no knowledge of Mr Smith, his life history or his intentions. Other Police who had feared for their welfare also provided assistance.

I have reviewed the NSW Police Force Safe Driving Policy. I am satisfied the driver of the Police vehicle has appropriate training and experience to engage a pursuit. He has been a Highway Patrol Officer since 2002. The Police vehicle appears to have been adequately maintained. All warning devices were operating. The pursuit was called by radio and was of very short duration. The only other occupant of the Police vehicle was another Police Officer. It became a pursuit in accordance with the Policy when Mr Smith drove away after indicating his intention to stop. The Police Officers were subject to routine drug and alcohol tests and all tests were negative for those substances.

Injuries to Ms Lipinski.

Ms Lipinski was struck by the motor vehicle driven by Mr Smith. She received compound fractures to the right leg and foot. She underwent external fixation by operation. Her prognosis is described as good but she is likely to have long term disability.

Injuries sustained by Mr Smith:

An autopsy report describes the direct cause of death as multiple injuries. A pathology summary describes a pattern of injuries consistent with a collision.

Those injuries are bilateral subarachnoid haemorrhage over the surface of both cerebral and cerebellar hemispheres, complete separation of spinal column and the junction of C1 and C2 vertebrae, attenuation of anterior longitudinal ligament of cervical spine, retro-esophageal hemorrhage overlying 1st to 4th cervical vertebra,

bilateral pulmonary contusions and probable inhalation of blood, fractures of 1st and 2nd right and left ribs, bilateral small haemathoraces, small pericardial tamponade, a transverse tear of aorta, subluxation of left shoulder joint and fracture of left ankle.

The pattern of injuries would have rapidly caused death. The Police Officer believed Mr Smith was immediately deceased.

Toxicology:

A toxicology report indicated that no alcohol was detected. However, 0 .05 mg/L of amphetamine and 0.19 mg/L of methyl amphetamines were detected. There is no evidence that Mr Smith was unable to control the motor vehicle but his consumption of those substances had previously been associated with paranoia and destructive behaviour.

The evidence that supports a finding that the actions of Mr Smith were deliberate is as follows:

- Mr Smith had previously expressed an intention to take his life and that of Ms Lipinski. He made similar comments that night.

- Mr Smith had previously expressed an intention to drive his vehicle into the home where she was residing.

- he had acted violently to her and her property when striking her car with a baseball bat.

- his behaviour was erratic before he left her home.
- he had consumed illicit drugs that had previously caused him to act irrationally and violently.

- Mr Smith had returned to the location where he had the earlier confrontation with Ms Lipinski knowing she was present and knowing he was being pursued by a Police vehicle that wanted him to stop.

- his decision-making may have been affected by his consumption of amphetamine and methyl amphetamines.

- there is no evidence that he applied his brakes or that he lost control of the vehicle before impact.

- his vehicle was driven at great speed.

- he drove the vehicle directly at Ms Lipinski striking her and causing serious injury before colliding heavily with the tree.

- there is no evidence that his vehicle lost control at any time on the roadway or that he lost control before colliding with the tree.

- he had left a note in the form of a Will that is consistent with an intention to end his life.
- .

Conclusion:

Mr Smith died when the motor vehicle he was driving collided with a large tree in the front yard of 47 Railway Parade Blackalls Park. The impact was so severe that he was likely to have died instantly.

It is more probable than not that his actions were deliberate.

The conduct of the Police Officer driving the Police vehicle was consistent with the NSW Police Force Safe Driving Policy in the circumstances.

The actions of the Police officer driving LM205 were not responsible for the death of Mr Smith.

Formal Finding:

That William Geoffrey Smith died on 27 September 2012 at 47 Railway Parade Blackalls Park New South Wales of multiple injuries whilst the driver of a motor vehicle that collided with a tree at high speed.

10. 314507 of 2012

Inquest into the death of XX. Finding handed down by Deputy State Coroner Dillon on the 15th April 2014.

XX died on 10 October 2012 when he fell from a ledge on the tenth floor of the Johanna O'Dea flats in Camperdown. His death was not only sudden and unexpected, but tragic for those close to him.

It has also affected numerous other people; the staff of the mental health and emergency departments at the Royal Prince Alfred Hospital; the good Samaritans who tried to prevent his death; the police officers and ambulance officers who responded to their calls for help; and no doubt many others who knew him such as the people at the Aboriginal Medical Service.

This inquest has been required under the Coroners Act because XX died in the course of a police operation, an operation intended if possible to prevent his death. When people die in the course of police operations their families and the community have a right to know what happened and whether the death could have been avoided.

The involved police officers also have a right to know that if they have behaved well and according to their duties and responsibilities, this will be publicly acknowledged in an official enquiry. In this case the police officers involved are Constables Serganis, Upple and Stockade did all they could to prevent XXs' death and should be commended for their efforts.

The desperate efforts of the good Samaritans, Daniel Timms, Dave Delaney and Tyrone Vargas, plumbers who were working at the flats that day are also worthy of the highest commendation. They recognised that XX was in grave jeopardy and took immediate action, first to stop him jumping and then to get emergency services to attend.

Their efforts, especially those of Mr Timms appear to have been successful initially in diverting XX, but as we know it was ultimately not to be.

The major issues in this case however concern the events earlier at the Royal Prince Alfred Hospital. XX was taken to the hospital on 8 October and discharged early on the morning of 9 October. He appears to have taken Ice when he got home. This resulted in a disturbance which led police to intervene and return him to the Royal Prince Alfred Hospital later that morning of 9 October.

The evidence shows that XX was most probably suffering from a drug induced psychosis when he presented at the hospital on the ninth. He was sedated in the emergency department on the morning of 9 October and was later assessed by a psychiatric registrar, Dr Nasti, who scheduled him.

At that stage the plan was to admit him to the psychiatric unit but no beds were available, hence he remained in the emergency department for about 24 hours.

During that time he slept and of course metabolised the methamphetamine that he had taken. As a result his condition improved markedly over the 24 hour period. He took occasional cigarette breaks without incident.

I think its common knowledge that emergency departments are very busy and noisy. There are lights and bells and whistles all going off constantly and they are not particularly restful environments.

On the morning of 10 October, some time before the psychiatric team's morning rounds, which were usually at around about 9 o'clock or some time before that, XX left the emergency department apparently for a cigarette but possibly simply because he was just sick of sitting in the emergency department. This was a view he expressed to Dr Wand when Dr Wand met him at the McDonald's Café which is in Missenden Road beside the hospital.

At that point, although he was seen to be leaving the hospital grounds, he did not go very far. The McCafé is right beside the hospital; in fact it is just on the other side of the driveway to the one of the hospital car parks. Whether he was really absconding at that time is not clear to me but he was off the grounds of the Royal Prince Alfred Hospital and I suppose in a technical sense he had absconded while subject to a schedule.

In any event, Dr Tim Wand, who had known XX for several years and who was also highly experienced in assessing XX and other patients suffering from mental illness and other conditions, spoke to him in the café or outside the café. They spoke for about five minutes. XX insisted that he wanted to go home to his own bed although he appeared to be significantly better than he had been the previous day and especially when he had been brought in.

No doubt he had not had the most restful nights sleep he had ever had in his life but his drug induced mental disorder appeared to have improved significantly.

And during the conversation Dr Wand came to a view that if he were assessed by the psychiatric team, as was the plan not much later in the morning, there was a real possibility, in fact a likelihood in Dr Wand's view, that XX would be discharged, and he said this to XX as he tried to persuade XX to return to the hospital. But as the conversation progressed XX became more and more adamant it seems that he simply wanted to go home. He was frustrated about having had to wait in the emergency department for 24 hours and, as he put it, he just wanted to go home to his own bed. Not an unreasonable opinion to have at that time one would have thought.

Dr Wand then had to make a quick decision.

He could have demanded that XX return to the hospital and if necessary he could have called security or the police to enforce that demand, or he could let XX go and go back to the hospital and advise Dr Hing,

Who was running the emergency department at that time, she was the senior staff consultant, and also the psychiatric team of his assessment of XX and that it was not necessary to enforce the schedule.

Dr Hing who had great respect for Dr Wand's experience and expertise accepted this advice. While she made no notes, she did give evidence that it is likely that she would have spoken to the psychiatric team when it came round to do its rounds in the emergency department at about 9 o'clock, and the inference we can draw from the fact that there was not a call the police to go and visit XX at his home, that the psychiatric team had agreed with the view of Dr Wand and Dr Hing, that the schedule could be revoked.

I will come back to the revocation of schedules in a minute, but I note that there is nothing under the Mental Health Act which specifically provides for revocation of a schedule. In my view that is a lacuna in the Act that should be clarified or filled, and I will be making a recommendation about that.

I also believe that a note, some short form of summary of the reasons for a decision to revoke a schedule ought be made and ought be required under the Act, and that will be part of the recommendation. But in any event, the schedule was revoked by striking a couple of lines through it and no further action were taken in respect of recapturing XX. Concerning XXs' mental state, when he had been first brought in he was very agitated, he was swearing, insulting the police, he apparently was under the illusion or the delusion that he had been taken to a jail.

He thought that the hospital was a jail apparently and he was both afraid of that and also angry about that, or so his comments suggested. After being sedated though he was not in an immediate fit state to be mentally assessed and so it was later in the day, I think around 1.45 but I stand to be corrected, that he was actually assessed by the psychiatric registrar, Dr Nasti.

Dr Nasti came to a view that, and his views were supported by the two consultant psychiatrist who gave evidence yesterday, Doctors Ryan and Nielssen, that the most likely diagnosis was a drug induced psychosis;

There was evidence of paranoia and so forth, but some of these things - there is delusional thoughts, disordered thoughts were resolving. He was reasonably lucid and able to convey his beliefs and ideas and thinking about suicide and self harm. Among other things, and its important to state that he told Dr Nasti that there were two choices available; he could be sent to jail or someone could push him off a building, but he told Dr Nasti and Dr Nasti noted it that he did not have the guts to thrown himself off a building.

On 8 October when he had been brought in the previous day, he had told one of the paramedics who had brought him that he was thinking about throwing himself under a truck but also did not have the guts to do it. As Dr Nielssen said yesterday it actually takes a lot of physical courage and it does not take much imagination to understand this. It takes a lot of physical courage for someone to throw him or herself off a building or off a height or indeed in front of a train or a truck.

And so it might be thought that although he had suicidal ideation there was at least some assurance to be found in the fact that he was telling paramedics and the psychiatrist with the registrar that he did not have the guts to take his own life, that this was some degree of assurance that he would not do anything to seriously harm himself.

Suicidal ideation is very common. As the consultant psychiatrists told us yesterday these types of statements concerning desires to self harm or commit suicide are made very commonly in emergency departments and psychiatric units and are not useful predictors of who will actually commit suicide. We know that patients like XX are a significantly higher risk for self harm than other members of the community, but high risk does not correlate easily with actual death by suicide. And so there really can be no criticism of Dr Nasti, or indeed Dr Wand or Dr Hing or anyone else at Royal Prince Alfred Hospital that they overlooked an obvious sign that XX was about to commit suicide.

The main criticism made of the hospital, or rather of the Sydney Health District, is that a psychiatric bed was not available for XX for the whole time he spent at the Royal Prince Alfred Hospital.

This is a resource issue for those who manage the Sydney Local Health District and its competing priorities. More widely I suppose it is a matter for government and ultimately for the community to decide how we fund our health system and what aspects of our health system get priority. If our psychiatric units are overfilled, if they are at 110% of capacity all the time, as Dr Nielssen said yesterday, this suggests that more resources are needed, but I am 100% certain that those who are trying to manage the resources of the Sydney Health District are well aware of that issue.

If more resources are needed, where will they come from? Obviously there is no magic pudding in the health system. The mining bonanza is over in Australia and the Federal government is promising a stringent budget next month. I do not envy the task of those who must manage public psychiatric units and community mental health teams in such circumstances. The community I think over the last few years has become more and more aware and sensitive to the issues concerning mental health. People like Dr Patrick McGorey and others have raised our consciousness of these things but again there is a competition for these resources and I cannot prescribe any simple solution to the problem.

Whether the availability of a psychiatric bed would have made a significant difference in XX' case is, in any event, impossible to say. Perhaps XX had simply got sick of the sad swings and roundabouts of his life and his daily struggles with drug dependency and his physical ailments. Certainly on 10 October when Dr Wand spoke to him he was frustrated, probably tired, not feeling in tip top shape and he certainly did not want to go back into the emergency department. Had he gone back in it seems to me that there was a reasonable likelihood that if he had been admitted to a psychiatric bed that he would have been discharged that morning after a further assessment by the psychiatric team.

It also seems to me that there is a reasonable likelihood that if he had been transferred quite swiftly from the emergency department into the psychiatric unit the same result would have come about. He would have undergone a further assessment by the psychiatric team; it is probable I think, and I base this opinion or this conclusion on the opinions of the expert evidence,

That his diagnosis was that he was not suffering from a chronic psychotic illness but a short term drug induced psychosis on a background of perhaps a borderline personality disorder.

It seems to me that it is unlikely, wherever he was detained, that he would have been detained in the hospital for very long, and he may well have been discharged some time soon after 9am. Who knows what the result then would have been.

Some criticisms have been made concerning the admission which does not seem to have been regularised until Dr Nasti's assessment, and also concerning the records kept in the emergency department concerning XX. No doubt these criticisms have some validity but I think it is also important to take account of the fact that this was, as one witness described it, an extraordinarily busy time in the emergency department and also for the psychiatric team.

In such circumstances I suspect that record keeping tends to take a second place to the assessment and treatment of patients. Again there is or was no magic pudding available at that time to provide all the ideal resources that the emergency department and psychiatric team could have utilised had they been available. So it is perhaps not surprising that in those circumstances the records were not as they ideally ought to have been.

But it is unfortunate anyway that when XX was allowed to leave the hospital some form of short summary was not made to record the reasons for that decision and the considerations that were taken into account. I do not doubt however that Dr Wand, Dr Hing, Dr Nasti and others who were responsible for XX care and management at the Royal Prince Alfred Hospital have given serious thought since his death to the questions that his death raises about the way they did their jobs and whether they can improve their personal performances and the performance of the organisation as a whole.

But I do not intend to indulge in personal criticism of them. I think they were doing their very level best to manage an extremely busy and a stressful situation, not just for XX but for many, many other patients whom they were trying to treat and move through the system.

Human beings cannot read minds. We do not know when XX decided to take his own life and we do not know what was different about this particular day from other days when he had contemplated taking his own life but did not. In my view the doctors and staff at Royal Prince Alfred Hospital did their best not only to treat him and to manage his illnesses and conditions, but to afford him dignity.

That is sometimes lost when we think about these types of issues. Patients deserve respect, respect as autonomous human beings who are adults who, when they are capable of making their own decisions, ought be allowed to do so and ought be given the dignity of making those decisions.

Dr Wand in particular appears to have had a genuine and respectful relationship with XX. Had he taken an authoritarian stance with XX at the McCafé, this might have both jeopardised that relationship of respect and it may have led to consequences that we cannot now foresee or understand. It is perfectly possible that if XX, for example, was seriously contemplating taking his own life, being detained in a psychiatric unit might have been the trigger that led him to do so in the psychiatric unit. Suicides in psychiatric units are not common but they occasionally happen and they are very difficult to prevent.

Dr Hing respected the judgment and expertise of Dr Wand. In my view this also was entirely reasonable and professional on her part. Dr Nasti made a thorough assessment of XX and was praised by Dr Ryan for the thoroughness of it. At the end of the day XX made his own decision as an autonomous adult human being. It was a despairing decision but he was making decisions for himself, not being treated as an object by others. It is however, in my view, very sad that this was the path that he ultimately chose.

And I am very sorry that you have lost your brother, I am sorry for your family. From what I have read he was a decent human being and the fact that you have sat here thinking about him and yesterday shedding tears for him, I think it shows that whatever might have gone wrong in his life, there was a lot of good in it too, and I am sorry that you have lost the benefit of that good. And I now turn to my formal findings under the Coroners Act.

Formal Finding:

I FIND THAT XX DIED ON 10 OCTOBER 2012 AS A 10 RESULT OF MULTIPLE INJURIES HE SUSTAINED AS A RESULT OF A FALL FROM HEIGHT AT THE JOHANNA O'DEA FLATS IN CAMPERDOWN, NEW SOUTH WALES, WHEN HE TOOK HIS OWN LIFE IN THE COURSE OF A POLICE OPERATION.

Recommendations:

To the Minister for Health.

I recommend to the Minister that the Mental Health Act be amended to provide specifically for a mechanism for revoking schedules under the Act and for recording short reasons for such decisions.

11. 323452 of 2012

Inquest into the death of Jason Thomson. Finding handed down by Deputy State Coroner MacMahon on the 16th April 2014.

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

A non-publication order has been made in respect of the following evidence given in the proceedings:

1. In the statement of Detective Inspector McKenna (Tab 7 of Exhibit 2) – the whole of paragraph 2:16, in paragraph 2:20 the words commencing with: *which Mulhearn* and concluding with *terminated*, the whole of paragraph 2:46, in paragraph 4:114 the words commencing with *to the public* and concluding with *or police,* in paragraph 12:07 the words commencing with *"(Catch up and concluding with page 340)"*, the definition of pursuit in paragraph 12:08 and the whole of paragraph 12:15;

2. In the transcript of the interview with Senior Constable Mulhearn (Tab 8 Exhibit 2) – question and answer 52, the words commencing *I don't think* and concluding with *or anything*, in answer 72, the words commencing with *when he* and concluding with *to terminate* in answer 73 and question and answer 136;

3. In the transcript of the interview with Inspector Steele (Tab 11 Exhibit 2) the words commencing *to either* and concluding with *officer involved* in question 14;

4. The report on Senior Sergeant Ron Dorrough (Tab 53 of Exhibit 2);

5. The NSW PF Safe Driving Policy (Tab 54 Exhibit 2); and

6. The evidence of Senior Sergeant Dorrough given at the inquest on 3 April 2014.

Findings made in accordance with Section 81(1) Coroners Act 2009:

Jason Mark Thomson (born 29 May 1970) died on 17 October 2012 at Tweed Heads District Hospital, Tweed Heads in the State of New South Wales. The cause of his death was multiple injuries that he sustained when the motorcycle he was riding left the road and collided with a tree during the course of a police pursuit.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

To: The Commissioner, NSW Police Force:
That consideration is given to amending the NSW PF Safe Driving Policy to require that, before a pursuit is commenced, the involved officer be required to give consideration the nature and handling capacity of the vehicle that is proposed to be pursued.

To: The Minister for Police:
That that the NSW Police Force Safe Driving Policy (SDP) component dealing with police pursuits be reviewed, in the light of Australian and international experience and research, by a panel of independent experts appointed by the Minister with a view to establishing best practice for the NSW Police Force (NSWPF).

Reasons for Findings:

Introduction:

Jason Mark Thomson was born on 29 May 1970. In these reasons I will refer to him as Jason. In 2012 Jason resided with his partner Lorraine Coates at Murwillumbah on the north coast of New South Wales. Jason and Lorraine Coates had been in a relationship since 2010 and the week before his death they had decided to marry.

Jason was also the father of three children. He had spent many years serving in the Royal Australian Navy as an engineer and, after leaving the Navy, had worked for the Tweed Shire Council. He was a motorbike enthusiast and had ridden and owned bikes for many years. Jason was also a member of the Odin's Warriors OMCG.

On 18 June 2012, Jason appeared before the Tweed Heads Local Court. He was convicted of the offence of driving whilst disqualified from holding a licence. He was sentenced to imprisonment for a period of nine months but that was suspended on him entering into a bond to be of good behaviour. He was also disqualified from holding a licence for a further period of two years.

In February 2011 Jason purchased a 2008 FXS Series Harley Davidson from a Queensland Bike Sales company. It would appear that Jason subsequently arranged for the bike to be registered in the name of a Steven Meeuwissen. The registration number was OOL 69 (NSW).

On 17 October 2012 at about 8:10pm Senior Constable Mulhearn observed a motorcycle in Terranora Road, Terranora travelling at a speed that he considered to be in excess of the posted speed limit. He followed the rider and, having caught up with him, directed him to stop. The rider pulled over and stopped momentarily before speeding away. Senior Constable Mulhearn then commenced a pursuit.

The pursuit concluded some 54 seconds later when Jason's bike failed to successfully negotiate a sharp bend and left the road and collided with a tree. Jason sustained multiple injuries as a result. Jason was conveyed by ambulance to Tweed Heads District Hospital where he was pronounced life extinct at 9:14pm.

Jurisdiction of the Coroner:

It is important at this stage to set out the role and function of the coroner in respect of the death of Jason. The role and function is established by the Coroners Act 2009 (the Act). All legislative references, unless otherwise mentioned, will be to that Act.

Section 6 defines a *"reportable death"* as including one where a person died a *"violent or unnatural death"* or under *"suspicious or unusual circumstances".*

Section 35 requires that all *reportable deaths* be reported to a coroner.

Section 18 gives a coroner jurisdiction to hold an inquest where the death, or suspected death, of an individual occurred within New South Wales or where the person who has died, or is suspected to have died, was ordinarily a resident of New South Wales.

Section 27(1) (b) provides that if it appears to a coroner that a person died, or might have died, in circumstances to which Section 23 applies then an inquest is mandatory.

Section 23 gives exclusive jurisdiction in respect of the investigation of certain deaths to Senior Coroners.

Section 22 (1) defines a Senior Coroner as being the State Coroner or a Deputy State Coroner.

The exclusive jurisdiction given to senior coroners includes the investigation of deaths that that occur *as a result of or in the course of a police operation* (Section 23 (c)).

Section 81(1) sets out the primary function of the coroner when an inquest is held. That section requires, in summary that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died, and the identity of that person, the date and place of their death and the cause and manner thereof.

In addition to the matters to be determined in accordance with Section 81(1), in a case such as this where a death occurs *as a result of or in the course of a police operation* it is important that the contribution of police action, if any, to the circumstances of the death be the subject of a full and public inquiry.

The Parliament requires that inquests in such circumstances be conducted so as to provide a positive incentive to police to ensure that their actions are appropriate in all situations and to satisfy the community that those deaths that occur when police are involved are properly investigated. It is also in the interest of the police that such deaths be properly investigated so as to ensure that the officers involved, and the police in general, are not the subject of unsubstantiated or malicious allegations.

Section 82 provides that a coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths of a nature similar to that with which the inquest is concerned.

Section 74 (1)(b) authorises a coroner during the course of an inquest, if he or she is of the opinion that it is in the public interest to do so, to prohibit to publication of any evidence given in the proceedings.

Identity and Date and Place of Death:

Jason's identity and the date and place of his death were not matters of controversy. Stephen Moore identified Jason's body to Senior Constable Broadhurst at the Tweed Heads District Hospital on 17 October 2012. Mr Moore was a friend of Jason's and had known him for some two years.

Jason was declared deceased by Dr Nicholas Childs at the Tweed Heads District Hospital at 9:14pm on 17 October 2012.

I accept the evidence of Mr Moore and Dr Childs and am satisfied that Jason died on 17 October 2012 at the Tweed Heads District Hospital, Tweed Heads in the State of New South Wales.

Cause of Death:

Professor Tim J Lyons, forensic pathologist at the Newcastle Department of Forensic Medicine, performed an autopsy examination following Jason's death. Following that examination Professor Lyons recommended that the cause of death be recorded as being 'multiple injuries' suffered following his bike leaving the road. I accept Professor Lyons's opinion as to the cause of Jason's death.

Manner of Death:

There was no controversy that Jason's death occurred as a result of injuries he received when the bike he was riding left the road whilst he was travelling at speed whilst being pursued by a police vehicle. In the circumstances the primary issue to be considered at inquest related to the circumstances that resulted in that police pursuit and the conduct of Senior Constable Mulhearn during the course of the pursuit.

A secondary issue that was raised by Jason's brother and others was the camber of the road at the point where Jason's bike left the road.

The issues for inquest, apart from the formal section 81 issues, were therefore identified as being:

- Was the police pursuit conducted in accordance with NSW Police Force Safe Driving Policy (SDP)?

- Was the part of Terranova Road, North Tumbulgum, where the accident occurred, appropriately cambered?

- Are there any recommendations that ought to be made under section 82 of the Coroners Act 2009?

In determining these issues, I was assisted by a comprehensive brief of evidence prepared by Inspector McKenna, the officer in charge of the investigation into the death of Jason on behalf of the coroner. I also received oral evidence from 10 witnesses and was provided with family statements from Lorraine Coates, Jason's partner, and Carolyn Roberts, his mother.

The Evidence:

Lorraine Coates stated that in the afternoon Jason had been at home however, at about 4:00pm, he decided to go for a ride. He said that he was going to see his mother and would be home later. He was in good spirits and had had drunk 4 Pure Blond beers. Lorraine Coates did not think that he was affected by alcohol.

Carolyn Roberts said that between 3:00pm and 4:00pm on 17 October 2012 Jason phoned her and said he would come around to visit.

He arrived as her home a short time later. They sat on the front porch for between one and a half and two hours and had two cups of coffee and smoked cigarettes. They discussed family issues. Ms Roberts thought that Jason was in good spirits and she did not think he had been drinking. As far as she could tell he appeared to be acting normally. He left his mother's home sometime around 6:00pm.

Jason was observed by Senior Constable Mulhearn to be riding motorcycle OLL 69 (NSW) in a southerly direction in Terranora Road North Tumbulgum at 8:10pm. Because of the speed that the motorcycle was observed to be travelling at Senior Constable Mulhearn decided to speak to the rider and to conduct a random breath test.

Senior Constable Mulhearn caught up with Jason and indicated that he wished him to stop. Jason moved his motorcycle to the side of the road and commenced to stop. Having almost come to a stop Jason accelerated his motorcycle and sped off.

The Pursuit:

Senior Constable Mulhearn then decided to pursue Jason. The pursuit lasted 54 seconds. The whole of the pursuit was recorded on the In Car Video Recorder (ICV) installed in the police vehicle driven by Senior Constable Mulhearn and was played a number of times during the course of the inquest.

The ICV recording shows the progress of the pursuit occurring as follows:

ICV Time	Description
20:09:40	Pursuit commences.
20:09:51	Cycle negotiates a right hand sweeping bend across a double unbroken line and travelling on the incorrect side of the road for about 4 seconds at speed estimated between 93kph and 115kph. Having passed the corner cycle returns to the correct side of the roadway and continues in a southerly direction at about 90-100kph.
20:10:03	Cycle negotiates a sweeping left hand bend at about 90kph. Cycle crosses the double unbroken centre line. Rider places left foot out in motocross style.
20:10:12	Cycle travels on incorrect side of the road for about 8 seconds before returning to the correct side of the road.
20:10:15	Cycle on inside of left hand sweeping bend at about 105kph.
20:10:18	Cycle crosses double unbroken centre line for about a second.
20:10:19	Cycle passes speed advisory sign suggesting speed of 35kph for approaching bend.
20:10:20	Cycle cuts corner and travels on the incorrect side of the road at about 90kph.
20:10:24	Cycle fails to negotiate corner, leaves the left hand side of the roadway and collides with a large tree.
20:10:30	Highway patrol vehicle stops on roadway adjacent to collision site.

The ICV recording clearly establishes that during the pursuit Jason was riding his motorcycle at speeds varying between 90 and 105 kph and that on entering the bend where the motorcycle left the road he was travelling well in excess of the recommended 35kph speed limit.

Subsequent to Jason's death evidence was gathered that was relevant to understanding the contributing factors to the collision and Jason's subsequent death.

At autopsy blood samples were taken and analysed that showed that at the time of his death Jason had a blood alcohol reading of 0.186g/100mL, an Amphetamine reading of 0.04 mg/L and a Methyl amphetamine reading of 0.40mg/L.

Had Jason been subjected to a random breath test, and the blood alcohol reading he was found to have at autopsy been recorded, he would no doubt have been arrested and charged with the offence commonly referred to as High Range PCA.

More importantly however in understanding the contributing factors to the collision Dr Judith Pearl, an expert forensic pharmacologist, expressed the opinion that:
Given the very high blood alcohol concentration of the deceased and his very high methyl amphetamine concentration, the deceased would have been very substantially impaired by the combined effects of these drugs and this intoxication would have certainly contributed to his actions and manner of driving and inability to maintain control of the motorcycle.

I accept the opinion of Dr Pearl as to the affect of alcohol and methyl amphetamine on Jason's driving and am satisfied that they were contributing factors to the cause of the collision that resulted in Jason's death.

Senior Sergeant William Darnell gave evidence at the inquest. He has been a police officer in the Highway Patrol for some 24 years. He has been certified to ride police motorcycles since 1991. On 30 November 2012 he conducted a number of controlled tests riding his motorcycle through the corner on Terranora Road where the collision occurred that resulted in Jason's death.

Senior Sergeant Darnell rode his motorcycle around the corner on two occasions and gave evidence that the fastest speed that he felt comfortable riding the corner was 68kph on each occasion.

Senior Constable Darnell was riding a different motorcycle to that ridden by Jason on 17 October 2012 however his evidence is indicative, but not necessarily conclusive, of the fastest speed that a motorcycle could safely negotiate the corner.

Having conducted the simulation and reviewed the ICV recording Senior Sergeant Darnell expressed the opinion that:

In my opinion (Jason) rode Harley Davidson OLL-69 above its handling limit and demonstrated poor riding craft into and out of the corners leading up to the crash location. In my opinion (Jason) entered the crash location corner too fast and at a point on the carriageway too far towards the centre of the carriageway to enable a safe and controlled exit upon (the) apex.

Greg Thomson, Jason's brother, also gave evidence at the inquest. He said that in October 2012 a number of his Jason's friends who were experienced riders also tested the corner in a similar way to that undertaken by Senior Constable Darnell. Mr Thomson's evidence was that a very experienced rider had been able to round the corner at between 90-100kph. Nothing more of the circumstances of that test were available to the inquest. Once again that information was nothing more than an indication of a speed that a motorcycle might be able to safely round the corner.

Motorcycle registration 0LL 69 (NSW) was examined by Senior Constable Paul Daley, who is employed in the Engineering Investigation Unit of the NSWPF, for mechanical defects. Following his examination of the motorcycle Senior Constable Daley formed the opinion that there were no mechanical defects that contributed to the collision. This finding is consistent with the evidence that Jason kept his motorcycle in good mechanical repair. I accept the evidence of Senior Constable Daley.

Greg Thomson, and other friends of Jason, also suggested during the investigation of his death that the camber of the corner in question may have contributed to Jason losing control of his motorcycle prior to the collision. Mr Thomson and Steven Moore referred to this aspect in their evidence.

Raymond Lambie Clarke gave evidence on this issue. Mr Clarke is a traffic engineer employed by the Tweed Shire Council. His role involves him monitoring traffic movements within the Shire, assessing developments, applying for black spot funding to address crash locations and improving road work generally.

Mr Clark inspected the scene of the collision with Inspector McKenna on 15 January 2013. Having done so he expressed the opinion that although there was some minor rutting in the road it was in generally good condition. He also gave evidence that the history of collisions on the road at the site did not qualify it as a black spot requiring rebuilding. His evidence was that the corner was a sharp one requiring the reduction of speed and that was why the Council had erected the advisory speed signs.

It was Mr Clark's opinion that the design, construction and condition of the road at the corner were unexceptional for the location and type of road. I accept Mr Clark's evidence and am satisfied that there is no evidence available to me to suggest that the road condition was a factor contributing to the collision that resulted in Jason's death.

Because Senior Constable Mulhearn was in pursuit of Jason's motorcycle at the time of his death it is important to examine whether or not the pursuing vehicle contributed in any way to the collision. An examination of the ICV recording makes it clear that at all times the pursuing vehicle maintained its distance and was not a contributing factor to the collision. I find that this was the case.

I note that there was not real contention about this matter and that during the course of the investigation of Jason's death the recording was shown to a number of members of Jason's family and friends and having seen the recording no one suggested that Senior Constable Mulhearn's driving in any way caused the collision.

The death of any person in a motor vehicle collision is a tragedy. Jason's death was no exception. Why, after slowing down and almost stopping as requested by Senior Constable Mulhearn, he chose to leave the scene at speed is a matter for speculation. One could reasonably infer that Jason would have known he would be subjected to a random breath test, would then be likely to be arrested and charged with an alcohol related offence and driving whilst disqualified. He would also have known that this, together with the consequent breach of the existing suspended sentence, would have resulted in him being sent to prison. This may be the reason that he sped off however we will never know.

Conclusion:

Whatever his intention there is no doubt that he rode off and the speed with which he did, together with the effects of alcohol and methyl amphetamine on his driving ability, resulted in him being unable to successfully negotiate a sharp bend in the road and this resulted in his motorcycle leaving the road and colliding with a tree resulting in his death.

Jason's death was therefore entirely preventable but caused solely by his own actions.

Compliance with NSWPF Safe Driving Policy (SDP):

The combined effects of sections 23(3) and 27(1)(b) requires that where a death occurs *as a result of or in the course of a police operation* an inquest is mandatory and such inquest must be undertaken by either the State Coroner or a Deputy State Coroner. As part of the investigation of a death that occurs during a police pursuit the compliance of the involved police with the SDP is always an issue to be examined at inquest.

The NSWPF however has concerns that if the detail of the SDP were to be in the public arena persons seeking to avoid apprehension by police may act in a manner that would require police pursuing them to discontinue their pursuit.

This concern has been recognised in the past and coroners have made orders in accordance with section 74(1) (b) prohibiting the publication of evidence of the content of the policy. In this inquest I have made similar orders.

It is, however, necessary to examine the circumstances of this pursuit and to determine whether it was undertaken in accordance with the SDP.

The SDP provides that a pursuit commences at the time it is decided to pursue a vehicle that has ignored a direction to stop. In this case it was not in contention that the pursuit commenced after Jason having initially slowed to a standstill and placing his feet on the ground sped off and Senior Constable Mulhearn followed him.

The SDP requires that before a pursuit is engaged in the vehicle must be a category 1, 2 or 3 vehicle and the driver must be the holder of either a silver or gold classification. There was no contention that the police vehicle and Senior Constable Mulhearin met both these requirements.

The SDP requires that before a pursuit is commenced the involved officer must have reasonable cause to believe that the person being pursued has committed, or has attempted to commit, an offence and the offender is attempting to evade apprehension.

Senior Constable Mulhearn's evidence was that having observed the motorcycle he considered that the rider was exceeding the speed limit. He followed and caught up to him with the intention of speaking to him about the speed and conducting a random breath test. When the rider ignored his direction to stop, he also considered that the motorcycle might have been stolen.

At the commencement of the pursuit the possible offences in consideration were therefore exceeding the speed limit, the failure to stop and the possibility of the motorcycle being stolen. Senior Constable Mulhearn also considered that by accelerating away the rider was attempting to evade apprehension.

The SDP provides that a pursuit should only be considered as a last resort and should only be engaged in when the gravity and seriousness of the circumstances require such action and there is no other immediate means of responding.

Senior Constable Mulhearn considered that in the circumstances the gravity and seriousness of the situation was sufficient to commence a pursuit and that he had no other immediate means of responding.

The SDP also requires that the involved officer must weigh the need to immediately apprehend the offender against the risk to the community and himself or herself. Senior Constable Mulhearn's evidence was that he considered there was little risk to the community, as there were no other vehicles in the vicinity, and there was little if any risk to him at the time.

Senior Constable Mulhearn's interpretation of the SDP in this regard was consistent with the opinion expressed in evidence by the Commander of the Traffic Policy Section of the NSWPF Senior Sergeant R.C. Dorrough.

At the commencement of a pursuit an involved officer is required to activate all emergency-waring devices if not already activated. The evidence shows that this was done.

The driver is also required to inform the Duty Operations Inspector (DOI) and the VKG Supervisor of the pursuit and to provide certain information concerning the pursuit. That information includes the call sign of the vehicle, the location and direction of travel, the description of the vehicle, including the registration number where possible, being pursued and the reason for the pursuit.

The evidence available at inquest was that the following interactions occurred between Senior Constable Mulhearn and the VKG operator during the course of the pursuit:

VKG Time	Transmitter	Transmission
20:08:12	TB 203	Radio I am just stopping, stand by radio, radio I'm in pursuit
20:08:17	VKG	Can I just copy your location
20:08:20	TB 203	Radio um, Terranora Road, towards Tumbulgum, OLL69 it's a Harley Davidson radio, it's an OMCG, speeds approximately 100 over 80.
20:08:36	VKG	Can I just confirm your location, Elanora Road towards where?
20:08:39	TB 203	Towards um Tumbulgum Radio, Speeds 80 over 80.
20:08:47	VKG	All cars stand by unless urgent. Tweed Byron 203 is in pursuit of a cycle. He's on Elanora Road heading towards Tumbulgum. Just traffic and weather conditions 203
20:08:58	TB 203	No traffic, dry conditions
20:09:03	VKG	Your licence details and experience
20:09:10	TB 203	Yeah, he's crashed radio; can you get me some assistance out here?

I am satisfied that Senior Constable Mulhearn complied with the requirements of the SDP to inform VKG of the various information specified in the policy. Clearly not all the information specified was provided however it is clear that in the time available (less than 60 seconds) the process of providing that information was occurring and the collision interrupted that process.

The SDP makes it clear that a pursuit is dynamic in that the involved officer is required to have regard to the changing circumstances of the pursuit and as the circumstances in which the pursuit is being conducted change then consideration is to be given to the appropriateness of its continuation.

In this case Senior Constable Mulhearn gave evidence that from his observations of the motorcyclist he considered that the rider was skilful and that there was nothing about the riding that suggested that the rider was not in control of the motorcycle. He said that at a point shortly before the crash he began to consider terminating the pursuit as he had given the rider time to pull over and it was apparent that he was not going to do so. In the circumstances be considered that the pursuit was not likely to result in the apprehension of the rider and that he might therefore terminate it. It was at about that point that the collision occurred. I accept Senior Constable Mulhearn's evidence on this matter and am satisfied that this aspect of the SDP was complied with.

Having reviewed the evidence available I am satisfied that at all relevant time on 17 October 2012 Senior Constable Mulhearin's actions in the initiation of the pursuit, and the continuation thereof, were in accordance with the NSWPF SDP.

Section 82 Recommendations:

Section 82 provides a coroner with discretion to make recommendations that he or she considers desirable in relation to any matter connected with the death with which an inquest is concerned. Jason's death raised two matters that would appear to me to require consideration. Those matters are:

- The specific matters an involved officer is to take into account in determining whether or not to commence or continue a pursuit, and

- The general issues or circumstances that would justify the commencement of a pursuit in the first place.
-

In this case Senior Constable Mulhearn was in a sedan pursuing a motorcycle. Although the SDP required that in determining whether to commence and continue the pursuit he was required to have regard to the 'weather, road and traffic conditions' there was no requirement that he have regard to the nature and handling capacity of the vehicle being pursued.

Senior Constable Mulhearn's evidence was that the fact that it was a motorcycle was not a matter that he considered in his decision making.

Indeed Senior Constable Mulhearn stated that he had not ridden motorcycles and knew nothing of their handling capacity and how it might differ to that of a sedan. It was however apparent, particularly having regard to the evidence of Senior Sergeant Darnell, that there are significant differences between the handling capacity of a motorcycle and that of a sedan.

The question therefore arises as to whether or not such differences should be specifically considered in deciding to commence a pursuit. During the course of the inquest Mr Hood, who appeared for the NSW PF, helpfully indicated that should I consider that the SDP ought to be amended to require such consideration then the NSW PF would be amenable to such a change.

Whilst I do not consider it appropriate that the matters an involved officer needs to consider be too prescriptive it would seem to me that the nature and handling capacity of the vehicle it is proposed to be pursued is a matter that should be specifically considered by an involved officer prior to the commencement of the pursuit and that requirement should therefore be specified in the SDP. I propose to make such a recommendation.

The second issue that Jason's death raises is the issue of what circumstances justify the commencement of a pursuit? At the time of this inquest I was aware that His Honour Deputy State Coroner Magistrate Dillon was proposing to deliver his findings and recommendations following an inquest concerning the death of Hamish Raj (2011/389491).

Those findings and recommendations were delivered on 7 April 2014.

In Raj His Honour considered the issue of police pursuits in detail. Having considered the matter His Honour made a number of recommendations.

The examination of Jason's death raises some of the issues that were raised in Raj. Specifically, in Jason's case, whether or not it is in the public intererest for a pursuit to be commenced following the suspected commission of what might be considered an offence at the lower end of the scale of criminality such as exceeding the speed limit, failing to stop when directed and the possibility of a vehicle being stolen.

I indicated that, should the decision of Deputy State Dillon give rise any matters that I considered might need further submissions from the parties in this matter; I would resume the inquest and call for such submissions. I do not think that this is necessary as I do not propose to reach a conclusion on the issue. I do however consider that the issue is a real one that requires serious consideration at a policy level.

In Jason's case once the pursuit had commenced, absent a collision, it was unlikely he would have ever stopped for Senior Constable Mulhearn. In the geographical area that the pursuit took place Senior Constable Mulhearn was therefore unlikely to ever be able to apprehend Jason. Senior Constable Mulhearn recognised this himself and acknowledged, in his evidence, and that was why he began to think about terminating the pursuit. The outcome of the pursuit was therefore likely to be a collision and the possibility of death or serious injury was a real one.

I would therefore wish to endorse the recommendation of Deputy State Coroner Dillon that the Minister for Police appoint a panel of independent experts to review the NSW PF SDP with a view to, in the light of Australian and international experience and research, establishing best practice in this regard for the NSW Police Force (NSWPF). I propose to recommend likewise.

Formal Finding:

That Jason Mark Thomson (born 29 May 1970) died on 17 October 2012 at Tweed Heads District Hospital, Tweed Heads in the State of New South Wales. The cause of his death was multiple injuries that he sustained when the motorcycle he was riding left the road and collided with a tree during the course of a police pursuit.

12. 349869 of 2012

Inquest into the death of Patrick Morena. Finding handed down by Deputy State Coroner Dillon on 18th July 2014.

Patrick Morena died in the course of being detained by New South Wales Police on 8 November 2012 in Bulli for a search in respect of a serious suspected drug offence. While being manhandled by police on the ground outside premises in Bulli he complained that he could not breathe, then suddenly stopped breathing. The police officers at the scene called for an ambulance and commenced CPR but his heart had stopped and neither the police officers nor the paramedics were able to revive him.

Under the *Coroner's Act 2009*, when a death occurs as a result of, or in the course of, a police operation an inquest is mandatory.

In a society in which the rule of law prevails, a police force is not a law unto itself. It is accountable to the society it serves to protect. It has been observed that:

The 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 the circumstances.

In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82.[5]

[5] (Abernethy et al. *Waller's Coronial Law & Practice in New South Wales* 4th Edition, Sydney (2010)at p.106 para [23.7]

It should be said at the outset that there is no evidence that the involved police officers had any intention of harming Mr Morena. The basic questions with which this inquest has been concerned have been to do with the cause of Mr Morena's sudden death and whether his death could have been avoided.

Patrick Morena

Although there is considerable evidence suggesting that Patrick Morena was both using and supplying drugs in the Wollongong area, he was much loved by his family and friends who mourn him and who are devastated by his death. His parents Rocco and Serina, and his sister Anna Lisa, miss him desperately.

Patrick was Rocco's and Serina's first-born child and therefore had a special place in the family. As a child and teenager he was an able student and a keen sportsman. After he left school, he began a plumbing apprenticeship and over time he developed other skills in the building trade – tiling, flooring, painting, landscaping, and kitchen and bathroom renovations. He enjoyed flashy cars and was popular with his mates who called him 'Mr Hollywood'. Unfortunately, he also developed a taste for drugs and this led to drug dealing.

While the police naturally were focussed on his suspected criminal activities, they are not the full measure of Patrick Morena. His parents and sister provided the court with a statement that demonstrates that he was a man of considerable talent and potential, as well as generosity and affection. It is therefore a great pity that he became heavily involved in a drug culture that is harmful to minds and bodies and depletes the potential of those who use drugs excessively. His family will remember his generous, affectionate, caring side and miss him very much.

The coroner's role

The coroner's role is to investigate sudden and unexpected deaths to determine the identity of the person who has died, the date and place of that death, the anatomical or physiological cause of the death and the manner or circumstances of the death.

It follows from this that an inquest is an independent judicial inquiry in which it is hoped that the answers to these questions, and issues of fact related to them, will be identified.

This inquest, therefore, is not a quasi-criminal trial of either Mr Morena or the involved officers but an inquiry into the manner in which the police operation was conducted, how Mr Morena's death came about during it and whether the police bear any responsibility for his death.

The fundamental reasons for conducting coronial investigations start with the basic right to life that is recognised in the law, conventions and philosophies of decent, civilised societies.

An inquest is one of our society's ways of demonstrating its respect for the lives of all its members. It is also a way of addressing the challenging questions that a sudden and unexpected death sometimes raises.

It is also a way of addressing problems that may jeopardise lives and finding better ways of reducing those risks.

The issues

This inquest has considered the following issues:

- Why was Mr Morena apprehended?
- Was that apprehension unlawful?
- How was Mr Morena restrained and why was he restrained in the way he was?
- Was he restrained in accordance with standard police training and procedure?
- From relevant underlying health issues did Mr Morena suffer?
- What was the cause of Mr Morena's death? In particular, was it due to natural causes, positional asphyxia, excited delirium, another physical cause or a combination of causes?

- To what extent, if any, did the actions of the involved officers cause or contribute to causing Mr Morena's death?
- Are there any recommendations that ought to be made pursuant to s.82 of the Coroners Act 2009?

The background to the events of 8 November 2012

Between July 2006 and the night of his death Patrick Morena regularly came to the notice of police for suspected and proven drug offences. They suspected he was using and dealing illegal drugs. It is, of course, quite common for drug users to fund their drug habits by dealing. It is also common for drug users to associate with other drug users and drug dealers: this attracts the attention of police.

Although Mr Morena was an affectionate son and family member when he was with his family, his behaviour in the wider community was far less admirable. At the time of his death, the police intelligence system recorded 161 events that had brought him to the attention of the NSW Police Force. He was charged 12 times and was suspected of many other offences, mainly to do with drug dealing. In 2007, he was nominated as a 'high risk offender' by the Campbelltown police. This meant that, as far as the police were concerned, he was one of a relatively small number of people who were suspected of being responsible for a large proportion of the serious crime in the Local Area Command. In 2007, after being caught with a large number of pills containing 'ecstasy' and amphetamines, he was sentenced to serve 12 months in prison with a 6-month non-parole period.

In January 2009, he was arrested again on drug charges. In 2010, he was stopped by police while driving and was found to be under the influence of drugs. In 2011, he was charged again for drug offences and for 'goods in custody' when he was caught with $8000 in cash that police suspected were the proceeds of drug sales.

In November 2011 a series of domestic violence complaints and interventions by police began. Mr Morena was alleged by the complainant, a young woman, to be threatening her.

This culminated in Mr Morena being arrested in March 2012 for assaulting the young woman. When arrested, Mr Morena became violent and unco-operative with police. Relevantly for this inquest, it took four police officers to restrain and handcuff him. When he was searched, he was found to have a large amount of cash and 4.6gms of methylamphetamine ('ice') on his person. He was on bail for those offences at the time of his death.

In April 2012, Mr Morena was classified as a 'high risk offender' by the Wollongong Local Area Command of the police force. In June 2012, Mr Morena was charged with another 'goods in custody' offence in relation to a sum of $7000 police found in his possession. In July 2012, he was charged with breaching an Apprehended Violence Order by threatening the woman whom he had allegedly assaulted in March. In August that year, he was stopped by police and was found in possession of an 'ice' pipe and $8000 in cash. Curiously, the police did not seize the cash or charge him with 'goods in custody' in relation to it.

That Mr Morena was involved in criminal activity may be confirmed by his own report of having been robbed in May 2012. Although he and the witness who reported the robbery to police did not, of course, describe it this way, the robbery has the indicia of a classic drug 'rip off' – a case of criminals stealing from a drug dealer.

In October 2012, Mr Morena was classified as a 'high risk' HRO ('high risk offender'). He was told of this by police on 6 November 2012. (The rationale for informing HROs that they are regarded by police as such is that it has a chilling effect on them. The suspects cannot be sure when they are under police surveillance and tend either to stop or reduce their criminal activities.) Mr Morena was believed by police to be the supplier of what was regarded by customers as the 'best product' in the Wollongong area. The 'ice' found on Mr Morena on 8 November was of 78 per cent purity. This was, as one police officer put it, 'pretty much as high as we ever see in the State'.

The events of 8 November 2012

At about 7.30pm on 8 November 2012, Mr Morena reported as required by his bail conditions at Wollongong Police Station.

When he left the police station, two police officers, Senior Constables Rice and Simpson, who were part of the Wollongong Target Action Group, followed him to conduct surveillance. Mr Morena drove away in a white Holden Rodeo utility vehicle registered in his mother's name.

Neither of the two officers had their appointments (firearms, handcuffs, capsicum spray, etc) with them at the time. The plan was only to conduct surveillance for intelligence purposes. They were dressed in plain clothes and were in an unmarked police car. As surveillance duties are sometimes carried out on foot, appointments can reveal a police officer's identity to targets or members of the public.

SC Simpson was an intelligence officer who knew Mr Morena from numerous past dealings with him. Although he had a general knowledge of Mr Morena's background, he had not familiarised himself with the various warnings about Mr Morena that had been placed on the police intelligence system.

But he was not especially concerned about Mr Morena becoming violent because, as he stated during his evidence, 'I had dealt with him on so many occasions I felt quite comfortable in his company'. SC Rice did not know Mr Morena personally. He was carrying out surveillance as a member of the Target Action Group because he was on light duties.

The surveillance of Mr Morena was intended to identify where he was living and whether he was complying with a residential condition in his bail undertaking. It was also an opportunity to gain more general intelligence about his activities. The plan, such as it was, merely extended to surveillance. Neither SC Rice nor SC Simpson, nor any other member of the Target Action Group, discussed or planned an arrest or even what they would do in the event that they observed Mr Morena carrying out a drug transaction. SC Simpson's general methodology was to observe his targets and, if he believed a drug transaction to be taking place, or some other crime was occurring, to coordinate police back up to "stop-and-prop" the person.

Two other officers, Det Sgt Hammond and SC Hone were also involved in the surveillance operation. They were in another car. All four officers kept in touch by mobile telephone. Neither of these officers was carrying appointments.

Curiously, none of these officers appears to have given much, if any, thought to the possibility that Mr Morena, a person known to them as a 'high risk offender', might commit a serious offence under their eyes that could warrant their immediate intervention.

SCs Rice and Simpson had followed Mr Morena's vehicle a short distance from the Wollongong Police Station when they saw his vehicle enter the rear parking area of a block of units at 61 Smith St. They observed his car stand stationary in that location for 30-90 seconds during which the engine continued to run. Mr Morena did not leave the vehicle and had the window down. The car reversed out of the car park position shortly afterwards and left the location, followed directly thereafter by a second vehicle a white hatch car with three passengers and a driver in it. Neither officer saw any transaction take place between the vehicles during the period of their observation, but both officers thought that one or more of the occupants of the white car were "familiar".

SC Simpson stated in evidence that based upon what he had seen and what he knew of Mr Morena's method of operation, namely supplying from his car, he believed that a drug exchange had taken place. SC Rice said that he had formed a suspicion that a drug exchange had taken place there and then and if he had been working on his own, he probably would have stopped the car…"*but I second guessed myself because I thought Senior Constable Simpson probably didn't want to*".

This suspicion was based on his knowledge that Mr Morena was reputed to be a drug supplier, the fact that his car had driven into an area of the car park that was concealed from the road for a short period with the engine running and the window down, and that second car had driven after it shortly thereafter driven by a person who he believed was familiar to him in some way connected with the use of methylamphetamine.

Although neither of them acted on their suspicions at that time, they called back to the station to alert Sgt Cairns, who was the TAG senior officer on duty that night, and SC Hone and Det Sgt Hammond to 'suspicious drug activity'.

SC Simpson gave evidence that despite these observations he had not formed the intention to search Mr Morena after leaving the Smith St location, and did not make any request to any back-up vehicle (containing Hone and Hammond) to assist in the arrest at that time.

From the first stop in Smith St, the police then followed Mr Morena to Bulli. When he turned off the highway, SC Simpson had a "*fairly good idea of where he was heading*" being Lauren Eager's unit block in Gwyther Avenue, a place at which he knew the supply of prohibited drugs to having taken place. Even on arrival at Gwyther Ave, he had not determined that he would affect an arrest at that time.

On 4 October 2012 Ms Eager and Mr Morena had been the subject of an intelligence report that Mr Morena was the supplier of methylamphetamine in the Wollongong area, but specifically north of Fairy Meadow. The report stated that Mr Morena spent a lot of time with Ms Eagar and at the Gwyther Ave Bulli apartment and that the two had a relationship of sorts. Ms Eagar was believed by police to be one of Mr Morena's "runners" and the unit car park was believed to be used as a place of supply.

SC Simpson directed SC Rice to park their car short of the Gwyther Ave premises and they walked towards the Gwyther St units. Rather than entering the driveway the officers went to the southern side of the block of units in an adjacent property where they could hear the sound of a motor vehicle's engine running.

At this point, suspecting that it was Mr Morena's car they could hear and that he was undertaking a drug transaction, the two officers decided to intervene directly. As SC Simpson stated, "*This is where it begins, it definitely starts to change*."

The police officers walked up the driveway of the Gwyther St flats.

They knew that Mr Morena would be likely to recognise Simpson so they decided that SC Rice should be the first to approach the car. He did not have his badge with him so SC Simpson lent him his so that he could show it to Mr Morena when he approached the car.

At that stage they had not notified Hammond and Hone to tell them where they were or what they intended to do. They knew that they did not have appointments on them and Simpson at least knew that there had been a recent pattern of resistance developing in Morena in 2011 and 2012 on arrest, even if he did not know the extent of it.

SC Rice gave evidence that he approached Mr Morena, who was sitting in the driver's seat of his car, and identified himself by name and badge and asked Mr Morena to get out of the vehicle. Mr Morena responded with words to the effect of "who the fuck are you?" Next to Mr Morena in the car was a walking stick. SC Rice said that Mr Morena's actions in the car made him think that he was attempting to secret drugs or reach for a weapon.

SC Simpson, who had approached behind SC Rice, stated that his concerns at the time were that Morena was still positioned in a vehicle that was running that Mr. Morena could suddenly reverse, and that he wished to prevent Mr. Morena from concealing any evidence. Simpson said his immediate order was "*Pat turn the car off*." To prevent him concealing something as he reached towards the middle of the car near the centre console (a position later found to contain cash, and behind which were located the inactive taser gun), Simpson said told Mr. Morena "*Pat, I want to see your hands, leave your hands where I can see them*."

At about the same time, SC Rice said he reached through the window and took hold of the collar of Mr Morena's shirt and pushed him backed into his seat. He said he did this to make him "recognise what was happening to him because … he wasn't recognising we were police".

A struggle, involving Mr Morena being put in a wristlock through the window by SC Simpson. They tussled over the keys which the police forcibly removed to disable the car.

Events escalated quickly and violently from this point. Around this time Lauren Eager, from her unit within the apartment block, reported that she heard the words "*get your hands off me*". She looked out the window and heard Mr. Morena's voice yell, "*Lauren help me*". Rice also heard the deceased cry out "*Lauren*". It is possible that this was an indication by Mr Morena of genuine fear. Despite the use of the badge and the word "police", it is also possible that, because he had been taken by surprise and was drug-affected, Mr Morena had not recognized the two officers as police.

After the initial tussle between the police and Mr Morena through the car window, he flung or kicked the door open and emerged from the vehicle. The officers described Mr Morena once he was out of the car as "beserk". Simpson described Mr Morena as "frothing at the mouth" and said that he was "very strong".

Witnesses reported hearing, and at times, seeing parts of the altercation. They support police claims that a significant struggle took place. The injuries sustained by SC Rice in particular, and Mr. Morena also indicates that the struggle was vigorous and difficult for the police to quell. It is common ground that the three men careered from the car door into the adjacent wall some metres away. SC Rice said he recalled about this time striking Mr Morena to the side of this face.

SC Simpson said that during this altercation he remained calm, telling Mr Morena to "*Calm down*" and saying "*Pat, stop resisting us, you need to calm down*". An eye witness, Ms Kathy Wills, a neighbour in the adjacent property, came to a gap in her fence to see what was happening. She described hearing an "*animalistic*" roar and another calmer, subduing voice. She later recalled that she heard someone calling out a name. She heard two of the males saying "*Police*" and "*Pat, don't move stay calm, Police calm down calm down*" and later "*Settle down Pat*" and "*Stop resisting*."

In evidence Ms Wills described one of the voices she presumed to come from a police officer: "*It seemed as thought they were trying to calm the person. The voice sounded firm but sort of with a touch of warmth in it..like, "Pat ..it's you know, not somebody scary It's us, sort of thing*." Other independent civilian witnesses gave similar accounts.

SC Simpson said that after the three of them had collided with the wall he used knee strikes to Morena's thigh and buttocks in an attempt to get Mr Morena onto the ground to get him under control. At the same time as SC Rice attempted to restrain him by getting him into a wrist lock (a technique referred to as pain compliance). SC Simpson estimated that this struggle went on for three to four minutes culminating with all three falling to the ground together.

SC Simpson described Mr Morena as continuing to struggle, scratch and strike whilst on the ground in a sort of "seated position". SC Rice gave a similar description.

At that stage SC Simpson used a wrist lock to get control of Mr Morena. He then decided to attempt to control Mr Morena's legs. He took hold of the waist band of Mr Morena's pants and placed him face down in the prone position, making it easier to prevent him "hitting out". From this position Simpson said he took control of his legs by folding them up towards the buttocks in a "figure four leg lock".

Once Mr Morena was in that position, SC Simpson described holding him there, positioned at and focused on holding his legs by placing his body weight against them, while SC Rice got control of Morena's upper body, positioned slightly on an angle, face down, by placing weight on his back. SC Simpson described SC Rice as having his left knee near Mr Morena's left shoulder with his left hand in between the legs and his other knee on the lower back. Mr Morena's hands were held behind him in the small of his back. SC Rice said that he in fact had his left knee positioned on the left shoulder of Mr Morena and his right knee on his back. He reached for and pulled Mr Morena's arms back although it took some time to get control of his arms.

SC Simpson said that he was exhausted by this time but could still feel the pressure of Mr Morena's continued resistance.

He said that from this position SC Rice was able to reach into his pocket and make a phone call. The records indicate that such a call was made at 7.56pm. During this call Mr Morena remained in the figure four leg lock position and, whilst Mr Morena's struggling had "significantly decreased", SC Simpson considered he was still resisting. It was at this time, and whilst in this position that Mr Morena said to the police officers, "*Get off me, I can't breathe.*"

This part of the incident was partially witnessed by Ian Bone, another resident of Gwyther Ave. He had heard a commotion and someone shouting "fucking cunts" and screaming. Mr Bone looked out his bathroom window. He saw a "tangle of men near the brick wall. He saw one of the males pull out what he thought was a mobile phone from his pocket…he heard "*It's the police*" and then he heard something to the effect of "*I need back up assistance and a pair of handcuffs would be handy*."

Ms Wills had a distinct recollection of seeing two males on the ground but had the impression of a third whilst one of the males called for "back up" and gave directions. Whilst this call was being made Ms Wills said there was still a struggle going on: "*He [Morena] was still moving around*".

SC Rice denied that extra weight was put on Mr Morena at the time of making the phone call to SC Hone. It is difficult to assess the accuracy of his account because he was attempting both to make a phone call (and give directions) and maintain control of a person he still considered to be aggressive and from whom he had already sustained a number of injuries. SC Rice said that he had considered the possibility of asphyxia at this time but did not consider any issues concerning the combination of restraint and the use of methylamphetamine or the issues related to the concept of excited delirium.

The records indicate that at some time between the phone call for assistance at 7: 56 pm and 8:01 pm when a call is placed over police radio about an unconscious male who was not breathing, Officers Hammond and Hone arrive at the Gwyther Avenue address.

According to SC Simpson, during this time Mr Morena was handcuffed using cuffs provided by SC Hone whilst he continued to hold his legs. He thought he could still feel a degree of resistance, perhaps consistent with gravity pulling the lower legs towards the ground.

Contrary to this, SC Hone said that by the time he arrived, neither SC Simpson nor SC Rice were holding Mr Morena's legs in the position of restraint. SC Hone said he was told by officer SC Rice to "be careful" at the time of cuffing but from the time of his arrival he discerned no movement at all from the male on the ground and felt heaviness when he assisted in putting on the handcuffs. Ms Wills, looking through the hole in the fence said there was no discernable resistance by the man on the ground at the time the handcuffs were administered.

It is unnecessary to attempt to resolve the inconsistency. Given the way the incident escalated then became a sudden attempt to save Mr Morena's life, it is unsurprising that recollections differ. In any event, the difference is relatively unimportant.

SC Simpson reported that SC Hone said words to the effect of *"Mate, we're going to roll you over and get you to sit up*". SC Rice said as they rolled Mr Morena over from his position on the ground he saw an "*expressionless look on his face*,", and heard a gurgling sound. SC Hone said at this point he realised something "was not right" and noticed Mr Morena's face had gone blue. The cuffs were removed and CPR commenced. At 8.01pm the '000' call was made.

The first ambulance arrived at 8.04pm. The paramedics found that Mr Morena had no pulse and took immediate action to attempt to restart his heart and to supply oxygen. He was transported to Wollongong Hospital but was unable to be revived.

Why was Mr Morena apprehended?

Mr Morena was apprehended following a decision by SCs Rice and Simpson to conduct a search of his vehicle and his person pursuant to s 21(1) (d) of the *Law Enforcement (Powers and Responsibilities) Act 2002* because they suspected that there may be illegal drugs on him or in the car or both.

This is not in dispute. Counsel for the Morena family, however, submits that the police officers did not have reasonable grounds for to detain Mr Morena for that purpose. To that issue I will now turn.

Was the apprehension of Mr Morena lawful?

Section 21(1)(d) of the *Law Enforcement (Powers and Responsibilities) Act 2002* empowers police officers to 'stop, search and detain' any person if they suspect on reasonable grounds that the detained person 'has in his or her possession or under his or her control, in contravention of the *Drug Misuse and Trafficking Act 1985*, a prohibited plant or a prohibited drug'.

It was argued by counsel for the Morena family that what was seen by SCs Rice and Simpson during their surveillance of Mr Morena on that evening leading up to the fatal did not raise reasonable grounds for them to suspect that they might find illegal drugs in his car or on his person.

Mr Marr referred to the tests applied in *George v Rocket* [1990] HCA 26, *R v Rondo* [2001] NSWCCA 540 and *Azar v DPP* [2014] NSWSC 132. In summary, a suspicion is more than an 'idle wondering' and less than belief and knowledge. It has a low threshold because it is an apprehension of something without sufficient evidence to prove the fact suspected.

In *George v Rockett*, the High Court stated (at [8]):

When a statute prescribes that there must be "reasonable grounds" for a state of mind - including suspicion and belief - it requires the existence of facts which are sufficient to induce that state of mind in a reasonable person.

So the question here is whether there were facts which were sufficient to induce in a reasonable person a suspicion that Mr Morena may have drugs on himself or in his car. In my view, there were.

The mere fact that a person may have a past history of drug-related offences is of itself insufficient to ground a reasonable suspicion. Indeed, a search undertaken on the basis of the Smith St observations alone might, arguably, not have satisfied the test for reasonableness of suspicion. But there was much more to raise a suspicion in this case.

At Bulli, the police had two independently suspicious acts that, when viewed to together, combined into a reasonable suspicion that an act of supply was either about to take place or was taking place at that time. The police officers had *current* intelligence that Mr Morena was dealing and using drugs and he was on bail for drug matters. He had been followed to a block of home units that, as far as police knew, was not his home address. SC Simpson had knowledge of the intelligence specific to the Gwyther Avenue location and Ms Eagar.

Mr Morena had driven down a driveway where his car was concealed or partially concealed from the road. He kept the engine running. Those facts, taken together, were certainly suggestive that he was down the driveway to meet someone in relation to drug supply. The officers had reasonable grounds then to stop and detain him pursuant to s 21(1) (d).

Although it is not necessarily indicative of the reasonableness of the decision to search, the suspicions of the police turned out to have been well founded. The evidence shows that police found $850 in cash in the ashtray of Mr Morena's car. A further search located a secret compartment in the white utility behind the console area, in which two mobile phones were located and an apparently disabled taser device. A search of Mr Morena's person located drugs secreted in his underpants, namely 24 packages containing a quantity of high grade methylamphetamine. Again, this evidence was consistent with the intelligence information.

Despite the overwhelming evidence that the police officers identified themselves as police and their reason for telling him to 'jump out of the car', Mr Morena refused to do so until he kicked the door open and started to struggle with the police, shouting for Lauren and powerfully resisting the efforts of the police officers to restrain him.

Pursuant to s 230 of the LEPR Act, the officers were entitled to use reasonable force to carry out the detention and search. There is no evidence that they used unreasonable force in doing so.

Mr Marr also argued that the detention and arrest of Mr Morena was unlawful because the officers did not comply with the requirements of s 201(1) of the LEPR Act. It is common ground that neither officer gave Mr Morena his name or station before the struggle began. Section 201 requires that when exercising powers under the LEPR Act, police officers must identify themselves as police [this was done]; provide their names and places of duty [this was not]; and the reason for the stop and detention [this was also done].

Section 201(2) provides that the officer(s) must provide these details to the stopped and detained person 'if it is practicable to do so, before or at the time of exercising the power, or … if it is not practicable to do so before or at that time, as soon as is reasonably practicable after exercising the power.'

SC Simpson knew Mr Morena and had previously always found him to be 'co-operative' with police (in the sense that he had no history of violently resisting previous stops or arrests. It was probably feasible for SC Rice to have announced his name and station when he appeared at Mr Morena's car window but it is reasonable to expect that had Mr Morena's reaction not been so surprisingly angry and unco-operative reaction that he and SC Simpson would have done so when he got out of the car.

Mr Morena's sudden reaction, which necessitated the police engaging in a fierce struggle, rendered it impracticable for the police officers to engage in formal conversation with Mr Morena until he was subdued. In my view, there was no breach of the provisions of the LEPR Act.

How was Mr Morena restrained and why was he restrained in the way he was?

Mr Morena was either fell to the ground and was restrained on his belly in a prone position or was wrestled down to that position by SC Simpson and SC Rice.

As has been made clear above, the reason for doing so was to gain control of a large man who had gone ‘beserk’ when detained by police.

It is probable that he was under the influence of ‘ice’at the time. ‘Ice’ notoriously enables those under its influence to exert great power. It is sometimes said that they gain ‘superhuman’ strength from the drug.

Police are trained to gain control of violent situations using a number of techniques. SC Simpson and SC Rice had no appointments with them so were forced back on their unarmed combat training to gain control of Mr Morena. They applied various standard techniques such as the figure four leg lock.

Was he restrained in accordance with standard police training and procedure?

Acting Sgt Watts, a NSW Police Force weapons and tactics trainer, gave evidence that police restraint training is primarily about gaining control. Referring to Mr Morena’s initial refusal to get out of the car, Sgt Watts said “*the entire situation is problematic and difficult with him in the car: the access is limited; you can’t necessarily use other options*.”

Sgt Watts had no criticism of the wrist locks or knee strikes as mechanisms appropriate for restraint, whilst stating that punches to the head were not taught but nor were they prohibited in exigent circumstances.

His evidence was that obtaining control by positioning a person on the ground in a prone position with the arms restrained behind him was appropriate and was part of police training in 2012, and still is. He said that an officer ideally should be supporting the bulk of their own weight whilst restraining the upper body but agreed that in the context of a struggle it could be difficult to be focused on weight distribution. He did not consider it inappropriate for the figure-four leg lock to have been applied.

Concerning training about the risk of positional asphyxia Sgt Watts made the following comment:

They have to be controlled first. That's the primary goal. The primary goal is getting control of the individual. Once you have got control, once the need for pressure on their back, weight on their back, has gone, and then you remove it as soon as that need has gone…generally you will roll them into a recovery position or if the situation is suitable sit them up.

Sgt Watts stated, however, that only the officers trying to gain control of the resisting person could really assess whether they had done so. This will depend on all the circumstances.

Sgt Watts confirmed the NSW Police provide ongoing training about the dangers of restraint asphyxia. The training includes discussion of the concept of excited delirium recognition of the signs.

Mr Morena was restrained in accordance with standard police training and procedure except for the fact that the arresting officers had no handcuffs with them. The standard procedure would have been for them to get Mr Morena under control, put him in the prone position, pull his arms back behind him, handcuff and then get him off his stomach. In this instance, because SCs Simpson and Rice had to call for back-up to bring handcuffs, Mr Morena was kept on his stomach probably longer than he would otherwise have been.

Did Mr Morena have relevant health issues?

Although in their statement Mr Morena's parents described him as a 'fit young man', he was, unfortunately, anything but fit. In the time leading up to his death, he was so grey and sick-looking that he was using make-up foundation to put some colour on his face. He was obese, had a poor diet, suffered sleep apnoea and was taking large amounts of methylamphetamine. We do not have evidence of his blood pressure at the time of his death but it is reasonable to assume that it was significantly elevated by these factors.

What was the cause of Mr Morena's death?

Dr Matthew Orde, the forensic pathologist, who conducted the autopsy on Mr Morena's body, reported that the cause of death was not specifically identifiable. Nevertheless he identified a number of factors that he considered were likely to have contributed to it. These included the toxic effects of the drugs in his system; agitation consistent with "so-called excited delirium", physical exertion, anxiety, elevated body mass index, and the element of asphyxia or compromised cardiorespiratory function due to forcible restraint and the position of the deceased's body.

Evidence was called in this enquiry that established that Mr. Morena had a long history of drug abuse. He was apparently building up significant tolerance of the drug methylamphetamine and was also using the drug Viagra almost daily. Witnesses stated that he would take ice daily, topping up every couple of hours, with an estimated use of between $700 and $1000 worth per day. One witness reported that Mr Morena complained to her that he wasn't feeling he was getting the high he used to.

Toxicologist Dr Judith Perl reported that blood test results showed concentrations of 0.31 mg/L of amphetamine and 3.8 mg/L of methylamphetamine ('ice'). The 'ice' reading is well into the known lethal range (anything above 0.2 mg/L).

The average concentration of methamphetamines of post mortem blood in a study of 13 methamphetamine deaths was 1.0 mg/L (range (0.09-18 mg/L). Mr Morena had an "extremely high methampethamine concentration", indicating that he had a very high tolerance for the drug. This meant that to get the effect he was seeking he had to take more and more of the drug.

But even a very tolerant user of drugs can overdose. Dr Perl said that 'ice' usage could not be excluded as the direct cause of death, nor the prone position combined with excited delirium. In her opinion, sudden death could have occurred at any time irrespective of restraint.

Although Mr Morena had seen doctors on 12 occasions between 2009 and the time of his death, he had made no complaints of anything in the nature of chest pain, apart from after a car accident and on one occasion in the week before his death. Despite his poor diet and weight, nothing of significance was found was found at autopsy that identified a likely cause of death (eg, evidence of heart attack).

But he was in very poor physical condition. Mr Morena's Body Mass Index placed him in the obese range. He had an unusually large abdomen. His girlfriend referred to him suffering from sleep apnoea and described him as a heavy smoker of 30 cigarettes a day whilst also eating bad food. It seems that normal daily activities were becoming problematic for him. In the weeks before his death Mr Morena was described by witnesses who knew him as looking tired, drained and "grey". His behaviour also was becoming irritable and aggressive.

Because of this, Prof Duflou, a senior forensic pathologist, considered that, despite there being no observed evidence of heart disease, it remained a possibility that Mr Morena suffered from cardiac disease, and could suffer from coronary artery spasm due to his long-term stimulant use.

Prof Duflou also considered excited delirium a possibility, but could not rule out obesity, methylamphetamine or restraint as reasonable causes of death instead of, or in combination with, excited delirium. He could not give a discrete cause of death with any degree of certainty. His diagnosis was that Mr Morena's death was probably caused by cardiorespiratory arrest in a person who is predisposed to cardiac arrhythmia because of the effects of methamphetamine, obesity, stress and possibly excited delirium while being restrained.

A day of evidence was devoted to discussing the possible role of the concepts of excited delirium or restraint asphyxia in this coronial hearing. Associate Professor Hall and Prof Duflou participated in giving concurrent evidence considering these concepts. In short, Prof Hall gave evidence of having participated in numerous studies involving the consideration of thousands of arrests, many in prone positions, only one of which involved deaths. In her opinion, the prone position during arrest is safe.

Professor Hill is a Canadian specialist in Emergency Medicine and a clinical epidemiologist. She has made a special study of the concept or phenomenon of 'excited delirium' and also of prone positioning.

Her evidence was that there are 10 signs and symptoms that are associated with fatal 'excited delirium' syndrome:

- Failing to respond to police presence
- Being naked or inappropriately clothed for the environmental conditions
- Attraction to or destruction of glass or shiny surfaces
- Constant or near constant physical activity
- Failing to tire despite heavy exertion
- Superhuman strength
- Tolerant to pain
- Rapid breathing
- Profuse sweating
- Hot to the touch

She observed that Mr Morena appeared to have five of the 10 signs or symptoms. Her evidence was that the presence of five or more of these was consistent with sudden, unexpected death due to 'excited delirium'. It is noteworthy that the list of signs and symptoms does not include 'restraint' or 'prone positioning'.

The syndrome remains scientifically controversial. It has been studied since the 1980s but, of course, it is not possible to conduct human trials or experiments. Thus the evidence is epidemiological and the conclusions those who accept the concept have been drawn inductively from ambiguous evidence. Nevertheless, although the concept of 'excited delirium' has been accepted by the American associations of forensic pathologists and emergency physicians, it is not universally accepted by physicians and psychiatrists.

Prof Hill described 'excited delirium' as 'a syndrome of devastating psychiatric discord with physiologic excitation, overload and eventual collapse, Which may lead to death.' Chronic stimulant drug abuse is a risk but not all 'excited delirium' deaths are associated with stimulants. She also acknowledged that 'It is currently unknown at what point a state of excited delirium transitions from survivable metabolic derangements to a state from which evolution to cardiopulmonary collapse is inevitable.' The American College of Emergency Physicians considers that the syndrome is real but has 'uncertain, likely multiple, etiologies' [origins].[6]

One theory that has some scientific support is that some people who use stimulant drugs are predisposed to excessive dopamine activity in their brains. This results in changes within the body that Prof Hill likened to 'an unregulated runaway of the sympathetic nervous system'. This increase in stimulation 'drives the increased heart rate, increased respiratory rate, increased temperature and increased mental and physical activites of the individual (psychomotor agitation, being in a frenzy, beserk behaviour)… If these processes are allowed to continue unharnessed, significant physiologic catastrophe will ensue. In short, a person in a state of Excited Delirium is on a runaway physiologic train'.

Prof Hill is sceptical of the theory that the prone position may result in positional asphyxia. She and others have conducted a large study into the question whether restraint by police of arrested or detained person is inherently dangerous.[7] In her report she stated:

We studied nearly 5000 use of force events that arose from 3.5 million police public interactions in seven police agencies across four major cities in Canada and in the entirety of our study one subject unexpectedly died.

[6] Vilke, G et al "Excited Delirium Syndrome (EXDS): Defining based on a review of the literature" *J Emerg Med.* 2012 Nov;43(5):897-905 at p.897. doi: 10.1016/j.jemermed.2011.02.017.
[7] Hall, C & Votova, K *Prospective Analysis of Police Use of Force in Four Canadian Cities: Nature of events and their outcomes* Defence R&D Canada – Centre for Security Science DRDC CR 2013-011 Ottawa (2013)

Because we had a single death, our study cannot determine the relative risk of death for each of abnormal status [mental illness, drug or alcohol intoxication], excited delirium, positioning and other factors like abdominal obesity save to say that death following police use of force is a profoundly rare but recordable event and that no person died in the prone position even though thousands of subjects were in that position.

Prof Duflou however, is less convinced that prone position during arrest has no risks. He gave evidence that he had conducted post mortem examinations in a number of cases in which the deceased had been held in the prone position, often with weight on their back. Professor Duflou stated that the limitation of Prof Hall's studies are that they *do not* include restraint deaths in the prone position.

The numerous studies tendered in this inquest indicate that the debate as to the existence of positional restraint asphyxia has been running since at least the 1980s and looks likely to remain an issue for some time to come.

To what extent, if any, did the actions of the involved officers cause or contribute to causing Mr Morena's death?

It is reasonable to suppose that the actions of the involved officers contributed in some way, directly or indirectly, or in some degree, directly or indirectly, to Mr Morena's death. It seems highly unlikely that it was merely coincidental that Mr Morena died while being restrained by police on his stomach.

It may be that the method of restraint contributed in some fashion as suggested by Prof Duflou. It may be, as suggested by Prof Hill, that he became so agitated by the police officers detaining him and seeking to extract him from his car that those actions set on course a chain of physiological events that ultimately caused his heart to stop. It may be that a number of factors, including his physical unfitness, his obesity, the quantity of methylamphetamine he had ingested, plus the agitation and restraint combined in immeasurable degrees at that time causing cardiac failure. In these circumstances, however, it is impossible to determine exactly how or to what extent the actions of the police contributed to the fatal chain of events.

If, as I believe is the case, the actions of the police officers contributed directly or indirectly to Mr Morena's death, it is unlikely that they were the primary or even major cause of death. As Professors Hill and Duflou agreed in evidence, most people placed in the prone position by arresting police come to no harm. Restraint by itself does not appear to constitute a major risk of sudden death. In combination with other risk factors.

However, it may be the 'last straw on the camel's back' in some situations but if so science is unable at present to explain the association between restraint and sudden death.

What this coronial investigation has clarified is that labels such as excited delirium and positional asphyxia with respect are not really helpful terms for police on the ground making decisions quickly and intuitively in dangerous highly charged circumstances, doing their best to put their training into operation.

As Acting Sgt Watt stated in evidence, "restraint is restraint… Officers select which technique they use when they are confronted with a situation".

Are there any recommendations that ought to be made pursuant to s.82 of the Coroners Act 2009?

In the inquest into the death of Steven Bosevski, Deputy State Coroner MacMahon investigated another death in police custody. In that case, Mr Bosevski died due to cardiac arrest caused by a combination of factors: pre-existing dilated cardiomyopathy, hypertensive heart disease, morbid obesity and psycho-stimulant toxicity during a period of intense physical exertion that occurred whilst being restrained.

DSC MacMahon made recommendations to the Commissioner of Police concerning the restraint of persons, especially obese persons, in the prone position.

That:

- That training provided to Operational Support Group, and other officers involved in crowd control situations, be reviewed to ensure that the risks of restraining a person in the prone position, with or without weight, particularly where the person is obese, as well as the need for careful and constant monitoring of such persons, is given appropriate emphasis and if necessary be amended to ensure that this is the case.

- That Operational Support Group teams be led by officers who have received appropriate leadership training emphasising the importance of communication and the co-ordination of an approach in crowd control situations, and

- That Operational Support Group officers receive training as to co-ordination and communication so as to ensure that appropriate procedures are adopted particularly in crown control situations.

Conclusion

Unfortunately, while a violent struggle is going on there is little opportunity for police officers to undertake a full risk assessment of the person they are attempting to control. There is no evidence of unlawful or excessive use of force to restrain Mr Morena. It appears to me that this was a very unfortunate accident.

Nevertheless, because there appears to be a risk of harm associated with restraint in the prone position for some people, and a small number of people die suddenly under restraint, continual reinforcement that the restraint position may lead to sudden death in some instances is important.

I hope that Mr Morena's family will accept my sincere and respectful condolences for the loss they have suffered.

Formal Finding:

I find that Patrick Morena died on 8 November 2012 at the Wollongong Hospital and that on the balance of probabilities his death resulted from a combination of factors including methylamphetamine toxicity; physical exertion; anxiety and agitation; morbid obesity and possibly some degree of compromised cardiorespiratory function due to forcible restraint by police in the prone position for a short period.

13. 379032 of 2012

Inquest into the death of Ian Connelly. Finding handed down by Deputy State Coroner Freund on 9th September 2014.

Ian Mathew Connelly was 40 years old when he passed away in custody at the Metropolitan Reception and Remand Centre at Silverwater Correctional Centre. He is survived by his brother, Stephen Connelly.

On 26 November 2012, Mr Connelly was bail refused at Bankstown Local Court and remanded into custody as a result of an assault upon his ex-partner Charlene Miller and a Malicious Wounding against a neighbour who attempted to intervene and protect Ms Miller. On that day Mr Connelly was transferred to the Metropolitan Reception and Remand Centre, Silverwater where he remained until his death.

Upon entry into the custody of Corrective Services, a Reception Screening assessment was conducted where it was identified Mr Connelly had a history of self-harm and as such he was placed in a 'two out cell.' As such he was required to have a cell mate at all times. At that time the records indicate that Mr Connelly was taking medication for high blood pressure and heart disease, however the specific medication was not nominated.

On 4 December 2012, a reassessment was conducted in relation to Mr Connelly's correctional housing, where a placement order was lifted and Mr Connelly was cleared for a normal cell. He resided by himself in a single cell and remained so until his death. Mr Connelly was placed in cell 60 of Darcy 1 Pod of the Metropolitan Reception and Remand Centre, Silverwater. This cell has a double bunk however Mr Connelly was housed by himself.

On 5 December 2012, at approximately 6:15am, Correctional Service Officers conducted a head check on inmates within Darcy 1 Pod. First Class Correctional Officer Jason McFarlane reported that he opened cell 60 which housed Mr Connelly and viewed him lying on the top bunk, on his back and he thought he heard him breathing. He also stated that he thought he saw movement of Mr Connelly's chest.

Officer McFarlane alleges he called out to Mr Connelly however he did not verbally respond. Officer McFarlane closed and secured the cell and continued the head count without partaking in a conversation with Mr Connelly.

Section 12.1.6.2 of the Corrective Services NSW Operations Procedures Manual states that of a morning, an officer will call an inmate by name and 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 officer is to assume that harm has come to the inmate and immediately implement the discovering officer procedures for inmates who self-harm. In this case these procedures were not followed. An internal review conducted by Corrective Services has already identified and addressed the failure of Officer McFarlane to adhere to procedure. He has already received and undertaken internal Corrective Services disciplinary action

At approximately 8:30am that day McFarlane returned to the cell to direct Mr Connelly to complete cleaning duties of his cell. Officer McFarlane entered Mr Connelly's cell and could see Mr Connelly was still on the top bed but not moving, breathing or responding to his directions. Officer McFarlane touched Mr Connelly's foot and noticed that it was cold to touch.

As Mr Connelly was located on the top bunk, Officer McFarlane determined he was unable to individually provide CPR. Officer McFarlane left secured the cell and called for assistance. He subsequently returned with corrective and medical staff. An attending registered nurse conducted a signs of life assessment and determined that Mr Connelly was deceased.

Resuscitation was not commenced due to Mr Connelly clearly being deceased. The cell was secured and Mr Connelly's body left in situ. A crime scene was established and remained so until further medical staff and police arrived. A canvas of inmates was conducted with nothing suspicious identified.

The role of a Coroner as set out in s. 81 of the Coroners Act 2009 ("**the Act**") is to make findings as to:

- **the identity of the deceased;**
- **the date and place of a person's death;**
- **the physical or medical cause of death; and**
- **the manner of death, in other words, the circumstances surrounding the death.**

As Mr Connelly's death arose whilst he was in custody, this is a mandatory inquest pursuant to s. 23 of the Act. With respect to Mr Connelly's death there is no controversy as to the identity, date, place, cause or manner of his death. The sole issue to determine is whether or not his care and treatment was appropriate in the circumstances.

A post mortem was carried out and found that Mr Connelly died from Ischaemic Heart disease. Accordingly his death was natural. I am therefore satisfied that care and treatment was appropriate in the circumstances. I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

Formal Finding:

Ian Matthew Connelly died of natural causes the cause of death being Ischaemic Heart Disease sometime prior to 6:30am on 5 December 2012 at the Metropolitan Remand and Reception Centre, Darcy Block Room D060 at Silverwater Correctional Centre.

14. 1220 of 2013

Inquest into the death of John Albrecht. Finding handed down by Deputy State Coroner MacMahon 28 February 2014.

This has been an inquest into the death of John Russell Albrecht. Mr Albrecht was born on 21 June 1947. Mr Albrecht was convicted on 14 October 2011 and sentenced to a custodial sentence of eight years with a non parole period of five years, as his head sentence and there are other concurrent sentences.

His earliest date for release was early 2015.

Mr Albrecht died on 1 January 2013. There is no contest as to the cause of his death. The medical records are clear. Mr Albrecht died as a consequence of a condition that he suffered being lung adenocarcinoma.

Were Mr Albrecht not have a person in custody at the time of his death an inquest into his death would almost certainly in the circumstances have been dispensed with. However deaths of persons in custody are the subject of mandatory inquests in accordance with the provisions of the Coroner's Act 2009. The matter is therefore required to come before me for inquest.

The reason for this is to ensure that when a person's liberty is taken from them by a sentence of custody being imposed upon them. Those responsible for their care whilst in custody, that being the Department of Corrective Services, or Corrective Services at any particular time referred to. Justice Health which is responsible for the medical, hospital, psychological care of persons in custody. Provide the appropriate care and support that is necessary so that the conditions of those of the deprivation liberty are not aggravated by the failure to provide resources or services which a person would otherwise receive within the community.

Mr Albrecht, as I've said, entered into custody in October 2011. I think he entered into custody before he was sentenced because of bail refusals. The records show that his earlier period of time in custody was of little moment. However on 19 December 2011 he was seen by a nurse because he was complaining of pain in the shoulder and chest. On 28 December 2011 he was examined by a visiting medical officer and the records show that nothing of significance was identified at the time.

On 20 January 2012 and 24 January he was also complaining of ongoing pain. On 6 February 2012 he was once again examined by a visiting medical officer. Following that examination Mr Albrecht was transferred to the Prince of Wales Hospital at Randwick for further testing. At that time he was diagnosed as suffering from adenocarcinoma for the left lung. Lung adenocarcinoma if the most common kind of lung cancer for both smokers and non smoker and in people under age of 45. It accounts for about 30 percent of primary lung tumours in male smokers and 40 percent of primary lung tumours in female smokers. Overall less than ten percent of persons with primary lung cancer survive for a period of five years after diagnosis. However that time of survival can vary depending on a number of factors.

The factors being the time, the stage of the cancer at which it is identified. Unfortunately lung adenocarcinomas can be developing without any symptoms. The common symptoms being shortness of breath, wheezing, chest pain, blood in the sputum, at some stages the illness can cause pneumonia or a collapsed lung. When a person is diagnosed with lung adenocarcinoma the carcinoma is put into a category of one to four. One being the least developed and four being the most developed. Various treatments are then designed to try and either resolve the tumour at least slow it down.

In Mr Albrecht's case the adenocarcinoma that was identified was of a fairly advanced stage. Immediately after diagnosis he went on pleurodesis, which is a procedure used to cause the layers of the lung lining the pleura to stick together by the use of chemical or medication that is inserted between the two layers of the pleura. This effectively glues the layers together.

This is designed to try and reduce the spread or development of the carcinoma. Following the undertaking of that procedure Mr Albrecht was recommended to undertake two cycles of chemotherapy. The first cycle of chemotherapy was completed, however, due to the side effects that Mr Albrecht was suffering he decided not to complete the second cycle of chemotherapy.

In November 2012 Mr Albrecht was transferred to Long Bay Hospital and went into palliative care. At the time of that occurring in conjunction with Doctor Sarks he completed an advance care directive. Directed that if he became incapable of making decisions for himself he was to be provided with appropriate support but not resuscitated. That advance care directive was initially dated 9 November 2012. It was reviewed and confirmed on 23 November 2012, 6 December 2012, 20 December 2012 and was for review on 2 January 2013. Mr Albrecht however died the day before.

The evidence is clear and I am satisfied, that Mr Albrecht was well aware of the nature of his condition and consequences. I am also satisfied that the evidence shows that immediately, that appropriate action was taken to first diagnose the condition within a timely fashion and once diagnosed to provide him with appropriate care. The nature or the state in which the cancer had developed to was unfortunately such that it was unsurvivable.

In the circumstances I am satisfied that no criticism of the Department of Corrective Services or the Justice Health, as to the manner in which they provided their care and support to the Albrecht should be made in respect of this matter.

Formal Finding:

That John Russell Albrecht died on the 1st January 2013 at Long Bay Hospital, Anzac Parade, Malabar in the state of New South Wales, the cause of death is Lung Adenocarcinoma.

15. 2130 of 2013

Inquest into the death of Scott Pickford. Finding handed down by Deputy State Coroner MacMahon on 21 July 2014.

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

Non-publication orders have been made in respect of the following evidence contained in Exhibit 2 in the proceedings:

- In the statement of John Zdrillic at Tab 4– paragraphs 162-167 and 170-171,
- In the statement of Anthony Grace at Tab 14– paragraphs 12-19 and 22-24 together with the annexure thereto,
- The statement of Kris Cooper at Tab 16a,
- The NSW Police Force – Safe Driver Policy at Tab 21 of, and
- The report of Kris Cooper at Tab 21b.
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It should also be noted that consistent with the abovementioned non-publication orders certain parts of the reasons for my findings in this matter are redacted and the redacted parts of my reasons are also subject to a non-publication order.

Scott Noel Pickford was born on 20 March 1972. I will refer to him in these reasons as 'Scott'.

On 26 December 2012 Scott was riding motorcycle bearing NSW registration QGH40 on Nelson Bay Road, Stockton, an area to the north of Newcastle. He approached a police random breath testing (RBT) site and was directed to stop for a breath test. He stopped his vehicle and spoke briefly with a highway patrol officer. As the officer was making inquiries about his motorcycle licence he sped away from the RBT site.

Police in two highway patrol vehicles left the site and sought to catch up with Scott. At the intersection of Cabbage tree Road and Salt Ash Road Williamstown Scott did not stop when indicated by police.

He sped off along Cabbage Tree Road and then into Masonite Road, Heatherbrae travelling at speeds of up to 180km/h. The police following him initiated a pursuit.

In Masonite Road Scott failed to negotiate a right hand bend. His motorcycle left the roadway and collided with a metal street sign. Scott was thrown from the motorcycle and sustained injuries. The police in pursuit stopped and rendered assistance. Ambulance assistance was called for and Scott was transported to the John Hunter Hospital.

Scott was found to have suffered multiple spinal fractures, a fractured sternum, a fractured left arm, a fractured right orbital, fractured ribs, fractured pelvis, internal bleeding and suspected brain injury. On 2 January 2013 a MRI scan showed that Scott was suffering from hypoxic brain injury. Active treatment was withdrawn with the consent of his family. He was declared deceased just before midnight on 2 January 2013.

Scott's death was reported to the Office of the State Coroner on 3 January 2013.

Jurisdiction of the Coroner:

It is important at this stage to set out the role and function of the coroner in respect of the death of Scott. The role and function is established by the Coroners Act 2009 (the Act). All legislative references, unless otherwise mentioned, will be to that Act.

Section 6 defines a *"reportable death"* as including one where a person died a *"violent or unnatural death"* or under *"suspicious or unusual circumstances".* Section 35 requires that all *reportable deaths* be reported to a coroner. Section 18 gives a coroner jurisdiction to hold an inquest where the death, or suspected death, of an individual occurred within New South Wales or where the person who has died, or is suspected to have died, was ordinarily a resident of New South Wales.

Section 27(1) (b) provides that if it appears to a coroner that a person died, or might have died, in circumstances to which Section 23 applies then an inquest is mandatory.

Section 23 gives exclusive jurisdiction in respect of the investigation of certain deaths to Senior Coroners.

The exclusive jurisdiction given to Senior Coroners includes the investigation of deaths that that occur *as a result of or in the course of a police operation* (Section 23 (c)).

Section 22 (1) defines a Senior Coroner as being the State Coroner or a Deputy State Coroner.

Section 81(1) sets out the primary function of the coroner when an inquest is held. That section requires, in summary that at the conclusion of the inquest the coroner is to establish, should sufficient evidence be available, the fact that a person has died, and the identity of that person, the date and place of their death and the cause and manner thereof.

In addition to the matters to be determined in accordance with Section 81(1), in a case such as this where a death occurs *as a result of or in the course of a police operation* it is important that the contribution of police action, if any, to the circumstances of the death be the subject of a full and public inquiry.

The Parliament requires that inquests in such circumstances be conducted so as to provide a positive incentive to police to ensure that their actions are appropriate in all situations and to satisfy the community that those deaths that occur when police are involved are properly investigated. It is also in the interest of the police that such deaths be properly investigated so as to ensure that the officers involved, and the police in general, are not the subject of unsubstantiated or malicious allegations.

The circumstances that led to Scott's death are such that his death was one that occurred *as a result of or in the course of a police operation* and, as a result, the conduct of an inquest into his death is mandatory and must be undertaken by either the State Coroner or a Deputy State Coroner.

Section 82 provides that a coroner conducting an inquest may also make such recommendations, as he or she considers necessary or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations is discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths of a nature similar to that with which the inquest is concerned. Section 74 (1)(b) authorises a coroner during the course of an inquest, if he or she is of the opinion that it is in the public interest to do so, to prohibit the publication of any evidence given in the proceeding.

Identity and Date and Place of Death:

Scott's identity and the date and place of his death were not matters of controversy. Scott's body was identified by his mother Cheryl Murrell at the John Hunter Hospital on 3 January 2013. He was declared deceased by Dr Claire Wohlfahrt at the John Hunter Hospital at 11:55pm on 2 January 2013.

Cause of Death:

Following Scott's death an autopsy was performed by Dr Brian Beer a forensic pathologist. On the basis of his examination, and taking into account the information available as to the treatment Scott received following his admission to John Hunter Hospital, Dr Beer recommended that the cause of Scott's death be recorded as being 'multiple injuries'. I accept that recommendation.

Manner of Death:

There was no controversy that Scott's death occurred as a result of injuries received when the motorcycle he was riding left the road whilst he was travelling at speed whilst being pursued by police vehicles. It was also not controversial that the actions of the police officers engaged in the pursuit on 26 December 2012 did not cause Scott's motorcycle to collide with the metal street sign.

In the circumstances the primary issue to be considered at inquest that required examination related to the circumstances that resulted in the commencement of the pursuit by the involved officers and their conduct, and compliance with NSW Police Force protocols and procedures, during the course of the pursuit.

Before I undertake that examination it would be appropriate for me to record some aspects of Scott's life and recent history that would seem to be relevant to understanding the events of 26 December 2012.

At the time of his death Scott was 40 years of age. He had had, at times, a turbulent life which had unfortunately involved on-again off-again periods of drug abuse. In early adulthood he inherited a reasonable sum of money but also started using drugs and possibly gambling. Later he managed to get things back on track and enjoyed a number of years living in Leeton, where he bought a house with his then partner and worked at the Berry Juice factory. He and his then partner also had a child together who is now aged 9 years.

Unfortunately after a number of years Scott sustained an injury at work and for a period could no longer work. He began to abuse Methylampetamine and Cannabis and his relationship broke up. In later years he had various jobs and would try to continue to see his son each weekend.

In 2012 after a brief period of imprisonment he received a substantial compensation payout for his back injury but relapsed into drug abuse.

At the time of his death he was living on and off at a motel whose proprietor described him as a generally happy and friendly person. He had told her that he could hear voices in his head which made him drive and ride fast.

Shortly before his death Scott was involved in two significant traffic matters. On 19 December 2012 he was detected speeding on his motorcycle, and changing lanes without indicating. He was pulled over and found to be unlicensed to ride a motorcycle. He was issued with a Court Attendance Notice and was then, shortly after, charged again after being seen to ride his motorcycle again.

On 23 December he was stopped again in his Commodore and while checks were being made accelerated away and was pursued, reaching speeds up to 180kmh. The pursuit was terminated after he went through a red light but he was later found in the car and told police he had taken speed (amphetamine).

As a consequence his car was confiscated, he was charged and a condition of his bail was that he not ride a motorcycle. The police officers for those two matters were different police officers to the police involved in the events of 26 December 2012. A mental health assessment of Scott was undertaken on 23 December 2012 however it did not detect any signs of delusions.

The Evidence:

To assist in reaching an understanding of the events of 26 December 2012 the inquest occurred at East Maitland Courthouse between 28 and 29 May 2014.
At the inquest evidence was taken from:

- Detective Inspector John Zdrilic, the Officer in Charge of the investigation into the circumstances of Scott's death,

- Senior Constable Aaron Brock, Geoffrey Barnes and Brett Petersen, officers involved in the random breath testing site on 26 December 2012,

- Senior Constable Scott Thompson and Ben Dixon who were the officers involved in the pursuit,

- Sgt Barry Chapman who was the coordinator of the random breath testing site on 26 December 2012,

- Sen. Sgt Anthony Grace who was the highway patrol supervisor on 26 December 2012 who had monitored part of the pursuit, attended the site of Scott's collision and convened the subsequent police safe driving panel,

- Inspector Craig Reid the duty officer for the Port Stephens Local Area Command on 26 December 2012,

- Chief Inspector Kim Sorensen the duty officer for the Lake Macquarie Local Area Command on 26 December 2012,

- Sgt. Kris Cooper from the Traffic Policy section of the NSW Police Force.

- Cheryl Murrell, Scott's mother, also made a moving statement to the inquest about her son.

In addition to the oral evidence a large number of statements and other relevant material assembled by the OIC was tendered and became part of the evidence in the proceedings.

Outline of the events of 26 December 2012

About 11am on 26 December 2012 police from Newcastle Traffic and Highway Patrol set up an RBT site on Nelson Bay Rd, Fern Bay. This was adjacent to the border between Newcastle LAC and Port Stephens LAC. Some vehicles apparently had radios tuned to Port Stephens VKG and some to Newcastle VKG.

About 11.30am Scott, riding a 1000cc Suzuki GSXR motorcycle, was waved into the RBT site by S/C Aaron Brock and given a breath test, which was negative, by S/C Brett Petersen. Scott was then asked for his licence by S/C Petersen but said he didn't have it. He gave S/C Petersen a bowling club card in his correct name. He had not removed his helmet at that point.

S/C Petersen got what he thought was the bike's registration (OGH40). He checked the police in car computer system which showed a photo of Scott and indicated that he did not hold a motorcycle licence. Because Scott had his helmet on the photo did not allow S/C Petersen to confirm his identity. In fact the bike's registration was QGH40.

As S/C Petersen came back to speak to him Scott sped away.

After Scott left the site three police then ran to their vehicles and started after him. In the lead vehicle was S/C Scott Thomson, driving NCC 203, a fully marked highway patrol vehicle. Behind him in a yellow fully-marked highway patrol vehicle was S/C Ben Dixon, driving NCC 204.

Following behind them, but apparently not at speed, was S/C Petersen in NCC 205. S/C Petersen's intention was to drive to the address that the licence search had identified for Scott. That address was an address in Raymond Terrace. This was Scott's mother's address.

At the time S/C Thomson (call sign 203) had his radio tuned to Newcastle VKG and S/C Dixon (call sign 204) had, or changed, his radio to Port Stephens VKG into which area he was travelling.

The effect of this was that the protocol that was required to be followed (of a Duty Officer remotely monitoring the pursuit) was made more complex because it involved two radio operators, two Duty Officers and consequential problems sharing relevant information.

By way of example, S/C Petersen broadcast on the Port Stephens channel, advised what he thought was the registration number of the motorcycle (which turned out to be wrong by one letter) but, for some reason, he did not broadcast the address which he was going to attend.

The first broadcast to Port Stephens VKG was at 11.34.28. To Newcastle VKG it was 11.35.40. It seems that both pursuing police knew that the bike had just fled the RBT; they did not apparently know, however, what offence the rider may have committed. NCC203 and NCC204 then drove after the motorcycle in an effort, as they said, to catch up to it.
Just before 11.37.20 Newcastle VKG records PolAir on its way; at 11.38.40 it stated that it is a couple of minutes out. During what might be described as the catch-up phase, various speeds were relayed back to the operators.

NCC203 (Thompson) variously told Newcastle VKG that the bike was doing maybe 190kmh (prior to 11.37), then at about 11.38.40, 180 over 90 (meaning in a 90kmh speed limit zone), which was shortly after VKG was told that a pursuit had commenced. At about 11.39.00 203 said the bike was 300 metres away. A further speed estimate was given after it turned off Cabbage Tree Rd into Masonite Rd, of 160kmh (after 11.39.40). At about 11.42.00 NCC203 told VKG that the bike rider had crashed; PolAir was not yet on scene until about 11.43.00.

On the Port Stephens channel, NCC204 (Dixon) told the operator that he thought the lead vehicle was on the Newcastle VKG channel. At 11.36.00 he spotted the bike in the distance and at 11.37.20 he estimated his own speed at 130kmh, in a 60 zone, in light traffic with dry conditions. At 11.37.40 the estimate was 150 over 90, on the correct side of the road, nil traffic. At 11.38.20 it was 180 over 90, which was shortly after it was announced as a pursuit.

At 11.40.00 the bike turned into Masonite Rd and the speed of the police was given as 120 over 80. At 11.40.20 it had increased to ‘140 and increasing’. At 11.41.20 NCC 204 tells VKG that the rider has come off his bike.

There is no doubt that very high speeds were reached in the lead-up to, and during, the pursuit. The ICV from each car shows the amount of traffic on the road during the catch-up phase, almost all of it fortunately pulling over in advance to allow police to pass, under lights and sirens. The bike is eventually caught up to at a roundabout at Cabbage Tree Road but does not stop and in fact drives round NCC 203 which has pulled up across where it had stopped in traffic. At that point both police advise that they are in pursuit.

The In-car video records the pursuing vehicle's speed and shows the apparent distance that the vehicle is away from the bike at any given time, the manner of riding by the cyclist and the traffic and road conditions. It seems from the video in NCC 203 that contact with the bike was lost shortly before the Masonite Rd intersection, or at least after the bike had turned into that road. The bike was not in sight of police when it crashed.

Scott was found unconscious and unresponsive at the roadside, severely injured. He was airlifted to John Hunter Hospital and was found on 2 January 2013 to have suffered a hypoxic brain injury. With his family's consent life support was ceased and he passed away shortly before midnight that night.

On admission to hospital at 1pm on 26 December 2012 testing revealed the presence of Methylampetamine in Scott's blood. A statement has been obtained from an expert pharmacologist, Dr Judith Perl, in which she expressed the opinion that Scott would have been under the influence of the drug to the extent that his driving ability would have been significantly impaired.

Crash investigators examined the scene and interviews were conducted with the involved police and statements taken from civilians and police at the RBT scene, as well as those supervising the pursuit via VKG.

As part of the investigation the motorcycle that Scott was driving was examined for mechanical defects. The report of Sgt. Stace was that no mechanical defects were identified that might have contributed to the cause of the collision.

Discussion and Conclusions:

The NSW Commissioner of Police, A. P. Scipione APM, in the forward to the NSW Police Force Safe Driving Policy (SDP), emphasises the significant dangers to the public of police engaging in a pursuit when he says,

The New South Wales Police Force has a major responsibility to improve road safety throughout the State. While enforcing the road laws obviously plays a big part in this effort, it's not the entire answer. We must lead by example.

The police motor vehicle, if used irresponsibly and inappropriately, can result in it being the most deadly weapon in the police arsenal. Police do not have to keep going until told to terminate. You are perfectly entitled to make that decision for yourselves. Please be assured that any decision to terminate a pursuit; for your safety or others, will not result in criticism.

This is the reason why it is important that the reasons for the commencement of as well as the continuation of a pursuit be examined carefully so as to give the public confidence, or otherwise, in the actions of the officers involved.

The SDP defines 'urgent duty' as being '*duty which has become pressing or demanding prompt action*'. The SDP also requires that officers undertaking high speed urgent duty do so '*as a last resort'* and when *'the gravity and seriousness of the circumstances require such action and there are no other immediate means of responding'*.

A pursuit is defined by the SDP as commencing when an officer *decides to pursue a vehicle that has ignored a direction to stop* or where there has been an *attempt by a police officer in a motor vehicle to stop and apprehend the occupant(s) of a moving vehicle when the driver of the other vehicle is attempting to avoid apprehension or appears to be ignoring police attempts to stop them.*

The events of 26 December 2012 involved the officers engaging in action that met the NSWPF definition of both urgent duty and a pursuit. The Coroners Act 2009 does not have regard to definitions contained in the SDP as it concerns itself with a death that *arises out of or in the course of a police operation.* It is important therefore to examine the events that occurred from the time of Scott entering the RBT site until the collision that resulted in his death.

The evidence is that the time period from when Scott left the RBT site to the collision that resulted in his death was a little over 7 minutes. NCC 203 (S/C Thomson) came on air at 11:35:40, advised that it was attempting to catch up, announced a pursuit at 11:37:20 and advised that Scott had come off his bike at 11:42:00. NCC 204 (S/C Dixon) came on air at 11:34:28, advised he was attempting to catch up, announced a pursuit at 11:37:20 and advised that Scott had 'lost it, he's off the bike' at 11:41:40.

What the officers described as being the attempt to 'catch up' met the definition of 'urgent duty.'

The SDP requires where both urgent duty and pursuits are undertaken the vehicle must be appropriate for that action. There was no dispute that NCC 203 and NCC 204 met that requirement.

The SDP also requires that officers engaging in urgent duty and pursuit have a specified licence classification. In this case there was no dispute that both Senior Constables Thompson and Dixon met this requirement.

Scott left the RBT location at speed. S/C's Thompson and Dixon were not the officers dealing with him at the site. They were not aware why he left the site at speed, whether or not he had committed an offence and if so what that offence was. This is made apparent by the response from S/C Dixon to a request from the Duty Officer for information about the original offence when he said that it was 'fail to stop RBT.'

This, of course, was incorrect. The evidence was that Scott had complied with the direction to stop and had undertaken a breath test which he did not fail. The issue that arose was whether or not he was licensed to ride a motorcycle. His recent experience with the police on other driving matters no doubt weighed on his mind when he decided to ride off at speed.

Certainly in the circumstances it was reasonable for S/C Thompson and S/C Dixon to try to catch up to Scott for a traffic stop. They were approved to do so and did so after having activated all warning devices. They advised VKG of their action which they were not required to do. The catch up phase took between 1 minute and 40 seconds in the case of NCC203 and 2 minutes and 52 seconds in the case of NCC 204.

The In Car Video (ICV), which was an exhibit in the inquest, allowed us to see the course of the catch up. It involved passing a large number of vehicles at high speed who, for the most part, moved to the side of the road to allow them to pass. The road was a single lane each way. The speeds reached by the police vehicles were considerable.

This raises the question of the appropriateness of undertaking such action when the original offence was not known however because of the speed that Scott had left the RBT site criticism of the officers for seeking to undertake a traffic stop would not be warranted.

At 11:37:20 both officers independently advised VKG that they were in pursuit. This was in accordance with their obligation under the SDP. The ICV recordings establish that at the time of calling a pursuit the actions of Scott met the SDP requirement that he was ‘seeking to avoid apprehension or appears to be ignoring police attempts to stop them.’ Indeed I am of no doubt that at that time Scott was trying to avoid apprehension. The officers were as a result required to comply with the SDP pursuit guidelines.

The SDP pursuit guidelines required that all officers engaging in a pursuit provide certain information to police radio (VKG). This requirement is to allow supervising police (the Duty Operations Inspector, the Local area Duty Officer and the VKG supervisor among others) to monitor the pursuit and, if necessary, decide to terminate it. The evidence is that both Officers Thompson and Dixon complied with this requirement.

The ability of supervising officers to actually undertake such supervision in this case was, however, made more difficult by the fact that the two vehicles involved were reporting to different radio operators. This meant that the full extent of the information reported was not available to any of the officers seeking to monitor this pursuit. This is an issue to which I will return later.

The time of the pursuit lasted between 4 minutes 20 seconds (NCC 203) and 4 minutes 20 seconds (NCC 204).

During the course of a pursuit the SDP requires that all vehicles involved in a pursuit [redacted] The ICV recording of the pursuit confirms that both S/C Thompson and S/C Dixon complied with this requirement.

An examination of the ICV recording in fact makes it clear and I am satisfied that it was the case, that the driving of the officers during the course of the pursuit did not cause nor was it a contributing factor to Scott's vehicle leaving the roadway and colliding with the metal street sign. Indeed the evidence available is that at the time of the collision both officers were not in visual contact with Scott's motorcycle. I am satisfied that this was the case.

The SDP requires that officers who commence a pursuit must, in doing so, weigh the need to immediately apprehend the offender against the risk to the community (which includes the person pursued) and police that will occur as a result of the pursuit. Both officers gave evidence that they did so and considered there were negligible risks to the police and minimal risks to the community. As such they considered the pursuit justifiable in accordance with the SDP.

I accept that this was the opinion of the officers. Making such a judgement is, of course a matter of judgment. It is not my function to second guess months or years later the judgement of the officers at the time. The evidence available to me would not allow me to come to another conclusion in any event and no criticism of the officers is made of their decision to commence the pursuit.

A pursuit must only be commenced as a last resort when 'the gravity and seriousness of the circumstances require such action and there is no other immediate means of responding'. The attitude of the officers was that they complied with this requirement. I accept that they considered the requirement to have been complied with.

With the information they had that opinion was, I accept, reasonable.

Of course they, and the monitoring officers, were not aware of all the information available in particular that S/C Petersen had a name and an address in Raymond Terrace that he was on his way to. That information was not provided to VKG, the monitoring officers nor S/C Dixon or S/C Thompson.

Whilst there was a difference of opinion as to the importance of this information between police I accept that it was not provided to officers Dixon and Thompson and even if it had been it is uncertain what affect it might have had on the decision making of those officers.

During the course of the pursuit a question was raised as to whether the officers had been able to identify the registration of the motorcycle that Scott was riding. I accept that neither of the officers involved in the pursuit were able to obtain the registration of the vehicle. Indeed the registration provided to VKG from the RBT site was incorrect. This however does not appear to have been a factor in the decision making of the officers at the time.

During the course of a pursuit the officers involved are required to continue to monitor the circumstance of the pursuit and where the circumstances change consideration be given to terminating the pursuit. [redacted]

This was an issue once Scott's motorcycle entered Masonite Road and there was a loss of visual contact between the police and the Scott's motorcycle. [redacted], once again, a matter of judgement and it is difficult to second guess the involved officers. It was put on their behalf that, at that point, the pursuit [redacted] as Masonite Road was a relatively straight stretch and there were no side roads that Scott could take. I accept that there were no roads off Masonite Road that Scott could have entered however by that time it was clear that he was not going to stop for the pursuing police and it seems to me that by the time the pursuing police entered Masonite Road the pursuit was not going to achieve to goal of apprehending Scott. In this regard the pursuit was, in my view, futile and the pursuit should have been terminated.

Officers involved in a pursuit are also required to anticipate changes in the risks involved in a pursuit.

The evidence is that, about 1 kilometre from the point at which the collision occurred, Masonite Road intersects with the Pacific Highway at Heatherbrae and that shortly before that intersection there is a roundabout that vehicles use to enter fast food enterprises. It is apparent that approaching midday on Boxing Day many people would be likely to be at that location and the risks to the community would have been magnified to such an extent that consideration to discontinuing the pursuit due to the increased risk to the public would need to have occurred.

S/C Thompson in his evidence did not appear to be alive to this issue believing that he would have 'caught up to' Scott at Heatherbrae. As to what he would do when he caught up to him there did not seem to be an answer.

S/C Dixon gave evidence that he was aware of the dangers and intended to reassess the situation on reaching the roundabout at Heatherbrae. I accept that S/C Dixon was aware of his obligation to reassess the changes in risk during the course of a pursuit and was doing so.

One might, however, reasonably question the reasoning of S/C Thompson and S/C Dixon at this time.

It seems to me that it was abundantly clear from the time Scott entered Masonite Road he was not going to stop for police. From that time the continuation of the pursuit was futile and should have been terminated.

Scott, from the time he entered Masonite Road was approaching a location of high risk to the community. There were only three ways this pursuit was likely to end.

The first, as occurred, was that Scott would lose control of his motorcycle and he would as a result suffer serious injury, the second was that when he reached the roundabout at Heatherbrae there would be a collision with an innocent third party and he, and perhaps others, would be injured. The third was that on entering Heatherbrae area the pursuit would be terminated or he would be able to evade the police and he would have made good his escape.

As I have already said it is never satisfactory, months and years later, to second guess the decisions police make in a matter of seconds in the course of an incident however in the factual circumstances of this case I am satisfied that this pursuit ought to have been terminated once Scott entered Masonite Road.

It is noted that Sgt Kris Cooper, of the Traffic Policy Unit, Traffic and Highway Patrol Command who gave evidence in the proceedings, was of the opinion that termination of the pursuit was appropriate at or about the entering of Masonite Road. It is also noted that Inspector Reid considered that the pursuit should be terminated before it reached the roundabout.

This reinforces that fact that the application of the SDP can vary depending on the individual applying it however it seems to me that once it is apparent that the objects of the pursuit, the apprehension of the offender, are unlikely to be achieved the pursuit is futile and should be terminated.

Of course it cannot be assumed that even if the pursuit had been terminated, and he was aware that this had occurred, that Scott would have slowed down and as a result not suffered the injuries he did.

He may have continued to ride at the considerable speed he had been riding at. He had told a person at the motel at which he had been residing that he had voices in his head that told him to ride/drive at speed. This may have been an effect of the Amphetamine and Methylampetamine that was found in his blood at the time of the collision. This is, of course, all speculation.

Although I am of the view that the appropriate application of the SDP would have resulted in this pursuit being terminated after Scott entered Masonite Road I do not propose that any action be taken against S/C Thomson or S/C Dixon. Whilst I question their application of the SDP I am not satisfied that the evidence available would allow me to conclude that had the pursuit been terminated at the time I consider it should the collision and Scott's death would necessarily have been avoided.

Section 82 Recommendations:

One issue that the investigation of Scott's death raised was the situation where both NCC203 and NCC 204 were communicating with different police radio channels. This was acknowledged as creating problems for supervision officers seeking to monitor the pursuit. This is a matter that would justify consideration of making recommendations in accordance with Section 82 of the Act. On the evidence available, however, it would seem that the NSWPF has recognised the difficulty and action has been taken to address it. As such it is not necessary for me to give consideration to the making of any recommendations on this issue.

It is also my opinion that the evidence in the proceedings does not raise any other issues that would require consideration being given to the making of recommendations.

Formal Finding:

Scott Noel Pickford (born 20 March 1972) died on 2 January 2013 at the John Hunter Hospital, Rankin Park in the State of New South Wales. The cause of his death was multiple injuries that he sustained when the motor cycle that he was riding at speed failed to negotiate a bend in Masonite Road, Heatherbrae on 26 December 2012 and collided with a metal street sign during the course of a police pursuit.

16. 18658 of 2013

Inquest into the death of Stanley Lord. Finding handed down by State Coroner Barnes on 11 September 2014.

Introduction

Mr Lord was referred to by his family as Bud. They request that he be called by that name in these proceedings.

On 19 January 2013, Bud suffered a cardiac arrest while in the Prince of Wales Hospital where he was being treated for a heart condition and cholecystitis. He was unable to be revived. He was 39 years old.

As Bud was in custody when he died, an inquest was held into his death. It received evidence sufficient to make the findings required by s81 of the Coroners Act and to consider the adequacy of the health care provided to him while in custody.

The evidence

Social history

Bud was born on 1 February 1973, the middle child of three children. He lived most of his life in Nyngan NSW.

Bud had strong connections to his family and his community. He played football in the area and was well regarded. He maintained contact with his nieces and nephews and his older relatives.He had a number of medical problems throughout his life. From around 2005, he began experiencing chest pains.

He sought medical treatment for this but did not advise his family of the details of his condition. His father understands that he had previously suffered a heart attack.

In 2006, Bud was imprisoned after being convicted of assault occasioning bodily harm, resisting police and driving while disqualified. As a result of that the last charge he received a lengthy disqualification from holding a licence which eventually led to him being imprisoned at the time of his death.

In particular, on 14 June 2012, he was intercepted and charged with driving while disqualified. Three weeks later, he was again seen driving and again charged with the same offence. On that occasion he was denied bail. A few weeks later he was sentence to 18 months jail. Although that sentence was reduced on appeal Bud remained in custody until his death.

Events leading to the death

On 6 July Bud was received into custody at the Wellington Correctional Centre on remand. At reception he reported some cardiac history involving an irregular heartbeat. An ECG was performed and blood was taken for analysis.

On 9 July blood tests revealed an irregularity suggesting a cardiac condition. Accordingly, Bud was transferred to the Wellington District Hospital. Following examination he was transferred to Dubbo Base Hospital where he was treated for a mild myocardial infarction. He was prescribed medication and further tests were undertaken.

He was discharged back to the Wellington Correctional Centre on 12 July. He did not complain of further symptoms. He attended a follow up appointment with a consultant cardiologist at Dubbo Base Hospital on 10 August 2012. That doctor recommended no change to his treatment.

On the 14 December 2012 Bud was transferred to Long Bay Correctional Centre to facilitate better access to health care.

On 1 January he complained of vomiting and associated gastro intestinal symptoms. The clinical notes record he did not complain of chest pain, however this changed on 2 January and he was at that stage transferred to the Prince of Wales Hospital. There he was diagnosed with cholecystitis- an inflammation of the gall bladder. This was initially treated with antibiotics.

A CT scan on 4 January showed an infarct in the lower pole of the left kidney. He developed acute kidney impairment and was treated with haemodialysis. Scans showed a severely dilated left ventricle with severely impaired systolic function and a dilated and impaired right ventricle.

His renal function continued to deteriorate as did his liver function. This was thought to be due to ischaemic hepatitis.

While awaiting surgery to attend to the gall bladder condition, Bud suffered a cardiac arrest. He was intubated and placed in the intensive care unit. His condition initially improved and he was extubated on 13 January. During this period he was visited by various family members.

In view of his condition the surgery planned to address his gallbladder complaint had to be postponed until his general health improved.

Bud's heart rhythm remained unstable and the medical records note consideration was given to inserting a pace maker when his sepsis resolved. On 19 January he developed increasing abdominal pain and sweating, an abdominal CT scan showed a mild increase in free fluid in the abdomen but no abdominal collection. He was returned to the Intensive Care Unit where a central venous catheter was inserted under ultrasound guidance. After the line was inserted Mr Lord again became bradycardic and suffered an asystolic cardiac arrest. He was unable to be revived.

The investigation

Scene examination

Officers from the Corrective Services Investigation Unit attended the hospital on the evening of Bud's death. They found his room secured and guarded by correctional officers. Bud's body and the room were photographed. Hospital staff confirmed that he had died as a result of a cardiac arrest and that no third party had been involved in the death in their view.

Mr Stanley Lord senior identified Bud's boy to police.

Autopsy results

On 21 January 2013, an autopsy was undertaken at the Glebe Department of Forensic Medicine by an experienced forensic pathologist. Bud's heart was found to be severely enlarged and dilated and there was thinning and patchy fibrosis and mottling of the left ventricle wall in keeping with the history of previous myocardial infarction. This was most likely due to chronic alcohol abuse and ischaemic heart disease as there were multiple areas of up to 80% narrowing in the right coronary artery. The liver showed congestion and necrosis in keeping with severe ischaemic hepatitis. The pathologist considered the enlarged and scarred heart was in keeping with Mr Lord's history of dilated cardiomyopathy.

No injuries or signs of trauma were found.

Conclusions

There is no evidence that any third party played any part in Bud's death. On the contrary, all of the evidence overwhelmingly points to his death being due to natural causes. It is apparent that he had been very unwell for a lengthy period. The autopsy report describes a combination of chronic and acute serious diseases to vital organs that precipitated a steady decline before a sudden death.

All deaths in custody, even from natural causes, are required to undergo an inquest to enable an independent assessment of whether the State has discharged its responsibility to provide the deceased prisoner with adequate health care and treatment. The standard required is the equivalent of that which the deceased would have received had he/she not been in custody.

In this case I am satisfied Bud received health care of an appropriate standard. Soon after his incarceration he was taken to Wellington Hospital and then to Dubbo where he was seen by a cardiologist on a number of occasions.

When his condition deteriorated he was moved to Long Bay Correctional Centre to be closer to higher level health care. This was provided by the clinicians at the Prince of Wales Hospital.

Despite the high level of care provided to him, Bud died as a result of the combined effects of long running cardiac illness and more acute multi organ failure. There was nothing that could reasonably have been done to avert his demise. It is very likely the outcome would have been the same had he not been in custody.

Formal Findings required by s81 (1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was Stanley Allan Lord.

Date of death

Mr Lord died on 19 January 2013

Place of death

He died at Prince of Wales Hospital in Randwick, NSW.

Cause of death

Mr Lord's death was caused by dilated cardiomyopathy.

Manner of death

He died from natural causes while serving a custodial sentence.

Recommendations

Pursuant to s 82 of the Act, coroners may make recommendations about matters connected with a death.

In this case the lawyer for Bud's family submitted I should make recommendations or comments about the habitual offender provisions of Road Transport (General) Act 2005 that resulted in his being subjected to ever lengthening periods of driving disqualification.

It is apparent those provisions impacted upon Bud in a way that made it almost impossible for him to foresee a time when he would be able to drive lawfully. In those circumstances, it is understandable perhaps, that on occasions he chose to ignore his disqualification and to drive – public transport in rural areas is very limited.

However, the road toll demands that governments respond robustly to drink driving and dangerous driving. Disqualifying offenders from driving is the most direct and obvious response, even though it will also have unintended consequences in some cases.

I do not consider Bud's death was sufficiently connected with the habitual offender provisions to bring a critique of that regime within the jurisdiction of this inquest. Further, I have insufficient evidence on which to base meaningful comment – a single undesirable outcome would need to be balanced against the benefits that presumably flow from the current arrangements. Accordingly, I decline to make comment about the issue.

17. 8375 of 2013

Inquest into the death of Amir Chouman. Finding handed down by Deputy State Coroner Forbes on 30 October 2014.

INTRODUCTION

This is an Inquest into the tragic death of Amir Chouman in the early hours of the morning of 10 January 2013. He died as result of drowning in the Parramatta River while he was trying to swim away from police.

Mr Chouman was only 28 years old when he died. He is a much loved son and brother.

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.

The Act also requires a Coroner to conduct an inquest where the death appears to have occurred "*in the course of police operations".* (s.23).

"The 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 the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation.

If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."[8]

It should always be borne in mind that inquests are not criminal investigations, nor are they civil liability proceedings intended to determine fault or lay blame on persons involved in the incident.

This Inquest has been a close examination of the police actions on the morning of Mr Chouman's death and pursuant to s.37 of the Coroner's Act a summary of the details of this case will be reported to Parliament.

FACTS IN OUTLINE

Shortly before 4am on the morning of 10 January 2013, Constable Rachel Edgar-Moore, and Probationary Constable Matthew Stewart were patrolling an area around Ermington in police car "Rosehill 18". They saw a white BMW sedan (NXR-555H) stopped on Spurway Street with its lights on and 2 passengers on board. The police officers decided to conduct a random breath test and did a U-turn to approach the vehicle.

During the process of completing the U-turn, the BMW drove off at a slow speed. Police were about 10-15 metres behind and activated their warning lights. The BMW then accelerated rapidly. The Police called for assistance and lost sight of the BMW. Sergeant Jayson Beaton, was driving Rosehill 14, and he was the mobile supervisor on that morning. He attended the scene and both he and the other two officers continued on to Nordica St where they located the abandoned BMW. As the three police officers were conducting enquiries at the scene, including searching the vehicle, they saw a taxi drive past their location with two passengers on board. Sergeant Beaton then followed the taxi, pulled it over and directed it to return to the location on Nordica Street.

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[8] Waller's Coronial Law & Practice in New South Wales 4th Edition, page 106

The driver of the taxi, Mr Mohamed Sankari, complied with the police request. Sergeant Beaton, the most senior officer, directed Probationary Constable Stewart to ask the passengers in the taxi to exit for the purposes of being searched.

Probationary Constable Stewart said that Mr Chouman alighted from the taxi unassisted. Probationary Constable Stewart asked him to face the taxi and put his hands on his head and said "I'm going to do a quick search". Probationary Constable Stewart noticed Mr Chouman had a bum bag on his shoulder and said "I'm going to have to come and get your bum bag off you". Mr Chouman then immediately fled in the direction of the Parramatta River.[9] He ran to the end of Nordica Street then through a small reserve and jumped into the Parramatta River. Probationary Constable Stewart ran after Mr Chouman until he reached the water's edge.

Constable Edgar-Moore ran after them both. From the water's edge Constable Stewart and Edgar-Moore could see Mr Chouman in the river.

The following action was then taken by police;

- At 4:20am Sergeant Beaton radioed for police assistance and attended the water edge[10]
- At 4:21am Constable Moore called on her radio for assistance[11].
- At 4:21am Inspector Hyde, the senior duty officer monitoring the radio, requested a police helicopter and announced on the radio that he was making his way to the scene. He also requested a police dog.[12]
- At 4:23am Inspector Hyde requested police radio contact water police.[13]
- At 4:25am Constable Edgar Moore announced on the police radio that Mr Chouman was still in the water and that he was swimming towards a gap in the trees and that he was making funny sounds.[14]

[9] Ex 2, Tab 7, p 6
[10] Incident Log 4377483, Ex 6, p 3
[11] Incident Log 4377483-Ex 6, p 3
[12] Incident Log 4377483-Ex 6, p 3; Ex 2, tab 43, p 8
[13] Incident Log 4377483-Ex 6, p 3.
[14] Incident Log 4377483-Ex 6, p 4

- At 4:26 am Senior Constable Melville of the NSW Marine Area Command at Balmain received a call on police radio requesting Water Police assistance.[15]
- At 4:30am Constable Edgar Moore announced that they couldn't hear him in the water anymore and that they thought he might have run through the park.[16]
- Two members of the dog squad arrived and commenced searching in the park.
- At about 4:30 am Water Police vessel 33 proceeded with lights and sirens to the Parramatta River near Silverwater Bridge.
- At about 5:04am Water police arrived near the location where Mr Chouman entered the water and commenced their search.[17]
- At about 5.10am, Senior Constable Gibson of the Marine Area Command located Mr Choumans's body on the Parramatta River Bank, and removed him from the water and into a police vessel[18]. NSW Ambulance officers attended, but sadly, there were no signs of life.
-

Police obtained CCTV footage from a block of units nearby to where Mr Chouman had left the taxi. This footage corroborates Constable Stewart and Constable Edgar-Moores description of events after Mr Chouman ran from the taxi.

At 4.07.57, the footage depicts Mr Chouman running along Nordica Street in the direction of the river. Probationary Constable Stewart is running about ten metres behind and Constable Edgar-Moore a further twenty metres behind. I have been informed that the clock on the CCTV is eleven minutes slow. Accordingly, Mr Chouman was running towards the river bank at 4:18am.

The female passenger in the taxi was taken to the police station to be interviewed. She initially gave police a false name, but was eventually identified as Sheena Dobson, 21 years of age. She said that she had taken Xanax earlier that day and was too drug affected to give police a statement.

[15] Ex 2 Tab20 page 1
[16] Incident Log 4377483-Ex 6
[17] Incident Log 4377483-Ex 6, p 8
[18] Incident Log 4377483-Ex 6, p 8

Ms Dobson returned to Bankstown Police Station on 5 February 2013 and participated in a record of interview. She admitted to being in the taxi and in the BMW with Mr Chouman, who she said was her boyfriend. She confirmed that they left the BMW and got into the taxi before it was pulled over by Police.

The driver of the taxi, Mr Sankari, also gave a statement and confirmed that Mr Chouman exited his taxi and ran towards the river.

There were a number of factors that may have been operating on Mr Chouman's mind when he decided to run from police. Police inquiries revealed that the BMW was a stolen car. Police located an ice pipe used for smoking Methylamphetamine in a bag in the vehicle and Mr Chouman had outstanding warrants for a number of offences.

This case is not about laying blame. The only relevance of that information is to explain why Mr Chouman may have run from police. Similarly, the toxicology results that detected Methylamphetamine, Amphetamine, Codeine and Morphine in his blood are relevant as possible contributory factors to the difficulties he may have faced whilst he was swimming.

FURTHER SUBMISSIONS

Since the Inquest concluded on 11 June 2014 Mr Chouman's brother has sent correspondence on behalf of his family. I have carefully read that material and have considered all of the matters he has raised.

As to the allegation that Constable Edgar Moore and Constable Stewart failed to perform the basic lifesaving task of contacting the water police,

I note that Mr Chouman was depicted on CCTV footage running past the units near to where the taxi stopped at 4:18am and that Constable Edgar-Moore called for radio assistance at 4:21 am when she announced he had entered the water. I also note that the Water Police received a request to attend at 4:26am. At this time Mr Chouman was still swimming in the water.

I am not of the view that the officers should be criticised in that regard. The Water Police are based in Balmain and cannot provide a lifesaving service in the nature of the surf life savers at a patrolled beach.

In relation to the allegation that it was unacceptable that it took the water police 45 minutes to reach the location I note that the water police were contacted at 4:26am and left Balmain in a vessel at about 4:30am and arrived at the location at 5:04am. I am not persuaded that the timing of their response was unacceptable or that there was any practical way the water police could have attended any sooner.

CONCLUSION

Police immediately adapted the critical incident guidelines. The Manager of Professional Standards was notified and Detective Inspector Bernie was appointed the Critical Incident Investigation Review Officer.

I am satisfied that the police actions did not contribute to the events in the sense that they were in any way the cause of what happened. Each of them carried out their duty in an appropriate manner.

NOTE: I note that the Coroner was not notified of this critical incident by the Duty Operations Inspector until later in the morning at 6:30am. This has revealed that there may be a lack of clarity around when the coroner is to be advised of a critical incident. I am informed that the Professional Standards Command of the NSW Police Force is in the process of reviewing the Critical Incident Guidelines and Duty Operations Inspectors checklist and an amendment is to be made to ensure that notification is made to a Coroner as a matter of priority for matters involving deaths in custody or police operations.

FINDINGS:

I find that Amir Chouman died on 10 January 2013 at the Parramatta River, Ermington, NSW. He died as a consequence of drowning while he was swimming in the river in an attempt to evade police who were pursuing him.

18. 31630 0f 2013

Inquest into the death of Andrew McGregor. Finding handed down by Deputy State Coroner Freund on 9 September 2014.

Andrew McGregor was 47 years old when he passed away on 1 February 2014 whilst serving a period of imprisonment at Prince of Wales Hospital Secure Annex.

At the time of his death he was serving a period of imprisonment for dishonesty and fraud offences and was detained at the Prince of Wales Hospital Secure Annex. His period of imprisonment commenced on 6 December 2012 and expired on 5 July 2013. His earliest possible release date was 19 April 2013.

On 17 January 2013, Mr McGregor was transferred to the Prince of Wales Hospital Secure Annex where he remained until his death on 31 January 2014. Mr McGregor was diagnosed to be suffering from “metastatic melanoma”. The cancer having spread to his brain, lungs, and spine.

His treatment options were considered by doctors to be limited. He was being reviewed by the Palliative Care Team at Prince of Wales Hospital and he agreed to a “No CPR” order. The Medical Oncology Department at Westmead Hospital stated, “Mr. McGregor has a complex medical history involving multiple consultant oncologists seen under different fraudulent aliases.”

Medical records show his health had deteriorated significantly in the days leading up to his death. It appears that from 26 January 2014 he was unconscious and semi-conscious up until his death.

On 31 January at 10:55 p.m., Registered Nurse Alofa Brown and Registered Nurse Lunisi Ta'akimoeka entered Mr McGregor's room and found that he was not breathing. Dr. Othmad pronounced Mr. McGregor life extinct at 12:05 a.m. on 1 February 2014. The deceased was last seen breathing by Correctional Officer Denton at 10:00 p.m. on 31 December 2014.

CCTV footage from outside Mr McGregor's room for 31 January 2014 was obtained.

No suspicious activity was recorded on the CCTV.

The role of a Coroner as set out in s. 81 of the Coroners Act 2009 ("**the Act**") is to make findings as to:

1. the identity of the deceased;
2. the date and place of a person's death;
3. the physical or medical cause of death; and
4. the manner of death, in other words, the circumstances surrounding the death.

As Mr McGregor's death arose whilst he was in custody, this is a mandatory inquest pursuant to s. 23 of the Act. With respect to Mr McGregor's death there is no controversy as to the identity, date, place, cause or manner of his death. The sole issue to determine is whether or not his care and treatment was appropriate in the circumstances.

A thorough examination of his care treatment has been conducted and I am satisfied that it was appropriate in the circumstances.

I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

Formal Finding:

I find that Andrew McGregor died on 31 January 2014 at Prince of Wales Hospital Secure Annex of natural causes the cause of his death being metastatic melanoma.

19. 77634 of 2013

Inquest into the death of Patrick Hudd. Finding handed down by State Coroner Barnes on 17 February 2017.

These are the findings of an inquest into the death of Patrick HUDD.

Introduction

At 10:15pm on 13 March 2013, a prisoner at the Long Bay Correctional Centre, Patrick Hudd, 75, was found dead in his bed in the Long Bay Hospital.

Mr Hudd had previously been diagnosed with metastatic lung cancer, which had been assessed as untreatable. His death was therefore not unexpected.

As Mr Hudd died while in custody an inquest into his death is mandatory.

The purpose of the inquest is to confirm the death occurred and make findings in relation to the deceased person's identity, the date and place, cause and manner of the death.

As Mr Hudd was in custody when he died, the inquest will also consider whether the medical treatment provided to him was appropriate and of an equivalent standard to that which he would have received had he not been in custody.

The evidence

Social History

Patrick Hudd was born on 22 November 1937 in Crookwell NSW. He attended the Five Mile Tree School at Crooked Corner. After receiving a basic education Mr Hudd worked on various regional rural properties as a shearer, farrier and farm hand.

In 1960 Mr Hudd married. In 1965 he and his wife had a son Wayne. Wayne was the only child of the relationship and when his parents separated in 1970, Wayne continued to reside with his father in the Goulburn area.

In 1964 Mr Hudd was convicted of a number of serious criminal offences and was sentenced to a lengthy term of imprisonment.

Thereafter, Mr Hudd was frequently before the courts and frequently sentenced to terms of imprisonment.

Most recently, in December 2002, he was involved in an armed robbery which resulted in the death of a storekeeper. As a result, in February 2005 he was sentenced to a term of 27 years imprisonment. His earliest release date was 22 September 2024.

Events Proceeding Death

In 2012 Mr Hudd was serving his sentence at the Goulburn Correctional Centre. Throughout the later part of that year, he had persistent chest symptoms suggestive of a cold or flu.

When these did not resolve, further investigations were undertaken which revealed advanced lung cancer.

In October he was transferred to the Long Bay Correctional Centre so that his condition could be further investigated.

In November he was admitted to the Prince of Wales Hospital and he was provided with two courses of chemotherapy. A CT scan after this treatment revealed further progression of the disease. As a result, his treating clinicians formed the view that further aggressive treatment would be unlikely to be helpful. After consultation with Mr Hudd it was decided that only palliative treatment would be provided. Mr Hudd was discharged back to the Long Bay Hospital on 15 January 2013.

Thereafter Mr Hudd remained in the medical wing of the Long Bay Correctional Centre.

Until shortly prior to his death Mr Hudd was relatively comfortable ambulating around the ward and was self-caring. He was visited by his son.

Following further consultation with the patient, in February 2013, a "*not for resuscitation*" order was made and placed on his medical file.

On 22 February the Commissioner of Corrective Services commenced a procedure to consider early release for Mr Hudd in view of his imminent demise.

The death is discovered

On 9 March 2013, his condition significantly deteriorated. He was described as agitated and confused and he required increased levels of assistance. Mr Hudd was provided with adequate pain relief and was closely monitored.

On the night of 13 March he was cared for in the usual manner by the on-duty nurses. The security manager had agreed to his cell door being left open so that the nurses could more closely monitor him.

The nurse on duty provided a statement saying that at 22:00 hours she checked Mr Hudd and found that he was asleep. At 22:15 she noted his breathing sounded ceased and so she went into his cell to check further on him. She found he was not breathing and was non-responsive. No pulse and no heart sounds could be detected and his pupils were fixed and dilated. A life extinct certificate was completed.

The Investigation

Officers from the Corrective Services Investigation Unit attended the scene and quickly satisfied themselves that no suspicious circumstance's existed. Photographs were taken of the deceased *in situ*.

In view of Mr Hudd's medical treatment, no internal autopsy was considered necessary after an external examination of his body and a review of the records was undertaken to confirm the cause of death to be Metastatic Lung Cancer.

Mr Hudd's niece received a number of notes from him after he had been diagnosed with the cancer. In one of them he raised a concern that a nurse at the Long Bay Correctional Centre had withheld some of his medication. He named her as "Simone". Searches have revealed no nurse by that name employed at the centre during the period in question.

Further review of the medical charts revealed that it appeared Mr Hudd had been given all the medicines prescribed for him by his treating team including Oxynom, Durogesic Fentanyl and Endone.

In the circumstance's I am of the view that this concern cannot be substantiated.

Concern was also raised that earlier diagnosis may have led to a prolongation of Mr Hudd's life. The investigating officer explored this possibility with a treating doctor at the Long Bay Hospital who advised that it was apparent from a review of the medical records that at the time Mr Hudd complained of his influenza symptoms it was highly likely that the cancer was already very advanced and no further treatment options would have been available.

Conclusions

In all of the circumstances, I conclude that Mr Hudd died of natural causes and that no third party played any part in his death.

I am also satisfied that while he was an inmate in the Goulburn Correctional Centre and the Long Bay Correctional Centre, Mr Hudd received appropriate medical treatment of an equivalent standard to that which he would have been able to access had he been living in the community.

Findings required by s81 (1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died was Patrick Hudd.

Date of death

He died on 13 March 2013.

Place of death

Mr Hudd died at the Long Bay Correctional Centre, Malabar, NSW.

Cause of death

The cause of his death was metastatic lung cancer.

Manner of death

Mr Hudd died of natural causes while in custody in Long Bay Jail.

20. 134128 of 2013

Inquest into the death of Cecil Dalton. Finding handed down by Deputy State Coroner Forbes 2 April 2014.

REASONS FOR DECISION

This is an Inquest into the death of Cecil Dalton who died on 30 April 2013. He died at Long Bay Hospital as a result of a metastatic lung cancer.

He had been taken to hospital from Junee Correctional Facility where he was serving an eight-year sentence. On 21 June 2012 he was sentenced at Newcastle District Court to imprisonment for eight years with a three-year non-parole period. His earliest released date was 23 November 2017.

Mr Dalton's family attended at Long Bay Hospital on the day that he passed away.
An inquest is intended to be an independent examination of the available evidence relating to the circumstances of a persons death. The *Coroners Act 2009* requires findings that identify the person whose death is being investigated, the date and place of the death and the cause and manner of the death.

The cause of death is the direct physical cause and the manner of death refers to the circumstances surrounding the death.

The Coroner's *Act* requires a Coroner to conduct an inquest where the death has occurred in custody. (s.23, s.27). This inquest has been a close examination of the care and treatment Mr Dalton received while he was in custody. Pursuant to s.37 of the Act a summary of the details of this case will be reported to the Minister.

Professor Richard Fox, Honorary Consultant from the Department of Clinical Haematology and Medical Oncology was commissioned as an independent expert to review Mr Dalton's medical records. His report can be found in Ex 3 Tab 8. After reviewing Mr Dalton's medical records he concluded that:

"In my opinion, all that was possible was actually done for Mr Dalton including diagnosis and then a very appropriate referral to perhaps the leading Palliative Care Unit of New South Wales"

Having regard to the evidence of Professor Fox. I am satisfied that Mr Dalton received appropriate medical treatment for his illness. I make the following findings;

Formal Findings:

Mr Cecil Dalton died on 30 April 2013 at Long Bay Hospital, NSW, as a result of metastatic lung cancer. The manner of death was natural causes.

21. 155396 of 2013

Inquest into the death of XX. Finding handed down by Deputy State Coroner MacMahon on 15 July 2015.

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

A non-publication order has been made in respect of the whole of the evidence in the proceedings.

Formal Finding:

That XX died on 19 May 2013 at Dubbo in the State of New South Wales. The cause of his death was Neck Compression due to hanging which was self-inflicted with the intention of ending his life.

22. 240615 of 2013

Inquest into the death of Patricia Goddard. Finding handed down by Deputy State Coroner MacMahon on 22 May 2014.

Very little is known to investigate regarding Patricia Goddard's personal history other than she was born on 31 October 1937 and was a mother to children. At the time of her death on 7 August 2013 Patricia was in Silverwater Women's Correctional Centre serving a custodial sentence. Patricia suffered from a number of health related ailments including hypertension, type 2 diabetes, blindness in one eye and poor vision in the other as well as mobility issues. During her time in custody Patricia was the subject of medical attention on a number of occasions however, she tended to refuse treatment.

At around 2.30pm on 6 August 2013 Patricia complained of abdominal pain however refused to attend a treatment room for assessment and also refused all medication save analgesia. Records show that at around 9pm that evening Patricia refused to leave her bed and refused to take medications or allow a nurse to examine her. Patricia was instructed to take nil by mouth after midnight in preparation for a medical examination the following morning. However, several minutes before midnight Patricia called for help using the knock up alarm in her cell with Corrective Services officers and a Justice

Health nurse quickly responding to her aid. Even at that time Patricia fought off their attempts to render aid up until the point where she lost consciousness. Paramedics were called at 5 past midnight on 7 August and by 10 past midnight Patricia's condition had deteriorated to the point where CPR was required. Paramedics arrived at 21 past midnight and commenced treatment. However, Patricia was pronounced deceased at 12.25am on 7 August 2013. 15 Patricia was 75 years of age at the time of her death.

Formal Finding:

Patricia Maureen Goddard (born 31 October 1937) died on 7 August 2013 at the Silverwater Women's Correctional Centre, Silverwater in the State of New South Wales. The cause of her death was Pulmonary Thrombo-embolism due to Deep Vein Thrombosis with the condition of Adenocarcionma contributing to but not causing her death. The manner of her death was natural.

23. 258164 of 2013

Inquest into the death of XX. Finding handed down by Deputy State Coroner Truscott on the 19th December 2014.

Section 75 of the Coroners Act prohibiting the publication of a report of these findings applies

Section 74 of the Coroners Act that the following evidence is not to be published: Paragraph 10-25 of the Statement of Chief Inspector Graeme Abel dated 16 September 2013 (Vol.1 Tab 13) and Accompanying Documents at Vol 1. Tab 79, 81 and 82 contained in the Brief of Evidence Exhibit 1.

This inquest concerns the death of XX on Sunday 25 August 2013 some hours after he was first sighted on the 41st floor sitting on an outside ledge of an apartment building in Park Street Sydney. XX had stepped onto the ledge by accessing it from a window of the apartment of his girlfriend, Ms L, who had yet to return home from visiting with a friend. A week earlier, XX had been on the ledge when Ms L arrived home from work claiming he was merely enjoying the view of the Sydney harbour. Ms L asked him to come back inside, he did so reassuring her that he had sat on the ledge to admire the view on some 25 prior occasions.

Ms L also came home to find XX again on the ledge on the afternoon of Saturday 24 August 2013. He was drinking alcohol from a plastic bottle. He told her he was not going to commit suicide, he said heights did not bother him as he was a professional climber and it was like sitting on a mountain to help him clear his head and think. He came inside when she asked him to.

Ms L again instructed XX that it was her apartment and he was not to go outside onto the ledge ever again. She printed out instructions on A4 paper taping them to the window.

On 25 August 2013 Ms L again returned home at about 4 pm and saw XX on the ledge. This time when she asked him to come back inside he declined to do so indicating that he was going to end his life.

Ms L was in the course of telephoning 000 but the police had already arrived as they had been alerted by another person who saw XX from their office in an opposite building.

The police cordoned off the relevant sections of streets and paths surrounding the building and Police Rescue and Police Negotiators were called in. The police operation ended at 10.15 pm when the police unsuccessfully attempted to physically restrain XX to bring him into the apartment through the window. A Critical Incident was declared as the death occurred in the course of a police operation.

This Inquest is required under s27 (b) of the Coroner's Act 2009, a Senior Coroner having jurisdiction under s23(c) of the Act, being a death in a police operation. The Inquest has examined the circumstances which resulted in XX being on the ledge, the nature and appropriateness of the NSW Police response in attempting to negotiate his safe return to the apartment, the decision to affect his apprehension and the circumstances of his falling to his death.

History

XX was born in London, United Kingdom on 3 March 1964 [19]and immigrated to Australia in about 1996[20], a NSW drivers licence was issued on 20 January 1998[21] and records indicate various addresses where he lived in Sydney over the following years. He married in 2003 but divorced about 2 years later. He had another relationship which ended in about 2009.[22] In 2007 he graduated with a business degree from the University of Technology and he worked in marketing. However, in 2008 he was made redundant and though he obtained another job he was again made redundant in 2009.

[19] Australian Passport in name of XX (Vol 5 Tab 78E Brief of Evidence)
[20] Statement of Detective Sergeant Tesoriero (para 93) (Vol 1 Tab 6 Brief of Evidence)
[21] NSW Transport Roads and Maritime Services records in name of XX (Vol 6 Tab 85 Brief of Evidence)
[22] Statement of XX (para 8) (Vol 2 Tab 39 Brief of Evidence)

In 2011 he obtained a graduate certificate in teaching English language to foreign language speakers. He engaged in some casual employment in teaching and bar service since 2009 to the time of his death.[23]

XX's older brother lives in Sydney and he describes XX as a "*free spirit and not having any real concerns*".[24] A friend of over 25 years, says "XX has always been a fun loving eccentric person…the divorce hit him pretty hard. He was drinking a lot and…he started taking anti-depressant tablets and was undergoing counselling. He seemed to be a little spaced out, and wasn't sleeping so well. Gradually he seemed to be getting better…had a girlfriend …life was picking up for him". He recalled an incident where XX had lost his job, was still taking anti-depressants and that his girlfriend was worried about him, she had reported him missing but he returned a few days later saying that he had been camping. The friend said that XX hadn't worked for about 5 years, possibly due to skin cancer and that he didn't want to put the girlfriend through any trouble so he ended the relationship. [25] At the end of 2010 the friend commenced travelling overseas and upon his return in October 2012 learned that XX was in prison. He was told that XX had tried to commit suicide in prison because it was hell. [26]

On 18 April 2012 XX was arrested and charged with very serious sexual assault offences against a woman he had befriended. The offences had allegedly occurred earlier that day in his home and he had videoed them. XX was arrested as he returned home that night and the police had seized exhibits including a 30 minute video. XX, who at that time was 48 years old, had never been charged with a criminal offence before. He appeared in the Local Court and was refused bail. He entered the Metropolitan Remand and Reception and Centre (MRRC) at Silverwater on 21 April 2012.

On 15 June 2012, while in his cell, XX severely lacerated both wrists with a razor blade. He was taken to Westmead Hospital and underwent surgery. He underwent psychiatric review.

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[23] Statement of Detective Sergeant Tesoriero (para 102) (Tab 6 Brief of Evidence)

[24] Statement of XX(para 4) (Vol 2 Tab 39 Brief of Evidence)
[25] Statement of (para 4-7) (Vol 2Tab 36 Brief of Evidence)
[26] Statement of (para 8) (Vol 2 Tab 36 Brief of Evidence)

Upon his return to prison he was housed in Long Bay Prison Hospital and continued to be reviewed by psychiatrists. On 1 August 2012 he used a secreted pen to cut his left arm again. He was taken to Prince of Wales Hospital and again underwent surgery. Upon his return he was housed in the Acute Crisis Management Unit (ACMU) at the Long Bay Prison Hospital. He again received psychiatric evaluations.

Throughout his time in prison after 15 June 2012, XX was assessed as being at a high risk of deliberate self-harm due to not any mental illness or mental disorder, but rather, not being able to adapt to life in prison. XX's left arm in particular was significantly disabled from the self-inflicted injuries. He received ongoing treatment for his arms whilst in prison. On 14 November 2012 he was released to bail by the Supreme Court. His bail conditions included that he live with his brother I (who lived with his wife and children in the northern suburbs of Sydney).

His brother is of the view that XX did not receive appropriate psychiatric treatment whilst in prison. The lapse of 9 months since XX's release from prison and the ensuing events prior to his death are such that there is an insufficient connection to the manner and circumstances of XX's death to require this inquest to inquire into the care and treatment of XX whilst in prison.

However, there is material from the prison and hospitals included in the Brief of Evidence as it is relevant as background material to understand his self-harm and to give a context to the circumstances of 25 August 2013.

Prison Records

The Reception Intake Team assessment noted in its intake screening (completed by Ann Parker) *"[XX] suffers from anxiety and takes medication as needed denies thoughts of self-harm or suicide ideation....anxious first time in custody will need coping strategies…presented as calm and co-operative, slightly nervous but stated he would be ok appeared stable at contact no immediate issues".* [27]

[27] Brief of Evidence Vol 3 Tab 66 p1395

Robert Moss the Welfare worker also interviewed XX and noted amongst other things: *"mental health deliberate self-harm situational anxiety nil history or ideation and none recent…denies perceptual disturbances denies mood…guarantees safety for himself and claims he will cope ok if he doesn't get bail…Impression: This interview took a long time as XX had no capacity to contain his needy attempts to get what he wants-protection issues-welfare-pen and paper-one out cell-property-even though he understood that this behaviour was perceived as demanding he couldn't stop himself. Was being put back in his cell he was caught trying to secrete a plastic bag in his clothing with no reasonable explanation. May have been planning self-harm/suicide though claim he was fine – was also insisting that he be one-out".* [28] He was referred to Mental Health for assessment. On 22 April 2012 he requested to be accommodated in Protective Custody due to the nature of the charge.[29]

On 25 April 2012 XX was reviewed by Erin Minard Forensic Psychologist who recommended that XX be housed in a two person cell until 25 May 2012 and then "*normal.*"[30]

On 26 April 2012 XX was assessed by a psychologist Steve Barracosa who wrote amongst other things *"Inmate displayed significant difficulty adjusting to incarceration and accepting nature of gaol processes and routine. Despite supportive counselling in regards to functioning in custody inmate continued to report expectations and wishes that are unrealistic considering his current incarceration…denied any history of substance abuse issues…denied experiencing any significant medical issues at time of contact…denied any history of diagnosis of mental illness…denied being prescribed psychiatric medications at any time in the past…Case Management File documents history of anxiety and whilst inmate's presentation was anxious he asserted that there was no history of diagnosis…strongly denied that he was experiencing thoughts to self-harm or suicide at time (22 April).* [31]

On 2 May 2012 XX completed a form to see a Psychologist, with the following reason set out: *"I had a meeting with psychology last week and was given some suggestions to think about and get back to them with an answer.*

[28] Brief of Evidence Vol 3 Tab 66 p1365-66
[29] Brief of Evidence Vol 3 Tab 66 p1373
[30] Brief of Evidence Vol 3 Tab 66 p1359-1360
[31] Brief of Evidence Vol 3 Tab 66 p1430

I have now had a week to think about it and would need to meet with them again as soon as possible. Thank you". There is a notation that the request was received at psychiatry on 18 May 2012.[32] On 10 May 2012 XX completed another form to see a Psychologist, with the following reason set out: *"On 25/4/12 I had a psychology assessment. The lady gave me suggestions to think about and get back to them. I have had a few weeks to consider those and would like to meet with someone from psychology again".* That document is marked that the request was received at psychiatry on 14 May 2012.[33]

XX met with Alitas Caon, psychologist on 23 May 2012 who after a narrative of their conversation writes *"Impression: Adjusted to custody and coping well. Stable in mental health. Guaranteed own safety and was assessed as low immediate risk of self-harm/suicide at completion of interview. PLAN/ACTION TAKEN: No follow-up scheduled. Inmate to self-refer".*[34]

On 14 June 2012 XX appeared in the Central Local Court by video-link and his case was adjourned to 19 June 2012. His bail was refused.[35] The following morning XX approached Ms Caon and told her that he had *"an extremely urgent issue that I need help with immediately".* He said he needed to be housed in a cell alone and though he managed to share a cell until now he was experiencing distress, having difficulty sleeping and was unable to go to the bathroom when another person was in his cell. He denied he was being threatened by his cell mates or that he was having thoughts to harm others. Ms Caon advised him that psychology services did not affect cell placement and he would need to refer himself to see Justice Health. He sent a self-referral to Justice Health.[36]

Four days earlier, on 11 June 2012, XX had attended the medical clinic for treatment of an abscessed tooth.

[32] Brief of Evidence Vol 3 Tab 66 p1426
[33] Brief of Evidence Vol 3 Tab 66 p1425
[34] Brief of Evidence Vol 3 Tab 66 p1427
[35] Brief of Evidence Vol 3 Tab 66 Tab 66A Remand warrants
[36] Brief of Evidence Vol 3 Tab 66 p1429

At that time he had also requested a single cell placement as he was experiencing insomnia and an increase in anxiety in sharing a cell stating that he prefers to be alone, the nurse made an entry "patient for normal cell placement – one out if possible. HPNF referral made.[37]

At 2.30 pm on 15 June 2012 XX was discovered in his cell bleeding profusely from deep lacerations to his wrists. The records indicate that he fought off and struggled with corrective service officers and later when taken to Westmead Hospital with nursing staff.[38] XX underwent surgery for *"multiple tendon artery nerve repair"*[39]at Westmead Hospital and was transferred to Long Bay Prison Hospital on 21 June 2012.[40]

He was placed in an observation cell for psychiatric care.[41] The following day XX made an application to be accommodated as a non-protective housing prisoner, the consideration of which was deferred pending the psychiatric evaluation.[42] Throughout the psychiatric reviews both at Westmead Hospital and the Long Bay Prison Hospital XX denied that his self-harm was a suicide attempt but rather was due to his distress about having to share a cell. At Westmead he told the psychiatrist that he had been sexually assaulted about 4 weeks prior and though he had spoken to guards and they advised him to make a formal complaint he had declined to do. He also set out that he had made enemies of people in the accommodation pod because he had told on them to the guards. He said he received threats of harm. He said he did not want to return to the MRRC and wanted to go to Parklea Prison.[43] When reviewed at Long Bay Hospital there is a note that though Paul reported that XX had told him that it was a suicide attempt XX continued to maintain it was an attempt to have a cell by him alone. [44] Throughout the material there are a few notes made by psychiatrists that XX was difficult to establish a rapport with.

[37] Brief of Evidence Vol 3 Tab 67 p1487
[38] Brief of Evidence Vol 3 Tab 67 p1488
[39] Brief of Evidence Vol 4 Tab 68 p1579
[40] Brief of Evidence Vol 3 Tab 66 p1444
[41] Brief of Evidence Vol 3 Tab 66 pp1331- 1332
[42] Brief of Evidence Vol 3 Tab 66 pp1324-1325
[43] Brief of Evidence Vol 4 Tab 68 pp1591-1615
[44] Brief of Evidence Vol 4 Tab 68 p1633

XX remained in the Long Bay Prison Hospital and received psychiatric reviews as well as ongoing treatment for the injuries to his arms. On 31 July 2012 he attended court, and at 6.30am on 1 August 2012 he was found in his cell, on the floor flooded by water, bleeding from his left arm. He had lacerated the wound of his healing left arm. He was conveyed to Prince of Wales hospital and underwent surgery to repair the ulnar artery and was discharged on 6 August 2012 back to the Long Bay Prison Hospital. [45]

XX was accommodated in the Acute Crisis Management Unit so the Department of Corrective Services could manage his high suicidality. On 14 August 2012 after review from psychiatrist Dr Roberts he was taken off constant observation as there was no evidence of mental illness and the risk of self-harm had dissipated in the context of evolving family support.[46] He remained in that Unit until he was granted bail by the Supreme Court on 14 November 2012.

XX at no time was diagnosed with a mental illness. His suicidality was due to his response to being in prison. There are notes that he experienced bullying in both primary and secondary schools and prior to entering prison he had some history of anxiety and perhaps depression. XX told doctors that he had harmed himself in June so that he would be allocated a single cell. He said that he had received threats of harm and at other times he said he had experienced actual harm. He had conveyed limited to no insight into having attempted to end his life.

Given the nature of his self-harm it is unavoidable to conclude that he must have wanted to end his life at that time he inflicted his injuries. However, given his knowledge that he would likely be discovered soon after inflicting the harm, he must have also wanted to be rescued. I do not know what the background to the second incident on 1 August 2012 was. It may have been a response to being bail refused on 31 July 2012. The evidence is clear that XX found prison extremely difficult to cope with and the prospect of staying or returning there, was so over-whelming that XX determined that a better solution or outcome was to take his own life.

[45] Brief of Evidence Vol 4 Tab 68 p1789
[46] Brief of Evidence Vol 4 Tab 68 p1731

In an email to the Crown Solicitor's Office dated 27 October 2014, X set out his concerns about the care and treatment his brother received while a prisoner on remand and whilst on bail. The Crown Solicitor's Office forwarded a copy of his email together with a letter to the Department of Corrective Services and Justice and Forensic Mental Health Network respectively. [47] X was particularly concerned with whether clinical information was shared between the services and why a discharge summary was not completed when XX was released to bail. Both Departments forwarded their responses.[48] It is clear information was shared and I am grateful to the appropriate persons of those facilities to attending to those issues on short notice and without requiring leave to be involved in these proceedings. XX was released to bail without the opportunity of any arrangements for his discharge to be made. Upon his release XX attended a medical practitioner who, if the need arose, could have with XX's consent obtained medical material from both Corrective Services and Justice Health.

Released On Bail

I have read the bail decision of the Supreme Court. The prosecution case against XX was such that a conviction was not a sure outcome of a trial and it was for that reason bail was granted. That decision was informed by evidence elicited through the cross-examination of the Officer in Charge about the contents of the video footage compared to the contents of the statement of the complainant. XX instructed solicitor Mr Peter O'Brien who briefed a barrister to appear for XX in his criminal trial. Mr O'Brien has provided an Affidavit with annexures setting out that XX was due to stand trial on 2 September 2013. Mr O'Brien gave evidence that the charges were 5 counts of sexual intercourse without consent (apparently relying on the number of acts of penetration contained in the 20-30 minute video. The initial charges involved 1 count of detain for advantage (sexual gratification) and 14 counts of sexual intercourse without consent, (some of which were aggravated counts involving actual bodily harm) between 4 and 8 pm on 18 April 2012).

[47] Brief of Evidence Vol 3 Tab 66C and Tab 66E respectively
[48] Brief of Evidence Vol 3 Tab 66D and Tab 66F respectively

Mr O'Brien says that in December 2012 representations had been made to the Director of Public Prosecutions offering a plea of guilty to a singular offence of sexual intercourse without consent, the defendant being reckless as to whether the complainant was consenting or not.

That offer was refused in early 2013 prior to waivered committal proceedings but was resubmitted in August 2013 and remained outstanding as at 25 August 2013. Mr O'Brien was unaware whether at that time a Crown Prosecutor had been allocated the trial.

XX's trial was ready to proceed. He had recently conferred with a barrister having decided to change from his previous barrister. His proof of evidence had been taken. His defence was that he and the woman had engaged in consensual sexual acts which involved consensual bondage which he had videoed. XX's case was that afterwards whilst sharing a candle-lit bath he and the complainant argued when he refused her request to delete the video. After the bath, the woman collected her belongings and left his home. Thinking that she was upset he left in his car to look for her and when he returned home two hours later he was arrested by the police.

The woman in her statement says that XX had tied her hands to his bed after which he repeatedly sexually assaulted her with a vibrator as well as his penis. The woman says that after a bath, when XX was in his room, she dressed, climbed out of the bathroom window, and hailed a taxi which took her to the police station. When police attended XX's home he was not present, but the police searched the house and in a room underneath the house they found a box containing the video, a used condom, the fabric ties, and the vibrator.

Mr O'Brien's evidence is that the video was equivocal as to consent and that XX had been advised that he had good prospects of an acquittal. Despite being told this XX focussed on the possibility of being convicted and returning to gaol. Mr O'Brien said that XX was highly anxious about being actually able to participate in the trial process, concerned with how he would come across in the witness box. He was highly stressed at the length of a sentence of imprisonment he would receive if convicted after trial compared to that of a plea of guilty to a single offence involving recklessness as to consent.

He had been advised that if the plea offer was accepted he may receive a non-parole period of about 18 months (of which he had served 7 months prior to bail) compared to the possibility of a 7 year non-parole period if convicted of all matters after trial.

Mr O'Brien said that XX assured him that he would be psychologically ready for the trial. On 12 August 2013 XX attended a psychologist Pandelis Tsomis from Sydney Psychology Services whose notes have been included in the brief of evidence. [49] The notes indicate XX's presenting problem was his anxiety in relation to his upcoming trial on 2 September 2013. He raised his father's death in 2003 which is the event was identified as the beginning of XX's anxiety and change of behaviour.

Mr Tsomis' notes indicate XX arrived late, nearly at the end of his appointment time and Mr Tsomis had to manage the end of the appointment time going over to time allocated to a waiting client. XX wanted to talk with him over lunch or after work and he rang back in the afternoon not sure whether he was engaging Mr Tsomis as a clinical or forensic psychologist so the difference was explained to him. Mr Tsomis identified that XX was likely to have *"mixed anxiety and depression"*. The notes also indicate that XX was asked whether he had attended any other psychologists previously that year to which he said he had about a month previously but when asked if that was beneficial he replied "*sort of*". It appears that he did not convey the nature of the trial other than "*some kind of assault*" and that he did not describe his history of self-harm or his earlier incarceration.

The Medicare Records show that shortly after being released to bail, XX consulted with doctors to ensure he received the appropriate treatment for his arms and attended a psychologist under the GP referred mental health plan (although he rarely attended a psychologist under that plan, perhaps 3 times). However, he attended a variety of doctors who prescribed him medication for his depression, anxiety and pain.

XX was bailed to live in his brother's home together with his wife and 2 children in a northern suburb of Sydney. XX owned a house in the southern suburbs.

[49] Brief of Evidence Vol 2 Tab 78H

It had suffered fire damage shortly after his arrest in April 2012, the source of which was identified as a non-extinguished candle in the bathroom. After his release, he set about repairing the house and organising it for sale. He engaged a real estate agent and by February 2013 it was to be shown to prospective buyers.

On 20 February 2013 the real estate agent entered the house and found XX in the bathroom unconscious from a deliberate overdose of his medication. There was an empty bottle of champagne and a detailed note setting out the resuscitation and treatment that he should be given to save his life. Had XX not been discovered and treated he would have died. However, he was likely to be discovered as he was aware that the real estate agent was attending his home. The writing of the resuscitation note indicates that he was anticipating that he would be rescued but other notes which indicated he was settling his affairs indicate that he was also intent on suicide. Taken together, these matters perhaps demonstrate he was somewhat ambivalent.

XX was taken by ambulance to Sutherland Hospital where he was resuscitated and placed on life support. Once recovered and reviewed by a psychiatrist he denied suicidal intent and asked to be discharged from hospital. This was refused and he was detained as a mentally disordered person at risk of serious harm to himself. He remained in hospital until his brother and his family were able to have him return to their home. Shortly afterwards, XX's bail conditions were changed so that he could live in his own home.

Sutherland Hospital referred XX to the Hornsby Community Health Team and his case was then transferred back to Sutherland Hospital when he moved to live in his own house. He attended a couple of interviews with the Sutherland Team. He was discharged from their service as he indicated he would attend a private doctor, Dr Jeet but he could self-refer back to Sutherland Hospital if needed.

Again during that hospital presentation it was identified that XX did not have a mental illness, the stressors he identified as being triggers for the incident were the recent deaths of his uncle and aunt in the last week.

He was worried about his elderly ill mother, had lost his job in 2009 and had to sell his house because he couldn't repay the mortgage.[50] It was queried with Dr Babidge whether the deaths of their aunt and uncle really were the trigger for XX suicide attempt because he had known about their deaths for over a month. His brother thought that it was more likely related to the prospect of returning to prison.[51]

During this time, XX was having a relationship with Ms L; they had met in December 2012. She did not know very much about him. She did not know that he was on bail for serious sexual assault offences that he had been in prison on remand, or had deliberately self-harmed. She was unaware that during the time she was going out with him that he had taken a highly lethal overdose and was detained in the Psychiatric Unit at Sutherland Hospital in February/March 2013. She did not know that he had a brother living in Sydney until about a week prior to his death. In her statement Ms L said that XX was very secretive and he mainly talked about his extensive overseas travels. Ms L lived in a one bedroom apartment on the 41st floor of the Park Regis Tower. XX stayed overnight with her about 3 to 4 nights per week during the term of their relationship.[52]

By July 2013 XX had sold his house and had moved into a rented apartment in Haymarket. He continued receiving treatment for his arm and continued attending doctors and filling scripts for medication. Ms L first met XX's friend, Chris on 19 August 2013. The circumstances surrounding that meeting were that she arrived home at about 6.30 pm expecting to then go out for dinner with XX. Unusually, her door was double locked, the dining room chairs were stacked up behind it, and the window was open. XX's favourite music was playing loudly and he was sitting on the ledge outside. She asked him what he was doing and he said he was enjoying the sunset. She was upset with him and after he came back inside he told her he was *"just really appreciating the view".*[53]

XX said that they would still go to dinner but she queried whether he could walk because he appeared drunk.

[50] Brief of Evidence Vol 4 Tab 72 p1969
[51] Brief of Evidence Vol 4 Tab 72 p1975
[52] Statement of t L (para 4) (Vol 2 Tab 35 Brief of Evidence)
[53] Statement of t L (para 8) (Vol 2 Tab 35 Brief of Evidence)

As they were walking to the restaurant they stopped at the Pie Face shop so that he could get something to eat because Ms L didn't think they would be allowed entry to the restaurant given his intoxication. She had to assist him in the shop as he appeared drowsy and drunk; she stood behind him to hold him up because she thought he would fall over. She took his phone and found a note that said call C with a phone number on it.[54]

C came and collected XX but they could not get him into the car so they called an ambulance which took him to St Vincent's Hospital. By the time that occurred XX was asleep on the ground snoring. C spoke to Ms L about XX's brother, and that was when she learned that he lived in Australia. She returned to her home and C went to the hospital. XX phoned Ms L at about 4 am asking her to come to the hospital to vouch for him and sign him out. She went to the hospital and only agreed to sign him out if C spoke with him over the telephone to check that he was alright to be discharged.

They went to a café for breakfast and then Ms L went to work. C telephoned her saying that he had given her number to P and he was going to ring her to speak with her about XX. On the Wednesday Ms L found a note in one of her drawers written by XX. It was in a bag with a loose foreign currency. The note said *"this is for your big trip to Europe or if you travel the world"*. It also said *"when you're travelling I will be there with you."* She telephoned C to ask if XX's behaviour was normal for him. C said *"that's so normal for him to sit on the ledge. I wouldn't even get scared that he got out of your window, that's something that he would do normally. But I'm worried about the chairs".* [55]

XX attended his solicitor's office on Thursday and had dinner with P. He then attended Ms L's apartment and they remained together until Sunday afternoon. XX apologised for the incident on Monday night reassuring Ms L that he wasn't trying to commit suicide. He asked her to not speak with C and P.

[54] Statement of L (para 9-14) (Vol 2 Tab 35 Brief of Evidence)
[55] Statement of L (para 9-14) (Vol 2 Tab 35 Brief of Evidence)

They spent the following day together trying to catch up on sleep and that night (Friday) XX said he wanted to go to dinner and out dancing because from Monday he needed to not drink because he needed to be with his lawyers and prepare for the trial, as he was innocent and would be acquitted.

On Saturday afternoon XX stayed in the apartment when Ms L went out and when she returned about 4.30 pm he was back on the ledge sitting down with a plastic bottle with dark brown liquid in it which she presumed was alcohol.

She asked him to come in and he did and reassured her he was not going to commit suicide.

They had a conversation about the court case and Ms L agreed that she would write to him if he went back to prison and suggested that he should write a book about his life. She printed out the A4 note and taped it to the window to remind XX that he was not allowed to go out onto the ledge. He wouldn't talk to her about the offence but said he wanted to go out dancing that night and to church the next morning. Ms L regularly attended church and it was something that he wanted to do with her in case he went back to prison.

They went out dancing that night and returned home in the early hours of the morning. Though Ms L said that she didn't want to go to church because she needed to sleep XX insisted that they go because it was on his check list. He set his alarm clock and the next morning they got up went to church, then to a late breakfast. She caught a bus to have lunch with a friend and before she left he asked how he was going to get his stuff from her apartment. She gave him the key and she reminded him not to go onto the ledge and he said he was fine. Ms L said that he looked well and was his happy self. While Ms L was out XX phoned her and asked her to call him before she came home. After lunch, she got on the bus and phoned him and he asked her how long she would be.

Ms L lived in an apartment in the Park Regis Tower at 27 Park Street Sydney. She pressed the buzzer for her apartment but XX did not answer it. She telephoned his mobile and despite him pretending he was in bed waking up, she heard the sound of wind and knew he was on the ledge.

She told him to get back inside. She kept pressing the buzzer but he did not open the door, she crossed the street and looked up to see his legs dangling from the ledge. She returned to the entrance and a neighbour who was exiting the building let her in and she travelled up to the 41st floor and entered her apartment. She saw XX drinking from the same bottle and she asked him calmly to come inside and he said *"No . I'm not coming inside this time."* He said "Can you just listen to me. I need to tell you something" and he said *"No I'm not coming inside this is going to be brief."* She told him she was scared and that he needed to come in. She took her phone to call triple 0.

Across the road Mr Jaggi was working on Level 33 and saw XX on the ledge. He said he looked relaxed but he thought that he was drunk and was concerned that he would fall. Mr Jaggi called triple 0. He saw a woman holding the man's hand and they looked comfortable with each other. He says a few minutes later the police and fire trucks arrived in the street. Mr Jaggi stayed on the phone to guide the police to the apartment. He says that about 10 minutes after the start of his call the police were in the apartment and appeared to be staying back and being cautious while observing the situation. The triple 0 call was terminated.[56]

The Police Operation

Detective Sergeant Tesoriero is the Officer in Charge of this matter and he has provided a statement which includes a thorough narrative of what occurred once the police arrived at the tower block.[57] In summary, the general duties police from the Sydney City Local Area Command (then called "City Central") closed off the streets around the apartment block and others entered Ms L's apartment at about 4.10 pm. They saw XX on the ledge. He appeared to be affected by alcohol and/or drugs[58]. The Kings Cross precinct's on-duty commander Inspector Lowery arrived and he remained in charge until about 6.30 pm when he was relieved by the Rocks and Sydney City duty commander Acting Inspector Biasi. Upon being told that XX was refusing to come inside, Inspector Lowery directed that officers from the Police Negotiators Unit and from the Rescue and Bomb Disposal Unit attend.

[56] Statement of Varun Jaggi (Vol 2 Tab 38 Brief of Evidence)
[57] Statement of Detective Sergeant Andrew Tesoriero (paras 12-39) (Vol 1 Tab 6 Brief of Evidence)
[58] This was confirmed in the Post Mortem (Vol 1 Tab 5 Brief of Evidence)

The Commanding officer was Acting Inspector Biasi. He consulted with the team leader of the Police Rescue Team (Senior Constable Hood) and the team leader of the Negotiation Team (Detective Sergeant Abeyasekera). He was also responsible for the closure of roads and areas around the building which was being performed by general duties police. Throughout the night he was also liaising with his superior. As commanding officer he was responsible for making a decision as to whether negotiations continued, in an attempt to have XX to come inside the apartment, and if it came to a point where the negotiations failed, whether a rescue could be affected in the event that XX attempted to carry out his threat to suicide.

He was on site outside the apartment on Level 41. Other police who were with him included rescue officers, negotiators, and general duty police who were amongst other tasks assisting to keep logs of events.

The Police Negotiators Team

Detective Chief Inspector Abel is head of the Negotiators Unit. He has given evidence about the negotiation unit's staffing and operational guidelines and procedures. Much of his evidence is subject to a non-publication Order under s74 of the Coroners Act 2009. Detective Chief Inspector Inspector Abel is on duty around the clock for NSW and is involved in each and every deployment of police negotiation services. His level of expertise and engagement is quite frankly astounding. On this night, as on each occasion, his role commenced when he received a call requesting that negotiators attend the site. He then telephoned the negotiators and they attended the apartment and sought to engage XX to negotiate his return into the apartment.

Senior Sergeant Sullivan and Detective Sergeant Thomas were inside the apartment with Ms L. Another member of the team, Detective Senior Constable Oldfield was nearby and he liaised with Constable Piper of the State Protection Group who set about collecting information about XX to give to the negotiation team. Detective Sergeant Abeyasekera was the negotiation team leader.

A soon as he could, Inspector Lowery obtained a print out of computerised information from the police network. These documents included the bail records, charges and facts sheet relating to the sexual assault charges.

There was a record from 2009 when XX's then partner had reported him as a missing person. There was also a record about XX having been taken to Sutherland Hospital in February 2013 for a previous suicide attempt.[59] Detective Senior Constable Oldfield gave evidence that he was handed these documents which he described as XX's CNI Profile. He said that at the conclusion of the evening he gave those documents to the Log Officer. There is no evidence as to what then happened to those documents.

Third Party

Usually the police would not allow a person who is not a member of the negotiators team to be involved in the negotiation. However, Ms L was involved throughout the negotiation and having heard the reasons for that, I am of the view that the police made the correct decision in that regard. Very early on, XX demanded that unless he could speak with Ms L alone he would jump from the ledge, he had already been speaking with Ms L as it was her apartment. He gave the negotiators 6 minutes to leave. He refused to speak with the negotiators. The police rescue team were able to ensure that Ms L was secured by a harness and an anchored line so that she was not at risk of danger. Detective Sergeant Abeyasekera liaised with an on-call psychiatrist Dr Andrew Ellis by telephone to confirm the appropriateness of this arrangement.

Dr Ellis advised that on the information he was provided, he agreed that XX seemed intent on suicide and involving Ms L in the negotiations was, in the circumstances, appropriate.

Ms L remained at the location and in the harness for the duration of the negotiation. She liaised with police negotiators and encouraged XX to come inside to no avail. I agree with Chief Inspector Abel's comments that Ms L carried out her role magnificently in her efforts to help XX and it was due to her efforts that his life was extended for the time that it was.

[59] COPS records (Vol 2 Tab 46 Brief of Evidence)

Psychiatric Consultation

I have heard evidence from Dr Ellis, Acting Inspector Biasi and Detective Sergeant Abeyasekera. Dr Ellis is a psychiatric consultant of at least 10 years standing and since late 2012, he has been consulted with by NSW Police Force High Risk Police Unit as needed. His role is to give behavioural advice to police negotiators to incorporate into their decision making.

Dr Ellis said that the role of a psychiatrist is to advise negotiators to interact with the subject and it is not the practice to be directly involved with the negotiation. This is one of the reasons why it is not usual for a psychiatrist to be called on site. Their role is to observe and synthesise the situation. He said that the police engage in gathering information prior to consulting him. In his statement, Dr Ellis says that he was telephoned by Detective Sergeant Abeyasekera at about 8 pm and 10 pm.

The police log indicates that he was phoned at 7.40-8.00 and 9.15 pm. Detective Sergeant Abeyasekera says he spoke to Dr Ellis twice and his contemporaneous notes/ log supports that position. Dr Ellis was content to accept the log records. By the time of the first telephone call, the police had heard XX's threats to jump unless he could speak with Ms L alone (at about 6 pm). At about 6.15 pm he said that he wanted to come inside and make peace with the world but then changed his mind.

Ten minutes later XX had stood adopting a prayer motion and half an hour later he began settling his financial affairs by sending by text message his bank details to Ms L phone. At 7 pm he was upset and yelling at the police about giving him "*the biggest bullshit in the whole world*", and at 7.10 pm he sent to his brother l and a friend texts of final farewells.

At about 6.30 pm Detective Senior Constable Oldfield had spoken with Mr D and together with the information contained in the CNI profile, information from Constable Piper, and information from Ms L, the police had a profile of XX that painted a picture of a man dealing with very difficult circumstances.

Having read the notes that impression can be fairly summarised as follows: he had never been in trouble with the law until 16 months previously when he was charged with very serious sexual assault offences which from the police perspective was an overwhelming case against him.[60] His case was in court in 7 days time and he would likely be sentenced to gaol for a long period. He was divorced, his house had burnt down, he was estranged from his family, he had attempted to suicide on at least 2 occasions since being charged with the offences, once by cutting his wrists and once by overdosing of benzodiazepines, sleeping pills and anti-depressants. Over the last couple of weeks he had been up and down drinking and taking pills.

According to C, XX said he was innocent of the charges that the sexual activities were consensual. It was the fact that XX had videotaped the activities that the complainant didn't like, but he had carried on, and she flipped out and ran out after a romantic bath.

In his statement Dr Ellis said that during the first telephone call he was advised that: XX was a known sex offender likely to be returned to custody; he had a prior psychiatric admission to Sutherland Hospital; and he had a prior suicide attempt in custody this year (no information to hand at that stage). Dr Ellis assessed the situation as a serious imminent risk of suicide (single older male, serious court matter with likely custody, arranging affairs, agitated demeanour, statement of finality, recent prior attempts). Negotiators were not mentioning the court matter (XX had not brought it up). Dr Ellis suggested that police negotiatiors were to continue with their strategy and that in the absence of any rapport with police, the third party remain engaged[61].

In his evidence Dr Ellis said that he presumed XX was a convicted sex offender because the police asked him if he knew him, as some of his work as a psychiatric consultant involved working with sex offenders in prison. Dr Ellis did not realise that XX was in fact a man without any prior convictions and that he had pleaded not guilty to the sexual offences which were pending trial.

[60] Evidence and Statement of Detective Sergeant Tesoriero (para 129) (Vol 1 Tab 6 Brief of Evidence)
[61] Statement of Dr Ellis (para 6-8) (Vol 2 Tab 31A Brief of Evidence)

He said that his statement that XX was likely to return to custody was based on information that was given to him by police. He thought the outstanding court case was that XX was *"unsentenced"*.

Dr Ellis said that even if the information or communication with police was more accurate, he would have still assessed XX as intent on an imminent suicide. He said that of persons charged with sexual offences there is a significant number who complete suicide because it is a very stressful situation. Dr Ellis said that had he been told that XX was disputing the allegations against him, he would not have changed his advice. Dr Ellis explained that XX was in a high stress legal predicament with a potential that he was going to return to custody.

Counsel Assisting showed Dr Ellis the note XX had written when he overdosed in 20 February 2013. The note, though described by Sutherland Hospital to the police as a suicide note, it is in fact more aptly described as a rescue note directing resuscitation. Dr Ellis indicated that the note, in circumstances where XX knew that the real estate agent was attending his home and thus likely to discover him, indicated an ambivalence to end his life.

He said that now knowing that XX had been on the ledge prior to 25 August 2013 may indicate that he was *"trying out and practising what he was going to do"*; preparation and planning still indicated suicidal ideation. Knowing those two features wouldn't have changed Dr Ellis' advice. His advice to the police was to continue with the negotiations using the third party person.

Counsel Assisting asked Dr Ellis about the negotiators' lack of rapport with XX's to which he replied *"I thought he might have issues or views with the police"*. He said that the lack of engagement with police and the ongoing engagement through the third party was sufficient information for him to advise that that strategy should continue. He said that he was not asked about whether there should be a physical intervention during the second call. He said that in the first telephone call he was advised that the police had considered rappelling down from the roof which was 5 levels higher but it was deemed too difficult to do so. He said he was not involved in those discussions.

Dr Ellis said that though XX's lack of engagement with the police could indicate that he had made his mind up, he had chosen a highly public situation despite there being available a number of choices to harm himself in a secluded location. He said it was important for negotiators to learn as much about the person so that they could develop an empathy and understanding to resolve the situation, but these things did not progress in this case and the alternate means was to use a third party.

P has given a statement that at no time did the police contact him by telephone or attend his home during the 6 hours in which XX was on the ledge. He said he was home all evening but had not seen the message XX left him at about 7.20 pm which said *"thanks for all the fish."* P also said that he had received a similar message after having dinner with XX earlier that week but did not know what it meant. Dr Ellis said that he thinks it is a *"final goodbye"* referenced from a book called *"The Hitchhikers Guide to the Galaxy."*

Counsel Assisting asked Dr Ellis whether he thought that contact with P could have been useful. Dr Ellis said that it depended on whether the police had the resources to attend P's home and though information from family members can suggest ways to interact with the subject, you wouldn't have them engage directly in a negotiation. Dr Ellis indicated that sometimes the subject has difficulties with life and interpersonal relationships and if those difficulties include conflict with a family member it can be not advisable to engage them. In answer to a question by Mr Saidi indicating that XX had his mobile telephone on him, Dr Ellis agreed that it could be counter-productive if a family member, becoming aware of the situation, telephoned XX.

Communication of Usage of Collected Intelligence

Detective Senior Constable Oldfield had obtained Mr D's telephone number and spoken with him about XX. The telephone number he had recorded in his notebook under P's name was not P's telephone number (it was one of XX's) and P's address that Constable Piper had obtained was not recorded in Detective Senior Constable Oldfield's notebook. Constable Piper had misheard the address given over the telephone to him so wrote an incorrect street number and suburb in his notes.

He obtained documents from mental health facilities which contained P's correct address however, though he said that he had read the documents and verified that those details accorded with the information he had been given over the telephone, it is apparent that he did not pick up on the error in his notes. Detective Senior Constable Oldfield told Constable Piper that he did not need to bring the hospital documents up to the site.

Having the incorrect address for P, not obtaining his telephone number and not calling him was a lost opportunity to have as much information as possible about XX. Mr Saidi in his questions raised the risk that P could have contacted XX by telephone and interfered in the police negotiation. Whilst that could be true, the same could have been said about Mr D and yet the police contacted him. Further, having seen P as a witness, I think he would never have done anything to jeopardise the police operation.

There is no evidence about why the police did not contact P or think that his information could be important. Though Mr D had told Detective Senior Constable Oldfield that P had had enough and that XX had told him he wasn't speaking to P that information was inaccurate or at least dated - the brothers had dined together on Wednesday night.

It is important that information is verified where possible. Since this operation the risk that information is miscommunicated has been minimised because police on site are now able to remotely access all police computer information by iPad.

It has been difficult to gauge what information or intelligence was passed on to the 2 negotiators who were in the apartment. Chief Inspector Abel says that the new iPad device allows for a log of what information is gathered and what is conveyed to each police officer. I think that this information is important so that a proper evaluation can be made.

The Sexual Assault Allegations as a Trigger for XX's Intent to Suicide

XX's solicitor, Peter O'Brien, gave evidence that XX was extremely anxious about his court case.

He was anxious about being able to participate in the trial, how he would manage giving evidence, how he would be perceived. Mr O'Brien said that despite telling XX he had good prospects of being acquitted; XX would dwell on the negative and would remain anxious.

Mr O'Brien said that he told XX that he thought he should seek professional treatment because he was concerned about XX's ability to manage his anxiety and run his defence. He said that XX was always reluctant to discuss anything about his mental health and was constantly reassuring Mr O'Brien that he would be alright for the trial. During the 12 months Mr O'Brien represented XX, Mr O'Brien said that there weren't really any differences in his behaviour or state of mind - he was always fairly pressured, awkward, unsettled and somewhat peculiar. Mr O'Brien said XX refused to have a copy of the brief of evidence in his possession, preferring to attend Mr O'Brien's office to read it on numerous occasions.

Mr O'Brien said that XX was concerned with media reports about the trial; he had major difficulties coping with feelings of shame, humiliation, indignity and embarrassment. The other factor about the case that was extremely troubling for XX was the prospect of not being successful at trial and receiving a much longer sentence upon conviction after trial as opposed to the sentence he would receive if he pleaded guilty to the charges.

The offences against XX had a standard non parole period of 7 years and he understood that if a plea of guilty was entered to a single count he might receive a non-parole period of 18 months (of which he had already served 7 months on remand). He had instructed Mr O'Brien to resubmit the offer to the DPP to receive a lesser sentence, Mr O'Brien thought that if the offer was accepted XX would probably have taken it to avoid the risk of a higher sentence (and to not have to cope with his anxiety during the trial process) though his case was always that the sexual activity was consensual.

In relation to XX's residential address, Mr O'Brien said that on 16 July 2013, XX's bail was changed in anticipation that he would reside in an apartment in Kent Street, Sydney, but that did not eventuate so on 18 July 2013 he returned to the District Court to have the bail address changed to 143/107 Quay Street Haymarket.

Mr O'Brien said that he had seen the video of the acts alleged against XX twice and cross-examined the police officer in charge in the Supreme Court about the differences between the complainant's statement and what is seen in the video. Justice Schmidt granted XX bail as a result of that evidence.

Mr O'Brien said that he had issued subpoenas for material to support XX's case that XX had not only arranged to collect the complainant from the airport when she returned from Perth but had paid for her flight, to counter the allegation that the complainant was surprised to see XX at the airport. Mr O'Brien had cancelled the subpoenas when he learned of XX's death.

The police were correct in identifying the charges against XX as a high stressor involved in his suicidality. Detective Sergeant Tesoreiro is of the view that the prosecution case was so overwhelming against XX that a conviction and consequent long custodial sentence was likely. I don't share that view. I have given consideration as to whether that sentiment effected the negotiation that night. I am of the view that it did not. Indeed it is difficult to identify whether either Senior Sergeant Sullivan or Detective Sergeant Thomas were even aware of the details of the case from either the prosecution perspective or that garnered from Mr Duncan which was consistent with Mr O'Brien's view.

Dr Ellis's advice at 8 pm for the police to not mention the charges was well identified – at that stage XX himself had not mentioned them. At about 8.15 pm XX was heard to tell Ms L that he didn't want to go back to prison. Shortly afterwards, the police spoke separately with Ms L giving her another conversation bracket to encourage XX to look forward to the future. Over the next 45 minutes XX was attempting to settle his affairs and his requests for paper and pen were denied. The police negotiators were asking him to come inside and Ms L was indicating to them that XX was about to jump. At about 8.30 pm he had texted his bank details to Ms L. At 8.40 pm XX snapped at the negotiator and said that if he didn't shut up he would jump. The next 45 minutes or so were spent between Ms L trying to convince him to come in and him focussing on not wanting to go to prison for 10 to 20 years.

Senior Sergeant Sullivan said in his evidence that he tried to reassure XX that what he was saying about the outcome of the case may not necessarily be correct, he should speak with his lawyer, and wait to see what did happen. XX was hostile to Senior Sergeant Sullivan's attempts to see more positive possible outcomes. Senior Sergeant Sullivan tried to reassure XX that if he came into the apartment he would not be charged as he had done nothing wrong and that he could spend more time with Ms L and she could go with him to the doctor to check that he was okay. Senior Sergeant Sullivan said that XX was set in his ways, he would listen and continued to refuse to engage. This is consistent with how both P and Mr O'Brien described XX's way of thinking. The negotiators' experience of XX being difficult, if not impossible to engage, was an experience of other professionals who had sought to help him both in prison and at Sutherland Hospital.

By 9.30 pm Ms L and the negotiators were of the view that XX was about to commit suicide. Following a debrief, they continued trying to convince him to come inside the apartment. XX started asking them to leave the apartment to avoid seeing his death; he started to thank the police of their time and efforts.

The Police Rescue Operation

The police rescue team arrived on site before the negotiators. Senior Constable Reynolds commenced speaking with XX until the negotiators arrived.

He and another officer, Senior Constable Pade, remained in the back of the apartment. They wore harnesses roped to anchor points. They assisted in securing Ms L. Other members of the police rescue team set out roping systems from anchor points on the roof.

Acting Inspector Biasi discussed with the rescue team leader the options of engaging in a physical intervention. They were confronted with a very difficult environment to execute a successful physical intervention if XX refused to come into the apartment. Early on, they considered the possibility of rappelling from the roof, some 5 levels but this was discounted as it would not be possible to do so without alerting XX, and risk him jumping from the ledge.

The only possibility available was to have a police officer gain access to an adjoining apartment's ledge in order to come up behind XX and pin him against the window while Senior Constable Reynolds and Senior Constable Pade would run in and assist in pulling XX through the window opening. The opening of the window commenced at a height of 1.3m, with a gap of only 60 cm in height and 120 cm wide. XX was 1.8m tall and weighed between 90-100 kg. There was a likelihood that he would resist the police in the rescue attempt. The prospect for success was so low that it was decided to only implement the attempt as a last resort option. That is, when they believed that XX was about to jump. To use one of the phrases contained in the interview of Senior Constable Reynolds, it was *"the last of the last resorts"*.[62] As he said, there were not any other options.

Senior Constable Jervis agreed to be the officer who would go onto the ledge. The method by which he was secured by the ropes was such that there was little to no risk that he would fall. There were two lines from above anchored on the roof and one line from the window of the adjoining apartment also anchored. However, the very high vertical environment on a cold, windy and dark night is not for the faint hearted and at best, XX's reaction was unpredictable (and in fact likely to be hostile and resistant). Senior Constable Jervis was required to wait on the adjoining ledge for over an hour, awaiting the instruction to move in the event the intervention was to be implemented.

Detective Sergeant Abeyasekera telephoned Dr Ellis at about 9.15 pm. By that stage XX was still not talking with the police and the only factor keeping him from jumping was Ms L. Dr Ellis advised that the police continue with the negotiation arrangement – he had been threatening to suicide since 4 pm and was still engaging with Ms L. Half an hour later Detective Sergeant Thomas took over from Senior Segeant Sullivan and tried to engage XX – also without success. Both Ms L and the police feared XX was about to jump. By 10 pm he started to ask the police to leave, thanking them for their time and he also asked Ms L to leave. He was told that the police would not go because they wanted him to be safe.

Acting Inspector Biasi consulted with the negotiator team leader and the police rescue team leader and determined that XX's suicide was imminent.

[62] Directed Interview of Sen Con Mark Reynolds (Q.269) (Vol 1 Tab 20 Brief of Evidence)

He was also concerned that fatigue could cause XX to slip; however, it was the urgency of his suicide that he had to deal with. Acting Inspector Biasi made the excruciating decision that the intervention should take place. I agree with Counsel Assisting's submission that Acting Inspector Biasi's decision to intervene was taken in the proper exercise of his functions and with the genuine intention of trying to save XX's life consistent with section 6 of the Police Act 1990.

Senior Constable Reynolds and Senior Constable Pade were put on notice that the intervention was going to occur, however the police negotiators were unaware because circumstances did not allow this communication. XX was leaning into the apartment through the window hugging Ms L. While he maintained that position, Senior Constable Jervis was directed to *"go"* so he very quickly shimmied around the pillar to the ledge where XX was. Whether XX heard him, saw a reflection, or saw a reactive glance of another police officer matters not, but as Senior Constable Jervis was about to grab him, XX turned and yelled out *"fuck off".*

Senior Constable Jervis grabbed hold of him as best as he could, Ms L was pulled out of the way and Senior Constable Reynolds and Senior Constable Pade rushed to the window to help.

They each leaned half out the window and grabbed what part of XX they could. XX was struggling and wriggling his body away from them dropping between Senior Constable Jervis' legs and with his back to the ledge XX deliberately caused the police officers to lose their grasp so that he dropped from the ledge falling to his death and impacting with the car park on level 5.

I agree with Counsel Assisting's submissions that I would conclude that XX's death was an intentional suicide. XX was not coping with the prospect of undergoing trial proceedings with its incumbent risk of conviction and custodial sentence. He was unable to manage his anxiety despite the reassurances put forward by his lawyers, mental health professionals, friends and family. He had previously attempted suicide whilst in prison on remand and whilst on bail. A search of his premises after this event indicated that he had been contemplating another means of ending his life in his car by carbon monoxide poisoning. He had previously gone out on the ledge in circumstances where he was probably contemplating his suicide from it.

XX did not waiver from his refusal to engage with the police or his decision to not come inside the apartment. Finally, he vigorously fought off the police and verbally made it clear that he wanted them to let go of him.

Mr Saidi asked Dr Ellis about the fact that XX struggled with police when they sought to physically restrain him. Dr Ellis agreed that this could indicate an intent to suicide as a person who did not struggle could be feeling relieved that they had been restrained. XX's struggle with police indicated that he was not accepting their help and he had not changed his mind. Dr Ellis agreed that some police negotiations progressed over days rather than hours and there is no suggestion in this case that the police were not prepared to take as long as was required and they indicated such to XX.

Mr Saidi asked Dr Ellis about the drugs and alcohol detected upon post mortem analysis. He agreed that he appeared to have taken a "cocktail" of prescription medication. He said it would be unlikely that he would have been prescribed to take that medication together. He agreed that the medication alone, but particularly taken with alcohol, would impair XX's judgment. Senior Sergeant Sullivan was also asked about XX's sobriety.

Senior Sergeant Sullivan said that when he attended the scene he was advised that police thought XX was affected by alcohol and drugs but he found him to be calm and he did not appear to be effected to any great degree. Senior Constable Sullivan said that XX seemed "compos" when he was talking and he was not slurring his words.

I can think of nothing that the police could have done more to have prevented XX from his suicide.

This was a death in a police operation and accordingly a critical incident was called so the matter was investigated by police located at a separate command. Each of the police directly involved were interviewed and I have read their interviews. Some police were deemed witness officers and I have read their statements.

I do note that some of the interviews were not conducted until some weeks rather than days later but nothing turns on that fact in this case. Now that the Inquest is complete the police involved will have an opportunity, I hope, to debrief together.

It goes without saying that the police involved in this operation have experienced significant trauma and I am sure that the experience of having someone literally slip through their fingertips to their death would be profoundly disturbing. Despite the prospect of being traumatised, the police were prepared to put their own well-being aside to rescue XX.

I have considered whether the police should be spared from attempting such an intervention to avoid this trauma but as Chief Inspector Abel said, rather than being before the Coroner explaining why they acted, the police would still be before the Coroner explaining why they didn't act.

Counsel Assisting has submitted that there are no matters which would attract Coronial recommendations. Mr Saidi urges me to make a recommendation under s82 (2) of the Coroners Act that the NSW Commissioner of Police commend the police involved with this operation, particularly Acting Inspector Biasi and Senior Constable Jervis for their bravery. Mr Saidi submits that too often the police are criticised by Courts and Coroners and this case is one which would alleviate or balance that experience.

Whilst I understand his submission and the sentiments he puts forward I do not think that it would be appropriate for me to make such recommendations under the Coroners legislation. Indeed I know of no contrary recommendation ever being made under that section and it would make for a poor precedent.

However, I suggest that these findings are brought to the attention of the NSW Commissioner of Police as a conveyance of my commendation of the professionalism and valour of the members of the police who were engaged that night, particularly Acting Inspector Biasi and Senior Constable Jervis.

My findings are that XX died on 25 August 2013 of multiple injuries sustained when he deliberately dropped from height having fought off police attempts to physically restrain him from suiciding from a ledge outside a window on 41st level of 27 Park Street Sydney.

XX's brother, X gave a very gracious statement to the Court and I share his commendation of the police and their conduct on the night. I extend the community's gratitude to them and also to Ms L for her role in a highly stressful and traumatic negotiation. I extend my sincere condolences to XX's family and friends and may he rest in peace.

Formal Finding:

XX died on 25 August 2013 of multiple injuries sustained when he deliberately dropped from height having fought off police attempts to physically restrain him from suiciding from a ledge outside a window on 41st level of 27 Park Street Sydney.

24. 265110 of 2013

Inquest into the death of Robert Stewart. Finding handed down by Deputy State Coroner Freund on the 9th September 2014.

Robert Stewart was 86 years old when he passed away on 31 August 2013 whilst serving a period of imprisonment at Long Bay Correctional Centre. He is survived by his three sons Robert Stewart Junior, Leslie Stewart and Maxwell Stewart.

At the time of his death Mr Stewart, was serving a period of imprisonment for three offences of "Sexual Intercourse with person under the age of 10 years". He was sentenced on the 1 September 2010 at the Wollongong District Court. His total sentence period was seven years and nine months. His earliest possible release date was 30 November 2014.

The deceased was received into custody at Metropolitan Remand and Reception Centre on the 1 September 2010. At the time, he was 83 years of age and suffering from multiple systemic chronic health concerns. On 23 September 2010, Mr. Stewart was transferred to the Long Bay Metropolitan Special Programs Centre Health Centre for ongoing management of his health.

The records indicate that between 2010 and 2012 Mr Stewart had several admissions to Prince of Wales Hospital relating to problems that included gout, delirium, sepsis, chronic kidney disease, falls, arthritis and anaemia. Mr Stewart's cognition deteriorated as a result of these admissions and this is recorded in his medical notes.

On 17 July 2012, Mr Stewart was admitted to the Prince of Wales Hospital for Transurethal Resection of Prostate. At this time Mr Stewart had a myocardial infarct and was acutely unwell. A “Not for Resuscitation” order was discussed with his two sons, who consented to a Not for Resuscitation order.

On 16 August 2013 Mr Stewart complained of nausea and chest pain, and had an audible wheeze. He was transferred to the Prince of Wales Hospital and was diagnosed with a small bowel obstruction and a nasogastric tube inserted.

On 26 August 2013, Mr Stewart returned to the Aged Care Rehabilitation Unit at the Long Bay Hospital for palliative care.

On 31 August 2013, at 3:05 a.m., nursing staff conducting ward rounds found that Mr. Anderson had no signs of life. Resuscitation was not attempted as there was a “No Cardiopulmonary Resuscitation” order in place. About 04:57 a.m. Justice Health Doctor Shweta Saraswat issued a life extinct certificate. The cell alarm call system in Mr. Anderson’s cell was tested and found to be working. A coroner’s certificate was issued with the cause of death being “sepsis”, “bowel obstruction”, and “chronic renal failure”.

The role of a Coroner as set out in s. 81 of the Coroners Act 2009 (“**the Act**”) is to make findings as to:

1. **the identity of the deceased;**
2. **the date and place of a person’s death;**
3. **the physical or medical cause of death; and**
4. **the manner of death, in other words, the circumstances surrounding the death.**

As Mr Stewart's death arose whilst he was in custody, this is a mandatory inquest pursuant to s. 23 of the Act. With respect to Mr Stewart's death there is no controversy as to the identity, date, place, cause or manner of his death. The sole issue to determine is whether or not his care and treatment was appropriate in the circumstances.

A thorough examination of his care treatment has been conducted and I am satisfied that it was appropriate in the circumstances.

I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

Formal Finding:

I find that Robert Stewart died on 31 August 2013 at Cell 011 ARU Long Bay Gaol Hospital Malabar of natural causes the cause of his death being Sepsis, Bowel obstruction and chronic renal failure.

25. 275420 of 2013

Inquest into the death of John Anderson. Finding handed down by Deputy State Coroner Freund on 9th September 2014.

John David Anderson was 74 years old when he passed away whilst serving a period of imprisonment at Long Bay Correctional Centre. He is survived by his wife of 35years, Susan, his sons Nathan, Ben and Michael and his daughter Kylie.

Kylie took a few moments at the conclusion of the inquest to tell me a little bit about her father who she described as a loving man who "looked out for his family". It is clear to me that his passing has left an enormous hole in the hearts of all that loved and knew him and that although he made mistakes he was a good man.

At the time of his death Mr Anderson, was serving a period of imprisonment for the offence of Conspiracy to Possess Border Controlled Drug and was detained at the Long Bay Hospital Aged Care Rehabilitation Unit (**ACRU**). His period of imprisonment commenced on the 25th October 2006 and was to expire on 24 October 2024, with an earliest possible release date of 24 October 2017.

The role of a Coroner as set out in s. 81 of the Coroners Act 2009 ("**the Act**") is to make findings as to:

1. the identity of the deceased;
2. the date and place of a person's death;
3. the physical or medical cause of death; and
4. the manner of death, in other words, the circumstances surrounding the death.

As Mr Anderson's death arose whilst he was in custody, this is a mandatory inquest pursuant to s. 23 of the Act. With respect to Mr Anderson's death there is no controversy as to the identity, date, place, cause or manner of his death. The sole issue to determine is whether or not his care and treatment was appropriate in the circumstances.

On 27 October 2006, Mr. Anderson was received into custody at the Metropolitan Remand and Reception Centre at Long Bay Correctional Centre. During the reception screening it was noted that Mr. Anderson suffered from the following medical conditions:

"*hypertension, arthritis, blood borne virus hepatitis C treatment, decreased platelet count, and chronic liver disease*".

Mr Anderson's health gradually deteriorated and on 19 December 2008, he agreed to various referrals to manage his healthcare and on 24 December 2008 Mr Anderson was reviewed by the Clinical Nurse Consultant Population Health and a management plan was instigated to manage his chronic liver disease.

On 19 February 2009, Mr. Anderson agreed to transfer to the ACRU for assessment due to his declining health. Accordingly, on 5 March 2009 he was transferred. Upon admission, his medical concerns were recorded as including "a current history of being hepatitis C positive, ischaemic heart disease, hypertension, anaemia, liver disease, cirrhosis and oesophageal varicies, osteomyelitis, thrombocytopenia, rotator cuff syndrome, benign prostate hypertrophy, multiple skin lesions, and declining memory".

On the 17 July 2009, Mr. Anderson was reviewed by the Hepatologist and his medical conditions included end stage liver disease.

By 10 July 2012, his condition further deteriorated, he had suffered several falls, was incontinent and confused.

On 22 March 2012 a CT scan of his liver revealed multiple new lesions. Operative management was not considered an option. Mr. Anderson's condition was palliative and he was treated as such.

On 11 September 2013 at 2:43 a.m., Mr. Anderson activated his Cell Call Alarm in Cell 14 of B Ward, in the ACRU. First Class Correctional Officer Kumar answered the call and attended Cell 14 with Registered Nurse Twomey. Mr Anderson had soiled his bed. Nurse Prasei attended to assist. During the change and cleaning, Mr. Anderson complained of pain in the back and hip. Nurse Twomey called for an ambulance. Ambulance officers Webber and Martyn attended and transferred Mr. Anderson to their ambulance. They began conveying Mr. Anderson to Prince of Wales Hospital, and en route he ceased respiring and his pulse stopped. As he was not for resuscitation CPR was not commenced. Mr Anderson was pronounced dead by Dr. Mulnar upon arrival at Prince of Wales Hospital.

On review of the medical records, Dr. Sim was satisfied that Mr. Anderson received the appropriate medication and medical attention while located at the Long Bay Correctional Centre Hospital.

The duress alarm used by Mr. Anderson was tested by Corrective Services and found to be working correctly. CCTV from the vicinity of Cell 14 was reviewed for the period between 2 a.m. and 5 a.m. for the 11 September 2013 and nothing adverse was observed.

The coroner's certificate listed the cause of death as end stage liver failure, liver cirrhosis and hepatocellular carcinoma, and chronic hepatitis C infection.

A statement was obtained from Mrs Anderson and she raised a number of issues in relation to Mr Anderson's care and treatment whilst in custody, they were:

1. That the advanced care directives purportedly signed by Mr Anderson were not signed with her knowledge or with her being present and she did not recognize the signatures on those care directives as Mr Anderson's signatures;
2. That he only received limited treatment at Long Bay Correctional Centre Hospital and that he was not permitted to continue his interferon treatment which he started before he was incarcerated;
3. That she was not advised as his next of kin that he had been transferred to hospital so was deprived of the opportunity to spend time with him prior to him passing away.

I will deal with each of these issues in turn.

Were the advanced care directives indicating no life saving measures properly executed?

Mr. Anderson was subject to two 'advanced care directives' that each included a "no CPR" condition. These directives were witnessed by geriatrician Dr. Weikee Sim. The first was purportedly signed by Mr Anderson on 24 May 2012 and witnessed by Dr Sim. The second was purportedly signed by Mr Anderson on 14 April 2013 and witnessed by Dr Sim.

I note that the first advanced care directive signed by Mr Anderson on 24 May 2012 was signed prior to Mrs Anderson being made his guardian as his SNOK.

Moreover, Dr Sim was Mr Anderson's treating geriatrician since 2008. He clearly had a therapeutic relationship with Mr Anderson and an understanding of his end of life wishes. He also indicated in his evidence that he witnessed Mr Anderson sign both advanced care directives.

Accordingly, I am satisfied on the balance of probabilities that the advanced care directives were entered into appropriately by Mr Anderson and that they were valid.

Should Mr Anderson have been allowed to continue or recommence his interferon treatment?

In her statement Mrs Anderson stated as follows:

"*the medical treatment provided by the Long Bay Correctional Centre Hospital was limited and John Anderson was not allowed to continue with treatment that he was undergoing prior to being sentences (sic). This treatment involved a program called interferon. John Anderson was advised after getting results from this program that it did not cure him however he could again undergo the program 18 months later in attempt to cure his condition. When this time expired John Anderson mentioned this to his specialist at Prince Wales Hospital however the treatment was refused*"

An expert opinion was obtained from Dr Jeffery Post, infectious Diseases Physician and VMO who opined as follows:

"*I have reviewed the medical records and the records note that Mr Anderson declined review in the liver clinic when he was reviewed by Dr Mark Yee on 26 July 2007. Mr Anderson was reviewed via teleconference on 13 February 2009 by a colleague of mine, Professor Andrew Lloyd after had been reviewed by a public/ sexual health nurse. At that time Mr Anderson had unexplained breathlessness that needed to be diagnosed before interferon based treatment for hepatitis C virus infection could be contemplated as the ribavirin used as part of the treatment can worsen breathlessness. Further investigation of the breathlessness was commenced. He was subsequently seen in person by Professor Lloyd on 26 March 2009. After investigation of the breathlessness was complete it was clear that Mr Anderson had severe liver disease and further interferon based treatment at that time was not possible*."

Accordingly, I am satisfied on the balance of probabilities that interferon treatment was not simply dismissed out of hand. Investigation was carried out as to Mr Anderson's suitability for such treatment and it was ultimately determined by the appropriate medical experts that it was not the suitable treatment for him at that time.

Should the SNOK have been notified upon Mr Anderson being transferred to hospital prior to his death?

The records indicate that Mr Anderson activated his cell call alarm at 2.43am on 11 September 2013. He was initially attended to by Officer Kumar and RN Twomey and an ambulance was called at 3.07am. Mr Anderson ceased respiration on route to hospital. CPR was not commenced as a result of the advanced care directive previously signed by him. Unfortunately as a result of the rapid decline in his status even if Mrs Anderson had been called she would not been able to spend time with him during his last moments.

Accordingly I am satisfied on the balance of probabilities that there was no time for the senior next of kin to be notified of his declining state. Mr Anderson at the time of his death was in failing health he had a number of complex medical conditions of which he was aware and had made a decision to be treated palliatively in relation to those conditions based on medical advice. A thorough examination of his care treatment has been conducted and I am satisfied that it was appropriate in the circumstances. My condolences his family.

I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

Formal Finding:

I find that John David Anderson died on 11 September 2013 at Prince of Wales Hospital of natural causes the cause of his death being end stage liver failure, liver cirrhosis and hepatocellular carcinoma and chronic hepatitis C infection.

26. 316085 of 2013

Inquest into the death of David Marshall. Finding handed down by Deputy State Coroner Freund 9th September 2014.

David Marshall was 64 years old when he passed away on 18 October 2013 whilst serving a period of imprisonment at Long Bay Correctional Centre. He is survived by his wife Patricia, his daughters Jacinta, Kathryn and Stephanie and son Owen.

The direct cause of his death was “metastatic pancreatic cancer”.

On 2 October 2013, Mr Marshall was admitted to Prince of Wales Hospital for chemotherapy to treat his pancreatic cancer. He had previously been treated with chemotherapy, but during his stay at Prince of Wales Hospital between 2 October 2013 and his discharge on 8 October 2013, a decision was made to discontinue chemotherapy due to the limited benefit given his poor prognosis. He was discharged back to Long Bay Correctional Complex with a plan to treat him palliatively for pain relief and for the Palliative Care Team to continue reviews. An Advanced Care Directive was already in place to manage his pain.

On 18 October 2013, Mr Marshall was located at 09:10 a.m. by nursing staff, not breathing and without a pulse. A “Not for Resuscitation Order” signed by Mr. Marshall was in place, accordingly CPR was not performed. Mr Marshall also suffered a number of other pre-existing medical conditions, including diabetes and ischemic heart disease.

He also received medication for pain relief, included up to 20 mg of Morphine per day. On the day of his death he had received only 2.5 mg of Morphine, administered at 9:00 a.m.

There were no suspicious circumstances identified by medical staff or police. Neither police nor Mr Marshall's family have identified any issues with his care and treatment while at Long Bay Correctional Complex. Clinical notes indicate that his condition throughout mid-October was worsening, with nursing staff making the note, "condition becoming weaker." A coronial certificate as to cause of death was issued. It gives the direct cause of death as being "metastatic pancreatic cancer".

The role of a Coroner as set out in s. 81 of the Coroners Act 2009 ("**the Act**") is to make findings as to:

1. **the identity of the deceased;**
2. **the date and place of a person's death;**
3. **the physical or medical cause of death; and**
4. **the manner of death, in other words, the circumstances surrounding the death.**

As Mr Marshall's death arose whilst he was in custody, this is a mandatory inquest pursuant to s. 23 of the Act. With respect to Mr Marshall's death there is no controversy as to the identity, date, place, cause or manner of his death. The sole issue to determine is whether or not his care and treatment was appropriate in the circumstances. Mr Marshall's illness was terminal, and I am satisfied that appropriate care and treatment appears to have been provided to him prior to his passing. There were no suspicious circumstances identified. I now turn to the findings I am required to make pursuant to section 81 of the Coroners Act 2009.

Formal Finding:

I find that David Marshall died on 18 October 2013 at Long Bay Correctional Centre of natural causes the cause of his death being metastatic pancreatic cancer.

27. 331891 of 2013.

Inquest into the death of Leif James. Finding handed down by Deputy State Coroner Forbes on the 15th April 2014.

The inquest into the death of Leif James was suspended by Deputy State Coroner Forbes in accordance with the Coroners Act 2009 as a known person was charged with an indictable offence in relation to this death.

28. 359900 of 2013.

Inquest into the death of XX. Finding handed down by Deputy State Coroner Dillon on 27 November 2014.

XX was a 69 year-old man when he died on 27 November at the bottom of cliffs near Jacob's Ladder at The Gap, Watsons Bay. XX took his own life during a police operation intended to save him, if possible, from doing so. Unfortunately for XX, for his family, for the police officers who saw this happen in front of them, and for other shocked witnesses, he jumped from the top of the cliff before he could be stopped.

Under the *Coroners Act 2009*, an inquest is mandatory when a death occurs as a result of, or in the course of, a police operation.

In a society in which the rule of law prevails, a police force is not a law unto itself. It is accountable to the society it serves to protect. It has been observed that:

"The 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 the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82." (Waller's Coronial Law & Practice in New South Wales 4th Edition at para [23.7] (page 106)

This inquest is not a quasi-criminal trial of XX or the involved officers. These proceedings are an inquiry into the cause of XX's death and the manner in which the fatal police operation was conducted.

XX's death and the police operation were investigated by Detective Inspector John Maricic under the NSW Police Force Critical Incident Guidelines. The investigation was thoroughly professional and objective.

XX had been charged with serious child pornography offences after police found images on his computer. He was arrested, charged and was released on bail. It seems evident that the humiliation of the experience of being discovered, arrested and charged triggered XX's decision to take his own life.

Despite their best efforts, for which I commend the involved officers, and which I will discuss further below, the police were unable to prevent his death.

The coroner's statutory role

The Coroners Act requires me, if possible, to identify the person whose death is the subject of the inquest, the date and place of death, the cause of death and the manner or circumstances of the death. None of these matters is controversial.

What happened?

On 27 October 2013, XX contacted his solicitor and made an appointment to discuss changing his will. Coincidentally, that appointment was for 27 November 2013.

On about 17 November 2013, following an Australian Federal Police media announcement, reports began to appear about the arrest of several hundred people worldwide (including 65 Australians) as part of a global investigation ("Project Spade") into a child pornography ring operating out of Canada. The operation concentrated on a particular website.

On 25 November 2013, Detective Senior Constable Richard McNally of the NSW Police Force received an AFP referral of an Online Child Exploitation matter in relation to XX. As a result, Detective McNally obtained a search warrant for XX's premises.

On 26 November 2013, XX contacted his sister to enquire about the address of a nephew as he was in the process of updating his Will. They discussed the upcoming Christmas and, according to his sister, he seemed fine.

At 9am on 27 November 2013, a team of police from the Miranda Local Area Command executed a Commonwealth Search warrant on XX's home.

When the police arrived, Det McNally had a conversation with XX in which he admitted downloading videos from the website in question and that he had attempted to clean up the hard drives of his computer to delete the material. Nevertheless, police found a number of images. He was arrested and charged with a number of offences relating to child pornography.

He was released on police bail that evening at about 6pm and took a taxi home. About half an hour later, he left a message on his solicitor's answering machine requesting an appointment and stating that he would call the following morning.

About two hours later, he drove to Watson's Bay from his home in the south of Sydney, leaving his car parked against the Eastern kerb of Old South Head Road, about 400 metres to the south of the area known as "Jacob's Ladder".

The Gap.

The Gap area is Sydney's most infamous suicide spot. It is on the ocean side of South Head. A long cliff line runs from South Head to North Bondi. In recent years, in an attempt to reduce the number of suicides, fences and CCTV cameras have been installed along the tops of the cliffs in Watson's Bay and The Gap Park just to the south.

At 9pm, a CCTV camera detected XX climbing over the fence. At about the same time, Mr Grant Boyle, who lived across the road, noticed him and ran across the road and tried to speak to him.

Just after 9pm, Probationary Constable Geraghty, the station constable at Rose Bay Police Station, received a call from Ashveen Chhabra at Yates Security who was monitoring the CCTV cameras at The Gap Park. Mr Chhabra alerted the police to two incidents at The Gap -- a group of three people who were jumping back and forth over the fence but also to a single man who was near the fence and who subsequently climbed onto the wrong side of the fence.

PC Geraghty immediately notified police radio (VKG). The radio operator then despatched police to the Jacobs Ladder area of The Gap Park, a few hundred metres south of The Gap itself.

Although it appears from the VKG messages that there was some initial confusion about whether the police should go to Jacob's Ladder North or South or both, Leading Senior Constable Andrew Dent, who was the mobile supervisor and was in a car at Bellevue Hill, quickly and correctly intuited that a single man pacing on the wrong side of the fence was in greater jeopardy than a group of three people who were jumping back and forth over the fence. He made XX his priority. He sought further information about the location of the single man and made his way there directly under lights and sirens. He turned off the lights and sirens as he approached The Gap. He was the first police officer to approach XX. When he arrived, he was directed to XX by a bystander.

Before the police arrived, Mr Grant Boyle, who lived across the road, had seen XX and approached him, offering him a cup of tea and a chance to talk. He was still with XX when LSC Dent arrived.

LSC Dent was followed to the scene shortly afterwards by Senior Constable Kylie Kemp and Constable Elena Velkovska. They were coming up behind LSC Dent as he approached XX.

As the three police officers approached, Mr Boyle stepped back. The police got within a few metres of XX, and LSC Dent said, "Hey buddy." XX did not respond and continued peering over the edge. Not sure whether XX had heard him properly, LSC Dent said in a louder voice, "Hi, it's the police".

XX turned to his left, looked at Senior Constable Dent, turned back towards the cliff and dived off the edge.

The next steps

XX's action shocked the police officers and Mr Boyle. Nevertheless, LSC Dent and SC Kemp reacted immediately, notifying VKG and the Duty Officer, Inspector Adam Pearce. Shortly afterwards a Critical Incident was declared by the Regional Commander, and Police Rescue and the Police Air Wing were called in.

The Police Rescue Squad located XX's body about 60 metres below the clifftop. They made an initial attempt to descend to retrieve him but this was found to be too dangerous in the dark due to snags and obstacles. For safety reasons, they postponed the retrieval until morning when the Police Air Wing helicopter was able to assist by winching XX out on a stretcher.

A Critical Incident team under Detective Inspector John Maricic was quickly established on the evening and the involved officers were separated, made notes and were interviewed in accordance with the Critical Incident Guidelines. Det Insp Maricic had previously worked as the Rose Bay Local Area Command Crime Manager and was highly experienced in dealing with incidents at The Gap.

The Critical Incident investigation

One of the key issues for the investigation was whether the involved police had complied with the Rose Bay Local Area Command Guidelines for dealing with incidents at The Gap Park. As we have noted, The Gap is notorious for suicides and suicide attempts. As a result, police serving in that LAC receive additional special training in dealing with incidents at The Gap. The LAC has developed a highly detailed protocol for all police officers attending such incidents.

Apart from training about the special features of The Gap area, including the CCTV cameras, fences, and the specific names of the various locations within The Gap Park, (Gap Bluff, The Gap Proper, The Dunbar Anchor, Jacob's Ladder North and Jacob's Ladder South) they receive training in negotiation.

While most officers are not trained as specialist negotiators, because of the high incidence of suicide attempts in the LAC, all police officers are trained in basic negotiation skills, managing relatives sensitively and protocols for calling other emergency service personnel and resources.

The need for the protocols is evident from LSC Dent's experience at Rose Bay LAC. He had previously attended approximately 190 incidents at The Gap in a 14 month period. About 12 of them involved negotiations with people who were apparently contemplating self-harm. All of those negotiations, up to XX's death, had been successful. Senior Constable Kemp had been to 20 incidents approximately.

Those Standard Operating Procedures are regularly updated, especially as the physical environment and safety features of The Gap park is upgraded or changed. Version 5 of the SOPs was published in 2014 and police officers at the Rose Bay LAC have been trained in the new version.

The Critical Investigation team found that the involved officers had complied in every respect with the Rose Bay Standard Operating Procedures as they stood in 2013. I agree with this assessment.

Conclusions

Before a finding of suicide is made a coroner must be "comfortably satisfied" that this is the most likely way that a person has died.

There can be little doubt that XX committed suicide. A suicide is not always the consequence of depression. In this case, XX was highly respected in his field but was also a very private person. It appears that the humiliation he had already suffered as result of the police action and what would inevitably have followed prompted his decision. For a proud and private man with a hidden secret of which he was evidently ashamed, the indignity of his position was obviously intolerable for him. It is, however, a tragedy that a man whose profession was keeping others alive ended his own life this way.

There was no failure in the way that the police treated XX at the police station at the time he was charged. When he was released on bail, Det McNally and Leading Senior Constable King, the custody manager, both of whom clearly understood how humiliating such an experience can be for people charged with child pornography offences, spoke to XX about his mental state and suggested that he could get psychological help if he needed it. Although XX deflected these inquiries and suggestions, they showed genuine humanity on Det McNally's and LSC King's part. But science has not yet managed to produce a reliable suicide prediction tool much less a means of reading minds.

There was also no failure of the police response at The Gap Park. In fact, the police acted with commendable speed and professionalism to try to save XX's life. He had made up his mind and acted on his decision. There was nothing more they could have done in the circumstances. In submissions, his brother who spoke on behalf of the family suggested that he may even have been waiting for the police so that his death could be witnessed.

Formal Finding:

I find that XX died at Jacob's Ladder, The Gap Park, Watson's Bay in the State of New South Wales on 27 November 2013 due to multiple blunt force injuries he suffered when he fell from height with the intention of taking his own life.

29. 366920 of 2013.

Inquest into the death of Mark Bennett. Finding handed down by Deputy State Coroner Freund 15 August 2014.

Mark David Bennett died on 23 November 2012 after being shot twice by a police officer in Redfern Street, Redfern. He leaves behind his partner, Nina Ihaka, his mother Cristel, and his sons Max and Bradley.

The role of a Coroner as set out in s. 81 of the *Coroners Act 2009* ("**the Act**") is to make findings as to:

1. **the identity of the deceased;**
2. **the date and place of a person's death;**
3. **the physical or medical cause of death; and**
4. **the manner of death, in other words, the circumstances surrounding the death.**

As Mr Bennett's death arose out of a police operation, this is a mandatory inquest pursuant to s. 23 of the Act, and the central issue for this inquest to determine is whether the force used by the police was appropriate in the circumstances. A coroner, pursuant to s.82 of the Act, also has the power to make recommendations, not in an attempt to lay blame but to look forward in an attempt to prevent future similar deaths and the pain and suffering that has been experienced by Mr Bennett's family being experienced by others in the future.

As stated at the start of the inquest there is no controversy in relation to the identity, date, place or direct cause of Mr Bennett's death. The primary issue for this inquest to in relation to the surrounding circumstances and in particular:

1. Was Mr Bennett in an impaired mental state at the time of the shooting?
2. What were the circumstances of the shooting?
3. Were the actions of the police officers namely, Constable Damien Thom and Detective Senior Constable Damien Livermore appropriate in the circumstances?

I shall deal with each of these issues in turn.

Background

Mr Bennett was born on 3 December 1965. His parents separated in 1978. He was known to his family and partner Ms Ihaka as “David”. Ms Ihaka has described David as a much loved partner and father.

On all accounts, Mr Bennett had an unsettled childhood and adolescence. He left school at the age of 15, had a lengthy criminal record that dated back to his adolescent years which involved the commission of serious offences in different jurisdictions. Moreover, Mr Bennett spent the preponderance of his adult life in custody[63].

Mr Bennett had a long-standing drug problem. At the time of his death he was receiving medication for heroin addiction. He was also known to use both methylamphetamine and cannabis. Mr Bennett used both of these drugs close to the time of his death.

The evidence also suggests that Mr Bennett also suffered over the years from mental illness. In the opinion of Dr Olav Nielssen, psychiatrist who reviewed Mr Bennett’s medical records, Mr Bennett had an underlying bipolar mood disorder (or manic depression)[64]. He had a manic episode in late 2010 while he was in custody in Queensland. The episode took three weeks to resolve while Mr Bennett was hospitalised and treated with anti-psychotic medication. Mr Bennett continued to take antipsychotic medication up until the time of his death. Traces of the medication were present in his blood at the time of death[65].

[63] Exhibit 1, Volume 3, Tabs 135-138;
[64] Exhibit 1, Volume 3, Tab 131;
[65] Ibid at pp. 7-8;

About six weeks prior to his death, Mr Bennett commenced staying over at an apartment occupied by Nina Ihaka, Mr. Bennett's long-time partner[66]. The evidence indicates that their child Max did not stay in the apartment when Mr Bennett was sleeping over, as at the time Ms Ihaka had shared custody of Max with a family member[67].

On the night of Thursday 22 November 2012, Mr Bennett was staying at Ms Ihaka's apartment. Mr Gavin Miller was also staying over as a guest. Mr Miller appears to have had a major drug habit at the time.

The evidence concerning Mr Bennett's movements during the night of 22 November 2012 and the morning of 23 November 2012, is incomplete and in certain respects, unclear. Ms Ihaka told police that she believed that Mr Bennett went to sleep at about 1.00 am. This belief does not accord with the banking records, telephone records or CCTV footage in the brief which can be summarised as follows:

> During the early hours of 23 November, from about 2.00 am to about 7.30 am, there were multiple attempts to access funds from Mr Bennett's bank account through the use of an ATM outside a pub in Redfern which was close to Ms Ihaka's apartment. As explained by Detective Sergeant Howe, on the first day of the inquest, $600 was successfully withdrawn from the account at 2.02 am. Thereafter, there were a number of unsuccessful attempts over the ensuing hours to obtain more cash;
>
> Mr Bennett's card was used for the final time at an ATM in Redfern Street at 7.24 am. Investigators were only able to obtain CCTV footage of this final transaction. That CCTV footage depicts Mr Bennett using the ATM and then entering Redfern Railway Station. It is not possible to conclusively determine whether Mr Bennett himself used his ATM card on the earlier occasions however I note that there is other evidence that Mr Miller was out and about in the Redfern area in the early hours of the 23 November 2012;

[66] Exhibit 1, Volume 2, Tab 97, paragraph 12;
[67] Ibid at paragraph 13;

> Mr Miller's SIM card was removed from his phone and placed into Mr Bennett's Nokia handset sometime between 5.19 am and 7.55 am. It appears that Mr Bennett's phone service account was out of credit at this time. It is likely that Mr Bennett put the SIM card into his own phone. The phone (with Mr Miller's SIM card) was found in Mr Bennett's possession at the time of his death;

The ATM transaction and telephone evidence suggests that Mr Bennett was in a confused or disordered state in the hours preceding his death. Assuming that he performed the ATM transactions during the early hours of 23 November, he may have had difficulty inputting the correct PIN number. Later in the morning, he also misdialed at least one telephone number, Ms Ihaka's, on multiple occasions (although, this might reflect the fact that he ordinarily relied on Ms Ihaka's number being saved to his own SIM card.) He repeatedly phoned the number connected to the very SIM card that was in his handset. It appears that he left a number of voice messages on this service. People who spoke to Mr Bennett on this telephone number during the morning of 23 November 2014 described him as being agitated, "out of it", nonsensical and drug affected[68]. Mr Bennett may also have sent a bizarre SMS message to a wrong number threatening loss of a car.

As indicated above, Mr Bennett is seen on CCTV at Redfern Street at 7:24am on 23 November 2012 walking towards Redfern train station. The cell tower locations recorded in the CCRs suggest that Mr Bennett may have travelled (likely by train) from Redfern to the Ashfield area at about 8.00 am. He appears to have travelled back to Redfern at about 11.00 am. It is not known what Mr Bennett did during this period of time, but it is possible that he collected a vacuum cleaner pole and a bike helmet in a shopping bag during this trip. According to Ms Ihaka, he did not leave the apartment with these items.

[68] Exhibit 1, Volume 2, Tab 99 paragraph 8;

Nina Ihaka, in her statement dated 10 January 2013[69] detailed her last moments with Mr Bennett on the morning of 23 November 2012 that when she woke Mr Bennett was already awake and dressed. He had packed a bag with some clothes and said that it was his pay day and he was going to get his medications at Regent House. He did not ultimately leave with the packed bag of clothes. Mr Bennett also said that he had to do something for Gav (Mr Miller) and that he would get the milk and paper. This was the last time that Ms Ihaka saw Mr Bennett alive.

Ms Ihaka described his behaviour that morning as "a bit strange" or "a bit off colour and stressed." He was not making a lot of sense. He told her: "Where I'm going I don't need clothes."[70]

The telephone records[71] indicate that Ms Ihaka rang Mr Miller's number four times between 10.26am and 10.46am. Three of these calls connected. Ms Ihaka recalls that Mr Bennett answered the phone and said that he was coming home and Mr Bennett also told her that he loved her.

Was Mr Bennett in an impaired mental state at the time of the shooting?

It is uncontroversial that Mr Bennett consumed methylamphetamine and cannabis in the hours prior to his death. The post mortem toxicology results record a reading of 0.12 mg/L for methylamphetamine and positive readings for chemicals associated with cannabis[72].

Professor MacDonald Christie, consultant pharmacologist provided a report dated 24 May 2014[73] analysing the significance of the post mortem toxicology results. He opined *inter alia* that:

[69] Exhibit 1, Volume 2, Tab 97;
[70] Ibid at paragraph 32;
[71] Exhibit 1, Volume 4, Tabs 141-144;
[72] Exhibit 1, Volume 1, Tab 5;
[73] Exhibit 1, Volume 3, Tab 133;

1. It is reasonable to conclude that Mr Bennett had most likely consumed a low to moderate dose of methylamphetamine if it was taken less than 12 hours before death, or possibly a large dose if taken much more than 12 hours earlier. Professor Christie also indicates that it possible but not certain that Mr Bennett was intoxicated by methylamphetamine at the time of the incident.
2. In respect of the cannabis results, Professor Christie concludes that it is very likely that the drug was consumed within 1–2 hours prior to death and perhaps less (possibly as little as 30 minutes before). It is very likely that Mr Bennett was intoxicated by cannabis at the time of his death.
3. It is not possible to perform a reliable back-calculation of the amount of methylamphetamine or cannabis consumed in view of the limited information available.

The drugs have different effects. The possible effects of methylamphetamine intoxication include increased energy, self-confidence, risk-taking, erratic behaviour and aggression. While increased violence is also a possible effect, Mr Bennett's reading at the relevant time was likely to be below the range of concentrations known to be associated with violent and irrational behaviour.

Cannabis intoxication can cause a range of effects including anxiety, paranoia, panic reactions, sensory and perceptual distortions, impairment of gross and fine motor skills and reduction in dexterity and reaction times. The degree of impairment is reduced if the user has developed tolerance to the drug. There is evidence that Mr Bennett was a long-time user of cannabis. It is reasonable to assume that he had developed a tolerance to some degree to the drug.

The evidence indicates that $600 was withdrawn from Mr Bennett's bank account at around 2.00 am. This cash was not found on Mr Bennett at the time of his death. It is possible that this money was used by Mr Bennett to fund a drug purchase.

The other possible source of impaired thinking and cognitive functioning is some type of psychiatric episode.

Dr Nielssen provided an expert opinion on this issue and opined that notwithstanding his opinion that Mr Bennett had an underlying bipolar illness, on the evidence available Dr Nielssen could not conclude that Mr Bennett experienced an acute psychiatric episode at the relevant time. Dr Nielssen was of the view that the main factor contributing to Mr Bennett's behaviour and hence to his death would appear to be the behavioural effects of self-induced methylamphetamine intoxication.

It is worth noting that Professor Christie, an expert pharmacologist, has also opined that both cannabis and methylamphetamine intoxication can exacerbate existing psychotic and hypomanic behaviours and this should be considered as a possible contribution to Mr Bennett's behaviour during the incident.

Accordingly it is not possible to determine what caused Mr Bennett to steal the truck and drive it in the manner that he did on 23 November 2012. It is also not possible to say with any degree of certainty that Mr Bennett was in an impaired mental state at the time of the incident, let alone the degree of such impairment. It is possible that his thinking and functioning were adversely affected by either his bipolar mood disorder or drug intoxication or a combination of both.

What were the circumstances of the shooting?

Much of the events as they transpired on that fateful morning, were caught on the numerous CCTV cameras located around Redfern police station and the CCTV footage provides the best evidence of the sequence of events[74].

The events as they unfolded between approximately 11:30 am and 11:39 am on 23 November 2012 can be sequentially summarised as follows:

A. Mr Bennett can be observed on CCTV at Redfern Station at approximately 11:30am. He inserts his ticket into the ticket turnstile and exits the station onto Gibbons Street. From this time, he displayed signs of disordered or confused behaviour.

[74] Exhibit 1, Volume 3, Tab 105;

B. It seems from the footage that he had some difficulty locating his ticket and appears to vacillate and change direction outside the train station. He then crosses Gibbons Street in what appears to be a dangerous manner, seemingly oblivious to the traffic.

C. After crossing Gibbon Street, Mr Bennett then loiters in a shared pedestrian and vehicle zone in Redfern Street. He enters the vestibule area of Club Redfern for a short period but does not enter the club itself. He leaves the Club and returns to the shared pedestrian and vehicle zone. At that time, two workmen were working installing signage on Redfern Street. They were using a white tray top truck. This truck was parked near where they were working on the shared zone. After leaving Club Redfern, Mr Bennett appears to observe the truck for a number of minutes in what appears to be a state of indecision.

D. Mr Bennett then enters the truck and starts to drive it. The keys were in the ignition. He drives down the shared pedestrian and vehicle zone and turns left onto Regent Street.

I note that this act of stealing the truck is somewhat bizarre in the circumstances. The truck did not appear to be a desirable vehicle and the theft occurred right outside Redfern police station.

E. From the time he entered the vehicle, it appears that Mr Bennett had significant difficulty operating and controlling the truck.

The video and witness accounts indicate that Mr Bennett had difficulty putting the truck into gear. This is consistent with witness's observations of bunny-hopping and loud revving of the engine, and the visible bursts of exhaust emission on the CCTV. I note that the evidence is that the truck had no defects at the relevant time[75].

[75] Exhibit 1, Volume 3, Tab 129

F. The workmen immediately notice the theft of their truck and draw it to the attention of police officers in a nearby marked police vehicle, RF450. RF450 then commenced following the truck down the shared pedestrian and vehicle zone and continue to follow the truck as it turns left into Regent Street then left into Lawson Street. The evidence is that the officers in RF450 set off to follow the truck with the intention of causing it to stop. It is probable that from the time they commenced following the vehicle in the shared pedestrian and vehicle zone, the RF 450's warning lights and sirens were activated. There is a controversy in the evidence as to whether RF450 commenced a pursuit. Resolution of this issue is not material to this inquest. It is probable, however, that by the time later police vehicles, RF14 and RF10, commenced following the truck, and those vehicles were in pursuit of the truck.

G. When the truck entered Lawson Street, the lights at the intersection with Gibbons Street were red. There were vehicles waiting at the intersection for the lights to change. Mr Bennett drove into the far lane of Lawson Street and stopped behind the waiting traffic. RF450 pulled up behind the truck and the CCTV clearly shows the truck reversing back into RF450 and causing damage to the car.

It is distinctly possible that Mr Bennett deliberately reversed the truck back into RF450 and Probationary Constable Bradbury (who had alighted from RF450 and was running between the truck and RF450 at the time and narrowly missed being hit by the truck in the ensuing collision), however, this is not certain given the apparent difficulty that Mr Bennett had manipulating the gears of the truck.

H. Thereafter, as the lights changed, Mr Bennett manoeuvred the truck across the three lanes of traffic on Lawson Street. His manner of driving leads me to the conclusion on the balance of probabilities that Mr Bennett was, from at least this point of time, deliberately seeking to evade the police and was not prepared to follow their instructions.

I. Mr Bennett then executed a left-hand turn from Lawson Street into Gibbons Street against the flow of traffic. This was on any account exceptionally dangerous and it was lucky that the traffic in Gibbons St had stopped at the traffic lights near the intersection of Redfern Street. At the time Mr Bennett made the left hand turn there was at least one pedestrian close to or at the intersection with Redfern Street who was in very close proximity to the truck.

J. The collision between the truck and RF450 on Lawson Street was witnessed by officers in two other nearby police vehicles. One vehicle, which was stopped on Lawson Street, was RF14, which was being driven by Leading Senior Constable Damien Livermore. Another police vehicle, which was waiting at the lights on Lawson Street, was RF10, which was being driven by Acting Inspector Atkins. After the collision on Lawson Street, RF450 was disabled and did not follow the truck any further. The truck was however followed from Lawson Street into Gibbons Street by RF14. RF10 also followed behind RF14 from Lawson Street into Gibbons Street. At the time of the turn into Gibbons Street, RF10 had the warning lights and sirens activated.

K. After turning into Gibbons Street, Mr Bennett then immediately turned left back into the shared pedestrian and vehicle zone of Redfern Street. The truck collided with a light pole, causing the pole to fall over and the light to come off the top of the pole at some speed. This light fitting then struck a passing pedestrian, Ms Irina Pavlovskikh, causing her to fall to the ground and causing some injury. After colliding with the pole, the truck came to a stop. I am satisfied on the balance of probabilities that the manner and speed at which the truck drove into the shared zone of Redfern Street was extremely dangerous. It may well be the case that collision with the light pole prevented the truck from colliding directly with a pedestrian at this time. The collision with the light pole itself posed a real danger. Ms Pavlovskikh was clearly fortune in the extreme not to suffer more substantial injuries as a result of this collision;

L. Upon the truck colliding with the pole in Redfern Street, RF14 (driven by Leading Senior Constable Livermore), pulled up alongside and slightly in front of the truck. RF10 pulled up behind RF14.

M. At the time Mr Bennett executed the left hand turn from Lawson Street into Gibbons Street, Constable Damien Thom was coming out of the Redfern Police station having just delivered a pizza to a colleague. He saw the truck travel the wrong way down the one-way-street with a police vehicle following with lights and sirens activated. He followed on foot and approached the truck, shortly after the truck collided with the pole. Constable Thom did not observe the collision with the light pole but heard it and was aware that there were pedestrians in the area. He drew his firearm, and aimed it at the cabin of the truck. This occurred around the time that Leading Senior Constable Livermore was exiting his vehicle. Leading Senior Constable Livermore had not drawn his firearm at this time.

N. The evidence indicates that Leading Senior Constable Livermore had observed Ms Pavlovskikh being hit by the projectile from the light pole and saw her in a prone position in the roadway after she was knocked off her feet. After he had exited the vehicle, Leading Senior Constable Livermore drew his pistol and also pointed it toward the driver of the truck.

O. As they both approached the truck, Leading Senior Constable Livermore and Constable Thom both yelled repeatedly to Mr Bennett to get out of the truck. He refused to do so. This is consistent with Mr Bennett's continuing attitude of non-compliance with police directions. There were moments when Mr Bennett was looking directly at both officers.

P. At this time, the truck was still being driver by Mr Bennett and was shuttling backwards and forwards. This may be because Mr Bennett was continuing to have difficulty with the truck's gears. While the truck may have driven slightly over the light pole, it does not appear that the truck was actually caught on the pole. On one view of the CCTV, the truck was actually

manoeuvred around the pole, which might explain its subsequent change in direction;

Q. Leading Senior Constable Livermore initially approached the truck from a position in front of and to the right of the driver's compartment. As the truck was moving backwards, Leading Senior Constable Livermore stepped towards the front of the truck, pointing his firearm at Mr Bennett. The truck then changed direction to its right and accelerated forward. This put Leading Senior Constable Livermore directly in line with the truck, such that he had to take evasive action to avoid being hit. It appears from the CCTV that Leading Senior Constable Livermore fired the first shot and then moved sharply to his left before firing a second shot. The truck commenced its forward acceleration before the shots were fired.

R. Leading Senior Constable Livermore fired two shots. The first shot was fired through the windscreen of the truck. That bullet struck Mr Bennett in the chest. The second shot entered through the driver's side window and grazed Mr Bennett's right shoulder and entered his neck. .

S. The first shot was fatal. There seems to have been no discernible attempt by the driver to control the vehicle from the time of the first shot. It is reasonable to assume that the first shot incapacitated Mr Bennett. The supplementary autopsy report dated 30 July 2014[76] states that the wound to the chest "was not survivable and would have caused virtually instant death".

T. After the first shot and through the second shot the truck continued to accelerate forward on a trajectory and ultimately collided forcefully with the side of the Railz Hotel.

U. After it collided with the wall of the Railz Hotel, the truck then impacted with a recessed window area further down Redfern St. Another pedestrian, Ms Christine Saltos was in this area at this time. It does not appear to be the case that the relevant police officers were aware of her presence at the time

[76] Exhibit 3.

the shots were fired. She sustained minor injuries from the collision. It is remarkable that she avoided serious injury or even death. There were other pedestrians in Redfern Street at the time, although it is fortunate that the area was less populated than is ordinarily the case.

V. Police then approached the vehicle and attempted to render aid to Mr Bennett. Ambulance officers arrived shortly afterwards and declared Mr Bennett to be deceased.

Where the actions of the police officers appropriate in the circumstances?

Leading Senior Constable Livermore and Constable Thom both gave evidence on the final day of the inquest. I found them to be witnesses of truth and their evidence credible. They both gave evidence in a frank and forthright manner.

The evidence clearly indicates that Leading Senior Constable Livermore moved in front of the truck with firearm raised in the hope that Mr Bennett would obey his directions and get out of the truck. Mr Bennett clearly did not do so.

Leading Senior Constable Livermore gave two reasons for firing at the truck namely:

1. To avoid death or serious injury to himself as a result of being hit by the truck; and
2. To avoid serious injury or loss of life to Ms Pavlovskikh.

In relation to his first justification, namely to avoid death or serious injury to himself, Mr Buchen, Counsel Assisting submitted that there were three potential difficulties with this first justification .

Firstly, Leading Senior Constable Livermore put himself in front of the truck, which thereby contributed to the very risk that he then sought to avoid by discharging his weapon.

The police training videos contained in Exhibit 1, specifically caution against taking this action. However, as Counsel Assisting submitted, Leading Senior Constable Livermore was entitled to take this action, so long as he did so to prevent the truck from endangering other pedestrians in the area. Indeed, as this appears to have been Leading Senior Constable Livermore's intention, placing himself in front of the truck may be considered a very brave act on his part.

The second potential problem with the first justification offered by Leading Senior Constable Livermore is that the risk to his own life could have been avoided by moving out of the path of truck, which is precisely what he did. Although, as Counsel Assisting noted, Leading Senior Constable Livermore's evidence was that before he fired the first shot, he did not know whether he had time to get out of the way of the truck.

The third potential problem with the first justification is that shooting at the driver of the truck was not an effective means of stopping the truck. This was conceded, quite properly, by Leading Senior Constable Livermore in his evidence. Once the truck had gained momentum and, given the very short distances involved, it was highly unlikely that shooting at the driver would bring the truck to a sudden halt. This point is emphatically made in the police training videos.

The second justification provided by Leading Senior Constable Livermore for the discharge of his weapon was that the shots were fired to avoid serious injury or loss of life to Ms Pavlovskikh. Counsel Assisting highlighted two potential difficulties with this justification.

Firstly, that Ms Pavlovskikh was not in the direct path of the truck. However, as noted by Counsel Assisting, it has to be said that given the exigencies of the situation, it was reasonable for Leading Senior Constable Livermore to form the view (which he clearly did form) that there was a real risk that Ms Pavlovskikh could find herself in the line of truck. After he had exited the vehicle, Leading Senior Constable Livermore's attention was drawn to the driver and the truck, not the exact location of Ms Pavlovskikh.

The second potential difficulty is that even if Ms Pavlovskikh were in the line of the truck (or if Leading Senior Constable Livermore believed this to be the case), shooting at Mr Bennett did not provide an effective means of stopping the truck. Indeed, the action may have increased the risks involved due to loss of control of a moving vehicle after its driver had been disabled. The risk to Ms Pavlovskikh's life was only mitigated because another pedestrian removed her from the road.

Acknowledgment must be made that the decision to discharge the firearm resulted in other risks. Firstly, there was a risk that the uncontrolled vehicle would collide with other pedestrians about whom Leading Senior Constable Livermore was unaware. This palpable risk was almost realised in this case. Second, there is always a risk that a bullet will not hit its intended target, particularly when multiple shots are fired at a moving target. Finally and importantly given the subject of the inquest, the decision to discharge the firearm posed an overwhelming risk of serious harm or death to Mr Bennett. This risk was assumed, even though Leading Senior Constable Livermore knew nothing about Mr Bennett at the relevant time other than the knowledge he acquired in the short period during which he pursued Mr Bennett.

Leading Senior Constable Livermore found himself in a very stressful, highly charged and difficult position. He had a very short compass of time to make a most difficult decision. He must have been under significant stress. He did not have opportunity to carefully identify and weigh the relevant risks. He did not have the benefit of hindsight, which comes from watching and analysing the CCTV frame by frame. In my view, and as submitted by Counsel Assisting, the reasonableness of Leading Senior Constable Livermore's actions must be considered in this light.

Leading Senior Constable Livermore had seen the truck driven in an extremely dangerous manner. He acted in a courageous manner by approaching the truck and put his own life at risk by attempting to block its path in an attempt to put himself between it and what he thought was a pedestrian incapacitated further up the road. The driver of the truck showed no intention of stopping; Mr Bennett drove at the police officer. It was not unreasonable for Leading Senior Constable Livermore, in the circumstances as they unfolded before him, to discharge his firearm.

Accordingly, I am satisfied that it was reasonable in the circumstances as they unfolded for Leading Senior Constable Livermore to discharge his firearm twice shooting Mr Bennett in the chest and neck.

In relation to Constable Thom, I note that although he pulled out his firearm he did not discharge it and his actions did not contribute to Mr Bennett's death in anyway. His actions in this regard were justifiable in the circumstances.

Recommendations

The evidence in this inquest serves to demonstrate the significant risks to public safety caused by discharging a firearm at a driver of a moving vehicle, particularly in areas populated by pedestrians.

Counsel Assisting submitted that I should consider making a recommendation pursuant to s. 82 of the Act, namely that the Commissioner of the NSW Police Force give consideration to the development or improvement of mandatory training that places greater emphasis upon:

(1) The fact that discharging a firearm at a driver of a vehicle is not an effective means of stopping the vehicle; and
(2) Discharging a firearm at the driver of a vehicle involves an extreme risk to innocent bystanders as a result of loss of control of the vehicle.

In support of his submission, Counsel Assisting relied on the evidence of both Senior Constable William Watt and Detective Inspector Michael Sheehy who acknowledged the potential benefit of including footage of this incident in an updated police training package. Mr Haverfield, Counsel for NSW Police has indicated that steps are already being taken in this direction.

Counsel Assisting also submitted that I should also give consideration to a recommendation that the Commissioner of the NSW Police Force give consideration to amending the relevant guidelines so as to give effect to the principle that a firearm should only be discharged at a moving vehicle or its driver in truly exceptional circumstances, because of the extreme danger posed by an uncontrolled vehicle.

At present the relevant guideline essentially reiterates the key requirements that apply to discharge of a firearm in any situation. That is, a firearm should not be discharged unless the police officer's life or someone else's life is in real and immediate danger and there is no other means available to avoid the danger.

While the evidence of Senior Constable Watt indicates that it is important that police officers maintain an operational capacity to fire at a moving vehicle in extreme circumstances, the present guideline does not, it is submitted, communicate that this action should only be taken in exceptional circumstances because of the risks involved.

The 2009 training video[77] incorporated a production prepared by the Victorian Police. This indicates (at least at the time of production) that in Victoria police are instructed to only shoot at a moving vehicle in "exceptional circumstances".

I have considered the submissions made by Counsel Assisting and stop short of making such recommendations pursuant to s. 82 of the Act. I note the comments made by Mr Haverfield for and on behalf of NSW Police that steps are underway to incorporate the footage of this incident into training packages for NSW Police about the real dangers of firing or discharging a firearm at a moving vehicle.

In relation to any amendments to the current guidelines I am of the view that for a member of the police force to discharge their firearm they must do so only in very specific situations namely when their life or someone else's life is in real and immediate danger and there is no other means available to avoid that danger.

[77] Exhibit 1, Volume 4, Tab 134;

Adding an additional protocol of ‘‘exceptional circumstances’’ in relation to moving vehicles could, in my view, confuse those who are at the coal face and having to make quick decisions in very stressful situations. In my view training is the best way to prepare for such circumstances and to that end the addition of the CCTV footage from this inquest is a clear and real example of what can happen.

Accordingly, I now turn to the findings I am required to make pursuant to s. 81 of the *Coroners Act 2009*:

Formal Finding:

Mark David Bennett died at Redfern in the State of NSW around 11.37 am on 23 November 2012 as a result of a gunshot wound to his chest inflicted by a NSW police officer. Such act was lawful and was in the exercise of his duties.

30. 189899 of 2013

Inquest into the death of Ahmad Ali Jaferi. Finding handed down by Deputy State Coroner Dillon on the 19th December 2014.

This inquest concerns the death of Ahmad Ali Jafari, an Afghani citizen, who died on 20 June 2013 at Liverpool Hospital, Sydney, due to heart disease. Mr Jafari was then 26 years of age. He had been detained at Villawood Immigration Detention Centre since 20 July 2012 under s 189 of the *Migration Act 1958 (Cth)* as an "unlawful non-citizen".

Mr Jafari was a member of the Hazara minority who have been severely persecuted by the Taliban in Afghanistan. According to accounts investigators have been able to put together, his father was killed by the Taliban when he was 10 years old. The survivors of his family then fled to Quetta in Pakistan. As the Taliban influence in Pakistan gathered strength, the Hazaras were subjected to further persecution, including kidnappings and frequent bombings. In 2009, Mr Jafari sought asylum in the United Kingdom but was refused refugee status and was deported to Afghanistan. He escaped and returned to Quetta where most of his family still lived.

In 2010, he left Quetta again and made his way to Australia, arriving by boat and being detained initially on Christmas Island. In 2012, he was released to community detention while awaiting a security clearance. A few months later, however, he was taken back into custody with the explanation that the Department of Immigration and Border Protection had been informed by British authorities that he had been convicted of a criminal offence in the United Kingdom. According to Mr Jafari this information was untrue.

Subsequent investigation cleared Mr Jafari of having committed any crime whilst in the United Kingdom, and revealed that the crime identified had in fact been committed by a person with a similar name, but with a different birth date.

Following finger print matching and a determination that Mr Jafari did not commit the crime, Mr Jafari requested a return to community detention. Unfortunately, this issue had not been resolved at the time of his death.

Mr Jafari was engaged to a young woman whom I shall only identify as Fatima. From the account given on behalf of the Jafari family by their lawyer Ms Jarvis I have learned that he was much-loved and very family oriented. He was a hardworking young man who, it seems, had sought refuge in the United Kingdom and Australia in the hope of a better life for his whole family. He was described as "the backbone of the family" who had struggled to fill the gap left by the murder of his father when he was young.

He was also much-loved by many others in Australia. A number of fellow detainees and refugee advocates came to know him well and admired and respected him. They were very distressed by his sudden and much unexpected death.

I was informed by the family's lawyer, Ms Jarvis, that, as a result of his failures to persuade British and Australian authorities of his and his family's genuine fears and their need for protection as refugees, he had lost his faith in God and had become deeply depressed. She also said that his death had extinguished the family's hopes of every escaping their fearsome and violent environment to the safety of Australia.

The coroner's function

A coroner's primary function is provided for by s. 81 of the Coroners Act. It is to make findings as to:

The identity of the deceased person

The date and place of the person's death

The manner and cause of the person's death.

In a society in which the rule of law prevails, law enforcement agencies and organisations, including those responsible for the detention of persons lawfully deprived of their liberty, are not laws unto themselves.

They owe a duty of care to those over whom they exercise control and custody and are accountable for their conduct to the society they serve to protect.

The Coroners Act requires that an inquest be conducted by the State Coroner or a Deputy State Coroner into any death in custody that occurs within this jurisdiction. The purposes of such an inquest are to fully examine the circumstances of any death occurring in a Department of Immigration detention facility in New South Wales so that the public, the relatives, the friends and the Minister and government responsible for that facility can be apprised of the circumstances by virtue of an independent, objective judicial inquiry.

In many cases there will be no grounds for criticism, but in all cases the conduct of involved staff and organisation will be closely considered, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to the Act.

This inquest, therefore, is not a quasi-criminal trial of Mr Jafari or the involved staff at the detention centre. It is an inquiry into the cause and circumstances of Mr Jafari's death and whether the organisation running the detention centre, or its staff, contributed in any material way to his death.

What happened: the background facts?

On arrival in Australia in January 2010 on Christmas Island, Mr Jafari was reported as having no obvious health issues that would require specific management[78].

During his time in Villawood however, the records indicate that Mr Jafari was suffering from depression and anxiety, and also possibly post-traumatic stress disorder. It does not appear however, that Mr Jafari or staff had any knowledge of any other health significant conditions.

On an Individual Management Plan completed by staff in May 2013, it was recorded that "Mr Jafari states that he is currently in good health"[79]. The only medication Mr Jafari was routinely taking appears to be that related to his depression[80].

[78] Vol 2, Tab 67.
[79] Vol 1, Tab 45, page 3.
[80] Vol 1, Tabs 48, 65.

More specifically, the medical and other records indicate that Mr Jafari was not aware of any heart condition. The medical records indicate that on occasion Mr Jafari suffered from elevated blood pressure but further noted that his blood pressure was predominantly in the normal range[81]. In none of the records, from Serco, International Health and Medical Services, or those available from Christmas Island, is there any indication of the existence of a heart condition.

On the day of Mr Jafari's death he was told he that was going to share a room with someone he did not know, and that he had become quite upset and angry about this. He later went to the gym, where he worked out on a weights machine. At some point he stopped working out and when asked why, stated that he had a sore chest. Mr Jafari was then advised by one of the Serco staff in attendance to go to the medical centre if he needed treatment. Mr Jafari, however, may have continued to train on the exercise machine but, in any case, presumably because he did not recognise the significance of his symptoms, did not seek help at the medical centre.

At approximately 6.00pm Mr Jafari returned to his room in the Hughes compound after working out. At about 6.19pm, Mr Jafari telephoned Bashir Ahmed, who was his roommate. He reportedly "sounded like he was feeling scared" and requested that Mr Ahmed go to his room.

Mr Ahmed walked to the room, arriving about a minute after the phone call. He found Mr Jafari lying on the floor with his hands out. Mr Jafari stated that he was suffering chest pain.

Mr Ahmed then informed two Serco staff members who were close by of these events, who in turn radioed for assistance: assistance which included requests for nurses and an ambulance.

Mr Ayman Sryta, a Client Services Officer for Serco, attended on Mr Jafari almost immediately after being approached by Mr Ahmed. He called a 'code blue' emergency at about 6.21pm, 'code blue' meaning medical emergency. Within about 30 seconds of the code blue being called, five or six officers had rushed to the room, with two nurses arriving less than a minute later.

[81] Vol 2, Tab 65.

The ambulance Incident Report indicates that the emergency call was received at 6.30pm, a unit being assigned at 6.32pm, which arrived on the scene at 6.37pm. The ambulance personnel arrived at Mr Jafari's location at 6.45pm; loaded him into the ambulance at 6.59pm; and arrived at Liverpool Hospital at 7.39pm. Mr Jafari was conscious but in considerable pain when the ambulance officers initially attended him.

Once loaded onto the ambulance, Mr Jafari went into cardiac arrest, and so additional assistance was requested and departure delayed in order to respond to the arrest. The additional ambulance personnel arrived on the scene at 7.17pm, and shortly thereafter, the ambulance conveyed Mr Jafari to Liverpool Hospital. Mr Jafari was still in cardiac arrest at the time of arrival. Additional attempts at resuscitation were unsuccessful and Mr Jafari was pronounced deceased at 7.56pm.

On 24 June 2013, Dr Isabella Brouwer, a forensic pathologist, conducted an autopsy examination of Mr Jafari. She diagnosed the cause of death as "presumed fatal cardiac dysrhythmia following acute myocardial ischaemia", with the antecedent causes being described as "coronary artery atherosclerotic disease with acute plaque changes". Of particular note is that Mr Jafari was observed to have a "critical narrowing of the left anterior descending coronary artery with possible acute plaque haemorrhage and plaque thrombus"

Issues

To investigate the statutory issues (identity, date, place, cause and manner of death) this inquest has sought to resolve a number of questions:

What was the physiological cause of death?

Before his death, was there clinical or other medical evidence disclosing or indicating that Mr Jafari suffered from coronary artery disease?

Was there a test or series of tests that could have identified Mr Jafari's heart disease in life?

If so, were there indications that Mr Jafari should be tested?

Absent specific indications of coronary artery disease, would it be appropriate to include such a test in the battery of general screening tests for immigration detainees?

Was the response to Mr Jafari's condition reasonable and timely?

Is there a need for recommendations?

What was the physiological cause of Mr Jafari's death?

The medical evidence both from the autopsy that was conducted after Mr Jafari's death and from Associate Professor Mark Adams, an independent expert cardiologist, clearly indicates that the cause of death was fatal cardiac arrhythmia due to a myocardial infarction (or heart attack). As explained by Professor Adams, a heart attack occurs when a coronary artery suddenly becomes blocked. This causes the electrical activity of the heart muscle to change, thus altering the heart rhythm. If the heart goes into ventricular fibrillation, as was the case here, the heart rhythm is completely disorganised. In effect, the heart begins to flutter ineffectually rather than operate as a circulatory pump. In some cases, even the application of defibrillation is unable to restore the heart's proper rhythm.

The blockage in Mr Jafari's heart was almost certainly caused by a thrombus or clot which had formed at the point at which a coronary artery plaque had ruptured suddenly. A plaque consists of fibrous tissue that contains a core of cholesterol. Plaques form without symptoms. If they rupture, however, the cholesterol core is exposed. The cholesterol core is highly thrombogenic – that is, it is highly likely to cause a clot in the artery.

Professor Adams explained that the process by which a plaque ruptures is not well understood but that acute physical exertion can trigger the sudden rupture without warning or indication. This is especially so if a person undertakes exercise significantly more strenuous than normal or does little exercise.

Professor Adams also noted that there is an association between depression, anxiety, and stress, and coronary artery disease. Nevertheless, the nature of that association is impossible to quantify and the causal connection, if there is any, is unable to be identified with any specificity.

Unfortunately for Mr Jafari, not only was there no history indicative of heart disease, and no clinical signs before he suffered chest pains in the gym on 20 June 2012, but when his heart became arrhythmic he suffered refractory ventricular fibrillation. In other words, the arrhythmia of his heart was unable to be reversed by the paramedics who applied defibrillation a number of times in the ambulance. This meant that his heart stopped operating as a pump but "fluttered" until it ceased to beat altogether.

Mr Jafari suffered depression for which he was being treated. Nevertheless, it appears that he remained depressed. Indeed, according to his room-mate, one of the reasons he exercised regularly was to tire himself out so that he would sleep better.

Professor Adams gave evidence that, even when all other factors are taken into account, depression reduces life expectancy and increases the risk of death due to heart disease. Just how that effect comes about is not well-understood. Nevertheless, in his view, it is unlikely that depression was a major risk factor in this case and it certainly could not be said that the heart attack Mr Jafari suffered was a direct result of his depression.

Before his death, was there clinical or other medical evidence disclosing or indicating that Mr Jafari suffered from coronary artery disease?

There was no clinical evidence of coronary artery disease before Mr Jafari's incident in the gym. While coronary artery disease is known to occur in young men, it is rarely obvious, especially in people who are apparently healthy, have a reasonable Body Mass Index as Mr Jafari had, and who do not take physical exercise.

Mr Jafari was a non-smoker, had a normal blood sugar level, and normal blood pressure. Unless he had had known history of heart disease or there was a known family history of congenital coronary artery disease, he would have been categorised as being at very low risk of a heart attack.

Was there a test or series of tests that could have identified Mr Jafari's heart disease in life?

Professor Adams's evidence was telling on this point. In his report he stated that "there is no real way to identify unstable plaques clinically and no real data from clinical trials to guide treatment if they were discovered."

He explained that the only definite way of investigating suspected plaques in Mr Jafari's coronary arteries would have been to conduct a highly invasive procedure involving the use of intravascular ultrasound or optical coherence tomography. These techniques carry significant risk (for example, a blood vessel can be ruptured), are costly and are certainly not indicated for routine screening of possible coronary disease in young men.

Less invasive techniques such as stress tests, stress echo tests, and nuclear scans, in Professor Adams's opinion, would probably not have detected the unstable plaque.

Imaging technologies such as coronary angiography and CT coronary angiography may not have detected the abnormality because they do not show the anatomy of the coronary artery wall in detail. The plaque was probably not obviously obstructive or obviously unstable. In any event, coronary angiography is also invasive and therefore carries some risk. It is not used without good cause and is not a routine screening tool.

If so, were there indications that Mr Jafari should be tested?

For the reasons given, there were no indications that Mr Jafari should be tested.

Absent specific indications of coronary artery disease, would it be appropriate to include such a test in the battery of general screening tests for immigration detainees?

If, as Professor Adams has explained, the only definitive tests available for the detection of unstable coronary plaques are intravascular ultrasound or optical coherence tomography, the answer to this question is clearly no.

Was the response to Mr Jafari's condition reasonable and timely?

One of the troubling aspects of this case is that media organisations reported claims that the response to Mr Jafari's cardiac event had been very slow and, in particular, that Serco staff had taken over an hour to call an ambulance.

On 21 June 2013, for example, the ABC Radio's PM program reported "disturbing claims" that it had taken over an hour for staff at the detention centre to call an ambulance for Mr Jafari. It quoted a claim by a detainee that Mr Jafari had begun to experience pain at about 6pm but that it was not until about 7.30pm that an ambulance arrived.

As the detention centre and ambulance records demonstrate, that claim was incorrect.

It seems that Mr Jafari had regular, perhaps daily, workouts. Mr Jafari was seen in the detention centre gym at about 5pm or shortly afterwards by a Serco staff member. There is some inconsistency in the detail of the accounts given by that officer, Mr Cenghis Khan. It is undisputed, however, that Mr Jafari was seen by Mr Khan to suffer chest pain, was advised to go to the medical centre if he needed medical assistance and did not do so.

On the first account, Mr Khan stated that he had seen Mr Jafari collapse holding his chest. He said that Mr Jafari had been helped up by other detainees and that he had told him to go straight to the medical centre. He said that Mr Jafari had left to go to the medical centre with a friend. He also said that about 10 minutes later a Code Blue had been called and that he had responded. This account was given on the night of Mr Jafari's death after his return from the hospital to the detention centre.

In his second and third accounts – statements made to Serco and the police investigators – he gave an account of seeing Mr Jafari bending over apparently in pain and complaining, through a friend who was interpreting, of chest pain.

According to Mr Khan, when he asked whether Mr Jafari was “ok” he nodded. Mr Khan said that he had then told Mr Jafari’s friend to take him to the medical centre if he “had an issue”. He said that Mr Jafari had indicated that he would do so but had continued his workout. In these accounts he noted that he had seen Mr Jafari in the gym at about 5.10pm and that the Code Blue to which he had responded had been called at about 6.20pm.

In retrospect it seems probable that the chest pain Mr Jafari was suffering at about 5.10pm was the beginning of the cardiac event that ultimately ended his life about two hours later. However, as Professor Adams explained, chest pains are not necessarily indicative of cardiac problems, especially in gyms when young men are exercising. In such situations it is much more common for chest pains to be caused by musculo-skeletal strains or injuries, or a range of other possible causes, such as gastrointestinal disturbances or radiculopathy in the chest wall, than heart disease.

Mr Khan’s first version was given shortly after Mr Jafari had died. Mr Khan had been involved in the incident virtually from the outset. Probably due to the urgency of the situation and the inevitable fragmenting of observations and memory under pressure Mr Khan made errors in recounting what had happened. For example, he recorded that the Code Blue had been called only 10 minutes after he left Mr Jafari at the gym. The detention centre records make clear that it must have been more than an hour later. His later accounts were given in calmer, more reflective circumstances. There may be inaccuracies in both accounts.

On both versions, Mr Jafari indicated to Mr Khan that he did not need help and was given advice to attend the medical centre. On both versions, Mr Jafari was conscious, breathing, responsive and mobile.

It is, however, unnecessary to determine which of Mr Khan’s accounts is the more reliable because in neither case was a Code Blue indicated. Mr Jafari was capable at that stage of getting himself – perhaps with the assistance of his friend -- to the medical centre. In fact he returned to his room where, about an hour later, he called his room-mate for help. It was not obvious to Mr Khan that Mr Jafari needed help and Mr Jafari had indicated that he did not. In my view, there is no criticism to be made of Mr Khan for not calling a Code Blue at the gym.

Once the Code Blue was called, due to Mr Jafari's room-mate raising the alarm, it seems that the response of Serco staff was rapid and appropriate. In particular, security staff and nurses responded immediately to the Code Blue and Mr Cameron Stuart, the Operations Manager for the shift, called an ambulance while this was happening.

The nurses took a "responder bag" or "Thomas pack" containing basic life-saving equipment for emergency use pending the arrival of a fully-equipped ambulance. While a defibrillator was not included in this emergency kit, in this case it would not have been used because Mr Jafari was not in ventricular fibrillation at the time the nurses responded. He was breathing and his heart rate, while fast, was in normal rhythm at that point. The nurses carried out all appropriate procedures during the period until the ambulance officers arrived. These included taking observations of his state of consciousness, his pulse rate, blood pressure, blood perfusion and capillary return (i.e., tests of circulation). There were no signs of cyanosis (turning "blue"). As he was well-perfused, able to breathe, and was in great distress rolling around, oxygen was not administered. This was appropriate in the circumstances.

Professor Adams gave evidence that, in his view, everything had been done as it should have been.

The Code Blue was broadcast by the detention centre control room at 6.21pm. The ambulance was called at 6.30pm and arrived at the detention centre from Fairfield seven minutes later. It then took some minutes to enter the compound due to security arrangements involving a number of gates. The paramedics arrived at Mr Jafari's room at about 6.45pm. On arrival the ambulance paramedics found Mr Jafari fully conscious but in considerable pain. They prepared him for transport to hospital. Unfortunately, once he had been loaded into the ambulance, Mr Jafari's heart went in to irreversible ventricular fibrillation.

Professor Adams gave evidence that once the plaque had ruptured in Mr Jafari's coronary artery wall it was unlikely that anything could have been done to save his life. This is because, unknown to anyone, once that happened, the process would inevitably lead to ventricular fibrillation which paramedics and doctors would be unable to remedy.

Evidence was given by Mr Cassar, an intensive care paramedic who had attended Mr Jafari in a second ambulance, that – despite it being against general practice – he had used the defibrillator on Mr Jafari in the moving ambulance on the way to hospital in an attempt to save his life.

In my view, the responses to Mr Jafari's predicament by Serco staff and NSW Ambulance officers were, contrary to some claims of some detainees aired by the media, timely, appropriate and professional.

Is there a need for recommendations?

I have considered making recommendations but do not think it necessary to do so. Although the emergency kit used by the nurses in June 2013 did not include a defibrillator, there are defibrillators distributed throughout the detention centre for emergency use. And the medical centre now has an additional defibrillator that can be utilised by the nurses when attending Code Blue incidents.

Secondly, I considered recommending an amendment to the IHMS protocols concerning the application of oxygen in cases such as this. Evidence was given by Professor Adams that there has been advice recently given by NSW Health that oxygen should not be given in cases of suspected heart attacks. As I understand it, this is because of concerns that pure oxygen can cause constriction of blood vessels. Professor Adams, however, noted both that oxygen had not be administered to Mr Jafari and that, because he was a relatively fit young man who was breathing air until he went into cardiac arrest, oxygen would have made only a marginal difference one way or the other if he had received it.

Counsel for IHMS informed me that the emergency response protocols are reviewed annually early in every New Year and said that IHMS would review this aspect of the protocol in light of Professor Adams's evidence. It would be superfluous to make a recommendation in that case.

Conclusions

Because we do not have a very good understanding of Mr Jafari's family medical history, it is difficult to understand how a young man of 26 became so vulnerable to coronary artery disease. As it is so rare for someone as young as this to die suddenly of a heart attack, it seems likely that there was at least some genetic factor at work.

If that is so, and the family in Pakistan have the resources to do so, it would be advisable for them to consult a cardiologist as a cautionary measure as other members of the family may have the same disposition to premature coronary artery disease.

While it would be inappropriate for me to comment on the highly controversial and complex political issues involved in dealing with Mr Jafari's claims for refugee status, recent events in Afghanistan and Pakistan demonstrate that life is far more dangerous for many people in those countries than most Australians can imagine. Whether or not he should have been accorded refugee status, it is tragic that decent, innocent human beings are subjected to the terrors that life in Pakistan brings upon them so regularly. And it is sad indeed that a family living in such an environment has lost a much-loved member and that his fiancée has lost the young man she loves and had hoped to marry.

I hope that Fatima and all members of the Jafari family and his many friends, including those who got to know him in detention and the refugee advocates who supported him, will accept my sincere and respectful condolences for the loss of Ahmad.

Formal Finding:

I find that Ahmad Ali Jafari died on 20 June 2013 at Liverpool Hospital as result of a fatal cardiac dysrhythmia due to acute myocardial ischaemia as a result of coronary artery atherosclerotic disease with acute plaque changes. Those plaque changes probably occurred during or following a period of strenuous exercise he was undertaking in the gymnasium of the Villawood Immigration Detention Centre earlier the same day.

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2014.

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	1074/11	15/05/11	Berkshire Park	23	In Custody
2	71675/12	02/03/12	Tamworth	40	Police Op
3	192526/12	19/06/12	Randwick	27	In Custody
4	247660/12	08/08/12	Cessnock	60	In Custody
5	273783/12	01/09/12	Silverwater	49	In Custody
6	83234/12	14/03/12	West Ryde	33	Police Op
7	20175/13	21/01/13	Silverwater	30	In Custody
8	52657/13	18/02/13	Muswellbrook	16	Police Op
9	59259/13	24/02/13	Penrith	41	In Custody
10	98426/13	31/03/13	Silverwater	42	In Custody
11	98427/13	31/03/13	Silverwater	55	In Custody
12	114526/13	14/04/13	Cessnock	32	In Custody
13	123760/13	20/04/13	Villawood	33	Police Op
14	153360/13	17/05/13	Randwick	19	In Custody
15	159048/13	22/05/13	Randwick	42	In Custody
16	162787/13	24/05/13	Junee	49	In Custody
17	177495/13	08/06/13	Malabar	37	In Custody
18	200685/13	01/07/13	Liverpool	21	Police Op
19	203515/13	03/07/13	Nerong	43	Police Op
20	222036/13	20/07/13	Marrickville	36	Police Op
21	246399/13	13/08/13	Kogarah	18	Police Op
22	265085/13	30/08/13	Goulburn	34	In Custody
23	267697/13	03/09/13	Silverwater	38	In Custody
24	286184/13	20/09/13	Coffs Harbour	37	Police Op
25	304282/13	09/10/13	Liverpool	14	Police Op
26	354840/13	24/11/13	Westmead	33	In Custody
27	365275/13	03/12/13	Malabar	60	In Custody
28	387501/13	23/12/13	Moree	23	Police Op
29	389043/13	28/12/13	Randwick	21	Police Op
30	22127/14	22/01/14	Maroubra	31	Police Op
31	38053/14	05/02/14	Gosford	38	Police Op
32	59894/14	25/02/14	Parklea	42	In Custody
33	83267/14	18/03/14	Randwick	43	In Custody
34	88509/14	23/03/14	Wagga Wagga	30	Police Op
35	161167/14	28/05/14	Cessnock	41	In Custody
36	166723/14	03/06/14	Silverwater	67	In Custody
37	174768/14	11/06/14	Rose Bay	58	Police Op

No	File No.	Date of Death	Place of Death	Age	Circumstances
38	192992/14	27/06/14	Berkeley	25	Police Op
39	214164/14	19/07/14	Randwick	80	In Custody
40	221203/14	26/07/14	Randwick	48	In Custody
41	6226574/14	31/07/14	Shellharbour	47	In Custody
42	229687/14	04/08/14	Malabar	61	In Custody
43	239934/14	14/08/14	Malabar	67	In Custody
44	253769/14	28/08/14	North Ryde	73	In Custody
45	256344/14	31/08/14	Tumut	72	Police Op
46	261690/14	04/09/14	Ryde	54	Police Op
47	286081/14	29/09/14	Baulkham Hills	60	Police Op
48	307093/14	18/10/14	Silverwater	56	In Custody
49	309325/14	21/10/14	Morisset	49	In Custody
50	315543/14	25/10/14	Malabar	60	In Custody
51	341985/14	19/11/14	Macksville	63	Police Op
52	343092/14	20/11/14	Hurstville	18	Police Op
53	368701/14	16/12/14	Sydney	34	Police Op
54	368881/14	16/12/14	Sydney	38	Police Op
55	369898/14	16/12/14	Sydney	50	Police Op
56	379966/14	26/12/14	Cessnock	68	In Custody