

# **REPORT BY THE NSW STATE CORONER**

**into deaths in custody/  
police operations**

**2006**

**(Coroner's Act 1980, Section 13A.)**

State Coroner's Office  
NSW Attorney General's Department

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The Honourable Robert John Debus  
Attorney General of New South Wales  
Level 20, Goodsell Building  
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**SYDNEY NSW 2000**

16 February 2007

Dear Attorney,

Pursuant to *Section 12A(4), Coroners Act 1980*, I respectfully submit to you a summary of all *Section 13A* deaths reported to the State Coroner or a Deputy State Coroner during 2006.

*Section 13A* provides:

- (1) ***A coroner who is the State Coroner or a Deputy State Coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died or that there is reasonable cause to suspect that the person has died:***
  - (a) *While in the custody of a police officer or in other lawful custody, or while escaping or attempting to escape from the custody of a police officer or other lawful custody, or*
  - (b) *as a result of or in the course of police operations, or*
  - (c) *while in, or temporarily absent from, a detention centre within the meaning of the Children (Detention Centres Act 1987, a correctional centre within the meaning of the Crimes (Administration of Sentences) Act 1999 or a lock-up, and of which the person was an inmate, or*
  - (d) *while proceeding to an institution referred to in paragraph ©, for the purpose of being admitted as an inmate of the institution and while in the company of a police officer or other official charged with the person's care or custody.*
- (2) ***If jurisdiction to hold an inquest arises under both this section and section 13, an inquest is not to be held except by the State Coroner or a Deputy State Coroner.***

Inquests into these deaths are mandatory and can only be heard by the State Coroner or a Deputy State Coroner.

These deaths of persons in the custody of the NSW Police, Department of Corrective Services, the Department of Juvenile Justice and the Federal Department of Immigration. Persons on home detention and on day leave from prison or a juvenile justice institution are subject to the same legislation.

Deaths during the course of a 'Police Operation' can include shootings by police officers, shootings of police officers, suicide and other unnatural deaths.

Deaths occasioned during the course of a police pursuit are always of concern to the State Coroner and, like deaths in the latter categories, these critical incidents are thoroughly investigated by independent police officers from an independent Local Area Command.

Some fatal shootings are investigated by experienced officers of the NSW Police Homicide Squad in accordance with the Critical Incident Guidelines, the established protocols between NSW Police and the State Coroner.

**32** *Section 13A* deaths were reported in 2006.

**29** matters were completed by way of inquest. In many inquests constructive and far-reaching Recommendations were made pursuant to *Section 22A, Coroners Act 1980*.

**51** cases await inquest. Many are still in the investigation stage.

In 2007 the State Coroner will revise the system of dealing with *Section 13A* deaths particularly in the area of inquests. Presently there are more deaths reported per annum than we deal with by way of inquest during the same period. We would be constantly in arrears if this trend continues. All outstanding *Section 13A* deaths will be reviewed and prioritized to ensure a more timely approach to these significant and important matters.

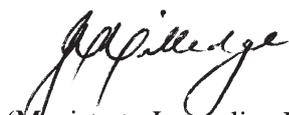
The number of deaths reported under *Section 13A* is marginally higher than those reported in 2005. This should not be considered a trend as the number of custodial deaths has fallen dramatically since 1997 when 56 deaths were reported.

The thoughtful work of the senior coroners and the bona fide implementation of coronial recommendations for change by agencies such as NSW Police, Corrective Services and Justice Health is one important reason for the reduction.

This report includes the last synopsis of retiring State Coroner, His Honor John Abernethy. He and his Deputies have played an important role in reducing the incidents of deaths in custody and those during the course of police operations.

I respectfully submit for your consideration the State Coroner's Report, 2006.

Yours sincerely,



(Magistrate Jacqueline M Milledge)  
**A/State Coroner NSW**

## **STATUTORY APPOINTMENTS**

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

### **MAGISTRATE JOHN ABERNETHY (Retired 9 February 2007) New South Wales State Coroner**

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

### **MAGISTRATE JACQUELINE MILLEDGE (A/State Coroner) Senior Deputy State Coroner**

- 1996      Admitted as a Legal Practitioner of the Supreme Court of New South Wales.
- 1996      Appointed a Magistrate for the State of New South Wales under the Local Courts Act 1982 and Coroner.
- 2000      Appointed Deputy State Coroner.
- 2001      Appointed Senior Deputy State Coroner.

**MAGISTRATE CARL MILOVANOVICH**  
**Deputy State Coroner**

- 1968     Joined the Department of the Attorney General (Petty Sessions Branch)
- 1976     Appointed a Coroner for the State of New South Wales.
- 1984     Admitted as a Solicitor of the Supreme Court of NSW
- 1990     Appointed a Magistrate for the State of New South under the Local Courts Act 1982.
- 2002     Appointed as a Deputy State Coroner.

**MAGISTRATE DORELLE PINCH**  
**Deputy State Coroner**

- 1984     Admitted as a Solicitor of the Supreme Court of NSW and the High Court of Australia
- 1984-98  Worked as a Solicitor, principally in government legal practice
- 1998     Appointed as an Advocate, Crown Solicitors Office
- 1999     Accredited as a Specialist in Criminal Law, Law Society of NSW
- 2003     Appointed as a Magistrate under the Local Courts Act 1982
- 2003     Appointed as a Deputy State Coroner

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## Introduction by the New South Wales State Coroner

### What is a death in custody?

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

- 1 the death wherever occurring of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the (Commonwealth) Migration Act, 1958.;
- 2 the death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care whilst in such custody or detention;
- 3 the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and
- 4 the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

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

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

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

In fact, in recent years the Department of Corrective Services has been releasing prisoners from custody prior to death, in certain circumstances. This has generally occurred 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 indicate a "technical" reduction of the actual statistics in relation to deaths in custody. In terms of Section 13A, 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.

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<sup>1</sup> Recommendation 41, *Aboriginal Deaths in Custody: Responses by Government to the Royal Commission 1992* pp 135-9

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

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

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

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

After ten years of operation, most of the scenarios set out above have been the subject of inquests.

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

It is most important that all aspects of police conduct be reviewed even though in a particular case it may be unlikely that there will be grounds for criticism of police.

It is important that the relatives of the deceased, the New South Wales Police Service and the public generally have the opportunity to become aware, as far as possible, of the circumstances surrounding the death.

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

**2238/02:** The Senior Deputy State Coroner found that the operational tactics of two police officers should have been very different in a situation where it was realised that an individual was potentially 'psychotic'. In this instance, the police had no power to detain the individual and should not have pursued him when he fled. The Senior Deputy State Coroner made recommendations relating to Police training in mental health issues.

**902/03:** The State Coroner criticised aspects of the police operation which culminated in a man's death. These aspects included the handling of a police shooter, the length of time he remained at the scene, and the failure to disarm and separate him. The Coroner reiterated previous recommendations made with regard to this in critical incidents. There was also criticism of the management of the siege surrounding the failure to consider utilising third party intervention. Recommendations were made that this present practice be revised.

**996/03; 997/03; 998/03; 999/03:** A Deputy State Coroner felt that police officers may need to "look outside the square" when dealing with what may be a concern for welfare in a domestic situation. It was felt that if Officers had sought further information when they responded to a concern for welfare call, subsequent events may have turned out differently. The Coroner also felt that the Police should not have placed the onus for action being taken on a reported breach of an Apprehended Violence Order on the victim. Accordingly, recommendations were made in relation to the adequacy and frequency of training for all Officers with regard to domestic violence issues. It was also recommended that standard operating procedures be examined with regard to the appropriateness of an arrest in the context of breach of domestic violence orders.

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

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

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

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

I agree also with Mr Waller that:

*In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution. When the death is by deliberate self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an*

*event pertaining to an individual. The focus there is far more upon the individual and that individual's pre-morbid state. It is entirely proper that any death in custody, from whatever cause, must be meticulously examined*<sup>3</sup>,

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

Immediately a death in custody/police operation occurs anywhere 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 immediately to notify the State Coroner or a Deputy, 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, though another Coroner may ultimately finalise the matter. The Coroner's supervisory role of the investigations is a critical part of any coronial inquiry.

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

Upon notification by the DOI, the State Coroner or a Deputy State Coroner will give directions that 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 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 coronial medical officer or the forensic pathologist. A member of the Coroner's Support Section must attend the scene that day if the death occurred within the Sydney Metropolitan area and, when practicable, if a death has occurred in a country district. The Support Group Officer must also ensure that a thorough investigation is carried out. He or she will continue to liaise with the Coroner and with the police investigators during the course of the investigation.

The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during it. If the State Coroner or one of the Deputy State Coroners is unable to attend a death in custody/police operations occurring in a country area, the State Coroner may request the local coroner in the particular district, and the local coronial medical officer to attend the scene.

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<sup>2</sup>Kevin Waller AM., *Coronial Law and Practice in New South Wales, Third Edition, Butterworths, page 28*

<sup>3</sup>Kevin Waller AM., *Waller Report (1993) into Suicide and other Self-harm in Correctional Centres, page 2.*

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 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 Coroners 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 Coroner, Counsel assisting, legal representatives for any interested party, and relatives so as to ensure that all relevant issues have been addressed.

In respect of all identified *Section 13A* deaths, post mortem examinations are conducted by experienced forensic pathologists at Glebe, Westmead or Newcastle.

### **Responsibility of the coroner**

*Section 22, Coroners Act 1980* provides:

- (1) The Coroner holding an inquest concerning the death or suspected death of a person shall at its conclusion .... record in writing his or her findings .... as to whether the person died, and if so:
  - (a) the person's identity,
  - (b) the date and place of the person's death, and
  - (c) except in the case of an inquest continued or terminated under section 19, the manner and cause of the person's death.

In general terms *Section 19* provides:

1. if it appears to the Coroner that a person has been charged with an indictable offence or the coroner forms the opinion that evidence given in an inquest is capable of satisfying a jury that a person has committed an indictable offence and that there is a reasonable prospect of a jury convicting the person of the offence; and

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

The inquest is terminated after taking evidence to establish the death, the identification of the deceased, and the date and place of death. The Coroner then forwards to the Director of Public Prosecutions a transcript of the evidence given at the inquest together with a statement signed by the Coroner, specifying the name of the known person and particulars of the offence.

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

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

The role of the coronial inquiry has undergone an expansion in recent years. At one time its main task was to investigate whether a suicide might have been caused by ill treatment or privation within the correctional centre. Now the Coroner will examine the system for improvements in management, or 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 22A* of the *Coroners Act 1980*. This section indicates that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations (*S.22A(2)*).

Any 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 Coroners 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.

Recommendations arising from a number of inquests of *Section 13A* deaths were made during **2006**.

**Some of these recommendations include:**

**1143 of 2004 Jessica Kaukau and 1160 of 2004 Nathan Mazurani,** (Abernethy).

**To the Commissioner of Police** (in relation to the Death of Nathan MAZURANI)

That the NSW Police “Tactical Operations Management – Operational Guidelines” be reviewed and altered where necessary to maximise the safety to NSW Police engaged in the operation of executing search warrants in potential “high risk” situations; that the facts of this case be utilised when conducting that review.

That all Local Area Commands, unless it has already been done, put in place (local) Standard Operating Procedures requiring the carrying out of a written Risk Assessment prior to the execution of all Search Warrants.

**364 of 2005 Andrew Coleman,** (Abernethy).

That the Department of Corrective Services reviews the Long Bay Hospital Complex (presently partly under renovation) in relation to so called “hanging points” in the Hospital Complex, with a view to having them eliminated or reduced where it may be possible to do so.

**988 of 2004 Scott Simpson,** (Pinch).

**To the Minister for Health**

1. In relation to inmates of Correctional Centres who have been diagnosed with a mental illness and require treatment in hospital:
  - A. There should be a standardised procedure for admission to hospital.
    - That procedure should be based on the provision of *Sections 97 and 98* of the *Mental Health Act 1990* and the completion of a Schedule Three form. The procedure should be set out in writing and circulated to all visiting consultant psychiatrists and Justice Health Staff;
    - The members of the Committee making the decisions about hospital admission (which has superseded Dr White’s role) should hear personally from at least one of the medical practitioners who have examined the prospective patient and completed the Schedule.
  - B. There should be standard criteria for admission to hospital to be taken into account by the Committee. The criteria should be set out in writing and circulated to all visiting consultant psychiatrists and Justice Health staff.
    - (a) The criteria should be based on the Principles for the Protection of Persons with Mental Illness, namely that persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings, and who are determined to have a mental illness, have the right to the best available mental health care;

- (b) Specifically, in addition to the inmate's present clinical condition, the committee should have regard to:
- Any likely deterioration in the person's condition;
  - Whether the person has been placed in segregation and, if so, for how long;
  - Any non-compliance with medication;
  - The treatment options available outside a hospital environment, including the frequency of access to a psychiatrist.
- C. Those persons in respect of whom a Schedule Three has been completed but who cannot be immediately placed in hospital should be placed under the care of a nominated appropriately qualified medical practitioner, who will take responsibility for their treatment and who will provide up-dated reports for subsequent meetings of the Committee.
2. In order to ensure that all relevant information is placed before Justice Health staff at the time of the Reception Assessment of inmates i.e. prior to the arrival of Justice Health files, a Discharge Summary should be completed by Justice Health staff on all inmates diagnosed with a mental illness within 14 days of their discharge. This Summary should then be made available in electronic form for access by Justice Health Reception staff in the course of all subsequent assessments on admission.
3. Given that decisions about placement within Correctional Centres and the release of forensic patients are made in other States by either an independent Tribunal such as the Mental Health Review Tribunal or by superior courts, a review should be conducted as to whether the present system of Executive responsibility is best suited to ensure the placement and movement of inmates on clinical grounds. The review should specifically assess whether, under the present system, the decision-making process about the movement of forensic patients ensures the best use is made of the limited available hospital beds.

#### **To the Minister of Health and the Minister of Corrective Services**

4. In relation to inmates with a mental illness, an integrated approach between Justice Health and the Department of Corrective Services should be adopted in decisions about placing those inmates in segregation and reviewing the relevant Segregation Orders to ensure that the consequences for the inmates' mental wellbeing are taken into account. As part of that approach:
- An appropriately qualified medical practitioner nominated by Justice Health should examine the inmate within 48 hours after the initial placement in segregation and a written report should be forwarded from Justice Health to the Department of Corrective Services detailing any clinical concerns and recommendations to address those concerns;
  - A similar assessment should then be conducted on a weekly basis and a written report forwarded to the Department of Corrective Services detailing any clinical concerns and concomitant recommendations.

### **To the Minister for Corrective Services**

5. The Department of Corrective Services should adopt the policy that inmates diagnosed with a mental illness should be placed in segregation only in exceptional circumstances and for a limited period.
6. The Department of Corrective Services should ensure that Discharge Summaries on all inmates are completed and can be accessed by Reception staff within a reasonable time, at least within 14 days, after an inmate's discharge.
7. The Department of Corrective Services should ensure that sufficient resources are allocated to the Working Party for the Reduction of Hanging Points, including the appointment of a full-time manager, to enable the current work of the group to be carried out at the earliest opportunity. Additionally, the scope of works should be expanded to include, on a priority basis, all cells in maximum and medium security institutions.
8. The Department of Corrective Services should implement a policy to ensure that any violent or other aberrant behaviour by an inmate at the time of reception into a Correctional Centre is immediately brought to the attention of the Justice Health Staff member conducting the reception assessment of the inmate. This should occur irrespective of whether the assessment has been completed.
9. The Department of Corrective Services should note that the policy in relation to immediately cutting down an inmate found hanging and commencing resuscitative efforts was not followed in this case. The Department should consider the best way of reinforcing that the policy should be complied with in all circumstances.

### **To the Attorney-General**

10. A protocol should be developed between the referring courts and the Mental Health Review Tribunal to ensure that notifications of the court's decision that a person has been found not guilty on the grounds of mental illness occurs at the earliest possible time and, at the outside, no later than seven days.

**1007/05 Jack Fisher, (Pinch).**

### **To the Minister of Police and Commissioner of Police**

The following policies should be implemented:

Where, in the course of a police operation, cries for help are made by a person being pursued, the police officers engaged in the pursuit should contact VKG so that the Duty Supervisor can be alerted.

Where cries for help are made by a person in the course of a police operation in a situation that could result in fatality, the police officers should be under a positive obligation to ascertain the safety of that person.

**343 of 2005 Cheah Kah BOO, (Abernethy).**

That the Department of Corrective Services considers relocating all Cell Call Alarms in gaol hospital wards, clinics, detoxification wards and the like, to positions adjacent to beds so that seriously ill prisoners can activate them from such beds.

**Contacts with outside agencies**

During 2006 the State Coroner's office maintained effective contact with the following agencies:

- New South Wales Department of Forensic Medicine (Department of Health);
- Division of Analytical Laboratories at Lidcombe (Department of Health);
- Aboriginal Prisoners and Family Support Committee (New South Wales Attorney General's Department);
- Aboriginal Deaths in Custody Watch Committee;
- Indigenous Social Justice Association;
- Aboriginal Corporation Legal Service;
- Aboriginal and Torres Strait Islander Commission;
- Australian Institute of Criminology in Canberra;
- Office of the State Commander New South Wales Police Service;
- Department of Corrective Services; and
- Corrections Health.
- Emergency management Australia.
- Crown Solicitors Office

Close links were also maintained with Senior Coroners in all other states and territories.

**OVERVIEW OF DEATHS IN CUSTODY/POLICE OPERATIONS REPORTED TO THE NEW SOUTH WALES STATE CORONER DURING 2006.**

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

**Deaths in custody/police operations which occurred in 2006.**

There were cases of deaths in custody and cases of death as a result of or in the course of police operations reported to the State Coroner in 2006. These cases have either been listed for hearing or are still under investigation.

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32

**Aboriginal deaths which occurred in 2006**

Of the 32 deaths reported during 2006 pursuant to *Section 13A, Coroners Act 1980*, 4 were aboriginal, of whom died in custody.

**Table 2: Aboriginal deaths in custody/police operations during 1995 to 2006.**

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	7	0	7
1996	2	0	2
1997	6	2	8
1998	2	3	5
1999	3	1	4
2000	4	1	5
2001	5	-	5
2002	3	1	4
2003	1	2	3
2004	2	3	5
2005	1	3	4
2006	4	0	4

## **Deaths investigated by the State/Deputy State Coroners during 2006**

During the year 14 “death in custody” inquests and 14 “police operation death” inquests were finalised (*Appendix 1*).

Findings were recorded as to identity, date and place of death, and manner and cause of death

### **Information relating to the 28 deaths into which inquests were held.**

Circumstances of death

#### **Persons who died in custody:-**

- 8 by taking their own life by hanging
- 3 of natural causes
- 1 by stabbing
- 1 by choking
- 1 by fall

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

- 1 from natural causes
- 4 from a motor vehicle accident
- 4 from gun shot wounds
- 1 from overdose of one or more drugs
- 2 from drowning
- 2 from injuries received as a result of a jump/fall

#### **Unavoidable delays in hearing cases**

The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is unavoidable. There are many different reasons for delay. One Section 13A matter remains outstanding from 2001 however is set down for inquest in 2007, 2 Section 13A matters remain outstanding from 2003 and 7 Section 13A matters remain outstanding from 2004.

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

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

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

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

The concerns of the family and relatives of the deceased and possible other interested parties must also be fully addressed. In the case of country deaths, delay can sometimes occur due to the unavailability of a suitable courtroom because of Supreme, District or Local Court commitments in a particular district.

## **SUMMARIES OF INDIVIDUAL CASES COMPLETED IN 2006.**

Following are the written findings of each of the cases of deaths in custody/police operations that were heard by the NSW State Coroner, Senior Deputy State Coroner and the Deputy State Coroners in 2006.

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

### **I.**

**2052 of 2003**

#### **Inquest into the death of Leonard Lawson at Grafton Correctional Centre, Grafton on 29 November 2003. Finding handed down by Magistrate John Abernethy, NSW State Coroner.**

This prisoner, the longest serving inmate in the NSW Correctional System died on in his Cell 242, 2 Wing, Grafton Correctional Centre, on 29th November 2003. He was two out in his cell at the time of his death.

The prisoner's first term of incarceration began in 1954 when a death sentence was commuted. Five Months after his release in 1961 he committed several other murders. In 1962 he was convicted and sentenced to life imprisonment. In 1972 the deceased wounded a visiting female performer at a concert at Parramatta Correctional Centre. For this latter crime he received a five-year custodial sentence. He had thus been in full-time custody since 1962. An application in 1994 to the Supreme Court of NSW for the determination of a maximum and minimum term in relation to his life sentence was declined.

In 2003 it came to the attention of Correctional Services staff that the deceased was alleged to have preyed on young inmates and was in possession of a quantity of pornographic videos. It was further alleged to Correctional Services staff that the deceased had attempted to make physical contact with a female dentist during a procedure. He was then assessed as being of high risk to all female Correctional Services and Justice Health staff. This latter allegation bears a resemblance to the 1972 offence involving the female entertainer at Parramatta.

He was thereupon re-classified from C2 to C1 security classification and moved from the minimum-security unit at Grafton to 2 Wing in the main facility. A recommendation was also made that he be transferred to a more secure environment at Lithgow Correctional Centre. At the time of the prisoner's death that recommendation had not been ratified by the Serious Offenders' Review Council.

The State Coroner found that there could be no doubt that the prisoner was opposed to this proposed transfer, and upset by it.

### **Medical issues.**

The deceased had a history of aortic aneurysm, hypertension and depression. Post-mortem examination by Senior Staff Specialist Forensic Pathologist, Dr. Paull Botterill found severe hardening and narrowing of the arteries of the heart and of the rest of the body, probable scarring of the heart muscle, indicating prior myocardial infarction, excess fluid in the lungs, asthma or airways disease, enlargement of the bladder and prostate and scarring of the kidneys. There was nothing untoward in the toxicology performed on the deceased.

Dr. Botterill determined that the prisoner died of ischaemic heart disease, a natural cause. He confirmed that the deceased's physical condition was unremarkable for a man of his age – that is to say, many men of his age die in a similar way and on death are found to have similar pathology.

### **Circumstances of Death.**

On 26th November 2003 the deceased was transferred to Cell 242 from the minimum-security section of the gaol. He shared this cell with another inmate. On the morning of Saturday 29th November 2003 he awoke and had a shower. He was pouring a bowl of cereal when he collapsed to the floor. His cellmate activated the cell call alarm and waited to Corrections Officers to arrive. They arrived with a Registered Nurse. The nurse checked for vital signs and found none. They removed the deceased from the cell and called for an ambulance. They also commenced CPR until life was pronounced extinct at 8.12 am.

### **Next of Kin concerns.**

The daughter of the deceased located a letter in his property, which she believed to be a suicide note. In that letter he spoke about being physically and mentally unable to cope with the proposed disciplinary transfer to Lithgow Correctional Centre. She raised issues of validity of that transfer.

Her major concern revolved around an article written in the Sydney "Sun-Herald) of 22nd February 2004 by a journalist by the name of Mitchell. In the article Mitchell indicates that a prison psychologist has drawn attention to the fact that Lawson's movies have certain clearly defined themes.

### **Conclusion.**

The evidence of Dr. Botterill is overwhelming. The deceased was 76 years of age and in medical terms quite unwell. The State Coroner was satisfied that he at all relevant times had received adequate treatment for his physical condition. He was also satisfied that his death was sudden and by way of natural cause.

The State Coroner found that officers of the Department of Correctional Services and of Justice Health acted appropriately on the alarm being raised by the cellmate of the deceased.

The Coroner accepted that the prisoner was dismayed at being transferred to another facility but indicated that Correctional Services Officers had an obligation to deal with him in view of the allegations against him. He could see nothing in the decision to transfer the deceased to another facility to warrant criticism, and felt that the decision was not inappropriate. In any event, he could see no nexus whatsoever between the proposed transfer and the death of the prisoner.

The NSW State Coroner commented that, significantly, such proposals to re-classify must be ratified by the Serious Offenders' Review Council and in such cases the prisoner involved is able to oppose a re-classification and/or proposed transfer. SORC will take into account the prisoner's submission on such a matter.

The Coroner was satisfied that this prisoner died almost immediately on collapsing in his cell whilst preparing breakfast.

The State Coroner found this to be a most thorough investigation which enabled him to be very satisfied that there were no issues (in relation to the actual death) which warranted criticism of any person or Government Instrumentality.

He was however concerned that a mere journalist could obtain sensitive materials, perhaps from an employee of the Department of Corrective Services, in relation to a prisoner and publish them prior to the conclusion of a coronial inquest.

#### **Formal Finding.**

**That Leonard Keith LAWSON died on 29th November 2003 in Cell 242, 2 Wing, Grafton Correctional Centre, Grafton, of ischaemic heart disease, a natural cause.**

#### **Recommendation.**

That the Department of Corrective Services investigates the circumstances whereby journalist Alex Mitchell of the *Sydney Sun Herald* was able to obtain sensitive material in relation to the re-classification and/or death of a prisoner prior to the holding of a coronial inquest into that death; that the Department of Corrective Services reviews its instructions to staff and standing orders to ensure that they are sufficient to minimise the prospect of a similar occurrence.

2.

1058 of 2003

**Inquest into the death of Richard Thomas on 28 September 2003. Finding handed down by Magistrate Milovanovich on 23 March 2006.**

The death of Mr Richard Thomas was reported to the NSW Deputy State Coroner on Monday the 29th September, 2003, following his death at around midnight of the 28th September, 2003, at the Penrith Rugby League Club, Penrith.

The death was immediately identified from the P.79A (Report of death to the Coroner) as a death examinable by the Coroner by virtue of Sections 13 and 13A of the Coroners Act. By virtue of Section 13 of the Coroners Act, the death of Mr. Thomas was sudden and unexpected and no medical practitioner had issued a certificate as to death. By virtue of Section 13A of the Coroners Act the information provided to the Coroner suggested that the deceased may have died whilst in the custody of NSW Police and accordingly became a matter that required mandatory reporting to a State Coroner. Similarly under the provisions of Section 13A a death in custody is a matter that is required to proceed to a formal Inquest, one which can only be presided over by a State Coroner.

The death of Mr Thomas was identified by Police as one falling within Section 13A of the Coroners Act, 1980, and Critical Incident Investigation protocols were put in place with Inspector Arpad Jim Szabo being appointed as the independent Critical Incident Team Investigator.

The role of the Coroner is to determine the identity of the deceased, the date, place of death and the manner and cause of death. In cases, such as this, which fall within the provisions of Section 13A the Coroner also has an implied obligation to ensure that all critical incident protocols have been followed and examine in detail the circumstances of the death and determine the manner and cause of death when it is evident that a person has died while in Police custody.

**The Facts.**

Counsel assisting the Coroner, Ms Belinda Baker has provided a succinct summary of the events and issues in this Inquest in her opening and closing address. The brief of evidence which has been tendered and marked Exhibit 2 is thorough and comprehensive and requires little more than a brief summary by the Coroner. It is known that Mr Thomas was celebrating a rugby league win by the Penrith Panthers Rugby League Club on the evening of the 28th September, 2003 at the Panthers Club. The evidence of witnesses and CCTV footage clearly indicates that a number of patrons, including Mr. Coffey and his son, Craig Coffey were asked to leave the Club as the Duty Manager Mr. John Kolkman formed the view, in accordance with the legislative requirements regarding responsible service of alcohol, that those patrons should be requested to leave. It would appear that Mr. Coffey, a

former Director of the Club and well known, took exception to the Duty Manager's direction and a number of other patrons, including the deceased rallied in support of Mr. Coffey. The evidence indicates that security personnel attended the T.C. Bar and a number of patrons were physically removed. It is apparent that the deceased took objection to being removed and physically resisted attempts by security staff to remove him from the licensed premises. The evidence at this inquest and the CCTV footage indicates that a decision was made to remove the deceased via the Directors Car Park. This decision it would appear was based on Club policy in regard to the removal of resisting patrons in order not to create a disturbance or an unpleasant incident if removal was undertaken through the main foyer of the club. The CCTV footage clearly indicates that Security Officers Elisara and Tonumaiepa took Mr Thomas by his left and right arms and that security officer Kengike assisted from the deceased's rear. The CCTV footage shows Mr Thomas being taken out into the Directors Car Park and walked a short distance before he appears to collapse onto the ground. The evidence would suggest that Mr Thomas did not collapse to the ground at this stage due to ill health but more likely due to the fact that he was continuing to resist and he allowed his weight to fall which made it difficult for the security officers to further remove him. It is evident from Exhibit 1 the Post Mortem Report that Mr Thomas was described as a well nourished adult male of 181 cm in height with an approximate weight of 127 kg.

The evidence and CCTV footage further describes that at a point in the Directors Car Park and adjacent to a boom gate, the deceased is seen lying on the ground and being restrained by the three security officers previously mentioned. It is evident that Mr Thomas is lying prone on the ground with two security officers restraining his arms and the other holding his legs. It is clear that at this point in time, Mr Thomas is well enough to exert forceful resistance and shortly thereafter Police including Cst Rodger and Sen Cst Hales are at the scene. Upon Police arrival Cst Rodger, with borrowed handcuffs attempts to handcuff the deceased with the assistance of Cst Hales and the security officers. The evidence indicates that Mr Thomas was still resisting the security officers and the Police in their attempt to handcuff him and the evidence also indicates that some difficulty was experienced in handcuffing Mr Thomas. It is known that Mr Thomas was handcuffed firstly onto the left hand and then attempts were made to bring his right hand around and adjacent to his left in order to complete the handcuffing procedure. The evidence would suggest that Mr. Thomas had to be restrained during this process and that some difficulty was experienced by the Police Officers as the right hand cuff was in the free spin position rather than the ratchet position, which caused some delay in the handcuffing process.

The evidence from witness statements, oral evidence in Court and the CCTV footage indicates that almost immediately after Mr Thomas was handcuffed an attempt was made to stand him up, however, it would appear that he was no longer resisting and may at this stage have been unconscious. The Court has heard evidence that witnesses could hear a distinctive noise which has been described as "snoring" and that almost immediately Mr Thomas was placed back on the ground, the handcuffs removed and he was placed in the

recovery position. The evidence of Cst Rodger, who completed the handcuffing procedure was that Mr Thomas stopped resisting almost immediately the handcuffs were secured and it was shortly thereafter that Cst Rodger noticed that Mr Thomas's hands had gone limp and that his lips were going blue. Not long after being placed back on the ground and in the recovery position Mr Thomas was again observed to be making snoring noises and not long after that his pulse was checked and it was believed that he was no longer breathing and no pulse could be detected.

Police called for an Ambulance and a face mask was obtained from the First Aid Room of the Rugby League Club which was in close proximity. The CCTV footage shows Mr Thomas being placed on his back and Sen Cst Hales commencing resuscitation with chest compressions. The CCTV footage shows that Mr Thomas had his pulse checked at 02.55am on 29/9/2003, that he was placed on his back at 02.36 and first compressions are noted at 04.30. It is noted that from the statement of Ambulance Officer Fitzpatrick that he records arriving at the scene at 00.04 am and observes resuscitation being undertaken. It is noted from the statement of Ambulance Officer Redmond that they responded to this incident at 11.59pm and were advised that the incident related to a man who had collapsed with CPR in progress and the Police at the scene. The evidence of both ambulance officers is well documented in their statements and requires no further clarification other than they found the deceased to have no cardiac output when they observed him at around 00.04am. Both officers describe their treatment of the deceased and that he was placed in an ambulance and taken to Nepean Hospital at which he arrived at 00.50am. Dr. John Foster examined the deceased in the Emergency Department of Nepean Hospital at about 00.49am and at 01.02am determined that further medical intervention was futile.

## **THE CRITICAL INCIDENT INVESTIGATION.**

I have examined the critical incident protocols and I am satisfied that apart from one minor omission they have been complied with. Involved Police Officers had been separated in order to ensure the integrity of their evidence and involved officers were subjected to drug and alcohol testing.

In regard to the reviewing officers report it is noted that it does not form part of the brief and it should have. The reviewing officers report, in accordance with the police guidelines in relation to critical incidents, requires that the officer attend the scene and amongst other things prepare a report for the Local Area Commander and identify any matters that may be subject to disciplinary action. It is also implied, although not expressed, that the Coroner would view the role of the reviewing officer as being responsible for a critical review of the incident and the role the police played.

It follows, that issues such as the difficulty in handcuffing due to the cuffs being in the locked position and issues associated with positional asphyxiation should have been identified and commented upon.

## **THE CAUSE OF DEATH.**

Dr. Bogdan Hulewicz was the forensic pathologist who performed the post mortem examination upon Mr Thomas. Unfortunately he was not available to give evidence today and we have had the benefit of the evidence presented by Dr Peter Ellis, Senior Forensic Pathologist at Westmead, who has reviewed Dr.Hulewicz's notes and his post mortem findings.

Dr.Hulewicz has attributed death as being due to Cardiac arrest due to the combined effects of severe cardiovascular disease and positional asphyxia caused by forceful prone restraint. I might comment firstly on Dr Hulewicz's finding, and without intending to be critical, I believe the role of the forensic pathologist is to determine the cause of death, while the role of the Coroner is to determine the manner and cause of death. Dr Hulewicz is correct in expressing his professional opinion as to the medical cause of death, however, the issue as to whether there was restraint, whether it was forceful or for that matter whether it was prone are findings of fact for the Coroner. I would have no objection to Forensic Pathologists expressing an opinion in their commentary as to possible contributing factors that go to the causes of death, however, the direct cause of death should be the medical cause of death.

Dr.Ellis has been kind enough to give evidence has given evidence today, and basically he agrees with all the findings and opinions expressed by Dr.Hulewicz.

In summary the medical evidence would suggest on the balance of probabilities that death may be attributed to a number of post mortem indicators, either in combination or in isolation.

Dr.Hulewicz found evidence of petechiae in the eyelids and linings of the eyes which would support an episode of positional asphyxia. There was also evidence of severe degenerative narrowing of the coronary blood vessels that supply blood to the heart muscle. The middle segment of the left anterior descending artery showed several foci of eccentric atherosclerosis producing between 20 and 30% narrowing. The middle segment of the left diagonal branch showed a focus of eccentric atherosclerosis of approximately 80% narrowing. The right coronary artery showed approx 70% narrowing. Evidence following post mortem also indicated a blood alcohol level of 0.200 g per 100 mls.

## **SUMMARY.**

I am satisfied that the Security Officers at Penrith Rugby League Club acted lawfully in removing Mr Thomas. I have found no evidence that they used excessive force or restraint. Similarly when Mr Thomas was being restrained on the ground and members of the NSW Police attended the scene with a view of taking Mr Thomas into custody for the purposes of him being removed from the licensed premises, the evidence would suggest that only reasonable force was used to ensure that he could be handcuffed. The evidence at this Inquest would suggest that Police applied restraint to Mr

Thomas in the handcuffing procedure according to the guidelines issued to Police. While with the benefit of hindsight it could be said that Mr Thomas's airways may well have been compromised when he was placed in the recovery position and some short periods of time elapsed when it is clear no resuscitation was undertaken, the time period was relatively short and it was believed at that time that Mr Thomas may simply have been either asleep or had passed out from the effects of alcohol.

## **POSITIONAL ASPHYXIATION.**

This is not the first inquest that has been held in which positional asphyxiation may have contributed to death. The death of Mr. Dalamangas at the Star City Casino, was a matter that received considerable media coverage and was subject to a lengthy inquest. I am aware of at least two other matters, one which is still pending before the Coroner and involves similar circumstances in which a man died after being restrained on the ground by two security officers.

My Counsel Assisting in consultation with me has submitted that I should make formal recommendations in regard to the issue of positional asphyxiation and I agree with that submission. As Dr Hulewicz pointed out in his commentary, a person who has consumed alcohol, possibly fatigued following resistance to restraint and as in Mr Thomas's case, a man who was overweight and with coronary heart disease, is highly susceptible to compromised air ways particularly if restrained in a prone position. Of course Police and Security Officers would have no knowledge of Mr Thomas's coronary disease, however, even healthy adults who have consumed alcohol, may be fatigued from resisting and when placed in a prone position could succumb to compromised air ways resulting in death.

It is for those reasons that I believe a formal recommendation should be made to the appropriate Minister and the Commissioner of Police. Police should receive further training in this area and perhaps it would be prudent before new guidelines are issued that the Police Service consider obtaining professional medical advice in regard to the most effective and risk minimised manner of restraint. Similarly, the Security Industry should also consider implementing mandatory training in the risks of positional asphyxiation and the Commissioner of Police who is responsible for the grant of the Security Industry Licenses may wish to consider whether such training should be a pre-requisite to the issue of licenses.

It has been noted, that in regard to the Penrith Rugby League Club, that Club of its own volition has a requirement that Security Officers employed by the Club undertake training in regard to positional asphyxiation. This is commended, and it should be industry wide.

I note that no family of the deceased appeared at this Inquest and they have not communicated with my office or my counsel assisting in regard to any issues. It is proper for this Court to express its condolences for their loss.

### **Formal Finding.**

**That Richard Mason Thomas died on the 29th September, 2003, in the car park of the Penrith Rugby League Club, Penrith in the State of NSW from a cardiac arrest due to the combination of severe cardiovascular disease and positional asphyxia. I further find that the deceased died whilst in the lawful custody of the NSW Police while being restrained in a prone position following a lawful eviction from licensed premises by Security staff of the Penrith Rugby League Club.**

### **Recommendation.**

**To the Minister for Police**

**To the Commissioner of Police.**

1. That consideration be given by the NSW Security Industry Registry as to whether instruction in positional asphyxia should be a mandatory component of courses required to obtain a security industry license in NSW and that NSW Police give consideration as to whether instruction in handcuffing techniques and the dangers of deaths associated with positional asphyxia should be reviewed and or implemented.

### **3. & 4.**

**59 of 2004  
and  
60 of 2004**

**Inquests into the deaths of Tabatha Berg who died on the 15 January 2004 and Peter James who died on the 16 January 2004. Finding handed down by Magistrate Milovanovich on the 3 March 2006.**

### **Inquest Summary:**

Deceased 1 (Peter James) was observed by Highway Patrol Police to be travelling towards them at 98 kph in a 60 kph sign posted area. Police negotiated a turn with a view of stopping the driver for a traffic infringement. Police activated their lights, however, the driver did not stop and Police accelerated with a view of catching up with the offending vehicle. The pursued vehicle did not stop and increased its speed and the Police vehicle then activated its sirens and called VKG radio indicating that a pursuit was in progress. At the time the pursuit was radioed to VKG the offending vehicle was travelling along a section of Windsor Road which was a sign posted 60 kph area and was subject to road works. Police observed the offending vehicle strike a number of mobile barrier boards. The speed of the offending vehicle was estimated at 140 klms per hour with the Police vehicle some 100 to 200 metres behind. At the intersection of Windsor Road and Curtin Road the offending vehicle failed to negotiate a left hand lateral diversion and entered the north bound carriageway of Windsor Road, that being on the incorrect side of the road. Police followed the offending vehicle, also onto the incorrect side of the road and some few seconds later the offending vehicle collided head on with a vehicle travelling in the opposite direction.

The driver and observer of the Police vehicle have maintained that they did not realise that they had entered the incorrect side of the road until they witnessed the head on collision some 150 metres in front of them. Deceased 2, a rear seat passenger who was secured in a child restraint died as a result of the head on collision. The pursuit from the time it was radioed in until the collision lasted some 30 seconds and traversed approximately 1100 metres of Windsor Road. From independent witnesses it would appear that prior to the offending vehicle crossing onto the incorrect side of the road it had overtaken another vehicle over double separation lines and caused another vehicle to take evasive action. The Police vehicle also overtook over double unbroken separation lines, however, the driver and observer of the Police vehicle had no recollection of so doing.

Apart from issues associated with the Police Safe Driving Policy a close examination was conducted of the traffic management plan that applied to the road works for Windsor Road. It was evident that at the intersection of Windsor Road and Curtin Road there was a left hand lateral shift and it would appear that the offending vehicle was travelling at such speed that it either did not notice the lateral shift or simply could not negotiate it and accordingly drove onto the incorrect side of the road and into oncoming traffic. The Coroner closely examined the traffic management plan and was of the view that it complied with the Australian Standard and that its design did not play any major part in the accident. The Coroner was of the view that the primary reason for the accident was the speed and alcohol content of the driver (deceased 1) in the offending vehicle.

The Coroner closely examined the Police Safe Driving Policy and formed the view that a window of opportunity did exist for the Police driver and or escort to terminate the pursuit when it was realised that the offending vehicle was not likely to stop. Considerations that should have been taken into account included that fact that the offending vehicle was travelling in excess of 120 kph and possibly 140 kph in a 60 kph zone. The offending vehicle had overtaken another vehicle by crossing onto the incorrect side of the road and contrary to double line markings. In so doing the offending vehicle almost collided with an oncoming vehicle. The Police in pursuit had observed the offending vehicle strike a number of portable barrier boards which indicated that his manner of driving was becoming dangerous. The Coroner was of the view that the pursuit should have been terminated at that stage. To some extent the Coroner also took into account that the driver of the Police vehicle was an experienced highway patrol officer and was familiar with that section of the road and should have been aware of the road works and the left lateral diversion which was coming up.

The Coroner formed the view that the Safe Driving Policy was not in any way deficient, however, that it was essential that mandatory training be provided to all Police on the Safe Driving Policy and to re-enforce that it is a Policy and not a guideline. No formal recommendations were made.

## Formal Findings.

**That Peter Greg James died on the 16th January, 2004, at Westmead Hospital, Westmead in the State of New South Wales from chest and abdominal injuries sustained on the 15th January, 2004, at McGrath's Hill in the State of New South Wales when the vehicle which he was driving impacted with another vehicle.**

**That Tabatha Berg died on the 15th January, 2004, at McGrath's Hill in the State of New South Wales from a Neck Injury, sustained there and then when the vehicle in which she was a passenger collided with another vehicle.**

5.

722 of 2004  
JD (Name  
suppressed,  
juvenile)

**Inquest into the death of JD on the 21 May 2004. Finding handed down by Magistrate Milovanovich Deputy State Coroner on 17 May 2006.**

### DEATH IN CUSTODY SUMMARY

JD died on the 21st May, 2004, following a motor vehicle accident in which he was the driver of a motor vehicle. His death was a reportable death to the Coroner on a number of grounds, viz his death was sudden and unexpected, his death was not from a natural cause, his death was one for which a death certificate could not issue and most importantly his death came under the provisions of Section 13A of the Coroners Act, 1980.

Section 13A of the Coroners Act, 1980, states;

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

*S.(1)(a) as a result of or in the course of police operations*

Section 13A(2) states;

*“if jurisdiction to hold an inquest arises under both this section and section 13, an inquest is not to be held except by the State Coroner or a Deputy State Coroner”*

The report of death to the Coroner by Police, the document referred to as the P.79A Report of Death to the Coroner, and which is marked Exhibit 1 indicated that the deceased had died following a pursuit by Police and accordingly falls within the definition of a death during a Police Operation. Accordingly the Police recognised the death as falling within those provisions and critical incident protocols were invoked. The death was originally reported to the State Coroner Office at Glebe and subsequently transferred to Westmead by the State Coroner in order that I take carriage of the matter and preside over the mandatory inquest.

## **THE ROLE OF THE CORONER.**

Under the provisions of the Coroners Act, 1980, a Coroner is required to make findings as to the identity of the deceased, the date, place, manner and cause of death.

In cases where there may be evidence to suggest that a known person has committed an indictable offence in relation to the death of the deceased, the Coroner is also required to address the provisions of Section 19 of the Coroners Act and consider whether the evidence is capable of satisfying a jury that an indictable offence has been committed and whether a jury would be likely to convict. In regard to the death of Justine Denniss it has not been suggested that my mind should turn to Section 19 and clearly there is no evidence that would require me to do so.

In addition to the statutory obligations imposed on a Coroner, a Coroner may make recommendations pursuant to Section 22 of the Coroners Act. Such recommendations are usually made on matters concerning public health and safety. Mr. Shridhar in his written submissions at point 5 has submitted that the Court would give consideration to making recommendations, and I will deal with that issue separately.

## **FACTUAL SUMMARY.**

On the afternoon of the 19th May, 2004, the deceased JD, his friend NS, CS and JS walked from Berkeley to Unanderra Railway Station where they caught a train to Wollongong. JD and the persons mentioned then went to premises at 6/2 Mercury Street, Wollongong. These premises were occupied by DS the brother of N and C. The unit was known as part of the "Headway" units and was used as housing for unemployed youth. The evidence suggests that the group slept overnight at these premises and various other friends and associates came and went during that evening and the following day. BH was one of the persons who attended the unit on the 20th May arriving at about 2.00pm. JH was another person that joined the group in Unit 6 and she resided at Unit 9 of the same complex. All of the aforementioned persons were witnesses to various stages of the police pursuit, either as passengers or as witnesses making observations from the balcony of Unit 6.

We know from the evidence that JD stole motor vehicle registration number ABT.295, a Holden Commodore station wagon on the evening of the 20th May, 2004, after leaving the Headway unit. It is known that he stole this vehicle while in the company of DS. JD and DS then returned to the Headway unit in the stolen commodore station wagon where they joined the other persons there. The evidence would suggest that at the unit at least some of the persons present had used drugs. Shortly before 3.15am on the 21st May, 2004, JD decided to return to his house in order to have a shower. DS and BH decided to join JD for the journey back to D's home and a music CD was taken from the Unit with the intention of it being played in the vehicle. It is known from witnesses that the commodore departed the Headway Unit and travelled up Mercury Street towards the hospital where the vehicle turned

right into New Dapto Road and then approached the intersection of New Dapto Road and Crown Street, Wollongong. At about this time a fully marked Police Sedan was stationary at the intersection of New Dapto Road and Crown Street. The Police vehicle was stationary indicating a left hand turn into Crown Street and was stationary due to red traffic control lights. It is apparent from the evidence that the vehicle driven by JD became stationary directly behind the Police Vehicle. The Police vehicle was a fully marked Holden Commodore V8 SS Sedan registered Number TNT.247.

Sen Cst Roberts the driver of the Police vehicle whilst stationary at the traffic lights became aware of the presence of the vehicle that was stationary behind him and observed two males whom he believed to be about 16 years of age. When the traffic lights turned to green, he negotiated a left hand turn into Crown Street and put his left indicator on with a view of stopping. The vehicle driven by JD at the same time negotiated a U turn at the traffic lights and commenced to travel back in the direction that it had come from, viz down New Dapto Road and then left at the roundabout into Mercury Street towards the Headway units. The Police vehicle then negotiated a U turn with a view of following the Holden commodore and Sgt Rivett the observer in the Police vehicle radioed VKG to indicate that they were in pursuit. The Police vehicle activated its lights and sirens when the pursuit commenced. The Holden commodore was followed down New Dapto Road and then down Mercury Street. Adjacent to the Headway units there is a roundabout which the Holden commodore negotiated and commenced to travel back up Mercury Street, however, the vehicle then deviated over the medium strip and drove up the laneway which is beside the Headway Units. The Police vehicle remained in pursuit and also followed the commodore up the laneway. In so doing the Police vehicle did not mount the medium strip, but travelled a short distance back up Mercury Street and then negotiated a turn before turning left in the laneway. At this time the evidence suggests that JD was still the driver of the commodore and that DS was seated in the front passenger seat and BH was in the rear seat. The driveway which runs along the side of the Headway Units opens up into a grassed area and is effectively a dead end. At the end of the grassed area there is a creek and a footbridge, however, there is no provision for vehicles to exit this area, other than to turn around. The evidence would suggest that the vehicle driven by JD attempted to stop before reaching the creek area, however, the vehicle partly entered the creek embankment and toppled over to its offside. The evidence suggests that both DS and BH were able to extricate themselves from the vehicle, however, JD became trapped under the partially overturned vehicle. The VKG tapes indicate that the pursuit from the point it was radioed in until the vehicle was sighted as having overturned had an elapsed time of approximately 35 seconds.

VKG records indicate that information concerning a person trapped beneath a vehicle was radioed at 3.18am. Records also indicate that other police vehicles arrived at 3.19am followed shortly thereafter by Fire Brigade appliances and the Ambulance. JD was removed from beneath the vehicle within minutes and resuscitation commenced, he was pronounced deceased at 3.34am.

## **IDENTIFIED ISSUES.**

As submitted by Mr.Eckhold, in his opening address the focus of this Inquest, apart from determining those statutory matters that deal with identity, date, place, manner and cause of death, is the Coroners responsibility to examine the circumstances leading to the death of JD and in particular the following;

- the police pursuit,
- compliance or otherwise with the Police Safe Driving Policy,
- attempts to rescue Mr.Denniss and
- the implementation of Critical Incident Investigation protocols.

### **The Police Pursuit.**

The NSW Police Safe Driving Policy sets out the guidelines in regard to Police Pursuits. There is firstly a requirement that no police pursuit be commenced unless the police vehicle is of an approved and appropriate category. The police vehicle involved in the this pursuit was a fully marked Holden Commodore Sedan, a Category 1 vehicle which is permitted to be involved in pursuits. The Policy also requires that the driver of the vehicle must hold a silver or gold police accreditation. Sen Cst Roberts was gold accredited at the relevant time.

The Policy sets out the procedure for calling in a pursuit, which requires that lights and sirens must be activated and VKG informed. There is a requirement to provide information to VKG as to the speed of the pursued vehicle, identification details if known, road conditions, weather conditions, amount of traffic etc. These matters are more fully set out in the Policy and the pursuit can be terminated at any time by the VKG Operator, the driver or the observer when the observer is of a more senior rank to the driver.

Dealing with the pursuit in this instance sight should not be lost of the fact that the pursuit lasted no more than 35 seconds and it commenced at the intersection of New Dapto Road & Crown Streets, Wollongong. The distance travelled for the entire pursuit was a little over 1500 metres ending in the open grassed area behind the Headway Units. A large part of this Inquest has focused on the evidence of a number of witnesses as to the speed and manner of driving of both the pursued vehicle and the Police Vehicle. The evidence of witnesses as to speed has ranged from 80 to 120 kph (estimates of Cst Roberts and Sgt Rivett and evidence of DS & BH) and to up to 200 kph by one witness who was making observations from the balcony of Unit 6. As far as independent witnesses are concerned AH thought the speed of the vehicles was about 100kph and RC estimates the pursued vehicle as travelling at around 70 kph when coming down Mercury Street.

As pointed out by Mr.Eckhold reliance on the evidence of any particular witness must be examined in relation to their respective experience and ability to make realistic and reliable estimates of speed over a short period of time. The disparity between the evidence of the witnesses who made observations from the balcony of Unit 6 is an example of how witnesses, purportedly seeing the same thing, can give such diverse evidence of speed

and observations. Those comments are not intended as criticism but rather reflect the reality that perceptions of speed etc can be grossly inaccurate. Similarly, the evidence given by various witnesses as to the distance between the pursued and the police vehicle is another example of how evidence can be remarkably different. Much the same can be said of the issue in regard to whether the pursued vehicle and the Police vehicle crossed onto the incorrect side of the road.

It is my view that much of the discrepancy in regard to speed and as to whether the pursued and police vehicle crossed onto the incorrect side of the road is somewhat irrelevant in terms of the safe driving policy. Sight should not be lost of the fact that it is not disputed that at the time of the pursuit, that being at 3.15am, traffic was light and there is no suggestion that the pursued vehicle or the police vehicle overtook any vehicles or that they passed any vehicles travelling in the opposite direction. This is an important factor in determining whether there was a risk to other road users.

The Police were of the view that during the pursuit down Mercury Street, the speed of the offending vehicle did not exceed 120 kph and they did not consider it necessary to terminate the pursuit at that stage. Sgt Rivett in his evidence was of the view that the pursuit became dangerous when the offending vehicle drove over the medium strip after negotiating the roundabout, however, it was at this point that the offending vehicle entered the driveway. It is clear from the evidence in my view that the Police officers were entitled to form a view at that point that the pursuit was effectively coming to an end as it was believed that by the offending vehicle driving down the driveway, the intention of the occupants was most likely to stop the vehicle and decamp.

One will recall the evidence of Sen Cst Roberts that when he drove down the driveway he was looking to his right to see if the vehicle had been parked. This evidence if accepted, and I have no reason not to, would also support the proposition that the Police vehicle did not have the commodore in visual contact once the Police vehicle entered the driveway. One must remember, that even witnesses from the balcony of No.6 confirm that the Police vehicle did not follow the commodore over the medium strip.

Having regard to the speed of the commodore at that time and the fact that some seconds would have elapsed while the Police vehicle re negotiated the roundabout, it is beyond doubt in my view that the commodore was not in visual contact with the Police vehicle in the driveway.

One should also keep in mind that 35 seconds is not a very long time and this was not a pursuit over some kilometres, where it would be expected that the Police could more accurately provide information, or assess for themselves, those elements of the safe driving policy that need to be considered, eg speeds, traffic conditions, danger to other road users etc.

Had the offending vehicle not entered the driveway but continued back up Mercury Street and thereby heading back towards major roads and intersections, it would have been incumbent on the Police and the VKG Operator (if so informed) to re-assess whether the pursuit should continue.

I am satisfied that the Cst Roberts and Sgt Rivett did comply with the Safe Driving Policy and that the pursuit did not reach a point where consideration due to speed or manner of driving necessitated termination of the pursuit. I form that view on the balance of evidence presented by both the involved Police Officers and the observations of civilian witnesses.

### **The Rescue and Retrieval of Mr. D.**

Apart from the Police Pursuit the other area of concern and focus at this Inquest was the attempts to rescue Mr D when it became apparent that he was trapped in or under the vehicle. It is clear from the evidence that when the Police vehicle entered the grassed area at the rear of the Headway Units the Holden Commodore had already skidded and had rolled onto its offside. Both officers have given evidence of their observations and both were of the view that the occupants of the vehicle, believed to be two persons, had decamped. It was also evident that at this time the vehicles engine was still running, the rear wheels turning and a CD player was playing. The immediate concern for the Police was to attempt to detain the persons believed to have been in the vehicle and accordingly Sen Cst Roberts commenced to pursue what he believed to be two persons who had entered the creek area. At about this time Sgt Rivett heard another person calling for help and it was then believed that a third person may have been trapped in the vehicle. On the evidence presented at this Inquest it is most likely that Sgt Rivett entered the vehicle via the rear hatch at this stage to see if he could locate the person in the vehicle. There is no reliable evidence whether his actions in entering the vehicle caused the vehicle to move and similarly there is no evidence that his weight may have in some way contributed to the death of Mr D. What is clear is that the actions of Sgt Rivett were motivated towards helping a person that he believed was trapped inside the vehicle and he did so without any regard for his safety and well being. He should be commended for that. It is now also known that about this time a strong smell of petrol could be detected and it was clearly a potentially dangerous situation with a possible fuel spillage, a running motor and live electrics. We know from the evidence presented that the second police vehicle arrived at the scene approximately 1 minute after Sgt Rivett radioed that a person was possibly trapped. NSW Fire Brigade arrived next and immediate action was taken to secure the vehicle by using a winch. The evidence would suggest that Sgt Rivett may well have entered the vehicle on a second occasion at which time he determined that Mr D was possibly under the vehicle.

The vehicle was secured and Police and Ambulance personnel were then able to move safely down the offside of the vehicle and extract Mr D. Ambulance Officer Daniels in his statement outlines his observations of the position Mr Denniss was in when he reached him and his medical condition. It was the view of Mr Daniels that Mr D was deceased when he was extracted, however, his vital signs were checked and he was pronounced deceased at 3.35am.

### **Critical Incident Investigation Protocols.**

Det Sen Sgt Harbin has in my view completed a very thorough, comprehensive and independent investigation into the death of J D. A number of minor omissions in regard to critical incident protocols have been detected, however, they are not matters that in any way impacted on the credibility of the investigation. Those matters have been identified in Detective Inspector Baileys report which forms part of the brief and requires no further comment. It was also noted that in this case the Police vehicle which was involved in the pursuit was required to be moved in order to allow access to rescue vehicles. No criticism should be levelled at Police for moving the vehicle, however, with the benefit of hindsight it may have been prudent to at least have marked the four wheels on the grass surface with an appropriate marker.

I have also noted Inspector Bailey's comments in regard to the incident log and the involvement of Wollongong 38. I am aware that Inspector Bailey's comments have been passed on. Any criticisms of the Police in securing the crime scene, maintaining a proper incident log and the movement of the pursuit vehicle should be considered in the light of the circumstances at the time. It was in the early hours of the morning, the area was not well lit and the immediate concern was to get rescue vehicles into the immediate area in order to secure the vehicle and release any persons trapped. It was also a difficult area to cordon off as a crime scene and understandably members of the public, most of whom we now know knew the deceased, were understandably upset and their presence created another issue for the Police to deal with.

### **Cause of Death.**

This court has heard evidence from medical and pharmacology experts as to the cause of death and the affect that drugs such as cannabis and methylamphetamine may have had on the decision making factors and driving ability of the deceased. Clearly the evidence of Dr Judith Pearl would suggest that the amount of cannabis found in the blood of the deceased following analytical tests, was at the lower range. The reading was either indicative of a small amount of consumption at same time within 12 hours before death or it was indicative of a residual reading from consumption at a longer period before death. In any event, Dr Pearl was of the view that the small amount of cannabis was not likely to have affected Mr D's ability to drive the motor vehicle. Dr Pearl also gave evidence in regard to the methylamphetamine reading and this reading was quite high and in the toxic range. Dr Pearl was of the view that the reading was such that it was high likely that Mr D would have been affected by this drug. She described some of the effects of this drug as causing impaired judgment, risk taking and the ability to control a motor vehicle would be compromised.

The primary evidence as to cause of death was given by Dr Duflou, Senior Forensic Pathologist, Glebe, who performed the post mortem examination of Mr Denniss. Dr Duflou in his opinion believes the cause of death was due to Traumatic Asphyxia. Professor John Hilton, a former senior Forensic

Pathologist was requested by the Legal Aid Commission, who represent the interests of C D, to review the post mortem findings. Professor Hilton has furnished his report which is in evidence and he has given further oral evidence at this Inquest. Professor Hilton does not dispute the findings of Dr. Duflou, however, points out that Dr Duflou did observe that the deceased's lungs were moderately hyper inflated with thickening of the basement membranes of the bronchi. This observation by Dr Duflou and supported by Prof Hilton may be indicative that J D may have been suffering from asthma. Accordingly Prof Hilton expresses the view that "the excitement of stealing the car, the chase, the crash and the fear and stress inducted by his being semi-ejected and trapped, may well have precipitated an asthma attack, which may have contributed to his death.

Professor Hilton may be correct, however, he does not and can not attribute the direct cause of death to asthma. In the same way the evidence of Dr Pearl in regard to the toxic levels of methylamphetamine's may be seen as a contributing factor, but not the primary cause.

I am persuaded to the views expressed by Dr Duflou in the witness box. Determining a direct cause of death in some cases is not always that simple. As he pointed out, it is a process of elimination. Mr D had no injuries to his body that would have been life threatening. Apart from a high level of methylamphetamine he had no toxic substances in his system that were detected in the fatal range and to which death could be contributed. Dr Duflou not only took into account his observations of Mr D at the scene, his external and internal post mortem examination, but also the known history of the events leading to death. In that regard Dr Duflou would have placed considerable weight on the fact that Mr D was conscious and able to call for help for a short time and he was aware that he was found pinned underneath an overturned vehicle. It is probably not likely that Mr D would have been able to call for help if he was suffering an asthma attack. On the balance of probabilities I am of the view that the cause of death was from asphyxia and the mechanism of asphyxiation was due to compression of the chest and abdominal region from the position of the overturned vehicle.

### **Recommendations.**

Mr Schridhar has presented a compelling submission, in particular in regard to the current policy of the New South Wales Police Force in regard to pursuits and the Safe Driving Policy. I propose to mark his submission as Exhibit No. 20. There is no need to restate the points in the submission, however, I will deal with the issues raised.

Firstly it should be restated that I am of the view that there was no breach of the safe driving policy on this occasion and ordinarily, a Coroner would be persuaded to make recommendations if it is perceived that either there was a breach of the Policy or that the evidence presented was such that the Policy needed to reviewed as a result of a ambiguity or a discrepancy that arose during the Inquest. It has not been submitted by Mr Shridhar that the Policy was breached on this occasion, however, his submission is one that questions

the policy specifically in regard to whether a pursuit can be justified if an offence is minor or unknown and whether a pursuit should take place when it is known that the driver of the vehicle may be a juvenile.

Dealing with the first point, that is should any pursuit be commenced when an offence is minor or unknown is a difficult area of policy and one that may require considerable research and input by the NSW Police Force, its legal advisors, the community and other interested bodies such as the various credible road safety organisations and or committee's. Mr. Shridhar has referred in his submission to the Queensland Crime & Misconduct Commission report of 2003 in relation to Police Pursuits, law enforcement and public safety issues. (Exhibit 12) He submits that other Australian states have introduced a more restrictive policy of pursuits and that in some states pursuits are terminated when the offender is identified as being a juvenile.

Certainly I can see some merit in any safe driving policy of having as one of its considerations the need to assess whether a pursuit should continue if it relates to a minor offence, or the offence is unknown and the driver is clearly identified as being a juvenile. One should accept that juvenile drivers, in some cases are inexperienced or possibly unlicensed and may well not appreciate the risks to themselves or other members of the public. The difficulty of course is how can one determine with any degree of certainty as to whether a driver is a juvenile and Mr Hood has covered this point in his submission and his submission has merit. The current NSW Safe Driving Policy does not make any reference to juvenile offenders and the problem with differentiating between juvenile and adult drivers will always be a matter of judgment. Clearly if a juvenile is recognised and his identity is known then the considerations as to whether a pursuit should continue would be determined by the nature of the offence and the competing interests of an attempted arrest and its dangers as opposed to proceeding by other means.

As Mr Hood has submitted there are competing considerations on this issue. There is the sworn responsibility of the Police to uphold the law and the community expectation that they will do so and the need to ensure public safety. It would be of concern should young offenders have the knowledge that if they fail to stop that the Police will not pursue them. That knowledge may well lead to an increase in crime if it is believed that they can flee police with some sense of immunity from immediate arrest. The power of the police to pursue and apprehend must be seen as a legitimate law enforcement strategy and a policy that in most law abiding members of the community should act as a deterrent.

I have also been informed by Mr Hood that the NSW Police Force has recently completed the installation of video camera's in all highway patrol vehicles. These cameras are activated during a pursuit and are able to record visually as well as store data as to the speed of the police vehicle. This new technology is certainly welcome, and it will provide reliable evidence that can be examined at some time later if the need arises. The cameras will also make Police Officers more accountable in relation to their dealing with the public and in regard to pursuits it will record details of those matters (eg speed, manner of driving etc) that are necessary considerations for termination.

Having considered the submissions made on the issue of the Safe Driving Policy and I am more inclined to the view to not make formal recommendations as there is no evidence that the Policy was defective or was breached in regard to the death of JD. However, as Mr Hood has submitted, and I would agree, any Policy should be robust enough to be subject to review and assessment from time to time. I understand from my own research that the current Safe Driving Policy was reviewed approximately 5 years ago following recommendations by the State Coroner. Since that time, there have unfortunately been a number of deaths that have occurred during police pursuits and as those matters, as in this case, all fall under the provisions of Section 13A of the Coroners Act, an Inquest would have been held. My concern as a Coroner in dealing with deaths in Police Operations, particularly pursuits is to try to reach a balance between appropriate law enforcement and the protection of the community. Invariably, policies are but a guide and their effectiveness depends on the training and experience of the police officers and adherence to the guidelines. In this Inquest and in at least two other matters that I have presided over (Inquest into the death of Tabitha Berg and Dean James and the part heard inquest into the death of Maxwell Phillips) police have pursued or followed drivers who have not stopped after the police activated their lights and sirens as an indication for them to stop. In this case and the others, while there might be a suspicion that the driver is unlicensed, driving a stolen vehicle or simply refusing to stop for a breath test, the offences are not serious indictable offences. The question is raised, should they be pursued if they fail to stop. The simple answer I believe is that they should be pursued, however, there must be strict compliance with the Safe Driving Policy and there must be termination of the pursuit immediately there is a recognised danger to the person or persons in the vehicle or other members of the public. As I have previously stated, in this Inquest, I have not found that the pursuit had reached the point where consideration for termination had been reached. It was possibly still in the minds of the Police Officers that the vehicle may still stop and the speeds and manner of driving had not reached the critical dangerous level where termination would have been required.

For the above reasons I am disinclined to make a formal recommendation, however, I would strongly urge the Commissioner of Police to examine the briefs of evidence in this matter and also in the Inquests into the deaths of Berg & James (Westmead files).

I would urge that consideration be given to setting up a working party with a view of reviewing the policy. Such review could examine the policy in other states, the effect of the installation of camera and as to how that might impact on the Policy and consideration could also be given to the issue of pursuing clearly identified young offenders. Any such working party, might also consider whether one of the State Coroners, who invariably preside over these mandatory inquests be included in any proposed Working Party.

## **SUMMARY.**

It gives me no pleasure in having to preside over Inquests of this nature. They are emotional and draining experience for the family who as in this case, have had to sit through and re-live the tragic events of almost 2 years ago. From my experience it is also devastating for the Police Officers involved, in many cases the officers never get over the events and in many cases suffer personal and emotional trauma as well.

If there is any benefit from a prolonged inquest such as this, it is that it provides a vehicle through which the family, can hopefully have some answers and perhaps some closure. Mrs D has sat through over 2 weeks of evidence with her family and friends and I know it has been a difficult time for her. Her kind comments in regard to the manner in which this Inquest was conducted are gracious and appreciated by me, as I am sure they are by members of the Bar Table and my Counsel assisting who have all assisted in this process.

I do not have a lot of personal information about JD, other than what is contained in the brief of evidence. I know he was 16 years old at the time of his death, that he lived with his mother at Berkeley and that he was unemployed. I understand that he was in a relationship. I do know that he was known to the Police and had been dealt with in the Children's Court for a number of offences. It is sad that Justin did choose to steal the motor vehicle on the 20th May as ultimately that very vehicle was the implement of his death. I do not wish to denigrate JD's life, every life is valuable and he was only 16 years of age and its sad that a life should be lost at such a tender age and particularly in circumstances that emerged at this Inquest.

## **FORMAL FINDING.**

**That JD died on the 21st May, 2004, at the rear of 2 Mercury Street, Wollongong in the State of NSW from Traumatic Asphyxia, when the vehicle he was driving rolled causing him to be trapped beneath it.**

6.

988 of 2004

**Inquest into the death of Scott Simpson at Long Bay Correctional Centre, Malabar who died on 7 June 2004. Finding handed down at Glebe by Deputy State Coroner, Magistrate Dorelle Pinch on 17 July 2006**

### **Brief Facts**

Scott Simpson was taken into custody at the Metropolitan Remand and Reception Centre ("MRRC"), bail refused, around 3.50pm on 30 March 2002. He was granted protection and, about 6.10 pm, he was placed in a two-out cell with Andrew Parfitt who was also in protective custody, having entered the MRRC the previous day following revocation of his parole. Within 15 minutes Simpson had brutally attacked Parfitt, inflicting fatal

injuries. The following day Simpson was placed in segregation. Except for two short periods, he remained in solitary confinement at various prisons until he hanged himself in his cell on 7 June 2004.

On 31 March 2004 Simpson was found Not Guilty of the Murder of Parfitt. Bell, J. in the Supreme Court ruled that at the time he killed Parfitt two years earlier Simpson was suffering from a mental illness. Her Honour had before her expert evidence from three psychiatrists, Dr Lucas, Dr Westmore and Dr Greenberg, describing Simpson as suffering from paranoid schizophrenia. Each expressed the opinion that at the time of the attack Simpson was suffering a psychotic episode.

It is pertinent to emphasise that Simpson was in prison not because he had been convicted of an offence and given a custodial sentence. Initially, he had been remanded in custody for alleged offences involving violence. As the history set out below illustrates, those attacks occurred when Simpson was suffering paranoid delusions. The subsequent attack on Parfitt in prison occurred in similar circumstances. The evidence before me indicates that Simpson's mental illness was not something incidental to his incarceration. His delusional beliefs and his actions in accordance with them were the very reason he was in custody.

Although Simpson was reviewed by seven psychiatrists over the next two years, there was no opportunity for a therapeutic relationship with any of them. Hence, the only on-going treatment he received was antipsychotic medication, which he took intermittently. There was evidence before me to indicate that medication should only ever be part of an overall treatment regime.

### ***Post Mortem Examination***

A post mortem examination conducted by forensic pathologist, Dr McCreath, confirmed that Simpson had died by hanging. There was no evidence of any trauma or struggle that would suggest that anyone else was with him at the time of his death. She also indicated that the toxicological blood analysis revealed no antipsychotic drugs were present when he died.

### ***Scope of Inquest***

As Simpson died while in custody, it is mandatory under Section 13A(1)(a) of the Coroners Act 1980 to hold an inquest. There were many issues raised that were pertinent not only to Simpson personally but to the treatment of mentally ill inmates and forensic patients in prison generally. In order to appreciate both the clinical and the systems parameters of Simpson's incarceration I had before me evidence from the following:

- The seven psychiatrists who reviewed Simpson;
- Senior staff from the Department of Corrective Services ("DCS") involved in the decision-making about Simpson's placements;
- Senior staff from Justice Health involved in administering the hospital facilities at Long Bay;

- Staff from both Justice Health and DCS who had relevant dealings with Simpson;
  - The President of the Mental Health Review Tribunal
- as well as some fifth documentary exhibits including medical records, DCS records and policy and procedure documents.

The focus of the inquest was, perforce, on the manner and cause of Simpson's death rather than a general inquiry into the treatment of mental illness in a custodial setting. Nevertheless, I am satisfied that where I have made comment or recommendations about systems generally, the material before was extensive enough to provide a sound basis for doing so.

### **History**

Simpson had a lengthy criminal history. It is not necessary for me to review that in detail. Suffice to note that from his previous terms of custody, DCS had documented a history characterised by self-harm attempts, violence and mental illness.

In order to place the events of March 2002 in perspective it is instructive to look at what was happening in Simpson's life during the previous six months.

On the 12 October 2001 police were called to premises in Granville where Simpson was seen to climb over garage roofs. He told police that he was being watched by ASIO and the NCA. He was subsequently admitted for treatment of a psychotic episode to Cumberland Psychiatric Hospital on the 19 October 2001. Following his discharge on 31 October 2001, he went to Coffs Harbour to see his family. His behaviour became violent and bizarre and he was charged with offences arising out of assaults on family members. He was seen by a psychiatrist whilst in custody at Coffs Harbour and was prescribed anti-psychotic medication. He was moved to Grafton then to the MRRC on 11 November 2001. He was initially placed in a two out cell. On 12 November he was also placed, at his request, in protective custody (limited association). The two out placement was reviewed on 13 November when he made homicidal threats to his cell-mate. Also on 13 November 2001 a Mandatory Notification Form for inmates at risk of Suicide or Self Harm was completed and a Risk Assessment Intervention Team (RIT) convened. On 16 November a notation on his file indicates that he was on the waiting list for D Ward – the acute psychiatric ward within Long Bay Hospital. A further note on that day recorded, "Inmate is presently at risk to himself and others". An entry on 18 November records a meeting between a psychiatrist and Simpson the previous day and confirmed that Simpson was going to D Ward. However, placement in a two out cell was now permitted. On 20 November the RIT was terminated. Also on that day Simpson was seen by Dr Ahmed who did not consider that he was mentally ill. Presumably, as a consequence of this diagnosis, his name was removed from the D Ward waiting list.

Simpson was discharged from the MRRC on 14 January 2002. However, I note that the Discharge Summary by DCS was not completed until 31 March 2002. On 27 March 2002 Simpson attended Parramatta Police station

requesting to be taken into custody because he had failed to comply with the reporting requirements of his bail. Concerned with aspects of his behaviour, police officers conveyed him to Cumberland Hospital but he was not assessed as being mentally ill within the meaning of the Mental Health Act 1990. Simpson was released on bail. On 29 March he initiated an unprovoked attack to a person and his vehicle while having a psychotic episode. The Custody Manager at Windsor Police Station, where Simpson was taken after his arrest, considered that Simpson could “snap” at any moment. The following day, 30 March 2002, he was taken to the MRRC.

Simpson was psychotic on 29 March. He was also psychotic, according to three psychiatrists, on 30 March. Why was his mental state not identified at his Reception Assessment on 30 March by Justice Health staff?

### **Reception Assessment**

When he was interviewed by Nurse Kumar from Justice Health, Simpson appeared “co-operative, alert and orientated”. She stated that her assessment relied totally on the interview - she had no access to previous Justice Health records or Department of Corrective Service records at the time of interviewing Simpson.

The Medical Alert Form that she completed has the following boxes ticked: general impulsive behaviour, violence to others, serious mental illness, suicide attempt while seriously mentally ill, illicit drug use, unintentional illicit drug overdose, self-harm behaviour – hanging. Yet the information as provided by Simpson himself does not provide a context and certainly does not convey his recent pattern of behaviour as set out above, most importantly the recent assault while under the influence of delusional beliefs. Hence, the medical alert form carries the notation “SMI” and recommends a two out cell placement, because of his previous suicide attempts. In the Justice Health file there is a note that Simpson should be referred to a psychiatric nurse.

I note that, on a previous occasion when Simpson was in custody, Nurse Kumar had, in the course of her duties, given him anti-psychotic medication. However, she was unaware of the details of his mental illness.

As mentioned previously, the discharge summary in relation to Simpson’s discharge on 14 January 2002 was completed on 31 March 2002 – a day after the ferocious attack on Parfitt. It provides information that should have been available to Justice Health in determining Simpson’s placement,

“ This inmate is a danger to staff and other inmates. He has made numerous threats against staff and has been involved in inciting other inmates to violence. He is unpredictable and violent, is alleged to be involved in standover tactics and drug trafficking. Extreme caution should be used at all times. Do not see this inmate alone. He has a history of mental illness and has made homicidal threats against his cell mates. He has been under RAIT management on numerous occasions, has an extensive history of self-harm and self-harm thoughts. He is an escapee and poses a high risk of escape.”

After he had been assessed by Justice Health but prior to being placed in his cell, Simpson punched another inmate in the reception area without provocation. This incident was not reported to Nurse Kumar at the time so that the initial decision about Simpson's placement could be reviewed if necessary. According to the Custodial staff at Reception "punch ups" are not unusual. Nevertheless, it was an important indicator of Simpson's mental state and ought to have been reported to Justice Health.

Nurse Kumar gave evidence that if she had known about the assault she definitely would not have recommended a two out cell placement. She stated that she would probably have put Simpson in an assessment cell because of his previous suicide attempts and then have the mental health nurse review him in the morning. She stated,

"I never ever put an agitated person or a person that assaults others with someone else."

## **Issues**

### **1. Access to records**

I am satisfied that the new Reception Triage Process which has been operational for the past two years has markedly improved the information flow from the Department of Corrective Services to Justice Health staff performing reception assessments.

The means is not only via files but also by computer link. However, the evidence indicates that the Justice Health files may not always be available for the reception interview, particularly of a weekend. It seems to me that Justice Health ought to generate a Discharge Summary from a health/mental health perspective and that this information should be recorded on computer so it can be accessed during the reception process as well as information from DCS.

### **2. Discharge Summary – DCS**

Under the system of information exchange in 2002 the DCS Discharge Summary would probably not have been available to Justice Health staff prior to the reception assessment. In Simpson's case it most definitely would not have been available because it was not completed until the day after Simpson was assessed and the attack on Parfitt occurred. It seems to me that the Summary needs to be completed within a reasonable time frame, say 14 days, after the inmate is discharged.

I note that the documented procedures for the Discharge Summary Unit emphasise the need for Justice Health to have the summary for screening "at risk of suicide" inmates prior to the initial assessment. This reference needs to be expanded to include not only instances of self harm but harm to others as well.

### **3. Mental health assessment prior to placement**

I note the formation of the Mental Health Screening Unit located at the MRRC and opened on 6 February 2006. This should enhance the ability of Justice Health to identify those remand prisoners with a mental illness and to facilitate an appropriate clinical response.

### **4. Notification of harm or attempted harm to self or others after review & prior to placement.**

Ms Kumar was not notified of the assault by Simpson on another inmate in the period between the conclusion of her session with him and his placement in the cells. Any such instances of behaviour must be reported back so that they can be taken into account and the initial assessment revised, if appropriate.

### **Appropriateness of Placement**

It is obvious from my comments above that I consider Simpson ought not to have been placed two-out. Least of all should he have been placed with Parfitt. Parfitt had previous suicide attempts and was placed in a safe cell with the requirement of continuous clinical observation. Parfitt had requested protection on the basis that he feared for his life and welfare. (Parfitt was a convicted paedophile whose parole had been revoked). On the RIT Management Plan drafted for him on 30 March, there is a notation that the risk from others is high and that he was afraid of being assaulted.

There is no indication on the Protective Custody Direction form whether Parfitt was to be detained in isolation or in association with such other inmates as the Commissioner (or governor on his behalf) may determine. Certainly, no other inmates were nominated as being safe for him to associate with.

Evidence was given that when neither box was ticked the inmate was to become a Special Management Area Placement ("SMAP") prisoner pursuant to Clause 32 (3)(b) of the Crimes (Administration of Sentences) Regulation 2001. I understand that the procedure attached to SMAP placements has changed since March 2002 so I do not intend to review the provisions of the Regulation in detail. Suffice to note that there is a particular form that needs to be completed for SMAP placements and it is not the Protective Direction form. From a substantive point of view, the Commissioner, or Governor in his stead, was required by Section 12 Crimes (Administration of Sentences) Act 1999 to nominate the type of protective custody that had been granted to Parfitt. He did not do so. Since no one had been nominated as suitable to associate with Parfitt, no one should have been permitted to share his cell. With his history of violence and recent assault, Simpson should never have been considered as a suitable cell mate for Parfitt.

## Treatment for Mental Condition

In the aftermath of the attack on Parfitt, Simpson was placed in segregation. Dr Murphy examined him and concluded that he was suffering from paranoid psychosis. He completed a Schedule Three under the Mental Health Act 1990, although it has not been co-signed by another medical practitioner as required by Act. Nor is it clear whether Dr Murphy intended to invoke the provisions of Section 98 or 97 of the Act. From his other comments, however, I infer that Dr Murphy had formed the opinion that Simpson was a mentally ill person and required treatment in hospital. Without a second signature, the Schedule is incomplete and there is no evidence that it was ever placed before the Chief Health Officer as required under the Act. However, Simpson's name was to be placed on the D Ward waiting list. The other components of the plan set out by Dr Murphy was that Simpson was to remain on his anti-psychotic medication, be seen daily by mental health staff and be reviewed frequently by a psychiatrist.

I intend to comment later on the system of the waiting list for D Ward and how it was administered. At this point I will note simply that Simpson had not been transferred to D Ward before he was transferred to the Multi Purpose Unit ("MPU") at Goulburn Correctional Centre on 26 April 2002. I do not know the condition of others who were waiting for admission to D ward at that time. However, it seems that Simpson should have been very high on the priority list – he was demonstrably acutely mentally ill to the extent that he had killed another person. However, instead of receiving treatment in hospital he was sent to a segregation cell in the MPU with minimal opportunities for adequate psychiatric care. That initial move to Goulburn typified how Simpson was dealt with during the rest of his time in custody, namely:

- a) mental health professionals in regular contact with Simpson advocated strongly for his hospitalisation;
- b) those making the decisions about priorities for admission to D Ward did not accord him sufficient priority for the transfer to hospital to be effected; while
- c) DCS focused on security aspects and kept Simpson segregated;

The result was that while Simpson's condition fluctuated depending on whether he was compliant with his medication, the time spent in segregation lead inevitably to a deterioration of his mental state until the crisis point was reached on 7 June 2004.

On 7 January 2003 Professor Greenberg in a report to the Serious Offenders Review Committee noted that Simpson was suffering a mental illness and required treatment in a psychiatric hospital. In a later undated report Greenberg reiterated his earlier comment and added that Simpson required psycho-education about his illness and needed to see a psychiatrist on a weekly or fortnightly basis. At that time a psychiatrist visited Goulburn for six hours per fortnight. There was no opportunity, therefore, for Simpson to receive the medical attention that he needed. That fact was drawn to the attention of the Director Mental Health, Ms Doherty, by Nurse Ricardo of the Goulburn Clinic in a letter dated 3 April 2003. By that time Simpson had moved from 33 to 32 on the D Ward waiting list.

It is significant to note Simpson had no insight into his illness. This accounts for the fact that he was noncompliant with his medication for long periods. It also accounts for his refusal to see psychiatrists and other mental health staff on occasions. For example, Dr McGrath noted on 3 April 2003 that Simpson had refused to see him. Indeed the Secretary of the Serious Offenders Review Council wrote to the Chief Executive Officer of Justice Health on 15 May 2003 outlining that since 30 March 2003 Simpson had refused to see medical staff or take his medication. The letter further enquired whether Simpson would be suitable for placement in D Ward.

On 20 June 2003 Ms Doherty accompanied Dr Samuels, Senior Consultant Forensic Psychiatrist and A/Clinical Director, to interview Simpson in Goulburn. Dr Samuels assessed Simpson, found he was compliant with his medication at that time and presented as mentally well. When questioned about the possible reason Simpson presented as mentally well to Dr Samuels, Dr McGrath commented that Simpson could appear rational for short periods if he wanted to but could not maintain that presentation for any length of time. He considered that Simpson's psychosis was fairly constant. The consequences for Simpson following the assessment by Dr Samuels was that his name was removed from the D Ward waiting list.

Dr Samuels considered that his assessment Simpson's mental state was vindicated because Mr Simpson remained safe for almost a year. However, Dr Samuels did concede that Mr Simpson's mental state deteriorated during that time.

It was submitted to me that Simpson was not disadvantaged because of his omission from the D Ward list because he could be added to the list at any time. The system did not operate so that those at the top were necessarily given the next available bed. The criteria was clinical need. However, the evidence indicates that being on the list should have ensured that Simpson's condition was reviewed on a regular basis by Dr White, psychiatry registrar at Long Bay, who decided on the priority of admissions to hospital.

The other consequence of Dr Samuel's decision was that Simpson remained at Goulburn where, apart from medication, he was offered no therapeutic treatment. Dr McGrath indicated that his attendance at Goulburn six hours per fortnight simply did not enable him to engage in any meaningful therapeutic relationship with Simpson. In my opinion, the decision whether to admit Simpson on 20 June 2003 should have been based on more than his presentation on that one occasion. There was no doubt that he had a mental illness although his condition fluctuated through phases of stability and instability. The prognosis for the illness needed to be taken into account, particularly in view of the fact that Simpson was kept in solitary confinement at the HRMU. Justice Health had a responsibility not only to ensure that Simpson did not self-harm in the immediate future but also to ensure he received the treatment needed to prevent his mental deterioration over a longer period. It is in the latter area that Justice Health failed.

## **Transfer to Long Bay Hospital Area 2 (“LB2”)**

This facility was previously referred to as a transit centre and, according to the evidence, it is still utilised for that purpose. It is one of two metropolitan centres that have segregation facilities and inmates on Segregation Orders who on have to attend court in Sydney are housed there for the duration of their court appearances. It was on this basis that Simpson was brought to LB2 on 22 March 2004.

Following the finding of Not Guilty on the grounds of Mental Illness on 31 March 2004 Simpson remained in Area 2. According to Dr Lewin, consultant psychiatrist, Simpson’s name was returned to the D ward waiting list on 1 April 2004 because of his legal status as a forensic patient, not for any clinical reason. Dr Lewin first saw Simpson on 8 April and conducted a detailed examination on 29 April, at which session Simpson was manacled. He diagnosed Simpson as suffering from Paranoid Schizophrenia, in partial remission, and recommended hospitalisation. Dr Lewin was gravely concerned about Simpson’s mental state and agitated to have him transferred to D Ward as quickly as possible. Dr Lewin saw him again on 6 May, at which time he decided that a cross-disciplinary team needed to be set up to manage Simpson’s behaviour. On 3 June when Dr Lewin was next expected to see him, Simpson was “locked down”. He was refusing to take his medication.

Dr Lewin stated in evidence that he was so concerned about being unable to get Simpson into hospital that he threatened to call the Minister. He described his exasperation in these terms:

“I have never had a higher index of concern about a patient. I felt powerless because it was absolutely apparent that he needed to be cared for in hospital and this was not happening.”

Later in his evidence he stated:

“My concern was that someone was going to get killed.....my concern was that a member of staff might have been harmed and I had almost the same index of concern with regard to Mr Simpson himself.”

From 10 May 2004 Simpson was number one on the list for admission to D Ward. However, on 1 June when the next bed became available another patient was given priority. Justice Health staff have consistently denied that Simpson’s security classification in any way influenced decisions in respect of his placement. However, it is understandably difficult for the Simpson family to accept that after being told that Simpson could not be admitted throughout all of April because he was not at the top of the list, he then waited for a month as number one without securing admission and was subsequently passed over when the next bed became available.

According to Ms Doherty a bed became available on the afternoon of 7 June but owing to the late notification, DCS transport for the transfer could not be organised until the following day. I note that the actual discharge records for D Ward show that a patient was discharged on 4 June. Ms Doherty explained

that there had been an overflow of D Ward patients into B Ward and that it seemed as if a patient had been transferred back to D Ward from B Ward. However, I note that there is no entry on DCS records that Simpson was to be transferred on 8 June. In the circumstances I am dubious that any arrangements had been made. After reviewing all the evidence I have reached the conclusion that Justice Health administrators were reluctant to admit Simpson to D Ward, whether unconvinced of the clinical urgency or because of security considerations or a combination of both, I am unable to determine. Certainly, one important aspect in the lack of urgency in respect of finding a bed for Simpson was the inadequacy of reviews of his condition undertaken by Dr White. Although Simpson's medication chart clearly indicates that he was noncompliant with his medication during his time at LB2, Dr White stated that he was unaware of this fact. Significantly, he gave evidence that had he been aware, it would have affected the decisions he made about prioritising Simpson's admission. Whether Simpson was taking his medication was crucial to his mental wellbeing. That this factor was not ascertained before deciding on his need for hospitalisation was a most serious omission. I note in addition that information about Simpson's non-compliance was specifically relayed to Ms Doherty by Simpson's mother around 27 May. Yet the information did not reach Dr White. **Dr White's response in court obviously showed that more could have been done to secure a hospital bed for Simpson. It wasn't. It ought to have been.**

On 7 June 2004 Simpson appeared at Penrith Local Court for the matters in respect of which he had been bail refused. The charges were withdrawn. He arrived back at LB2 at 1.16 pm. In just under seven hours later he was found hanging in his cell.

### **D Ward Waiting List**

In the period under review, Long Bay Hospital comprised four wards that comprised the following facilities for male patients:

- A Ward – 30 beds for long-term mental health patients;
- B Ward - 17 general medical beds (including female patients as well);
- C Ward – 30 beds for sub-acute mental health patients;
- D Ward – 29 beds for acute mental health patients.

### **Movement of Forensic Patients**

Demand for beds in D Ward far exceeds the supply. One reason is simply the number of mentally ill prison inmates who require hospitalisation. The other is that forensic patients who are found not guilty on the grounds of mental illness move very slowly through Wards C and A. According to Dr Lewin, mentally ill inmates outside hospital are often sicker than those in hospital. Evidence from Dr Chappell, President of the Mental Health Review Tribunal indicated that the NSW forensic system was structured so that the final decision on the release of forensic patients into the community rested with the Executive. Hence, there were political considerations that were involved in the decision-making process as well as clinical factors. He contrasted this

with other States in which the decision rested in the hands of either a Tribunal or a division of the Supreme Court. The structure of the mental health review system was, however, not fundamental to this inquest and hence, I received little evidence on this aspect. Nevertheless, I am sufficiently concerned from the limited evidence before me to recommend a review of the present structure to ensure that the limited hospital beds available are accessed by those inmates who most need them.

### **Number of Beds**

The number of beds available to forensic patients was clearly inadequate. As previously noted the opening of the Mental Health Screening Unit that opened on 6 February with 40 beds is an important initiative to ensure those entering prison with mental health problems are identified at an early stage and appropriately placed. Additionally, I heard evidence of the expansion of mental health services that is scheduled to occur over the next five years:-

- An 85 bed hospital complex jointly managed by DCS and Justice Health at Long Bay with 40 beds dedicated for mental health patients;
- A 135 bed maximum security hospital for forensic psychiatric patients at Long Bay administered by the Department of Health and managed by Justice Health;
- A medium security unit at Bloomfield which will also take forensic patients.

### **Priority Assessment**

In the relevant period, determining which inmates were given priority for admission to the scant beds available in D Ward was the task of a psychiatry registrar at Long Bay, Dr White. If he could not assess prospective patients personally because of their location, Dr White would discuss their condition with mental health staff at their respective institutions by teleconference. I heard evidence that this task is apparently now carried out by a Committee. While I am sure there are many advantages of a committee structure, nevertheless the effectiveness of the decision-making process depends on the information available to it. I have previously drawn attention to the fact that Dr White was unaware of Simpson's non-compliance with his medication. Unless there is some way of guaranteeing that such vital information is available to the committee, then the structure is no guarantee of the efficacy of its decisions.

The other aspect that is of concern is that the process for consultant psychiatrists to draw their patients' needs to the hospital administrators was not clearly understood. For example, two of the psychiatrists who gave evidence considered it was not appropriate to complete a Schedule 3 until a bed in D Ward became available. However, Ms Doherty stated that this was not the case and a Schedule could be completed at any time. I note that the completion of a Schedule does have legal consequences in that, pursuant the Sections 97 and 98 of the Mental Health Act 1990, the Mental Health Review Tribunal has to be notified when a Schedule is received by the Chief Health Officer.

It was submitted to me that if Dr Lewin was so concerned about the lack of progress in securing a hospital bed for Simpson he could have gone over Dr White's head and approached Ms Doherty or the Clinical Superintendent directly. Yet this was not part of the system as understood by Dr Lewin or, for that matter, the other consultant psychiatrists who gave evidence. If there is to be an avenue for appeal against the decision of the committee now performing Dr White's previous role, it must be clearly articulated so that all those involved in the system understand the process. As far as I am concerned there is nothing to criticise in Dr Lewin's approach.

### **Indications of Suicide**

Simpson had a documented history of suicide attempts, one occurring previously in the very cell in which he died. It was suggested in evidence that if Dr Lewin was so concerned about Simpson he could have convened a Risk Intervention Team. However, I note that Dr Lewin did not see Simpson after 6 May. Justice Health staff who saw him most regularly expected his imminent transfer to D Ward. They perceived his condition as chronic rather than acute. Those who gave evidence did not notice any significant change in his condition in the days prior to 7 June. In hindsight it is clear that Simpson ought to have been placed in a safe cell.

On the other hand I have no information about what transpired on 7 June except that Simpson attended court and the charges were withdrawn.

I cannot discount that there was something about the change of status or something else that occurred on 7 June that triggered Simpson's actions that night.

### **Segregation**

On 10 April 2003 Simpson was placed on the High Risk Management Unit ("HRMU") Program. He remained on that program until he died. Initially he was located at the High Risk Management Unit at Goulburn. However, the program continued when he moved to another location. Indeed, no movement could be undertaken without the authorisation of the HMRU. The evidence indicates that being on segregation would not affect a person's admission to D Ward ie there are facilities for segregation available in the hospital.

However, the HRMU is solely the domain of DCS. All decisions about an HRMU inmate, including segregation, are made without any input from Justice Health. Pursuant to Sections 10(1) and 10(2) Crimes (Administration of Sentences) Act 1999, the governor of a correctional centre may direct that an inmate be held in segregated custody if of the opinion that their association with other inmates constitutes, or is likely to constitute, a threat to the security of a correctional centre, or good order and discipline within the centre. Simpson was initially placed on segregation on 10 April 2002. During the periods 17 June – 21 September and 11 October – 6 November Simpson was allowed to associate with one other inmate, although in the latter period the association was permitted only through a secure barrier.

From the time of his arrival at Long Bay Area 2 on 22 March 2004 Simpson was placed in segregation. The last Segregation Order was due for review on 21 June 2004. This meant that Simpson spent some 10 weeks alone in a cell for up to 22 hours per day. He was allowed access to a “day yard” for around 2 hours per day. This caged area has a shower but no facilities for exercise. All of the psychiatrists who gave evidence stated that prolonged periods in solitary confinement would most likely exacerbate an inmate’s mental illness, particularly if he were suffering from paranoia. As Dr Lewin commented,

“Solitary confinement is not a medical treatment. There is no circumstance in which that is appropriate in the care of a mentally ill person.....I regard it as fundamentally inappropriate for someone as disturbed as this man (Simpson) to be in solitary confinement outside hospital.”

Yet Justice Health had no input into Simpson’s initial placement in segregation or any input into the review of the subsequent Segregation Orders. Moreover, Justice Health did not, in its own assessment of Simpson’s condition, consider the prospective impact of extended periods in solitary confinement.

### **Mental Health Tribunal**

One of the functions of the Mental Health Tribunal is to review the placement of forensic patients. Forensic patients include those inmates found not guilty on the grounds of mental illness and those who are “scheduled” under sections 97 or 98 of the Crimes (Administration of Sentences) Act 1999. Simpson became a forensic patient on 31 March yet the Tribunal was notified officially only shortly before his death, over two months later. If the Tribunal is to play an effective role, then it needs to be notified in a timely manner. I would have considered it appropriate for the court order to be sent by facsimile to the Tribunal within days rather than weeks. In any event, there ought to be a protocol between the Tribunal and the relevant courts setting out the maximum time-frame within which notification is to occur.

### **Procedures for Inmates found Hanging**

DCS policy about what a Custodial Officer should do if he finds an inmate hanging in his cell is clearly set out, namely:

“Should the person be discovered hanging, the officer shall immediately cut the body down protecting the head and neck as much as possible. (If another officer is present, one officer supports the body whilst the other officer cuts the suspending item.) The need to preserve a ‘crime scene’ does not take precedence over the immediate requirement to cut down a hanging body. The procedure is as follows;

- i) Lower the body to the ground;
- ii) Remove or cut the noose while leaving the knot intact (observe the location of the knot on the neck);
- iii) Check for signs of life; and
- iv) Commence resuscitation and other appropriate first aid procedures and institute active resuscitation techniques until a medically qualified person takes over.”

The policy stipulates that the steps of this procedure should be strictly adhered to. Yet the two officers who discovered Simpson hanging from the bars in his cell did not immediately attend him. They chose not to enter until a senior officer arrived. The reason they gave at the inquest was that they thought Simpson might be feigning and they were too concerned for their safety to approach him. On the other hand, Justice Health staff who viewed Simpson from the doorway to his cell considered that he was clearly deceased, yet they did not examine him. Another part of DCS policy advises staff that the absence of vital signs does not necessarily mean that a person has died. Therefore, the discovering officer must immediately commence resuscitation and first aid. Given the observations of Justice Health staff, this was a genuine hanging and the Custodial Officers should have rendered immediate assistance without waiting for a senior officer to appear. In this instance the policy is adequate. The response of the Custodial Officers was not.

### **Hanging Points in Cells**

I note with approval the steps taken so far by the Department of Corrective Services to eliminate obvious hanging points in cells. I acknowledge it is a complex and costly task. However, I am concerned that the Manager of the Working Party for the Reduction of Hanging Points is engaged in that role only on a part-time basis. I intend to recommend that the role be full-time so that the work can be concluded as expeditiously as possible.

### **Submission by Human Rights Commission**

I gave leave for the Human Rights Commission to appear before the inquest. I have noted in particular submissions on behalf of the Commission that the long period that Simpson spent in segregation and his lack of care and treatment in an appropriate setting are contrary to some basic human rights' principles. I have taken these matters into account in formulating my recommendations.

## **FINDING**

**Scott Ashley Simpson died on 7 June 2004 when he deliberately hanged himself in his cell at the Long Bay Correctional Centre, Malabar.**

## **RECOMMENDATIONS**

### **To the Minister for Health**

1. In relation to inmates of Correctional Centres who have been diagnosed with a mental illness and require treatment in hospital:

A. There should be a standardised procedure for admission to hospital.

- That procedure should be based on the provision of Sections 97 and 98 of the Mental Health Act 1990 and the completion of a Schedule Three form. The procedure should be set out in writing and circulated to all visiting consultant psychiatrists and Justice Health Staff;
- The members of the Committee making the decisions about hospital admission (which has superseded Dr White's role) should hear personally from at least one of the medical practitioners who have examined the prospective patient and completed the Schedule.

B. There should be standard criteria for admission to hospital to be taken into account by the Committee. The criteria should be set out in writing and circulated to all visiting consultant psychiatrists and Justice Health staff.

- (a) The criteria should be based on the Principles for the Protection of Persons with Mental Illness, namely that persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings, and who are determined to have a mental illness, have the right to the best available mental health care;
- (b) Specifically, in addition to the inmate's present clinical condition, the committee should have regard to:
  - Any likely deterioration in the person's condition;
  - Whether the person has been placed in segregation and, if so, for how long;
  - Any non-compliance with medication;
  - The treatment options available outside a hospital environment, including the frequency of access to a psychiatrist.

C. Those persons in respect of whom a Schedule Three has been completed but who cannot be immediately placed in hospital should be placed under the care of a nominated appropriately qualified medical practitioner, who will take responsibility for their treatment and who will provide up-dated reports for subsequent meetings of the Committee.

2. In order to ensure that all relevant information is placed before Justice Health staff at the time of the Reception Assessment of inmates ie. prior to the arrival of Justice Health files, a Discharge Summary should be completed by Justice Health staff on all inmates diagnosed with a mental illness within 14 days of their discharge. This Summary should then be made available in electronic form for access by Justice Health Reception staff in the course of all subsequent assessments on admission.

3. Given that decisions about placement within Correctional Centres and the release of forensic patients are made in other States by either an independent Tribunal such as the Mental Health Review Tribunal or by superior courts, a review should be conducted as to whether the present system of Executive responsibility is best suited to ensure the placement and movement of inmates on clinical grounds. The review should specifically assess whether, under the present system, the decision-making process about the movement of forensic patients ensures the best use is made of the limited available hospital beds.

**To the Minister of Health and the Minister of Corrective Services**

4. In relation to inmates with a mental illness, an integrated approach between Justice Health and the Department of Corrective Services should be adopted in decisions about placing those inmates in segregation and reviewing the relevant Segregation Orders to ensure that the consequences for the inmates' mental wellbeing are taken into account. As part of that approach:

- An appropriately qualified medical practitioner nominated by Justice Health should examine the inmate within 48 hours after the initial placement in segregation and a written report should be forwarded from Justice Health to the Department of Corrective Services detailing any clinical concerns and recommendations to address those concerns;
- A similar assessment should then be conducted on a weekly basis and a written report forwarded to the Department of Corrective Services detailing any clinical concerns and concomitant recommendations.

**To the Minister for Corrective Services**

5. The Department of Corrective Services should adopt the policy that inmates diagnosed with a mental illness should be placed in segregation only in exceptional circumstances and for a limited period.

6. The Department of Corrective Services should ensure that Discharge Summaries on all inmates are completed and can be accessed by Reception staff within a reasonable time, at least within 14 days, after an inmate's discharge.

7. The Department of Corrective Services should ensure that sufficient resources are allocated to the Working Party for the Reduction of Hanging Points, including the appointment of a full-time manager, to enable the current work of the group to be carried out at the earliest opportunity. Additionally, the scope of works should be expanded to include, on a priority basis, all cells in maximum and medium security institutions.

8. The Department of Corrective Services should implement a policy to ensure that any violent or other aberrant behaviour by an inmate at the time of reception into a Correctional Centre is immediately brought to the attention of the Justice Health Staff member conducting the reception assessment of the inmate. This should occur irrespective of whether the assessment has been completed.

9. The Department of Corrective Services should note that the policy in relation to immediately cutting down an inmate found hanging and commencing resuscitative efforts was not followed in this case. The Department should consider the best way of reinforcing that the policy should be complied with in all circumstances.

#### **To the Attorney –General**

10. A protocol should be developed between the referring courts and the Mental Health Review Tribunal to ensure that notifications of the court's decision that a person has been found not guilty on the grounds of mental illness occurs at the earliest possible time and, at the outside, no later than seven days.

7.

I 102 of 2004

**Inquest into the death of Wendy Hancock on 3 October 2004.  
Finding handed down by Magistrate Milovanovich on 26 April 2006.**

#### **Findings:**

Female, Aboriginal, aged 38 years died from Hypoxic Brain Injury following an attempted suicide.

The deceased had a history of medical problems which included asthma and gastrointestinal oesophageal reflux disease and was also diagnosed with depression for which the Mental Health Team had intervened. Her medical condition was further compromised due to her use of alcohol and illegal drugs and the deceased had been involved in a number of failed violent relationships. Evidence also suggested that the deceased may have been sexually abused as a child and was the victim of a serious sexual assault shortly before being taken into custody.

The deceased entered custody following bail being refused after the deceased was charged with a number of summary matters. Bail was refused at Walgett Local Court on the 27th September, 2004 and the deceased was moved to Bathurst Correctional Centre and subsequently the Mulawa Reception and Remand Centre for Women at Silverwater, where she was received on the 29th September, 2004. Correctional staff upon induction formed the view that the deceased was at risk of self-harm and this view was formed having regard to her history and three known prior suicide attempts.

Accordingly a Mandatory Risk Notification was evoked and the deceased was held overnight in a safe cell until she could be further assessed by the Risk Intervention Team. That team, consisting of a Correctional Officer, a Nurse and a Psychologist on the 29/9/2004 formed the view that the deceased was at risk of self harm and accordingly recommended that the prisoner be kept in a camera cell, that she be provided with a modesty gown and placed on 10 minute observations.

Following the recommendations of the Risk Intervention Team the deceased was placed in Cell 15 of the Intensive Management Unit. Cell 15 was designated as a Camera Cell, which meant that the prisoner could be observed 24 hours. Cell 15 was not a safe cell, however, it is understood that in the past Cell 15 had Perspex covering the grilled doors, however, the Perspex was removed some time ago to allow better circulation of air. It is also understood that following the installation of air conditioning, the Perspex sheeting was not replaced. It is been replaced following this death.

On the 1st October 2004, the prisoner was reviewed by the Risk Intervention Team, however, the team reviewing her was not the same team that made the recommendations on the previous day. Nevertheless, the assessment on the 1st October, recommended that there be no changes to the prisoners current Risk Management Plan, viz to remain in the Camera Cell with modesty gown and 10 minute observations. The issue in regard to the Modesty Gown is of some significance for these reasons. The Psychologist who assessed the prisoner on the 30th September 2004, was of the view that her recommendation that the prisoner be provided with a modesty gown, meant that the prisoners underwear would be removed. The Psychologist in her evidence indicated that she considered the retention of underwear as posing a risk in terms of self-harm and believed that it was the policy in safe cells for prisoners to be provided with modesty gowns when underwear was removed. The Psychologist was not aware that on the 9th August 2002, the then Governor had issued a Local Order No. 37/2002, which amongst other things stated, "On no account are inmates to be deprived of their underpants".

The Intensive Management Unit is under video surveillance and Cell 15, which housed the deceased, was also being monitored and recorded. An examination of the video for Cell 15 indicates that at 3.03pm on the 1st October, 2004, the deceased is provided with a cigarette, at 3.05pm she is observed to remove her underwear, at 3.15pm she is seen to throw milk over the camera lens (possibly with a view of distorting the picture) and at 3.16pm she is seen making a noose with her underwear and placing it around her head. At 3.25pm a Correctional Officer observes the deceased in a "sitting" position near the grilled door. A request is made to check on the deceased and she is found hanging from the ligature made from her underwear and secured to the grilled door. Resuscitation was commenced immediately and the deceased was transferred to Westmead Hospital, however, she passed away 2 days later due to deprivation of oxygen to the brain during the period of suspension.

It was evident at the Inquest that the Risk Management Plan, correctly assessed and recommended by the Risk Managements Team was not effectively implemented and monitored by the Correctional Staff on duty on the relevant day. A device known as a Morse Watchman which can be used to electronically record and down load data in relation to observation times, appeared not have been used for some 9 hours prior to the deceased being located. It was also evident that correctional staff failed to monitor the video screens for at least 22 minutes during which period the deceased is clearly seen acting in a manner that would have raised immediate concern. The failings of the staff on duty where compounded by the lack of clear delegation of duties, no apparent management structure and no clear and concise statement of responsibilities. The experience of the staff, some with less than 10 months service and the overall staff resources were also identified as contributing factors.

An internal investigation was conducted by the Department of Corrections and number of recommendations have been made and implemented. The Perspex screening has been replaced on Cell 15. Staff resources in the Intensive Management Unit have been reviewed and increased. Clear delegation of duties has now been implemented. The Coroner heard submissions in regard to a number of proposed recommendations, however, formed the view that formal recommendations were not required as there was no evidence of a systemic failure and that most of the identified problems had been remedied. The Coroner did however make an informal recommendation that consideration be given to reviewing whether Order 37/2002 (in regard to underwear) should be rescinded. The Coroner was mindful of the sensitivity of this issue, the need for prisoner dignity and the competing responsibilities of ensuring that the prisoner is not at risk of harm, particularly in cases of prior documented suicide attempts. A suggestion was posed that consideration could be given to providing disposable underwear that would meet the need for privacy and dignity and remove the risk of the garment being used as a ligature. The Coroner was also concerned that Local Orders, when made should be appropriately disseminated to all relevant staff and that a system be put in place to ensure that vital orders are regularly brought to the attention of new staff and periodically re-enforced. The Coroner was of the view that this did not require a formal recommendation and noted that the Department of Corrections was legally represented and that the Coroners comments would be brought to the attention of the Commissioner.

### **Formal Finding.**

**That Wendy Helen Hancock died on the 3rd October, 2004, at Westmead Hospital, Westmead in the State of New South Wales, from a Hypoxic Brain Injury, sustained on the 1st October, 2004, at the Mulawa Correctional Facility, Silverwater in the State of New South Wales, when attempting to take her own life by hanging.**

8.

I 160 of 2004

**Inquest into the death of Nathan Mazurani on 3 July 2004. Finding handed down by Magistrate Abernethy, NSW State Coroner on the 30th March 2006**

**Facts.**

The facts can be stated with brevity.

Jessica Kaukau died on 1st July 2004 at her home at 26 Gladstone Street, Kogarah of gunshot wounds to the head and abdomen. I am satisfied that they were inflicted by a person since deceased.

Jessica Kaukau had known Nathan Mazurani for about four years. She met him soon after her arrival in Australia from her native New Zealand. For several years they lived together as a couple at 15 Banksia Avenue, Banksia, but Jessica moved out well before she died. She moved into a house at 26 Gladstone Street, Kogarah, with some other young people. Two of these, Heather Davies and Jamie Pollock were a couple, but Jessica and the fourth person, Heather's brother Benjamin, were simply flatmates.

Jessica was found on the floor of Heather Davies' bedroom at about 4 pm by a friend of Davies, Adam Reynolds. Reynolds had gone to the premises at Heather Davies' request to "check the premises". Her brother Ben had returned to the house earlier and noted that it appeared to have been broken into.

Police and ambulance were called but Jessica Kaukau was deceased.

The relationship between Jessica Kaukau and Nathan Mazurani had deteriorated markedly over the months and weeks prior to Jessica's death. In fact, it appears that Jessica felt that the relationship was over. Problems had arisen over Mazurani's drug use, and particularly the probable use of "ice". At least in the weeks prior to the death there is strong evidence that Nathan was unprepared to let Jessica go. This was coupled with strong evidence of psychosis. I do not need to detail it. Much of it stems from the evidence of his father, James Mazurani, as set out in the clinical notes of Mental Health Team members, particularly Natalie Cutler, RN. It also stems, for that matter, from the evidence of his mother Yvonne Hunter (from a phone call she received from Nathan). It also stems from the opinion of two psychiatrists, Dr. Murray Wright and Dr. Diamond, and their interpretation of facts presented to them during the siege. Finally the evidence of Jessica Kaukau, as given to police prior to her death, together with the evidence of her friends and fellow workers at St. George Tavern, is relevant.

Nathan was using drugs heavily. Post mortem toxicology alone showed a level of morphine, which very probably represented heroin, well into the fatal range.

## **Issue.**

### **1) The likelihood that somebody else had either shot Jessica or that somebody else had been with Nathan Mazurani at the house when Jessica was shot.**

There can be no doubt that no weapon was found at the Gladstone Street premises when Jessica was found. There can be no doubt that the 9 mm parabellum pistol that was found beside Nathan Mazurani's body several days later was the weapon that killed Jessica Kaukau. In that regard, Mr. Saidi, assisting me, took a number of witnesses, but particularly the ballistics expert, Mr. Christiaan Pieterse, very carefully through their evidence where relevant to that issue. In any way to suggest that police or some witness may have found and removed the weapon would be utterly unfounded.

The inference that somebody else may have been present and possibly shot Jessica, stems from the natural concerns of Nathan's mother and father, and from the evidence, in particular, of one Svasti Toulla Millienos. Millienos gave evidence that Nathan Mazurani was her regular supplier of cannabis. After attesting to his behaviour on 30th June 2004 (that he seemed to be hiding something under his jacket and appeared paranoid and very upset), she deposed that she saw him again at about midday on 1st July 2004.

She also gave evidence that her own son left her house with Nathan "probably to get drugs". She was very vague about time but a reasonable interpretation of the whole of her evidence, was that it was during the early to mid afternoon of 1st July, probably at about the same time Jessica Kaukau was shot.

The son is at present an inmate of Parklea Prison and was quickly interviewed by NSW Police. He has now given evidence. He agrees that he left the premises with Nathan Mazurani that day, but that it was much earlier. In essence he says that Nathan returned him to his home at Brighton-le-Sands at about noon. It is likely that Millienos, in my witness box, was not being truthful about the reason he and Nathan went for a drive to the Sydenham area that morning. There has to be a real possibility that in some way it was for the purchase of drugs. There is of course, insufficient evidence to enable me to find as a fact that that is the case. Nevertheless, I have no reason to disbelieve him on the issue of the time he and Nathan Mazurani went for their drive, or for that matter, the direction of their travel. To get to Jessica Kaukau's residence at Gladstone Street, Kogarah from the Brighton-le-Sands area, one would normally drive due West, probably along President Avenue to the Princes Highway, a very short right hand and then left hand turn would bring one to Gladstone Street. Millienos spoke of driving the "natural" way to Sydenham from his residence at Moate Street, via West Botany Street and Bestic Street to the Sydenham area. He spoke of returning via General Holmes Drive. That drive would have taken him nowhere near Kogarah or Gladstone Street.

I am afraid Mrs Milienos was a very poor witness, among the worst to have given evidence in this case. She was difficult to elicit evidence from and tended to be "all over the place". I have no difficulty in being satisfied that she was well out with her times.

What possible motive would Millienos have for going to Gladstone Street with Nathan Mazurani? This death was about issues between Nathan and Jessica and also about Nathan's illness at the time.

Mrs. Hunter also raised the prospect that James Mazurani may have killed Jessica Kaukau. There is no doubt he did not like her. That is extremely unlikely. Mazurani was not a good witness and, I think, not a witness of truth. He has a history with firearms. But let us not forget his concern about his son's lack of stability particularly in the week of Jessica's murder.

Significantly, there is simply no evidence at all that goes to the proposition that James Mazurani killed Jessica.

On the facts before me it is probable that Nathan Mazurani, in a psychotic state, went alone to 26 Gladstone Street, Kogarah and shot and killed Jessica Kaukau. In fact, I am satisfied beyond reasonable doubt of that.

I discussed this issue with the mothers of Jessica and Nathan after court on Tuesday. By that time they had spoken to each other at length. I understand the difficulty they have in accepting my finding in relation to Jessica's death. I stress that my finding is based upon the evidence and not upon hypothesis or supposition. Whilst it is always possible that another person was involved in Jessica's death, or perhaps even carried it out, there is simply no evidence of that. Perhaps, if they leave this inquest understanding that the Nathan of before 1st July and the days thereafter, was not the Nathan they knew, whether as a mother or through Jessica, they will understand just why I must return the finding I shall, based on the evidence before me.

In due course I shall return a formal finding.

## **DEATH IN POLICE OPERATIONS OF NATHAN MAZURANI.**

### **Preamble**

Sadly, so called "murder suicides" occur reasonably frequently in a city of this size. This one is complicated by the fact that the death of Nathan Mazurani occurred during "police operations" within the meaning of *Section 13A, Coroners Act 1980*. In those circumstances an inquest into his death must be conducted and conducted by the NSW State Coroner or one of the three Deputy State Coroners. Moreover, a synopsis of this death must be included in the 2006 Annual Report of the NSW State Coroner to the Parliament of NSW. The most important issue to decide at inquest is, of course, the manner and cause of death.

However, it is also important to look at the police operation itself, and where appropriate criticise police, and for that matter, other NSW Government instrumentalities, in a constructive way and where necessary make recommendations for change pursuant to *Section 22A, Coroners Act 1980*.

## **Facts.**

In the mid-afternoon on 1st July 2004, Nathan Mazurani shot and killed his girlfriend, or former girlfriend, Jessica Kaukau with a 9 mm “Colt” brand parabellum pistol.

## **Events leading up to the homicide and siege at 15 Banksia Avenue, Banksia.**

On 19th February 2004 Nathan Mazurani’s mother left Sydney to care for her elderly parents in the United Kingdom. On 20th March 2004, Nathan presented at St. George Hospital Emergency Department presenting with a sudden onset of chest pain. He gave a history of smoking “ice” in the week prior to presentation. An ECG was taken and a provisional diagnosis of Myopericarditis was made, with a differential diagnosis of coronary artery vasospasm attributed to the use of the drug “ice” (methamphetamine hydrochloride).

On 25th June 2004 Mrs. Hunter received a telephone call from Nathan Mazurani. She describes him as being in a “hysterical state” and indeed gave evidence about this call in the witness box.

Much of what her son was saying to her is actually corroborated by Jessica Kaukau, describing him as “paranoid at the moment because of the drugs and will not leave me alone.”

James Mazurani corroborated this display of apparent paranoia by his son at this time. His son, he said, indicated to him that people were out to get him and that he was hearing voices coming from power points. Whilst Mrs. Hunter basically adhered to what she told police, James Mazurani seemed to play Nathan’s state down in the witness box.

Mrs. Hunter telephoned Jessica and was told that she had noted the same problem with Nathan and that they had recently broken up because of it. I am satisfied that the relationship by this time, in Jessica’s mind, had been terminated by her.

It was on this night and morning that Nathan Mazurani attended the home of Jessica Kaukau on at least three occasions. Ultimately Jessica took a broom handle to him and at 8.30 am on the 26th June, attended Kogarah Police Station and applied for an Apprehended Domestic Violence Order.

Nathan Mazurani telephoned his mother again on 27th June 2004 and this time she was so very concerned about him that she contacted her former husband James Mazurani. Because of extreme ill feeling and a history of serious problems between the two, Mrs. Hunter kept contact with James Mazurani to an absolute minimum. Therefore this was a significant step for Mrs. Hunter. She requested that he initiate contact with the Mental Health Crisis Team for intervention with her son. James Mazurani agreed. It is clear that he too was concerned about his son.

The appropriate records of the St. George Hospital and Community Health Service have been considered closely at inquest. The clinical notes of the Acute Community Care Team are contemporaneous in nature and closely corroborate the evidence given by Mrs. Hunter and James Mazurani.

For its part, the Acute Community Care Team recognised the clear problem facing it and attempted to obtain assistance from James Mazurani with his son. The team wanted to examine Nathan and if necessary admit him to hospital for treatment.

In fact one home visit was made on 28th June and Nathan, though hostile towards his father, agreed to a further home visit the next day. Nathan was not at home on 29th June. A card was left and it was decided to firstly await contact and secondly to contact the father, particularly in relation to Nathan's mobile telephone number. Mr. Mazurani was contacted. He would not give out his son's telephone number as he "did not want to break his trust". Whilst, I suppose, this is understandable, it may have helped to do so.

On 30th June, Mr. Mazurani reported that he and Nathan had had an altercation and that he found Nathan to be "very aggressive". He gave the Team other information, but could not help with his son's whereabouts.

On 1st July the Team learnt more. It learnt of the AVO and of paranoid thoughts of being in danger. Firearms were canvassed, as was the earlier hospitalisation.

It was planned to await a telephone call from Mr. Mazurani in relation to Nathan's re-appearance; if no call was received, Nathan's address would be checked every two to three days; when found there would be a psychiatric review. Registered Nurse Natalie Cutler, in writing her clinical notes at this time, noted potential for self-harm and harm to others.

Later, on 1st July, Gareth Brown and Joanna of the Acute Community Care Team visited 15 Banksia Avenue. There was no response to their knocking. After leaving they were questioned by police. It was at this time that police learnt of the Acute Community Care Team's involvement and made use of it. (Police had by that time "staked out" the house at Banksia Street but had not attempted to make contact with Nathan Mazurani. His vehicle was not there and police simply did not know whether he was there or not.

Returning for a moment to the homicide of Jessica Kaukau, there is no particular evidence as to what Nathan Mazurani did after the shooting on the afternoon of 1st July, beyond exiting the house at Gladstone Street with the firearm. NSW Police investigators believed that he may have been at one of three addresses. The most likely address was seen to be rented premises at 15 Banksia Avenue, Banksia. His motor vehicle was also missing.

Strike Force Moye was formed and during the evening of 1st July 2004, investigators decided that a search warrant should be executed on the residential home of Nathan Mazurani because of his status as a strong suspect in the murder of Jessica Kaukau. A murder weapon had not been located at

the crime scene. There were also concerns for the stability of Nathan Mazurani and the possible danger he presented to the community. His vehicle (YPW-353) had not been located and it was thought that he was probably with it.

At about 10 pm on 1st July, in preparation for the search warrant application, Detective Sergeant Joe Maree contacted the Operations Co-Coordinator of the Tactical Operations Unit (TOU), A/Inspector Peter Forbutt, to canvass the availability of the Unit for assistance in executing the search warrant on 15 Banksia Avenue. The TOU are specialised officers within the State Protection Group (SPG) who are trained and equipped for high-risk arrests and entries. Detective Sergeant Maree informed Forbutt that Nathan Mazurani had not been sighted and that there was no evidence that he was actually in the premises. Maree was informed that if a search warrant was granted he should submit a formal request to the SPG for assistance.

At about 2.30 am a search warrant was obtained through the Duty Justice. It authorised entry into the subject premises between the hours of 3.10 am and 9 pm to search for a 9 mm firearm, ammunition and other items.

At about 2.30 am assistance in the execution of the search warrant was formally requested, by fax, of the SPG. The Local Area Commander had authorised the planned use of the SPG. Forbutt was informed of the request and contacted the Commander of the TOU, Chief Inspector Craig Jennings. Jennings considered the job as within the TOU charter. At 3.10 am, therefore he contacted the Commander of the SPG, Chief Superintendent Peter Gillam. Despite being advised of the homicide, the weapon, and Mazurani's status as the prime suspect, Gillam did not assess the request as "high risk" as Mazurani had not been sighted since the beginning of surveillance on the subject premises, and, as there had been no movement, lights or vehicles sighted there, there was nothing to indicate that Mazurani was within the premises. The request for assistance was denied on that basis.

Assistance was not forthcoming either from the NSW Police Telephone Intercept Branch or the Surveillance Branch.

The decision was made not to execute the search warrant until the daylight hours of 2nd July, with St. George LAC surveillance in the meantime.

### **The Siege.**

Detective Sergeant Maree conducted a briefing at 9 am on the 2nd July 2004. It was decided that execution of the search warrant on the Banksia Street premises was a priority. A team was dispatched to the vicinity. Shortly after 10 am a meeting was held with the entry team in the car park of the KFC on Princes Highway. Investigators were assigned specific tasks in relation to the warrant. A general duties police dog was asked for and obtained. An independent officer, Inspector Hunt was assigned.

The Critical Incident Investigator, Detective Inspector Adam Purcell notes:

*“No written or structured risk assessment or Operational Orders were prepared for the execution of the search warrant. It would appear that an informal risk assessment was conducted, however, no risk rating was allocated to the entry.”*

When he asked about the risk assessment, Inspector Hunt was told:

*“It’s ok. We’ve had surveillance on the place for more than 12 hours, there is no sign of anyone being there, no lights on overnight, no sign of his car, and neighbours last night said they haven’t seen him. We’ve still got officers sitting off the place. It looks like he was gone and no one has seen him since his girlfriend was shot. SPG have declined to attend. Wherever he is, he is likely to have a 9 mm pistol in his possession. There is no indication he’s in the house so what we are going to do is knock on the door. If there is no answer we’ll use the hammer on the door and execute the search warrant anyway. No one else lives in the house and no one is expected to be home... we have a dog here and we’ll use him to clear the house after we knock down the door, just to make sure no one is hiding in there before we do a search.”*

At about 10.15 am on Friday, 2nd July 2004 the search warrant team approached the house. Several members made their way to the front door with the sledgehammer. Constable Macklin stood to the left of the door with the hammer. Detective Senior Constable Lukacs stood to the right side of the door with Detective Senior Constable Yannakis on the second step down from the verandah. Lukacs knocked on the door three times. He yelled out “Nathan, police, open the door”. Shots were then fired through the door at about waist level. Police retreated upon realising that they were being fired upon.

Only the dog squad officer was wearing a bulletproof vest.

Detective Senior Constable Angela Green was standing adjacent to the bottom step. She says:

*“About one or two seconds passed (after police demanded entry) and I heard a loud bang come from the direction of the front door. At this time I felt something travel quickly past the top of my head, causing me to touch the top of my head with my right hand. I immediately turned and ran .....”.*

There can be no doubt at all that the police in the area of the front door whether they were on the verandah, steps or below the steps were in great danger.

Police took cover, VKG was alerted and further shots were fired. The SPG arrived and extricated various police from their positions of cover to positions of safety. An inner and outer perimeter was formed and a command post established. Siege Negotiators were brought in and negotiations

continued during the day. Forensic Psychiatrists attended in shifts and during the afternoon Nathan Mazurani's motor vehicle was located nearby.

The siege continued during the night of 2nd-3rd July 2004 and Nathan Mazurani was speaking from time to time with siege negotiators including Detective Senior Constable Christine Meszaros. She spoke with Nathan for just over half an hour from 11.55 am (3rd July). He asked for food. He received a meal at 12.11 pm. She continued to talk to him until 12.35 pm when he terminated the conversation saying "*Goodbye Christine*". No sound was heard from the house after that and it is likely that Nathan Mazurani took his life then.

Post mortem examination, ballistics evidence, the position of his body, the lack of any other person in the house and other factors make it abundantly clear that Nathan Mazurani took his life by gunshot wound to the head.

Moreover he had a very high level of morphine (probably heroin) in his body at 3.2 mg/l. He is also believed to have swallowed acetone. Had he injected the heroin it is likely that the drug would have killed him. It is likely that he attempted to take his life by overdosing, resorting to the firearm when that failed.

The siege finally ended when a police dog with camera entered the premises at about 7 pm on 3rd July 2004. (A bomb robot had been tried unsuccessfully. The door had been blown in). An entry team of TOU officers then entered the house. Nathan Mazurani was found deceased.

## **Issues.**

### **Involvement of a 3rd Party in the death of Jessica Kaukau?**

As I have indicated the evidence is compelling that Nathan Mazurani was responsible for the death of Jessica Kaukau. He had developed a severe state of paranoia in the period leading up to his death and had become quite obsessed with Jessica Kaukau who during that time finally terminated any relationship they had had. He was clearly affected by Jessica's recent rejection of him.

The gun used to take Jessica's life was certainly the gun Nathan used to end his own life.

Whilst there may be some evidence of a hearsay nature, relating to the statements made by James Mazurani to his former wife Yvonne Hunter in the presence of her brother, at the Novotel Hotel, Brighton-le-Sands to the effect that James may have been aware of the fact that Nathan was in possession of a firearm on the morning of Jessica's death, there is no evidence that James Mazurani gave the gun to his son. I certainly prefer Mrs Hunter's version of that conversation. It makes me suspicious, but as I have said, there is simply no evidence. James Mazurani certainly did have contact with his son on the morning of 1st July, but there is no evidence that later in the day he was in Nathan's company or anywhere near 26 Gladstone Street.

Whilst I am satisfied that James Mazurani did not like Jessica Kaukau, it cannot be said that, on the evidence before me, he played any role at all in Jessica's murder, directly or indirectly.

It must be remembered that James Mazurani cared for his son to the extent that he heeded Mrs. Hunter's direction to him that he obtain help for Nathan. Whilst one may have concerns about James Mazurani's behaviour when dealing with the Acute Community Care Team in the period leading up to 1st July 2004, this court has the specific task of determining, inter alia, manner and cause of death. It is not a court of "blame" or a court in which moral judgments ought to be made. In that context I refrain from so doing.

**James Mazurani's concerns in relation to the siege that developed.  
Yvonne Hunter's concerns.**

Both parents were concerned about the denial of a real opportunity for them to make contact with their son during the course of the siege by way of telephone or otherwise. James Mazurani was permitted to communicate by way of an audio recording that was played by loudspeaker.

This is a common complaint by relatives (and friends) of deceased persons following siege situations. It is their natural expectation that if they could only be given the chance to speak to the person under siege, they may be able to convince that person to give him or herself up and surrender.

For this reason I called both Forensic Psychiatrists involved in this siege, Dr. Murray Wright and Dr. Michael Diamond. Both explained carefully that "third party intervention" does not always lead to a successful outcome and, indeed, may itself be a catalyst for a disastrous outcome. For this reason, worldwide, "third party intervention" is only used in the most exceptional circumstances. As an experienced coroner I accept that evidence. Problems associated with using third parties is a lack of accurate knowledge of the dynamics between the person under siege and the third party; the risk that third party intervention may enable the person under siege to say his or her "goodbyes", thus "enabling" the person to end his or her life.

Tactics performed by NSW Police on this occasion in relation to siege negotiation accorded with "best practice" as understood throughout the western world. At all times those tactics were geared towards achieving a successful outcome as quickly as possible. They were designed to save Nathan's life and negotiators at all time acted with compassion towards him. Remember Nathan's haunting message "Goodbye Christine". They also acted with compassion towards Nathan's relatives. Both parents were communicated with during the siege.

It is, in my view, highly unlikely that any different outcome would have come about even if Mr. Mazurani or Mrs. Hunter had been permitted to communicate directly with Nathan. **Overall, I am satisfied that the siege, from the NSW Police viewpoint, was conducted professionally and that despite the best efforts of those involved, resulted in an unfortunate and fatal outcome.**

Another issue of concern was whether or not the siege could have been brought to an end at an earlier point of time. The police approached this critical incident in a restrained, patient and thoughtful manner. As was indicated by Dr. Diamond, the negotiators tried to use the benefit of time on their side. Had the police been more aggressive and attempted forced entry at an earlier time, the lives not only of Nathan Mazurani but also those of the entry team would have been placed at high risk – far too high a risk whilst the “contain and negotiate” option was still available.

In fact, had either Nathan or NSW Police officers been killed, in a forced breach of the stronghold the issues confronting both police and coroner would have been considerable, and Nathan’s relatives could justifiably have sought the most trenchant criticism of NSW Police by the coroner.

As James Mazurani says, the tape and transcripts of the conversations between negotiators and Nathan show that a great deal of patience and thought went into those negotiations.

Police negotiators attempted *negotiation* as was their task, in an effort to achieve a successful outcome.

The siege was conducted at all times according to best practice. It is heartening to see that siege negotiation by our police has now reached a point of excellence. The unfavourable outcome should not cloud this fact.

### **Was there police involvement in Nathan Mazurani’s death?**

It has been suggested that there was third party involvement, and most likely that of NSW Police in the death of Nathan Mazurani. James Mazurani apparently believes that, having regard to the position in which the body was located, the hand of Nathan Mazurani and the position where the firearm was found, together with the fact that the gun was “cocked” at the time of police entry, may point towards either a police conspiracy of some kind, or, alternatively, police involvement in the death of Nathan Mazurani. In my view there is a satisfactory explanation to this suggestion.

During the course of this inquest an attempt was made to call virtually all relevant police officers that first entered the premises, so as to deal with the issue of whether or not any police officer may have been involved in interference with the crime scene, or, alternatively, Nathan’s death. It is clear that from the commencement of the siege the only firearm discharged came from within the premises – the stronghold. No police officer, on all the evidence before me, fired a shot in return or in any circumstances. Upon final entry into the stronghold no gunshot sound was heard by any witness. The evidence suggests rather, that at a point of time some hours before entry, Nathan Mazurani discharged a weapon with the intention of taking his own life. For that period of hours after the last gunshot sound was heard there was not one further gunshot sound heard emanating from the premises which were under surveillance from a time well before the siege itself commenced, and under heavy surveillance from the point of time the first shots were fired. All witnesses, in fact, gave common evidence that not one person, civilian or

police officer, was seen to enter or leave those premises at any time, or more particularly, from the period of heavy surveillance after the first shots were fired. On the evidence before me I am satisfied that no person entered or left the premises at any relevant time.

One of the very first police officers (SPG) to enter the premises and the actual room where the deceased was located was Senior Constable Jason Semple. At the time, Senior Constable Compton also entered the room.

As Semple moved further into the room, he could see the person of interest lying on his back with what appeared to be a head wound to the right side of his head. He called to his colleagues “offender in here”, and touched Nathan Mazurani’s right arm, feeling that it was stiff and cool. He quickly asked Senior Constable Stewart if the firearm he had noticed should be moved from a position adjacent to the waist or right elbow of the deceased. Both Compton and Stewart responded in the affirmative. Prior to it being moved the firearm, cocked, was lying on its left side with barrel towards Nathan’s feet and magazine towards the bed to his right. He also noticed loose 9 mm bullets lying about the left of Nathan’s position. Both Stewart and Compton corroborate this version. Whilst best police practice is not in any way to interfere with a crime scene, there are occasions when police are entitled to do so. In this particular case, police did not know that Nathan was deceased immediately and moved the weapon a short distance from him onto a bed, for safety. All police were doing was to create a safe situation for themselves and those who came after them.

James Mazurani made much of the fact that the weapon was in the cocked position, and thus to his mind cocked by “someone”. This has been completely explained by the forensic ballistics expert, Christiaan Pieterse, a civilian expert of great experience and qualification, employed by NSW Police. He gave lengthy evidence in these proceedings and Mr. Mazurani was expressly invited to attend by Counsel Assisting. He declined and therefore lost any opportunity of hearing this evidence and of asking Mr. Pieterse questions relating to the issue of the cocked firearm.

Mr. Pieterse made it clear that the firearm itself, a semi-automatic weapon, when fired, led to the weapon being *automatically cocked* in readiness for the next discharge of a bullet. This, said Mr. Pieterse, is the manner in which this particular firearm, and those like it operate when functioning correctly. He went on to say that had the weapon not been in the cocked position then that would be a matter of concern and suspicion. I accept Mr. Pieterse’s evidence in its entirety and the concerns of James Mazurani have been satisfactorily answered.

Further, ballistics testing of all cartridges, cases and the magazine, showed that the same weapon, the only weapon found, was fired on multiple occasions. There was no forensic evidence to suggest that any other weapon was used at either premises.

There is absolutely no basis for suspicion that there was any conspiracy by the police, or any police involvement, whether directly or indirectly, inferentially or otherwise, in the death of Nathan Mazurani. There is no evidence capable of raising any suspicion, even the slightest suspicion, that there may have been any interference with the crime scene where Jessica Kaukau was located. As I have indicated previously, all of the evidence supports the finding that Nathan Mazurani was solely responsible for the death of Jessica Kaukau.

In these circumstances, with Nathan being the prime, if not the only person of interest in relation to that death, on what possible basis could it advantage or benefit NSW Police to engage in any conspiracy to harm Nathan? Why would any NSW Police officer be the least motivated to do anything other than to bring the siege to an end by way of a positive outcome so as to bring Nathan Mazurani to justice?

One cannot think of a possible reason and I have no difficulty coming to a finding that the police did not conspire with themselves, or otherwise have any direct or indirect involvement in the death of Nathan Mazurani. To the contrary they did everything possible to ensure that the critical incident came to an end in as positive a manner as possible, with the clear intent that Nathan's life be saved.

#### **The seeking of an Apprehended Domestic Violence Order (DVO).**

It is clear on the evidence before me that there was an incident involving Nathan Mazurani and Jessica Kaukau during the early hours of the morning of 26th June 2004. This incident, together with prior incidents between the two, led to Jessica attending the Kogarah (St. George) Police Station where she provided a statement to Constable Adam Townsend. Whilst she was at the Police Station, Nathan Mazurani himself also attended and spoke to Constable Sarah Chalmers. For his part, Constable Townsend took a formal police statement from Jessica on 26th June, setting out the details of her complaints about Nathan Mazurani, and why she felt she was a "person in need of protection". As she was leaving Constable Townsend gave Jessica a card with his telephone number and a reference number and suggested that she contact him should there be any change in her situation. It should also be noted that Jessica gave James Mazurani's address rather than Nathan's. Nathan Mazurani, upon being alerted to the fact that an Apprehended Domestic Violence Order (DVO) was going to be sought by NSW Police on Jessica's behalf, then provided Chalmers with a formal statement. In many aspects, Nathan's statement in fact corroborated Jessica's complaints. Unfortunately the Application did not come to be sworn prior to the death of Jessica Kaukau, or the subsequent siege.

Constable Townsend stated in evidence that he left a copy of the Application for a DVO in the relevant pigeonhole at the Police Station, and from that point of time it became the responsibility of the Domestic Violence Liaison Officer to follow the procedure required for the matter to be listed before the Kogarah Local Court. That involved taking the Application and Statement

over to the Court House for swearing before a Justice of the Peace. Unfortunately the matter was not actioned early that week. The DVLO's at Kogarah worked part-time during that period, and leave and other factors (the business of the court on the Thursday) intervened. Jessica's death occurred before it was actioned.

It must be said, however, that had it been sworn out prior to 1st July, a hearing date for the Application would have been set for two to three weeks hence and certainly not prior to 1st July. Constable Townsend, correctly, assessed the complaint as worthy of a summons and not a Warrant. He had no basis for applying for urgent relief on what he had been told by Jessica and I am of the view that had he done so a warrant would have been refused by the Justice.

Though there was continued harassment by telephone after the Application was made by Jessica, she did not see fit to contact Constable Townsend or Kogarah police generally. Had this further behaviour come to the attention of police then appropriate further steps could have been taken, perhaps for an urgent Order, or at least an earlier return date. I personally believe that Jessica may have been torn between wanting the relationship to end, and continuing to act in a somewhat protective manner towards Nathan – not wanting him to get into trouble with the authorities.

The Domestic Violence Liaison Officer at the time, Senior Constable Bronwyn O'Donnell was an impressive witness. She indicated that that particular week the three DVLO's had unforeseen leave on the Monday, Tuesday and Wednesday. The Thursday was DV day at court and thus extremely busy. Friday was the earliest day the matter could have been actioned. Importantly, she also indicated that since the time of this incident, and partly because of it, the Local Area Command has looked closely at its processes and systems in relation to domestic violence, including the making of complaints to the Local Court.

As a result of that review there is now one full-time DVLO attached to the LAC and the processes have since flowed far more quickly and efficiently. Other changes have been made.

In his submission to me, Mr. Breckinridge suggested a number of changes that Mrs. Kaukau would like considered by NSW Police. I believe that most of them are in place.

Moreover I do not believe that the delay in processing Jessica's Application, for the reasons I have just given, had any bearing on her death.

Nevertheless, without making a formal recommendation pursuant to *Section 22A, Coroners Act 1980*, I shall write to the NSW Police Commissioner, forwarding a copy of Mr. Breckinridge's submission, together with a copy of this summing-up, findings and the recommendation I am about to make. I shall draw to his attention particularly the suggested changes to ADVO SOP's as set out by Mr. Breckinridge at 1 – 8 on pages 3 and 4 of his submission.

### **The involvement of the Acute Community Care Team, The St. George Hospital, South East Sydney Area Health Service.**

I am pleased to be able to say that once Nathan Mazurani's apparent illness was brought to the attention of the Acute Community Care Team, St. George Hospital (South East Sydney Area Health Service), his case was handled entirely properly by the Team.

The Team made every effort to diagnose and then treat Nathan. Once NSW Police knew of the Team's recent involvement with Nathan, the Team provided police with very relevant information in relation to his mental health. In fact it provided a great deal of relevant information. This in turn enabled NSW Police to maximise its chances of ending the siege successfully.

The Team, as is usual, made quite detailed clinical notes in relation to this case – contemporaneous notes. Those notes, or the information contained in them, was invaluable, firstly to NSW Police, and secondly to this inquest. They have, themselves provided corroboration, not only of Nathan's condition, but also of the evidence of a number of witnesses. Registered Nurses Hexton, Isaac, Brown and Cutler are but four members of the Team who at various times were involved in attempting to secure medical help for Nathan Mazurani.

### **Lack of SPG/TOU Involvement in the execution of the Search Warrant, and other policing issues.**

Throughout this summing-up I have detailed the lack of SPG/TOU involvement. It really does concern me. A number of police officers could clearly have lost their lives in the line of duty. Although Chief Inspector Craig Jennings was ill and unable to give evidence, I have heard the evidence of the Applicant for assistance in the execution of the search warrant, Detective Sergeant Joe Maree. I have also heard the evidence of (then) Acting Inspector Peter Forbutt and the evidence of Chief Superintendent Peter Gillam, whose decision it was not to permit deployment of TOU resources to assist local police.

It is clear from the evidence that Mr. Gillam relied on the fact that there was no information to suggest that the person of interest was on the premises. That is in keeping with what he had been told via the conduit of Maree to Forbutt to Jennings to himself. That was a judgment call and, to my mind, may be understandable.

The "conduit" of two intermediary officers concerns me as in this case there is no evidence that Maree or Forbutt ever indicated that investigating detectives were of the opinion that the premises were unoccupied. By the time Gillam was reached, on his own evidence, he had been told that that was the situation – that "detectives conducting the surveillance were of the opinion that the premises were unoccupied". In part at least, he acted on that advice and intelligence.

As the Critical Incident Investigator, Detective Inspector Adam Purcell points out (Statement of 29.4.05: Page 44):

*“Current guidelines in place for activating Tactical Operations Officers to assist in high risk search warrants were followed.*

***If the Person of Interest cannot be confirmed to be in attendance within a stronghold, guidelines suggest that the TOU personnel not be deployed. Clearly in this instance these guidelines did not protect police who attempted to execute the search warrant.”***

I agree with him and shall **recommend** that the Guidelines in relation to Assistance by the TOU be reviewed. I strongly suggest that the factual matrix of this case be utilised for such a review. Mr. Saidi, assisting me, made the point that perhaps unless police on the ground can affirmatively say that a person is not in the place of execution in a high-risk situation, then specialist resources ought to be deployed. That may be an option, but I would prefer to give NSW Police the freedom to implement change if it considers it to be necessary,

Detective Inspector Purcell went on to comment on the “informal” Risk Assessment carried out in relation to the Search Warrant and suggests that such Assessments should always be more structured, using the risk matrix available to all police.

Again I agree and note that St. George LAC has recognised this and now has in place Standing Operating Procedures requiring a *written* risk assessment in relation to all search warrants.

I shall **recommend** that all LAC’s, if not already in place, put into effect local SOP’s in relation to a written risk assessment.

Detective Inspector Purcell also commented on issues of **fatigue** amongst TOU members and **ammunition problems** (differing quantities of ammunition in magazines). Those comments do not warrant coronial recommendation but ought to be considered by relevant police.

In relation to the varying numbers of bullets in magazines, I can only say that there are cases where bullets must be counted and accounted for – it seems that there will be a potential problem if this is not possible because each magazine is not completely filled at the commencement of each shift.

### **Conclusion.**

This tragedy has warranted a close investigation and a thorough inquest. It has had both, and Detective Inspector Purcell assisted by Detective Senior Constable Alison Brazel, and Detective Sergeant Maree are to be commended for the fine investigative work they have carried out.

The manner and cause of each death is clear to me and it is appropriate for me to make formal findings.

I urge NSW Police to consider my Recommendations. They are constructive and the first one, at least is firmly intended towards review of police procedures in a “root cause analysis” sense, with the aim of improving those procedures as may be considered necessary.

Elsewhere I have commented without going to the extent of making formal recommendations. I urge that those comments be carefully considered.

### **Formal Findings.**

**That Jessica Lucille Kaukau died on 1st July 2004 at 26 Gladstone Street, Kogarah, of gunshot wounds to the head and abdomen, inflicted upon her then and there by a person since deceased.**

**That Nathan Nicholas Mazurani died on 3rd July 2004 at 15 Banksia Avenue, Banksia, of a gunshot wound to the head, self-inflicted then and there, in the course of a police operation, with the intention of taking his own life.**

### **Recommendations.**

- 1) That the NSW Police “Tactical Operations Management – Operational Guidelines” be reviewed and altered where necessary to maximise the safety to NSW Police engaged in the operation of executing search warrants in potential “high risk” situations; that the facts of this case be utilised when conducting that review.
- 2) That all Local Area Commands, unless it has already been done, put in place (local) Standard Operating Procedures requiring the carrying out of a written Risk Assessment prior to the execution of all Search Warrants.

### **9.**

**1649 of 2004**

**Inquest into the death of Basil Anastasiadis at Prince of Wales Hospital on 20 September 2004 while temporarily absent from Long Bay Correctional Centre, Malabar. Finding handed down at Glebe on 9 March 2006 by Magistrate Dorelle Pinch, Deputy State Coroner.**

### **Facts**

Basil Anastasiadis entered custody on 21 February 2003 when he was sentenced to six months’ imprisonment for “Drive while Disqualified”. However, when that period expired on 20 August 2003 he remained in custody, bail refused, on other charges.

On 8 May 2004 he was transferred to Long Bay Hospital Area 2 because of his categorisation as a SMAP (general protection) inmate. He developed chest pain on 16 September 2004. An ambulance was called and he was taken to the Prince of Wales Hospital. I am satisfied that the relevant authorities acted appropriately in getting him to hospital as quickly as possible.

During his time in Prince of Wales Hospital, Mr Anastadiadis was treated in the Coronary Care and Intensive Care Units. Statements were obtained from all of his treating medical practitioners and the medical records examined. In addition, the specialist in charge of his coronary care, Dr Walsh, gave oral evidence. According to the results of test, Mr Anastasiadis suffered from dilated cardiomyopathy. This would predispose him to deep vein thrombosis and, for this reason, he was prescribed the blood thinning drug, heparin. Despite this a blood clot did develop and travel to the heart. Dr Ward commented that the situation was most usual and he could only explain it by suggesting that a blood clot had formed in the patient's leg prior to his presentation at hospital.

#### **Post mortem examination.**

An autopsy conducted by Dr McCreath confirmed that the cause of death as "Pulmonary Thrombo-Emboli".

#### **Formal Finding**

**Basil Anastasiadis died on 20 September 2004 at the Prince of Wales Hospital, Sydney as a result of Pulmonary Thrombo-emboli.**

10.

1887 of 2004

**Inquest into the death of Charles Keith Chenery on 3 February 2004. Finding handed down by Magistrate John Abernethy, NSW State Coroner on 14 July 2006.**

#### **Preamble.**

This death was assessed as having occurred "in the course of police operations" within the meaning of *Section 13A, Coroners Act 1980*. In those circumstances an inquest is mandatory and it must be conducted by a NSW Deputy State Coroner or by me.

This inquest will focus on the police operation – a request by NSW Ambulance Service for a NSW Police vehicle to attend premises at Windale, a suburb of Newcastle to assist officers of NSW Ambulance who had themselves been asked to attend the victim of a suspected drug overdose.

Ambulance officers "stood off" the premises to await arrival of police, as their intelligence was to the effect that the patient could be violent.

The statutory issues, with which I must deal as coroner, are clear (*identity, date, place, manner and cause of death*) and in due course I will be able to return a formal finding. The main issue of concern, of course, is manner of death.

Returning to *Section 13A*, Counsel Assisting is correct. The assessment of this death as a “police operations” death is reasonable, and though technical in nature it does raise issues in relation to involvement of NSW Police and NSW Ambulance in this instance, and the appropriateness or lack thereof of their actions.

The NSW Police Critical Incident Guidelines usually come into play immediately after a case is assessed as requiring investigation under the Guidelines. In most *Section 13A* matters that assessment is immediate. History has shown that some cases might be termed borderline and in such cases the assessment may not be made immediately. In fact this case was reported to the Newcastle Coroner who cannot deal with *Section 13A* cases. It was not seen as a *Section 13A* matter for quite some time following the death. In view of the nature of the factual matrix, that is not really a matter for criticism and certainly not a matter that requires me to look at systems already in place. By far the majority of cases are quickly assessed and I can understand why this case was not. It has meant though that Detective Chief Inspector. Humphrey was not able to come into a “fresh case” but rather has had to investigate a matter some 12 months old. He has made a very good job of it.

It is appropriate in this case to remind everybody of the concept of “hindsight”. Hindsight is a wonderful thing but none of the actors in this tragic drama that night had the benefit of hindsight. Decisions were made which, with hindsight, might not have been made. This inquest has not only had the benefit of hindsight, but has spent the best part of a week, clinically dissecting the roles played by ambulance officers, police officers, NSW Ambulance call takers and dispatchers, NSW Police civilians at VKG and Community Treatment Team members.

I must, in making any criticisms, attempt to put myself in the place of those persons and not use my hindsight in any criticism that I feel I must make.

### **Factual Matrix.**

Charles Keith Chenery died on 3rd February 2004 in the Mater Misericordiae Hospital, Waratah, of clozapine toxicity. He had overdosed on this drug on the night of 2nd February 2004. He had been taking the drug as treatment for schizophrenia.

The facts of this matter are well set out in the brief of evidence and especially in the statement of the Officer-in-Charge, Detective Chief Inspector Humphrey. All interested parties have been given a copy of the brief and have been able to read those facts.

Mr Chenery was aged 25 years. He lived at 53 Lachlan Street, Windale with his de facto wife, Kelly Scholes. He had been suffering from schizophrenia for about six years. Like so many sufferers of schizophrenia, Mr Chenery had really struggled with his illness and was admitted to various hospitals on a number of occasions. He had previously overdosed on his medication. Personal circumstances including the death of his brother and a diagnosis of testicular cancer had not assisted him. He had also been dealing with a problem with illicit drugs.

On 30th December 2003 Mr Chenery was “Scheduled” under the *Mental Health Act 1990*. He was assessed by Dr Amrit Kumar Nahar at Lake Macquarie Health Team, Charlestown on 16th December 2003. He had returned home after being missing for three days. He had stopped taking his medications and was having psychotic features, describing voices telling him peaceful things, and getting messages from television. He denied thoughts of self-harm to Dr Nahar. Mr Chenery and family felt that Clozapine was helpful in keeping him stable.

He was recommenced on the drug and on 23rd December 2003 described similar features. He was again reviewed on 30th December 2003. He was agitated and aggressive, throwing things in the house. Keith Chenery described voices telling him he was not a man. He was looking for ways to bring his brother back. Mr Chenery senior reported to the doctor that he feared that his son might be using amphetamines again.

The doctor assessed him, fairly in my view, as violent, aggressive and dangerous with ongoing psychotic features. He was sent to James Fletcher Hospital on a Schedule in consultation with Kylie Harvie, case manager and Dr Sandhu the Staff Specialist.

Keith Chenery was seen by Dr Mark Robertson there and was admitted as a mentally ill patient – an involuntary patient. He was assessed as at risk of harming himself or another. He was closely monitored because of aggressive behaviour and agitation. He was again commenced on Clozapine and Seroquel to stabilise his psychosis and agitation. He was initially placed in Waratah ward (psychiatric intensive care unit for close monitoring). He started to settle down and was transferred on 2nd January to a locked open ward.

A family visit followed on 3rd January 2004. Mr Chenery’s partner and father were keen to take him home for weekend leave. Given that Keith Chenery had started to settle and that family was prepared to monitor him closely, he was given this leave. He returned from leave on 5th January. There were still florid psychotic symptoms to the illness. He remained in hospital.

He was seen by Dr Sandhu on 7th January. Dr Sandhu reported that he seemed to be definitely on the improve so allowed a further two days leave.

It is important to note that in Dr Nahar's opinion, Keith Chenery had real compliance problems with Clozapine and the drug several times had to be recommenced. This in turn resulted in ongoing psychotic features that in turn caused significant distress to Keith and his family. He also had a problem abstaining from illicit drugs, particularly amphetamines that in turn contributed to a decline in mental health.

There was some consensus that a Community Treatment Order ought to be sought. The idea was a good one – to better manage Keith Chenery in the areas of medication compliance, to address drug use and intervene appropriately with ongoing stressors that might contribute to mental health decline. Keith indicated that he would comply with the CTO. An application was duly made to the Mental Health Review Tribunal on 8th January 2004. Keith Chenery appeared before the Tribunal and the CTO was granted.

I accept the evidence of Ms Harvie, that had a Community Treatment Order not been obtained, the hospital would have faced an uphill battle in convincing the visiting justice to keep Mr Chenery as an involuntary patient. Had he been discharged then there would have been nothing in place. I am of the opinion that the better option was a Community Treatment Order.

Keith Chenery was therefore discharged on 8th January 2004 on a CTO, to the care of his family with a plan of follow up through the Community Team. Dr Nahar reports in his statement that the Community Treatment Team kept in touch with the family and Mr Chenery on a regular basis and also made an appointment to see Dr Singh Sandhu at Clozapine Clinic on 3rd February. The Team did not report any concerns to Dr Nahar about compliance or mental health issues. Mr Chenery was last contacted by Kylie Harvie on 29th January 2004. Mr Chenery told Harvie that he was doing well; he denied thoughts of self-harm or harm to others.

There is an issue at inquest of the inadequacy of ensuring compliance with the taking of medications. There is also an issue of what could be seen as a conflict in the evidence of Kylie Harvie, RN the Case Manager and of Janet Sharples, RN. Those matters will be better left until I deal with the issue of Community Treatment.

With that background I move to the events of the night of 2nd February 2004.

On that night Charles Keith Chenery was at his home at 53 Lachlan Street, Windale with his de facto partner Kelly Scholes. M/s Scholes had, since his release from hospital, been taking responsibility, or primary responsibility for his compliance on his medication that included the drug Clozapine. There was a need for her to hide the medication from Mr Chenery as he had previously attempted to overdose on the drug.

Whether this overdose was merely his method of helping make the psychotic signs disappear, or was for some other purpose is not entirely clear, though there is a probability that it was for the first purpose. He really needed to be supervised quite closely. On his history there had been dealings on his part with illicit drugs, which experience showed, tended to make things worse.

Late that evening Mr Chenery woke Ms Scholes and informed her that he had taken an overdose of the drug Clozapine and to call an ambulance. Ms Scholes did contact NSW Ambulance, via Triple 0 and provided information as to the overdose and Mr Chenery's state of mind. An ambulance unit was quickly dispatched to the home, but due to an alleged propensity to violence on Mr Chenery's part, the crew elected to "stand off" around the corner from the home and request the police to attend to assist in protecting the crew from possible harm.

The Triple 0 call was made at 22.09.26 by Kelly Scholes. It was answered immediately by the call taker at NSW Ambulance, Pauline Campbell. Scholes' message to Campbell disclosed the address, phone number, fact of overdose of clozapine and age of Mr Chenery. In addition Ms Scholes informed Ms Campbell that Keith Chenery was conscious but agitated and that he "can be violent", was drowsy but awake and breathing normally.

Pauline Campbell immediately entered relevant data onto the computer as set out below. She gave the message a Code 17 (drug overdose). The case was then transmitted to the relevant dispatcher, Christine Bond. Bond had no vehicle available on her "board" (Newcastle) so referred the call to another area and to Lisa Dodds (Central Coast "board), who allocated the case to Car 237 – Officers Dries and Tomkins.

Christine Bond, however, first called NSW Police at 22.11.13 and advised them of their need to be involved. Her message really followed the message generated by Ms Campbell. She spoke to a civilian call-taker for NSW Police, Sharlene Holgate, telling her that there was a case at Windale, that Ambulance was going to an address there and needed NSW Police there as well. She said:

"I've got a patient named Keith Cheney C-H-E-N-E-Y, [sic] overdosed on schizophrenia tablets, can be violent, drowsy and agitated."

Holgate said:

**"Can be, or ..."**

Ms Bond, as would not be uncommon, felt she understood what Holgate was asking and cut her off, accepting that Holgate was saying words to the effect "*can be or is*".

She then said:

***"Yeah, he's got a history of violence, we won't know if he's actually violent until we get there."* (emphasis added)**

Meanwhile, Lisa Dodds took control of the job for NSW Ambulance, or at least took control of the task of obtaining an ambulance to send (the evidence appears to be to the effect that the job technically remained that of Bond as it was in her "board" area). As I have said Lisa Dodds was referred the job by

Ms Bond. At 22.14.12 Ms Dodds spoke to the crew of 237 who indicated its willingness to do the job. The ambulance was in the Belmont North – Jewells area and therefore not far away from Windale.

In fact Officers Scott Dries and Peter Tomkins were in vehicle 237. They were assigned to the case at 22.15. They were en route with Tomkins driving. Dries accessed information via the vehicle's mobile data transmitter (MDT) in these terms:

“25YOM. CODE 17 ON SCHIZOPHRENIA MEDS. PT IS DROWSY AND AGITATED. PT CAN BE VIOLENT. PTS NAME IS KEITH CHENEY.”

The officers discussed the matter and agreed that they should “stand off” and await police assistance, as they were not trained in any way to handle violent clients. Dries contacted the Northern Ops Centre by radio at 22.15.49 and spoke to dispatcher Lisa Dodds advising her that they were “standing off”. Ms Dodds advised that she would call the police and seek an estimated time of arrival for them.

So by 22.16.18 an ambulance was “standing off” at the intersection of Iona and South Streets, Windale waiting for NSW Police to assist. Up to this point the operation had been exemplary. The ambulance was quite close and got to location quickly.

Meanwhile over at VKG (NSW Police Radio) civilian call-taker Sharlene Holgate gave the job a “**Priority 3**” rating (need to attend but no need to expedite (that is, no lights and sirens and/or high speed)). This is the priority given, for example, to a break and enter in progress or just completed. She justified her chosen priority by really saying in evidence she understood ambulance to be saying that they were making further inquiries. In evidence she said that she did not think that Ambulance would not enter the premises. In evidence and in her Record of Interview she described the lack of an “urgent feel” to the job.

The job was passed by Sharlene Holgate to dispatcher Christine Herrmann. Herrmann was a very good witness. At 22.17.40 she requested a Lake Macquarie vehicle to attend.

The message was broadcast to the Lake Macquarie primary response vehicle, Lake Macquarie 15. At 22.21.26 she again requested the Lake Macquarie vehicle to attend, advising that ambulance 237 was “standing off”. It should be noted that both of these requests were in effect to any available police vehicle. At 22.29.30, Ms Herrmann made a third request for a vehicle and at 22.30, Lake Macquarie 22 acknowledged the job and advised that they were at Pelican, to the South of Belmont.

When speaking about whether or not the job was properly rated as Priority 3, Herrmann mentioned the lack of the term “urgent” at any time. She indicated that “urgent police assistance” had never been sought and had it been the priority would have changed. She also relied on the fact that she was only told that the patient “can be aggressive” and not that he was being aggressive.

Recapitulating. The job had been given Priority 3 by police. It took time obtaining a car to deal with the case. A car was located at 22.30, 15 minutes later and proceeded to the job within the speed limit of 60 kph.

It must be said that during that period of about 15 minutes, NSW Ambulance was not idle. At 22.18.23, Ms Dodds advised VKG (Stuart Davies) that an ambulance was standing off and the location of that ambulance. She contacted ambulance 237 at 22.19.03, and again at 22.25.48, advising that a police ETA had not yet been received.

At 22.29.17, Kelly Scholes again telephoned Triple 0, hysterical, advising that Keith Chenery was fitting. Lisa Dodds at NSW Ambulance immediately informed car 237 that the patient was now convulsing (22.30.01) and that she would be requesting Level 4 (Paramedic) back up. The officers elected to remain “standing off”. In fact Ms Dodds also took the step of requesting her supervisor, Terry McKendry, a trained paramedic, to speak to Ms Scholes over the telephone, to assist her in dealing with Mr Chenery.

At 22.31.03 Police VKG contacted Ms Campbell and gave an ETA of “however long it takes to get from Pelican to Windale”. Ms Campbell replied “probably 5 to 10 minutes”. Police VKG acknowledged this estimate. Ms Campbell could not ultimately be called to give evidence but it is clear that that ETA was converted by her to one of 5 minutes. 5 minutes then appeared on the mobile data transmitter (MDT).

At 22.31.29 Christine Bond at Ambulance requested car 215 (which contained a Level 4 officer) to back up car 237.

At 22.33.40 Ms Bond also requested car 245 to back up 237. Officers Sean Vallance and Dean Whitelaw in 245 went directly to the scene and arrived there at approximately the same time as NSW Police, Senior Constable Anthony Finn and Probationary Constable Simon Moore (driving).

At 22.33.54, Michael Scholes made a third family call to Triple 0, concerned about the apparent delay.

At 22.34.36, Lisa Dodds advised Car 237 that Level 4 assistance was “minutes away”.

There were a number of other communications but it was not until 22.41.18 that car 245 arrived at the scene. In fact, within about one minute the police vehicle, Lake Macquarie 22 attended and together police and ambulance officers entered the premises and treated Mr Chenery.

Effectively, then the initial ambulance vehicle had been “standing off” at the scene for a period of about 28 minutes. This inquest has examined the reasonableness of that standoff, in terms of the data given about the “dangerousness” of Keith Chenery.

Mr Chenery was conveyed to the Mater Misericordiae Hospital. He was appropriately treated by ambulance officers and by emergency staff at the Mater Hospital.

The evidence of former ambulance officer Dean Whitelaw who was one of two treating officers that evening, is to the effect that as the patient was not in cardiac arrest and that a grand mal epileptic fit had been able to be controlled en route. In those circumstances he and his co-worker opted to take Keith Chenery to the Mater Hospital rather than John Hunter Hospital. The Mater, Mr Whitelaw pointed out, specialises in overdose and toxicology cases. He estimated that on that urgent duty drive, with lights and sirens, late on a Monday night, the trip would only have been about 3 minutes longer to Waratah.

In this regard, Dr Michael Downes, an Emergency Medicine and Toxicology specialist gave good evidence of the medical challenge presented by Mr Chenery once he had gone into cardiac arrest at the hospital. Mr Chenery was barely alive on arrival at the hospital and could not be saved. The unusual thing about this case is just why he went into cardiac arrest and doctors have no firm opinion as to this. The issue of a possible bolus of the drug and Dr Allender's Review was canvassed and Dr Downes did not understand how Dr Allender (a Pharmacologist rather than a medical practitioner) could have known that there was a bolus in situ. Dr Allender commented initially on a different course of treatment on the basis of a bolus. Once he had read Dr Downes' interview he modified his view. In fact, the autopsy report shows that there was no bolus in Mr Chenery's stomach.

Dr Downes, in his statement to me, recalled a case of clozapine overdose of 16 grams – almost three times the dosage taken by Mr Chenery. In that case the patient survived without complication. I find this curious as Mr Chenery's ante mortem and post mortem blood levels, at 5.1 mg/litre and 12 mg/litre were both well into the statistical fatal range. The patient referred to by Dr Downes did not have a cardiac arrest and in fact I accept that heart attacks from clozapine overdoses are very rare. Dr Downes notes that the patient presented in a critical condition from the outset.

Therein may lie the explanation. Mr Chenery was probably in a critical condition well before ambulance officers began treating him whereas the patient referred to by Dr Downes may have been optimally treated soon after ingestion of the drug.

Forensic Pathologist Dr Kevin Lee was of the opinion that the dosage taken by Keith Chenery was well into the fatal range for the drug and that he therefore died of an overdose of the drug clozapine.

Opinions were sought from Drs. Downes, Allender and Lee. I think it is fair to say that the weight of evidence is to the effect that the delay in receiving treatment caused by the "stand off" may not have made a difference in terms of enabling Keith Chenery to be saved.

It is, therefore, quite possible that Charles Keith Chenery would have died had treatment begun immediately at the time ambulance 237 commenced to stand off the premises at Windale. Dr Allender, in particular, is of the opinion that the delay in first receiving ambulance treatment probably made no real difference.

Nevertheless there are important issues in this case that must be considered.

## **Issues.**

I felt it necessary to develop a rather full factual matrix. There was a general indication at my bar table, that counsel for the various interested parties generally agreed with the submissions of Counsel Assisting, Ms Belinda Baker. In those circumstances I believe I can adequately deal with the issues arising from this case in somewhat less detail. The reader will have to digest the facts in order to fully understand the issues.

I would like to thank all at the bar table for their assistance to me in what has actually been quite a complex and difficult inquest.

I would particularly like to thank my Counsel Assisting and Solicitor Assisting. Emman has been very helpful throughout the inquest and in the lead-up to it. She has assisted me in checking my work for accuracy. I have been assisted by many Counsel, often Senior Counsel. Belinda stands out as being one of the best I have ever worked with.

Her diligence and ability to put her own mind to the issues has enabled me to use her work in writing up the issues of the inquest. That is, in fact, rarely the case.

## **NSW Ambulance Service Issues.**

In fact the NSW Ambulance vehicle arrived at Windale very promptly and then stood off for some 28 minutes whilst it awaited the arrival of the NSW Police Force vehicle, before going into the house to treat Mr Chenery.

This decision was largely made because Ms Kelly Scholes had (truthfully) told the call taker at NSW Ambulance that Keith “could be violent”. About half way through this “stand off” ambulance officers were told that Mr Chenery was in fact “fitting” or “convulsing, and unconscious. They remained “standing off” after receiving this information.

A number of issues are thus raised:

### **Standing off premises.**

#### **a) Whether the ambulance officers were justified in waiting for police on the information that they received initially.**

When one looks at the matter coldly, it is, of course extremely disturbing to imagine Mr Chenery’s condition becoming rapidly more critical whilst qualified ambulance officers who could at least begin to provide assistance are standing off at a nearby intersection. On all of the evidence before me, however, I am of the opinion that the two officers involved were in fact justified in waiting for NSW Police to arrive on the basis of the information they had been given. They received information that Mr Chenery had overdosed on schizophrenia medications and that he was “agitated and drowsy” and that he “could be violent”.

Ambulance officers of course perform a most difficult job at the best of times. Highlighted in this case is the fact that from time to time they must enter unknown and potentially dangerous places, confront unknown and potentially dangerous persons suffering largely unknown conditions. Others in the vicinity could also be difficult or dangerous. Most NSW Ambulance Officers giving evidence testified about times when they personally have been assaulted whilst attempting to assist people in real need of assistance. The evidence before me about the need for “stand offs” is strong indeed.

Whilst it is true to say that on the information the officers received, it could not be stated that Mr Chenery was in a violent state, and we know of course that he was not, the information of “potential violence” was certainly sufficient to raise the prospect that Mr Chenery could, or might be violent should officers attend. In those circumstances I have to find that in the particular circumstances of this case that this “prospect of violence” amounted to sufficient justification for ambulance officers to “stand off” from the residence to await the arrival of and assistance of NSW Police officers.

**b) Whether the ambulance officers were justified in continuing to “stand off” after they had received information that Mr Chenery was unconscious and “fitting/convulsing”.**

I must put from my mind, the image of ambulance officers “standing off” around the corner whilst Mr Chenery was convulsing from the very toxic effects of his drug overdose. All medical and ambulance officers conceded that Mr Chenery going into convulsions was an indicator that his situation was becoming a great deal more critical.

Nevertheless, at the time this information was actually received by ambulance officers, they had also been informed that the police vehicle was “minutes away”. As stated earlier, there was evidence that the “five to ten minutes” ETA as taken by Ms Campbell, became “five minutes”. Then there was a period of two minutes given. It should be noted that Mr Terry McKendry, the DOCO and a senior officer of NSW Ambulance who was also a paramedic, had spoken to Kelly Scholes at the request of the call-taker. He had, in doing so, gained much insight into the situation at the residence. He questioned Ms Scholes carefully and the responses he was given indicated to him that Mr Chenery was breathing and that his fits had subsided. Mr McKendry in fact reasonably came to the view that whilst Mr Chenery’s condition was life threatening, he was not in a position of imminent death. His evidence was to the effect that he come to the opinion of imminent death he would have communicated that to the officers in the field.

**c) Adequacy of the “stand off” policy.**

This inquest has surely demonstrated, despite my findings of fact as set out above, that there are significant deficiencies in NSW Ambulance Service policies concerning “stand offs”.

There are only two policies that have been suggested as being relevant to a decision to stand off. The first of these, “Basic Protocol 2” really only advises officers to be alert as to safety and well-being and not to enter dangerous situations. It could not be termed a protocol in relation to stand offs.

The second policy is complicated. It is entitled “Mobilisation: Dispatch Procedures to Potentially Violent and High Risk Situations.” Attached to the policy is a flow chart. The first page of this policy, as Ms Baker said, has only tangential relevance to a situation where ambulance officers seek police assistance. Its real relevance is to the opposite – where police seek assistance from ambulance officers in dangerous situations. It simply has little application to the situation raised in this case.

I had strong words to say about the flow chart in court and frankly, now that it has been explained I find that it provides me with little assistance. It is confusingly drafted. NSW Ambulance Superintendent Jamie Vernon was examined by various counsel. By way of example, on the flow chart, the words appear “*is the assault in progress*” and “*is the perpetrator still on scene and/or still may pose a threat to staff*”. On my understanding of his evidence he explained that those words could be applied to this situation. In other words, for the word “*perpetrator*” and “*assault*” read “person who is potentially violent”. It is stretching the imagination to do that and I don’t believe it can legitimately be done by me, or, for that matter, by the persons within NSW Ambulance for whom it was written. Mr Vernon was defensive in the witness box as it was his document. He did, however, fairly concede that the document could be clearer.

What is important is that the document does not provide actual assistance as to how to evaluate a potential risk to safety.

On the evidence before me there is simply no policy that governs questions of (1) whose decision is it to stand off; (2) how that decision is to be made (how is the risk to be assessed); (3) what should occur when a decision is made to stand off (where the stand off should actually take place).

Although an ambulance decision to stand off necessarily will involve NSW Police resources, there is apparently no joint NSW Police Force and NSW Ambulance Service policy or protocol in existence concerning such stand offs.

Mr Dean Whitelaw was until relatively recently a highly skilled and trained member of the NSW Ambulance Service. A highlight of his evidence, was that the absence of a formal stand off procedure or protocol had been a “hot issue” amongst officers. He also said that he had raised the issue with his “line managers” but nothing had come of him doing so. It is time for the matter to be attended to in my view and a recommendation pursuant to *Section 22A, Coroners Act 1980* will have to be made.

## **Training.**

I am satisfied that there is very little training about “standing off” and the evidence of training was very general. The documentation in relation to training, too, was limited though I appreciate that there is now a deal of new or revised training material in draft at least. What is important is that Mr Vernon could not point to any substantive instruction, for example, on risk assessment as given during training. Nor does it appear that there is any substantive training in relation to “stand off procedures”.

Having said that, the officers who gave evidence generally appeared to have a uniform understanding about who was responsible for making the decision to stand off (dispatcher could recommend, but ultimate decision was for the car crew). They also seemed to be in agreement that most stand offs would be out of sight of the relevant premises. It is most unlikely that they obtained this information from formal, training, rather, it seems that they probably obtained this training on the job.

In any event, all officers denied receiving any substantive training concerning the assessment of risk in making such a decision. As a result, there was differing evidence given by officers as to when they would stand off. Some officers would continue to stand off after advice that a patient had stopped breathing. Others said they would reassess and might “proceed with caution”, depending on what they were told about changes in patient condition and the like.

By way of striking example, as I understand the evidence, whilst the first ambulance stood off the premises, the later cars elected not to do so, but rather to “proceed with caution”, or at least make inquiries of the householder.

Even with full-time training there will be differences in the risk that individual officers are prepared to assume. Proper training will ensure that officers are better equipped to assess the risks on an individual case basis.

I shall make a recommendation in relation to training.

### **d) Whether the ambulance call-takers conveyed sufficient information to NSW Police when they called police to request assistance.**

With the benefit of hindsight, in this case, the call-takers at NSW Ambulance may not have conveyed sufficient information to NSW Police VKG when they sought NSW Police assistance.

All VKG operators expressed confusion about aspects of the job, including, importantly, its urgency. By way of an example, in the initial call, Ms Bond said “we don’t know if he will be violent until “we” get there. Although Ms Bond may have intended (in fact I believe she did intend) that “we” meant “police and ambulance”, it is entirely understandable that Ms Holgate at VKG could interpret the “we” to mean “ambulance only”. This

understanding continued through later calls and at no time did VKG ever understand the urgency that needed to be conveyed by NSW Ambulance. Unsurprisingly, the crew in Lake Macquarie 22 did not have that urgency conveyed to it.

It follows that the priority given to police by VKG was probably different to what it might have properly been. All VKG operators stated that had they been told that the job was urgent they would have classified it as Priority 2.

In this context, Police Standing Operation Procedures classify various priorities in relation to calls from VKG to officers in the field.

Priority One is an “Urgent Response” call.

Priority Two is an “Immediate Response” call:

*“Serious incidents where there is, but not limited to, a serious threat to life or property, requiring an immediate police response: ie: armed hold-ups, violent domestics, serious assaults, person trapped in motor vehicle etc”.*

Such calls are preceded by a “2 tone alert” by the dispatcher.

Priority Three is a “Routine Response” call:

*“Incidents of a routine nature, that require police to attend as soon as possible. Not life threatening or likely to cause serious public disruption. For example, a break and enter and steal, noise complaints, motor vehicle accidents, non-violent domestic, animal complaints, shoplifters etc.”*

It is quite likely on the evidence before me that ambulance dispatchers assumed that police would understand that the call was urgent. In fact, Mr Vernon indicated that “all calls for assistance” are urgent at one stage, though I believe he did resile from that stance.

In my view such assumptions are indicative of a need for improved communications, at least between NSW Police and the NSW Ambulance Service. The effective liaison, not only between these two very essential emergency agencies, but others such as NSW Fire Brigades and NSW Rural Fire Service is incredibly important to the well being of the people of New South Wales. Regular liaison is involved and that liaison must be effective. To be effective there must be effective communications between Agencies.

As Ms Baker pointed out, not all ambulance calls are equally urgent. An overdose on drugs will probably be urgent whereas a migraine headache will probably not be. NSW Police call takers and dispatchers cannot be expected to judge the urgency of medical issues. They need assistance from NSW Ambulance. It is also essential that NSW Ambulance indicates to police that a car will be standing off, and if that situation changes.

The NSW Ambulance and NSW Police call takers and dispatchers each were of the view that they would be assisted by standards in communication, such as by Memorandum of Understanding, Protocol or the like. Joint training might be helpful. Close proximity between the two radio rooms might be one way of making the relationship easier though I could never raise that thought to a recommendation on the evidence before me.

I shall make a recommendation in relation to this issue.

**e) Decision to convey Mr Chenery to the Mater Misericordiae Hospital, Waratah rather than to the John Hunter Hospital.**

The evidence before me is that provided an ambulance travelled at high speed, under lights and sirens, at that time of night the Mater Hospital was only about three minutes further journey from the John Hunter Hospital.

Mr Chenery's condition was critical in the ambulance, with a Glasgow Coma Scale score of three (lowest level of consciousness). He had suffered a seizure at his residence and a full, grand mal seizure whilst in the ambulance. That required quite dangerous and risky treatment with midazolam, itself an antidepressant. He clearly required the emergency hospital acute care treatment.

The officers treating him had to make a judgment between the closer John Hunter Hospital, and the more distant Mater with its better arrangements for acute drug overdose cases, and toxicology generally. Whilst Mr Chenery's condition *en route* was clearly critical, he did not suffer a cardiac arrest whilst in the vehicle. He did not stop breathing. I am satisfied that the officers were well justified in electing to travel to the Mater.

There, it is common ground that he obtained a very high standard of emergency treatment.

**NSW Police Force Issues.**

The NSW Police call-takers gave the job a "Priority Three rating (routine response). The priority did not change even after police were advised that Mr Chenery was convulsing. This raises issues of:

- a) Whether the call was correctly prioritised from the outset.**
- b) Whether the call should have been ranked higher once the police received the information that Mr Chenery was fitting or convulsing.**
- c) Whether NSW Police should have sought more information from NSW Ambulance in order to better prioritise the call or to review the earlier prioritisation.**

The Officer-in-Charge of this investigation, Detective Chief Inspector Humphrey, after investigating the matter, is of the view that the call ought have been prioritised Priority Two from the get-go. With the benefit of hindsight I am also of that view. The situation involved a *serious threat to life* and it was not of a *routine nature* in terms of NSW Police Instructions or Standing Orders. Ambulance could not enter without police. Clearly the NSW Ambulance call-takers considered the call as urgent. *A fortiori*, once the advice was received that the patient was fitting/convulsing, the call should have been upgraded to Priority Two.

I have indicated that I am of the view that the ambulance officers did not sufficiently convey the urgency of the call to NSW Police VKG. It could also be said that VKG could also have made greater attempts to clarify the information received from ambulance. My view is that this was a Priority Two case *ab initio*. At the very worst, it could be seen as a borderline Priority Two Case (so close to Priority Two as to seek clarification).

It is not my function in a case like this to apportion blame. Nor do I believe that the “blame and punishment” game will assist anybody. To the contrary the personnel involved here perform most difficult tasks and need to be supported by their respective employers (NSW Police Force and NSW Ambulance Service) by being given constructive assistance which might reduce the series of misunderstandings as has occurred in this instance. Those misunderstandings led to an under-prioritisation of the call and are in my view, indicative of an underlying problem in communications between Police VKG and NSW Ambulance. For this reason, as I have already stated, an MOU or Protocol between the two organisations ought to be considered.

On one view the call did not clearly fit within either of the relevant existing priorities. That is not actually my view but the weight of evidence suggests that it may be the feeling of the actual operators. As I have said it was either a Priority Two matter or at the very upper limit of Priority Three.

Whilst many felt a further Priority rating for such cases might be helpful, I am aware that considerable thought has already been given to this issue by NSW Police and by the NSW Ombudsman. There is no doubt that adding layers of priorities may complicate the system. It is also likely that the whole system would need to be reviewed.

Nevertheless I believe a recommendation is appropriate.

#### **d) The NSW Police crew of Lake Macquarie 22.**

There is consensus at the bar table that Senior Constable Finn and Probationary Constable Moore could not be criticised for their actions in responding to the call. It must be remembered that they were in a so-called “caged truck” which is not an appropriate vehicle for high-speed work except in exceptional circumstances. Moreover the driver was a Probationary Constable who was not allowed to drive either in “pursuit” mode or in “urgent duty call out” mode. (See NSW Police Safe Driving Policy).

The distance to be travelled was relatively short and not much would be gained from “urgent duty” driving in circumstances where the crew would have to stop the vehicle, change places and begin to drive again.

Senior Constable Finn did not report this incident to his Duty Officer or Supervisor, though he knew that it resulted in Mr Chenery’s death. He very honestly concedes that he should have done so and has clearly learnt much from his experience. Such reporting is important and may have had the effect of recognising that this was in fact a critical incident within the meaning of the NSW Police Critical Incident Protocol. Even if not so recognised, appropriate investigating police could have become involved more quickly.

Senior Constable Finn, in my view, has learnt a salutary lesson in policing. He is a valuable resource to the people of this State. I strongly suggest that no disciplinary action should be taken against him. I am confident that he will know what to do next time.

### **Generally.**

Mr Cavanagh submitted that a Recommendation ought to be made that a publicity campaign be devised by NSW Ambulance Service alerting the community to the possibility of delay in potentially violent call-outs. I accept Mr Butcher’s submission that such a campaign might potentially lead to persons not giving appropriate, truthful data in relation to violence or potential violence. That would worsen the position. That can be considered by NSW Ambulance but I do not propose to make a formal Statutory Recommendation.

Mr Butcher was concerned about any “training” recommendation in view of potential Occupational Health and Safety concerns for the employer. I acknowledge that OH & S legislation is draconian in relation to employers, having just completed a mining case.

That legislation simply has to be kept in mind by those responsible for training. Perhaps that is one reason why I, as Coroner, do not draft Recommendations in a manner that forces my views onto experts in a given field.

### **Community Treatment Issues.**

Mr Chenery died whilst subject to a Community Treatment Order. The Order was obtained by the Lake Macquarie Mental Health Team following Mr Cheney’s admission to hospital as a Scheduled patient, and his subsequent status as an involuntary patient. Rather than place Mr Chenery before a visiting justice again and potentially have him discharged, the Team, with Mr Chenery and his family’s consent, elected, properly in my view, to place him before the Mental Health Review Tribunal and seek a Community Treatment Order. That order was duly made on 8th January 2004 and Mr Chenery was discharged from hospital.

**a) Was Mr Chenery's supervision under the CTO adequate.**

Ms Kylie Harvie, RN, case manager was responsible for supervising the CTO. Ms Harvie did not see Mr Chenery in the three or so weeks between the commencement of the CTO and death. However, she said that was satisfied that Mr Chenery's condition was satisfactory because she understood that he was seeing Ms Janet Sharples on a face-to-face basis each week. Ms Harvie stated that Ms Sharples had agreed to "pseudo-case manage" Mr Chenery.

Ms Sharples, however, denied agreeing to "pseudo case manage" Mr Chenery. She said that from September 2003 she did not have any one on one contact with Mr Chenery, but did see him when she saw Kelly Scholes. Ms Sharples stated that she would not assess Mr Chenery's mental state but would talk about social matters. However, as a matter of ethics/ courtesy, she would inform Ms Harvie every time she saw Mr Chenery of how he appeared.

Ms Harvie was in my opinion an honest witness. Ms Sharples was also an honest witness. There was a clear misunderstanding between the two as to any role Ms Sharples was to play in Mr Chenery's supervision, particularly in relation to compliance with the drug regime, but also generally.

Ironically on 3rd February 2004, Dr Singh Sandhu, Consultant Psychiatrist was to have seen Keith. Death intervened.

Ms Harvie did however, obtain the Tribunal proceedings on 12th January 2004. On 14th January she spoke to Kelly Scholes and satisfied herself that Mr Chenery was well. No concerns were expressed. She (wrongly) believed that Keith was to see Nurse Sharples approximately weekly. I think it was implicit in the Community Treatment Plan that some reliance would be placed upon Mr Chenery himself and on his partner Ms Scholes. That was also Dr Sandhu's evidence. (Nurse Harvie had formed the view that Ms Scholes was generally accurate in any advice she was giving about Keith Chenery).

On 23rd January he was actually seen by Nurse Sharples who conveyed to Nurse Harvie the opinion that Keith Chenery was well and was stable.

Then on 29th January Nurse Harvie spoke to Keith Chenery himself. He indicated to her that he was having no problems, was sleeping well and had no thoughts of self-harm.

Mr Cavanagh submitted that there was a gross failure to deal with the patient in terms of ensuring compliance with the Community Treatment Order especially as to compliance.

I note the misunderstanding between the two nurses. Whilst it could be said that the ground was covered in some way, both nurses contemplated a level of supervision higher than that which was achieved. I do not have sufficient

evidence before me to be able to find that there was as serious failure on behalf of Nurse Harvie and the Team, either in relation to ensuring compliance or generally.

It is perfectly open to either Mr Chenery or Kelly Scholes to file a complaint in relation to Keith Chenery's care and treatment under the Community Treatment Order, with the Health Care Complaints Commission. I certainly do not have sufficient evidence to make a "coronial referral"

b) Why did Mr Chenery have an apparently large quantity of medication on him at the time he overdosed.

Mr Cavanagh also raised the issue of not ascertaining, or attempting to ascertain the number of tablets Mr Chenery may have been holding at the time he obtained his last monthly prescription. Again I have heard insufficient evidence to take that issue further. That too, might more properly be looked at by the HCCC.

Criticism of NSW Police Officer-in-Charge and State Coroner of NSW Ambulance assistance to them.

That issue has been aired in the brief of evidence and in court. It is a fact that NSW Ambulance is rarely criticised by this Coroner. Actually, NSW Ambulance quite rarely becomes the centre of my coronial investigations. That is an indicator that the Service operates generally very well indeed.

I have simply reminded the Service, through its Counsel, that the Office of the State Coroner expects full cooperation from large public Agencies being investigated by the Coroner. NSW Police and NSW Department of Corrective Services, for example have learnt that as a general policy, "cards on the table" is the way to go. Often NSW Health, as Mr Butcher well knows, takes a similar approach. They are usually positively constructive at looking at their own deficiencies prior to inquest and even taking steps to implement change prior to inquest. I simply urge NSW Ambulance Service to consider a similar mindset.

In saying what I have said, of course, I fully recognise the rights of the Service under the law and the rights of its individual members under the law. Nothing I have said should be construed as appearing to cavil with those rights, or to trample on them. An inquest, though, is a fact finding exercise – an important one. It is usually a constructive process. Much can be gained by a similar constructive and honest look at relevant issues well prior to inquest.

### **Conclusion.**

Having heard the evidence, I am not satisfied to the standard of "comfortable satisfaction" (*Briginshaw v Briginshaw* – (1938) 60 CLR 336) that Mr Chenery took the drug Clozapine with the intention of ending his life. In fact, the evidence tends to go precisely the other way. He told Ms Scholes earlier, that he had extra tablets on him "in case the voices got bad". He then

consumed a large number of tablets, over what period I am unsure, and later woke Ms Scholes stating “I don’t want to die, ring an ambulance”. A strong contra hypothesis, then, consistent with accidental death, is that Mr Chenery took the tablets in an effort to quieten the voices in his head. Such is the tyranny of this dreadful illness, schizophrenia.

This inquest has attempted to look honestly and constructively at the important issues raised by Mr Chenery’s death.

I am hopeful that my proposals for change will be closely considered by NSW Ambulance Service and NSW Police Force. If change comes about, and my replacement will be advised, then the family should feel that Keith’s death has not been completely in vain.

I hope that my inquest will help the Chenery family and Kelly Scholes to come to terms with Charles Keith Chenery’s death.

### **Finding.**

**Charles Keith Chenery died on 3rd February 2004 at the Mater Misericordiae Hospital, Waratah as a result of an overdose of the drug Clozapine on 2nd February 2004 at Windale, such Clozapine being deliberately self-administered, but not with the intention of taking his own life.**

### **Recommendations.**

- 1) That the NSW Ambulance Service considers the implementation of a comprehensive policy in relation to car crews “standing off” from premises, and sites after requests of assistance to NSW Police and whilst awaiting the arrival of police;
- 2) That the NSW Ambulance Service gives consideration to the implementation of a comprehensive training program to all field and radio personnel in relation to “standing off”; that such program deals particularly with the issue of assessment of risk;
- 3) That the NSW Ambulance Service and the NSW Police Force give consideration to the formalisation of a Memorandum of Understanding or Joint Protocol covering the field of NSW Ambulance/NSW Police interaction and communication in relation to the issue of “stand offs”; the MOU or Protocol should deal, in particular, with the issue of relevant information to be conveyed between the two Services in “stand off” situations;
- 4) That NSW Ambulance Service and NSW Police give consideration to regular joint training of call takers/dispatchers – such training might include development of a glossary of each other Service’s relevant terminology;

- 5) That NSW Police Service gives consideration as to whether or not a further priority level might be developed between call-out “Priority 2” and “Priority 3”. That consideration might include assessment of whether a special priority might be added to cover ambulance requests for assistance.

## II.

2057 of 2004

**Inquest into the death of Thuong Lam on 2 December 2004. Finding handed down by Magistrate John Abernethy, NSW State Coroner on 17 March 2006.**

### **Preamble.**

There can be no serious matter than an investigation and inquest into the death of a civilian who has been shot by an officer of the NSW Police. Such a shooting is, of course, a homicide and the coroner must determine whether or not that homicide is justifiable.

Where, as is often the case, the next of kin is unrepresented, the task of ensuring that the evidence is tested and tested rigorously, falls upon counsel assisting the coroner and the coroner him or herself. This case has been no exception and Mr. Saidi has pursued his duty vigorously.

All such deaths fall within *S.13A, Coroners Act 1980*. In those circumstances the State Coroner or a Deputy State Coroner must conduct the inquest. Moreover, details of the matter must be included in the Annual Report of the State Coroner to the NSW Parliament.

By protocol, such deaths are investigated as critical incidents and in those circumstances according to NSW Police Critical Incident Guidelines, by independent investigators. Also by protocol, independent Counsel is appointed to assist the coroner.

### **Facts.**

A number of people observed this police operation. They included NSW Fire Brigades Officers, a Bankstown City Council Ranger and a number of civilians. When one takes into account peripheral differences and differences of perspective, their observations are, in fact, remarkably similar. Moreover those versions are markedly similar to those of the two police officers involved, and, so far as they were observed, to other police who attended the scene.

It must be remembered that police were separated from each other within minutes of the arrival of other police, and in any event shortly after the incident. They each underwent a directed ERISP record of interview. They each underwent a directed video walkthrough. They were each required to give evidence at my inquest. Their versions did not manifestly change.

The factual matrix, then, is of short compass.

## **Background of the Deceased.**

Thuong Huy Lam was born on 14th October 1966 and was aged 38 years. The deceased arrived in this country from Vietnam in about 1989, though his brother Kien Lam came here in 1981. Although he lived with his brother and family initially on arrival, things became strained and he moved away. Thereafter their contact was only intermittent. He appears to have entered a relationship with a woman, Binh, and has a son of that union. That relationship broke down and for a time Mr. Lam was living on the streets around Marrickville.

In 1996 Lam applied for Department of Housing accommodation but lost contact with the Department. Finally in 2001, with the assistance of Mr. Peter Nguyen, priority housing was obtained. Lam never really grasped the English language. Moreover it is clear that he had a long history of psychiatric illness that affected his ability to work and to properly conduct his life affairs. In 1997 Lam spent time in the Missenden Unit, Royal Prince Alfred Hospital. During the late 90's a number of minor criminal matters were dealt with pursuant to Section 33, Mental Health Act.

He had been diagnosed with schizophrenia. Mr. Peter Nguyen of Bankstown Community Health Service had been his Case Manager since about 2001. When supporting Lam's application for priority housing, Mr. Nguyen said:-

“When Thuong has a psychiatric onset, he often feels he is controlled by a “spirit” in the sky, is being followed and has become itinerant because of this delusion. When being not well, Thuong also hears voices but cannot describe these. Thuong appears to be of borderline intelligence.

.....

*Thuong has a girlfriend who herself has mental illness and she had kicked Thuong out of her Department of Housing Unit after having arguments with him. Thuong has wandered from place to place without a fixed abode .....”*

Thuong Huy Lam was thus allocated a bed-sitter known as Unit 4, 287 Waterloo Road, Greenacre – part of a five unit complex, transferring there from premises at Chester Hill. Living next door in Unit 5 was a Vietnamese lady, Binh Phung Luong, with whom Lam had been in a relationship. Leading up to the 2nd December 2004, it appeared that the relationship was becoming unstable. Arguments about Lam's gambling and smoking were occurring. Mr. Nguyen had noticed that from about September 2004, Lam had not been taking his medication. A number of medical examinations were carried out and on 30th November Nguyen made another home visit. This time there was little food in the premises and Lam appeared to be delusional. He had not been taking his medication. Mr. Nguyen offered to take Lam to Banks House, Bankstown Hospital but Lam refused to go. On 1st December, Mr. Nguyen again visited Lam at home. On this occasion the Unit appeared to have been tidied up and cleaned. Mr. Nguyen undertook a mental state examination and risk assessment. He formed the impression that

Lam appeared to find it difficult to care for himself in terms of personal hygiene, food preparation and compliance with medication. Nguyen was also concerned with Lam's social isolation and finances. His delusions concerned him.

On 2nd December Mr. Nguyen attended a case review for the rehabilitation team of Bankstown Community Health Centre. He thought it necessary to present Lam's case and prepared a case summary. Long and short-term rehabilitation plans were formulated. These included an acute care visit that would probably have led to involuntary admission to a psychiatric unit. Unfortunately Lam's death intervened before these plans could be put into effect.

### **The Police Operation.**

John and Hellena Feltrin resided at 2 Pandora Street, Greenacre. Their premises backed on to the Five Units that included Lam's residence. Just before 7 pm on 2nd December, 2004, they became aware that a fire had broken out and contacted the NSW Fire Brigades. In fact Thuong Huy Lam appears to have deliberately set fire to his premises. Mrs. Feltrin ran into the back yard and noticed some young men attempting to put the fire out. She took her garden hose to them for their use. As she was running the hose towards the back fence she noticed Mr. Lam standing near the back fence, apparently on her side of the fence. At the time, Mrs. Feltrin also spoke to Mr. Eddie Bosnjak the Bankstown City Council Ranger who had arrived at the fire.

Mrs. Feltrin thought Mr. Lam might have been armed with a knife. A number of onlookers were already at the scene. The first call to the NSWFB was logged at 6.55 pm and the brigade arrived at 7.04 pm.

By that time the fire was out or substantially out. The interior of the premises had been completely destroyed.

Whilst in front of Unit 4, Mrs. Feltrin approached Michael Forbes, OIC, Lakemba Brigade, NSWFB and advised him that the man who lived in the burnt unit was standing on the fence in her back yard and he had a knife in his pants. Forbes walked to the rear and noticed an Asian man, by now standing on the fence leaning against the roof of a small out building. He attempted with no success to engage Mr. Lam in conversation. Because of the suspicious nature of the fire and the fact that the suspicions about the knife had been reported to him, Forbes contacted NSW Police. Fire Brigades operatives were warned not to approach Mr. Lam.

NSW Police Constables Simon Moore and David Tonkin arrived at 287 Waterloo Road at 7.19 pm on 2nd December 2004. They parked their vehicle (Bankstown 37) and proceeded to the front of the unit block. The officers first spoke to a fire brigade member who directed them to another group of fire fighters near a burnt out Unit (4). They then spoke with Officer Forbes. Forbes informed them about the fire and that a lady had told them there was an Asian man located on the fence at the rear of the property who may have a knife.

Constables Moore and Tonkin proceeded to the rear of the property and saw the deceased, Mr. Lam, standing on the fence behind the Units. At this stage no knife could be seen in Mr. Lam's hands. As Constables Moore and Tonkin approached Mr. Lam, Constable Tonkin drew his can of Oleoresin Capsicum ("OC") spray from his belt and held it behind his back. Constable Moore attempted to engage Mr. Lam in conversation, saying, conversationally, words to the effect: "*Hey mate, come down from the fence, we want to have a chat.*" Mr. Lam did not give an intelligible response.

At this point Mr. Lam leaned onto the roof of an out building adjacent to the fence and a large knife was visible in Lam's right hand. Constable Moore yelled at Lam to drop the knife. Mr. Lam did not drop the knife, but climbed off the fence into Mrs. Feltrin's yard (2 Pandora Street, Greenacre), where he had been before climbing onto the fence. He stood there for a moment, looking at police and with the knife raised and pointed in their direction. Constables Moore and Tonkin rushed to the fence. Constable Tonkin immediately attempted to spray Mr. Lam over the fence with OC spray, whilst Constable Moore scaled the fence. The OC spray did not appear to have any effect then, or at any time, on Mr. Lam. Constable Tonkin also jumped the fence. On the evidence before me, Constable Moore was over the fence very shortly after Mr. Lam came down off the fence.

Thus both police were very quickly in the back yard of 2 Pandora Street, with Tonkin closely behind Moore. There was no discussion between them. At this time Mr. Lam moved quite quickly to a point near the right rear of the house and away from the fence. The constables moved towards Lam, forming a "triangle of safety" with each of the three sides approximately 3-4 metres.

Once over the fence, Constable Moore called for Mr. Lam to "put the knife down", and I accept the evidence of many, that this directive (or a directive in words to similar effect) was given to Mr. Lam a number of times by both officers, over the course of the event that followed. Mr. Lam did not at any stage put the knife down.

Thus, in this "triangle of safety" Mr. Lam had his back to the house and was facing the two constables with the knife held in front of him. Looking from the back fence Constable Moore was at 10 o'clock and Constable Tonkin at 2 o'clock. This formation was kept to throughout the rest of the operation, though the three moved to various points in that back yard.

Mr. Lam moved back in an easterly direction close to the right rear of the house. Constable Moore also removed his OC spray from his belt. Both police deployed their spray, to no apparent effect.

Whilst this was occurring, the Lidcombe and Lakemba NSWFB crews and a Bankstown City Council Ranger, Mr. Bosnjak proceeded to the fence to look into the adjoining back yard and observe the events as they unfolded. Mr. Omar Said, who had earlier helped his cousins extinguish the fire using Mrs. Feltrin's hose also observed proceedings. Said and Bosnjak, civilians, and

not members of any emergency service, gave evidence at inquest. Their evidence, allowing peripheral differences, mirrored that given by police. Importantly, both felt that police had little option but to use lethal force against Mr. Lam. A number of civilian onlookers were standing in a laneway to the eastern side of the Pandora Street block, observing proceedings. As I have said the crews of two fire brigade pumpers watched from the rear fence.

It appears from the evidence that Constable Tonkin had at this point, already drawn his Glock appointment. Constable Moore also drew his Glock. Both police continued to order Mr. Lam to drop the knife, using words to that effect in a loud voice. NSWFB Station Officer Forbes was one witness who stated that by the time he got to the rear fence he observed both officers had their OC spray out and appointments drawn. Both were attempting to spray Mr. Lam with OC spray. This is well corroborated by “ISRAPS” photographs depicting the rear of the house stained with OC spray. Rather than escaping along the Southern side of the house, Mr. Lam moved across the rear of the house towards the Northern boundary of the property (left side of the house when viewed from the back fence) and at the same time moving slightly back towards the rear fence to the west.

Constable Tonkin’s OC spray ran out and the can was discarded. Further directions were given to Lam to put the knife down. Constable Moore’s OC spray also ran out.

NSWFB Officer Adam Hodges indicated in evidence that Mr. Lam was moving from left to right and initially waving the knife from side to side.

From the evidence of Eddie Bosnjak, Bankstown City Council Ranger, Mr. Lam at one stage threw a piece of debris at the officers just prior to the first shots being fired. He then moved towards Constable Moore swinging the knife. Neither constable can recollect the debris being thrown at Moore.

Mr. Lam then lunged, or moved quickly towards Constable Moore.

NSWFB Officer Matthew Campton stated: -

*“The Asian male continued along the wall towards the police officer at his 2 o’clock (10 o’clock when viewed from the rear fence). The police officer took a number of steps backward as the man advanced. The Asian male still held the knife up at waist level. However rather than continue along the wall and make an escape around the corner of the house, the Asian male headed directly towards the police officer at his 2 o’clock. ...The Asian male appeared to be intent on the police officer at his 2 o’clock position. It appeared to me that he intended on using the knife against the police officer. ...At that time I heard two shots”.*

It is unclear whether these two shots were fired from the same pistol or where they made contact with Mr. Lam. Witnesses described “grass or dirt flying up”. Several scenarios are possible. For example, more than two shots may have been fired initially. One or more may not have contacted with Mr. Lam. Certainly any wound sustained by Mr. Lam at this stage was not lethal.

By this time, Constable Andrew Pippett was also in the back yard behind Constables Moore and Tonkin. He had his baton drawn and OC spray out. Constable Jacqui Chadwick, Pippett's partner followed.

Campton gave evidence that Mr. Lam stumbled from these shots but got up very quickly and after being directed to "drop the knife", again lunged at Constable Moore. Matthew Ward, NSWFB Officer from Lakemba station states: -

"... the next thing I remember seeing was the Asian lunging and rolling forward and at the same time hitting out at one of the police (*Constable Moore*) with a knife. He looked like he struck the Constable in the leg with a backhanded blow. I remember seeing the Constable jump back and yell. At the same time I heard sounds of further gunfire."

Finally I shall quote from a civilian, the Ranger, Bosnjak:-

"The officer with the spray yelled again, "Drop the knife". The Asian male moved towards the ..... officer (Moore) with the knife in his right hand pointing towards the officer. The officer yelled "Drop the knife", a couple of times and drew his weapon and fired a shot.

This shot hit the Asian male but he kept moving toward the officer with the knife in his hand and the officer fired a couple of more shots. Two I think. They hit the Asian male and he fell to the ground. I couldn't say how long between the shots but they were within a matter of seconds. It all happened very quickly. I heard one of the officers yell, "Stay down". The Asian male seemed like he was trying to get up and screamed in pain. The officers went to his aid when they felt it was safe to do so."

The evidence given by the eyewitnesses, viewed as a whole, substantially corroborates the version of events surrounding the shooting as recounted by Constables Moore and Tonkin. Rather than detail the versions of the constables I have focussed on the more detached versions of several of the eyewitnesses. Though the many versions of the eyewitnesses differ, I believe the eyewitness accounts, generally, are a little more accurate – it should be remembered that neither constable has any recollection at all of a large square piece of debris being thrown.

Various witnesses attested to the lack of choice police had but to shoot Mr. Lam. All witnesses were basically of the same view. NSWFB Officer Grant O'Regan, for example said:-

"When I saw the Asian man with the knife and waving it around toward the police officers, I was amazed and thought I'm glad I'm not a copper. I thought the police were in danger of getting stabbed and the Asian male was not going to relent on what he was doing in swinging the knife."

Thus, the evidence before me is overwhelmingly to the effect that this shooting of a civilian by a police officer was justifiable or effected in the execution of duty.

Mr. Lam fell to the ground after the second round of shots. He was subdued and restrained by police, who then began to administer first aid, as did the NSW Fire Brigade officers who produced an oxy viva and gloves from one of their appliances. They assisted police in administering first aid to Mr. Lam.

Sergeant Grant Howell, Bankstown Local Area Command, arrived at about 7.25 pm and dealt with involved police appropriately. NSW Ambulance officers Ray Picone and Linda Lodge arrived at 7.32. First aid was administered at the scene and en route to hospital. On arrival at about 8.13 pm, hospital staff took over care of Mr. Lam but he succumbed from a gunshot wound to the trunk.

### **Issues.**

#### **Death in custody/police operation protocols.**

Sergeant Grant Howell, Bankstown Local Area Command, arrived with Constable Macarthur at 7.25 pm. Upon arrival, Howell separated Moore and Tonkin from each other and from other involved police. He ensured that they surrendered their weapons. He ensured that their appointments were secured for ballistics examination.

The matter was recognised from the start as a critical incident and appropriately investigated by the NSW Police Homicide Squad. A very comprehensive brief of evidence was compiled for me by the OIC, Detective Sergeant Pieter Schouten.

I am satisfied that all relevant guidelines were followed.

#### **Shots fired – the fatal shot.**

The officers fired five shots in either a two – three or a three – two sequence. The evidence on the issue is unreliable. The evidence does not enable me to say which officer fired the lethal shot. At least three, and possibly four shots struck Mr. Lam, but only one, to the trunk, was lethal.

#### **Mr. Nguyen and the Bankstown Community Health Centre.**

Mr. Peter Nguyen was an impressive witness. From 2001 when Mr. Lam came into Nguyen's area of work, Mr. Nguyen appears to have taken a particular interest in his client. As a social worker attached to the Bankstown Community Health Centre, he appears to have worked very hard to establish and maintain good rapport with Mr. Lam. And he appears to have succeeded. Amongst other things he succeeded in assisting Mr. Lam to obtain Department of Housing accommodation. Mr. Lam, when Mr. Nguyen first met him, often spent his time living on the streets. He inducted Mr. Lam into a Vietnamese Group and conducted regular sessions.

He described Mr. Lam as being a sociable person who was neither assessed as a threat to himself or to others.

Between September and early December 2004 he noticed that Mr. Lam was becoming non-compliant on his psychotropic medication. He had not been attending the Vietnamese Group Therapy sessions. Mr. Nguyen made a home visit on 15th September 2004. He found that Lam had stopped taking his medication as it was “destroying his body”. He also noted that Lam had “grandiose ideas” and considered that he had “special powers giving him superior strength and knowledge”. Nguyen noted that Lam’s personal skills had become poorer; that he was not eating, as he felt he did not need food; that he was suffering sleeping problems; and that he was suffering from poor concentration and memory.

On 16th September Mr. Nguyen took Lam to see a GP. He saw to it that he recommenced on his medication. He also booked with the consultant psychiatrist for 20th December 2004. His next home visit was on 24th September. This time he noted that Mr. Lam was complying with medication, still expressing grandiose ideas, but keeping his unit clean. Between then and December there was regular contact. He also spoke several times with Binh Luong, Lam’s girlfriend who informed him that Lam was well and from time to time working in a bakery.

Mr. Nguyen made two unsuccessful attempts to visit on 15th and 26th November 2004.

At about 5.45 pm on 30th November Mr. Nguyen visited Lam at his home. He briefly assessed him and was concerned, as there appeared to be little food in the place, which was also very untidy. Mr. Lam appeared delusional insofar as he believed there was something unstable and unknown outside the Unit. He advised that he had again discontinued his medication. Mr. Nguyen offered to take Mr. Lam to Banks House for voluntary admission as by now he felt self-harm might be a possibility. (He had no money, no medication and was also having problems with his girlfriend from Unit 5). She had left the Unit.

Lam did not want to go.

The following morning Mr. Nguyen returned and this time made a full mental state examination and risk assessment. The Unit had been tidied and cleaned. He concluded, reasonably, that there did not appear to be any immediate threat of self-harm or violence, though he was concerned for Lam’s welfare and apparent physical deterioration. More fully put, he concluded that Mr. Lam appeared to be having difficulties caring for himself in terms of personal hygiene, food preparation and compliance with medication. There were also difficulties associated with inability to sleep, poor concentration and decision-making. He had no money and no real contacts due to the departure of his girlfriend. He also appeared to be suffering delusions of persecution relating to unknown people or presence outside the Unit. He stated that there was something in the air that was unsafe and people in the street who may follow or harm him.

Mr. Nguyen did not assess him as an immediate threat of violence or self-harm. Nevertheless that very afternoon he conducted a case review with Dr. Owen, principal psychiatrist and Clinical Nurse Consultant James Bradbury. Mr. Lam was upgraded to high priority. An acute care visit was scheduled for 3rd December. At a case review on the morning of 2nd December, a short-term treatment plan was formulated which included an acute care visit that may well have resulted in involuntary admission to hospital. Death, of course, intervened.

Mr. Nguyen acted reasonably at all times. Once Mr. Lam's apparent condition was brought to senior members of the Community Health Team, they acted promptly and appropriately. It is likely Mr. Lam would have been hospitalised had death not intervened.

Significantly, Mr. Lam appeared to be suffering delusions of harm by others. This may provide an explanation for the carrying of a knife and for his conduct when he came into contact with officers of the NSW Police.

Implicit in my remarks is my finding of fact that the care and treatment afforded Mr. Lam through the Bankstown Community Health Service was appropriate at all relevant times. In fact, Mr. Nguyen, his social worker cared for his client in a superior fashion.

#### **The NSW Police Expert and the nature of his Report.**

So far as it went, the report was of some value. I note however, that the expert, Senior Sergeant Peter Davis of the Operational Safety Training Unit, NSW Police only had the benefit of the video walkthroughs of the two police involved in the shooting. It is surely normal for "experts" to have the benefit of briefs of evidence. In this case the brief included not only statements and ERISP interviews with a range of eyewitnesses, but also much physical data including the nature of the weapon and detailed plans of the scene (entrance and egress from the yard and the physical nature of the surroundings for example). I was surprised that Senior Sergeant Davis did not see the need for this extra data, and cannot escape a feeling that his evidence might have changed slightly had he been seized with this raft of extra information. To be fair to the officer, I accept from the bar table that another expert attended the actual scene, but some time later Senior Sergeant Davis, because of illness, was forced to conclude his review.

I shall recommend, however, that NSW Police considers inclusion of a comprehensive expert review of the actions of involved police in the context of the whole of the brief of evidence in all coronial critical incident cases.

These matters are incredibly serious and the coroner, the police themselves and the community will be greatly helped by the fullest possible independent investigation.

## **Taser.**

The “Taser” gun is being trialled at present. From the evidence I heard at inquest it is likely that use of a taser may have defused this situation without a need to resort to lethal force.

I have insufficient relevant evidence before me to make a recommendation in relation to the finalisation of the taser trial. **I suggest however, that it be concluded as soon as practicable and a final decision made.**

## **Conclusion.**

I am comfortably satisfied that this shooting was justified and carried out in the execution of duty. All officers involved were incredibly young and relatively inexperienced – certainly inexperienced in a situation such as this. Mr. Saidi, in his address, referred to several discreet areas.

Firstly, he submitted that a critical analysis will always occur and be finalised by one of the State’s most experienced coroners. At issue will always be a determination as to whether or not a homicide such as this is justified. With the forthcoming extension of legal aid to this jurisdiction, next of kin can be expected to be competently represented. Competent, independent counsel will always assist the coroner. With those remarks I agree.

He further suggested that the police should have made more inquiries than they did at the beginning. That may have been possible, but more inquiries may also have been of little or no value. They learnt that Mr. Lam probably burnt down a residence – a serious matter, and that he may have been armed with a knife – another most serious matter.

He also suggested that police could have backed off whilst in the “triangle of safety” situation. I am not sure that that is correct, as police were some distance from Mr. Lam most of the time and attempting to contain him in the yard and convince him to put his weapon down. Once in that position Mr. Lam appears to have escalated the situation by moving towards one of the officers, forcing him back anyway. The yard is only 10 metres long and a “strategic withdrawal” would have been difficult, and may even have been risky. It should be remembered that they were, appropriately enough, attempting to subdue Mr. Lam with OC Spray.

One point made, however, which I would like NSW Police to focus on, was the fact that Constable Moore, followed immediately by Constable Tonkin, jumped the fence at the moment Mr. Lam jumped down from the fence. On the evidence before me I cannot say that that was a wrong option, but I raise it as an issue. They could have looked over the fence at him and reconnoitred the yard over the fence for people, obstacles and the like. It would only have taken a moment. They could also have briefly discussed their next option before acting by jumping the fence themselves. They knew for example that other police were expected to arrive at least reasonably soon. Once over the fence they were really committed to the one course of action.

This criticism is constructive criticism. It is qualified. In no way should it be taken as otherwise.

To Mr. Tien Lam, brother of the deceased, who has sat quietly through this inquest, I offer my sympathy for his loss.

To the officers involved. You will have learnt salutary lessons the hard way. You and your families must now put it behind you.

#### **Formal Finding.**

**Thuong Huy Lam died on 2nd December 2004 at Bankstown District Hospital, Bankstown, of a gunshot wound to the trunk inflicted upon him earlier that day at Greenacre by either David Edward Tonkin or Simon Anthony Moore, members of the NSW Police, acting then and there in the execution of their duty.**

#### **Recommendation.**

- 1) That NSW Police considers inclusion of a comprehensive “expert” review of the actions of involved police by requiring its experts to consider the whole of the brief of evidence prepared in all coronial critical incident cases.

#### **12.**

**290 of 2005**

**Inquest into the death of Ryan Teaken on 13 March 2005. Finding handed down by Magistrate Milovanovich on 12 January 2006.**

#### **Inquest Summary:**

The deceased was arrested on the 19th February, 2005, and charged with a number of domestic violence, assault, weapon and drug offences. He was bail refused on his first court appearance and was on remand to appear at the Moss Vale Local Court on the 19th April, 2005. The deceased had a history of self harm. On reception at the Parramatta Correctional Centre he was assessed as being at risk of self harm and was transferred to the Silverwater Detention Centre where he was placed under observation and eventually placed in a “two out” cell. Investigations have determined that the deceased had communicated to his family that he intended to take his own life, however, it would appear that the family did not pass this information on to Correctional staff. On the 11th March, 2005, the deceased was transferred back to Parramatta Correctional Centre and again placed in a “two out” cell.

On the evening of the 12th March, 2005, at about 9.00pm the deceased was seen alive by the prisoner who was sharing his cell and at 6.30am the following morning the deceased was found deceased. The cell had been locked overnight and there had been no entry. The duress button had not been activated and the deceased’s cell mate had not noticed or heard anything during the evening. The deceased has hang himself using a bed sheet which

was secured to a window. The deceased had left a suicide note and crime scene investigations determined that there were no suspicious circumstances. The deceased next of kin had not raised any issues of concern, nor did they attend the Inquest.

#### **Formal Finding.**

**That Ryan Teaken died on or about 13th March, 2005, at the Parramatta Correctional Centre, Parramatta, in the State of New South Wales, from Hanging, self inflicted with the intention of taking his own life.**

13.

312 of 2005

**Inquest into the death of Daryl Duckworth on or about 20 March 2005. Finding handed down by Magistrate Milovanovich, Deputy State Coroner on 7 March 2006.**

#### **Inquest Summary:**

The deceased was imprisoned in September 2004 for a number of offences with a release date on parole being the 23rd March, 2005. The deceased had a history of schizophrenia and had been hospitalised for his condition in the past. In December 2004 he self harmed by pouring hot water over himself and was hospitalised and then transferred to the Rozelle Hospital for psychiatric treatment. He was returned to the Silverwater Reception Centre on the 10th January, 2005.

On the 19th March, 2005, all prisoners in Pod 18 were locked in their cells. The deceased was last seen alive at 7.26pm when a registered nurse offered the deceased his medication of Chlorpromazine which he refused to accept. Cell security checks were conducted during the evening, however, in accordance with Policy, checks are not physically made of prisoners in order to allow them privacy. At 2.50am on the 20th March, 2005, a motion activated surveillance camera detected movement in the form of smoke in the common area of H block, Pod 18. Accordingly, Correctional staff attended the block to determine the origin of the fire and make visual checks of the cells through the observation windows. During these visual checks the deceased was observed sitting near his bed with a large amount of blood nearby. Assistance was sought and upon medical and other staff arriving the cell door was opened and the deceased was found with no signs of life.

The death was thoroughly investigated and it was clear that no person had entered the deceased cell from the time he was locked into it at 7.26pm on the previous evening. The duress button was tested and found to be working and that it had not been activated by the deceased at any time. Initial crime scene investigations could not determine how the injury to the deceased carotid artery had been inflicted, notwithstanding a thorough search of the cell, the drains and the area outside and below the cell window. Some 10

days later and a cleaner found a razor blade from a disposable plastic “Bic” razer congealed in blood on the bed frame. This blade was subsequently tested and determined to have the deceased blood on it.

The Coroner was satisfied that there were no suspicious circumstances surrounding the death of the deceased and that he had inflicted the injuries to himself with the intention of taking his own life. The Coroner was satisfied that the deceased had been appropriately assessed in terms of any risk of self harm and was considered suitable for placement in a “one out cell”. The Coroner noted the Department of Corrections Policy in regard to the hand out and returning of razor blades had not been followed and, while not making any formal recommendations, requested that the Department ensure its policies are followed, particularly in prison units which house prisoners with a mental illness.

#### **Formal Finding.**

**That Daryl John Duckworth died between 7.26pm on the 19th March, 2005 and 2.50am on the 20th March, 2005, at Cell 552, Block H, Metropolitan Remand and Reception Centre, Silverwater, in the State of New South Wales, from a stab wound to the neck, self inflicted with the intention of taking his own life.**

14.

343 of 2005

**Inquest into the death of Kah Boo Cheah on the 26 February 2005. Finding handed down by Magistrate Abernethy, NSW State Coroner on the 14 August 2006.**

#### **Circumstances of Death.**

This 44-year-old sentenced prisoner died in Prince of Wales Hospital, Randwick, of a natural cause, intra-cerebral haemorrhage due to hypertension and chronic renal failure

He was at the time of his death receiving dialysis thrice weekly. The afternoon before his death, 25th February he was taken, as was usual, to Prince of Wales Hospital for dialysis. He was returned to the Long Bay Hospital, Area 1, given his evening meal and locked down in his cell for the night. A registered nurse spoke with him and he indicated that he was well.

Another inmate, noticed him shortly after “let go” on the morning of 26th February, to be unwell and lying on his bed. Corrections Officers attending to “let go” had not obtained a verbal response from the prisoner, as was their instruction.

The alarm was raised and Corrections Officers and nurses attended. An ambulance was called. It arrived within ten minutes. The prisoner was taken to hospital where he died later that day.

## **Issues.**

### **1. Death in Custody Protocols.**

The State Coroner was generally satisfied that death in custody protocols had been carried out. There had been a competent investigation by NSW Police and an internal investigation by the Department of Corrective Services.

It was noted that the bed sheets had been removed by staff of Justice Health. Once Corrective Services staff noticed this, they were returned for examination by NSW Police. The coroner indicated that that breach of procedures did not warrant a formal recommendation but that both Corrective Services and Justice Health should be reminded of the need to leave such scenes intact for examination by NSW Police.

### **2. Failure to obtain a response at “let-go”.**

The State Coroner noted the breach and that the Correctional Officer involved had been dealt with internally by the Department of Corrective Services. Without proceeding to a formal recommendation, he reminded the Department that the obtaining of a verbal response at let-go was an important requirement that itself came through coronial recommendation. Whilst it would have made no practical difference in the case of this prisoner, in other cases it might literally mean the difference between life and death.

### **3. The Cell Call Alarm.**

The State Coroner noted the recommendation in the internal Department of Corrective Services Department that Cell Call Alarms be placed adjacent to prisoners' beds so that they could be activated by ill prisoners whilst in bed. He felt that the implementation of such change throughout NSW prisons would not be warranted, but that such change should be considered by the Department at the Long Bay Hospital, clinics, detoxification wards and the like.

## **Formal Finding.**

**That Cheah KAH BOO died on 26th February 2005, in custody, at Prince of Wales Hospital, Randwick, of intra-cerebral haemorrhage, due to hypertension and chronic renal failure, a natural cause**

## **Recommendation.**

That the Department of Corrective Services considers relocating all Cell Call Alarms in gaol hospital wards, clinics, detoxification wards and the like, to positions adjacent to beds so that seriously ill prisoners can activate them from such beds.

## **15.**

**364 of 2005**

**Inquest into the death of Andrew Coleman on the on or about the 28 February 2005. Finding handed down by Magistrate John Abernethy, NSW State Coroner on 24 April 2006.**

### **Preamble.**

Pursuant to *Section 13A, Coroners Act 1980*, an inquest is mandatory in relation to any death in custody. That inquest must be conducted by one of the Deputy State Coroners or by me.

### **Facts.**

The deceased was admitted to the Metropolitan Remand & Reception Centre, Silverwater, having been arrested on serious charges. He was bail refused on those matters. On 29th December 2004 he was transferred to the Long Bay Complex of prisons. He was placed "one out" as he had received threats from other inmates.

The deceased was last seen alive at 8.30 pm on Sunday 27th February 2005 when he was asked if he was all right by Registered Nurse Colleen Murray. At no stage during his incarceration did the deceased give an indication that he intended to end his life.

Mr. Coleman was located in his cell, Cell 2, 12 Wing, Long Bay Hospital Area 2, Long Bay Correctional Complex, at 8.40 am "let go" on 28th February 2005, hanging by a bed sheet secured to a hanging point located at the window. He had been dead for some time prior to being found. I am unable to say which side of midnight he died.

### **Issues.**

#### **Scene Security.**

Department of Corrective Services Officers have attended promptly, secured the area and kept a log pending arrival of investigators from NSW Police. Detectives and Physical Evidence (Crime Scene) police have examined the prisoner and the cell and determined that this death was probably by suicide rather than foul play. The prisoner was "one out" in his cell and safe from others.

#### **Hanging Points.**

The deceased seemed to have no trouble in taking his life. Perhaps it is time for the Long Bay Hospital Complex to be assessed for safety and hanging points removed where possible to do so. At short notice, Ms. Paxton for the Department made inquiries for me.

This issue will be the subject of a Recommendation pursuant to *Section 22A, Coroners Act 1980*.

I stress that I am not being critical of the Department. I have followed the “hanging points” issue for many years now and know well not only that hanging points are difficult in the extreme to eliminate, but also that much has already been done throughout the system to reduce and eliminate hanging points generally.

### **Knowledge of a depressed state.**

The officer-in-charge has detailed the fact that apart from an initial admission as to thoughts of self-harm at the Sydney Police Centre at the time of arrest and prior to being taken into the prison system, the prisoner at all later times denied being likely to harm himself. I am of the view that he may always have considered ending his life but successfully hid that intention from those with whom he came into contact, whether they might be assessing officers or other prison officials.

### **Nature of protection from other inmates and status of being “one out” in cell.**

Andrew Coleman immediately underwent detailed assessments on entry into the MRRC on 18th September 2004 (Risk Assessment and Intervention Team Assessment (RAIT) and Justice Health Assessment.) These assessments are carried out at approximately the same time and those carrying them out discuss their assessments each with the other. He was assessed as unlikely to self-harm. Dr. Virginia Noel has now commented on the Justice Health Component of these assessments and I accept her evidence that the assessment was a reasonable one in terms of the prisoner’s input.

A possible need for anti-depressant medication was initially identified on 18th September, but the full assessment the following day made it clear that such medication was not required, at least immediately.

The induction assessor’s notes show, for example, that Mr. Coleman was mood assessed at 8/10; he had nil thoughts of self-harm or suicidal ideation; he had good family and church support networks; he was cooperative and concentrated well; he made normal eye contact.

He was, of course, assessed as not suicidal. The assessors recommended “two out” placement for one month until 19th October 2004. Finally, the assessment indicated that Mr. Coleman was aware of the referral process and how to contact mental health services. He was referred to the Department of Corrective Services psychologist and did attend the psychologist.

Andrew Coleman, nevertheless, was left “two-out”, initially in normal cell placement until on 22nd September 2004, when following allegations of assault his status was changed to “Protection Limited Association”.

On 29th December 2004 Mr. Coleman was transferred to Long Bay Hospital 2, Wing 13. He was again assessed and placed in a normal cell. The following day however, it became clear that Coleman feared assault by other inmates, so should remain on the same protection status.

On 24th February Andrew Coleman sought “Protection – non-association” status because of his fears. This was granted on a temporary basis two days later by Area Manager, Tracey Melrose. He was then moved to a cell “one out”. Shortly afterwards he took his own life.

### **Conclusion.**

The decision Andrew Coleman took to end his life may have been a spontaneous one. It is, I think, more likely that he may have been planning to do so for some time and waited to be “one out” in a cell in order to carry out such a plan.

The Department of Corrective Services at all relevant times was careful about safe custody issues in relation to Andrew Coleman. He gave convincing reasons for needing to be “one-out” in a cell and it was reasonable to grant his application for “protection non-association” status.

Justice Health too attended to Andrew Coleman’s physical problems and was simply unable to detect anything in the prisoner’s demeanour that might point to thoughts of self-harm.

I hope that this short inquest has shown the mother of the deceased that deaths in custody are indeed taken very seriously. To her I extend my sympathy.

### **Formal Finding**

**Andrew Coleman died in custody on or about 28th February 2005 in Cell 2, 12 Wing, Long Bay Hospital, Area 2, Long Bay Correctional Complex, Malabar, by hanging, self-inflicted with the intention of taking his own life.**

### **Recommendation.**

That the Department of Corrective Services reviews the Long Bay Hospital Complex (presently partly under renovation) in relation to so “hanging points” in the Hospital Complex, with a view to having them eliminated or reduced where it may be possible to do so.

### **16.**

**418 of 2005**

**Inquest into the death of Jian Guo Song on the 14 march 2005. Finding handed down by Magistrate Abernethy, NSW State Coroner on the 27 Febraury 2006.**

### **Preamble.**

Even though this death occurred whilst the deceased was in the custody of Australian Federal Police Officers, it occurred at private premises in Burwood NSW and in those circumstances is a death in lawful custody within the meaning of *Section 13A, Coroners Act 1980*. This inquest is therefore mandatory and must be conducted either by one of my Deputies or by me.

## **Facts.**

Jian Guo Song died at about 10.30 am on the morning of 14th March 2005 outside his home unit premises at Burwood NSW. He died of multiple injuries when he threw himself from the balcony of his fifth floor Unit onto the pavement below. Prior to throwing himself from the balcony he had been in the presence (and custody) of Officers of the Australian Federal Police (AFP). An official interpreter in the Chinese languages was also present.

NSW Police were called by one of the AFP officers at about 10.40 am and arrived at the scene at 11 am. A crime scene was established immediately. Following discussions with me, NSW Police assessed the matter as a Critical Incident within the meaning of their Critical Incident Guidelines. An independent investigation team was set up led by Detective Sergeant Enrico Coffen. Detective Sergeant Coffen himself arrived at the scene at 11.20 am. On his arrival the AFP officers were separated. They remained separated until either a statement or an ERISP Record of Interview had been obtained. Importantly, Video “walkthroughs” were later obtained from the relevant officers.

Physical Evidence or Crime Scene Police were called and a careful examination was made of the preserved scene. The Duty Forensic Pathologist was called and he made his own examination of the deceased *in situ* and of the scene.

Jian Guo Song was born in June 1963 and thus 41 years of age. He migrated to Australia from China in 1970 and achieved permanent residency in 2002. He was also known as Raymond Song. His original wife was not in Australia at the time of his death. He is believed to have one daughter of that relationship, also in Australia but not residing with Song. Song appears to have been in a subsequent relationship and fathered a child. He appears then to have entered a third relationship and the woman of this relationship, Li Qin Wei, resided at 19 George Street, Burwood, with the deceased staying there from time to time.

As I have said, at the time Mr. Song threw himself from the balcony of the premises at Burwood he was in the custody of two AFP Agents, Scott McAllister and Simon Henry. Also in the Unit at that time was Mandarin Interpreter Louisa Lim.

Mr. Song was handcuffed, with his hands behind his back. He was in the dining room of the premises but then very suddenly ran through an open door onto the balcony. He did not stop at the balcony wall, which was about one metre in height, but continued over it in a “toppling” fashion. Agent McAllister chased after him but could not catch him. He saw his body fall in a twisting motion from the balcony to the ground. The distance to the ground was approximately 12.9 metres.

The Federal Agents who attended the Burwood premises were involved in an operation in respect of the arrest of Mr. Song. Property seized by these Agents from the motor vehicle of the deceased, a red Honda Civic Registered

Number SG 315, and from the premises consisted, *inter alia*, of documents pertaining to identities other than that of the deceased. The investigation involved the allegation that the deceased was involved in a fraud or fraudulent behaviour relating to NSW Drivers' Licences, Medicare Cards, Bank Access Cards and the like.

### **The Police Operation.**

Federal Agent Scott McAllister was interviewed and made a statement to police at Balmain Police Station on 14th March 2005. McAllister had been investigating matters of passport fraud, involving Jian Guo Song since 2004. A warrant for the arrest of Song had been obtained. On 11th March 2005, a search warrant was obtained in respect of premises at 29/19 George Street, Burwood and for a red Honda Civic Sedan, Registered Number SG 315 (NSW). It was obtained from the Downing Centre Local Court and issued by Paul Morgan JP, an issuing officer within the meaning of the (Commonwealth) Crimes Act 1914. On the same day, a briefing in relation to the execution of the search warrant was held between McAllister and Federal Agents Sullivan, Henry, Poiner, Zappavigna and a "non-sworn" member Webster. During that briefing a "Standard Tactical Plan" was provided to each member of the search team. Essentially the Plan outlines the "*Background*" to the investigation and Song's involvement in the creation of false identities emanating from an earlier search warrant on 25th July 2002. The subject address was identified in the Plan, as was the motor vehicle.

The background information appears to me to be reasonably accurate. Importantly it disseminates to the investigative team necessary information in relation to the operation.

The Plan also outlines the "*Mission*", that being the Arrest of Raymond Song. It outlines the warrant of arrest, offences, legislation and police powers. In my view it too is sufficient.

The "*Execution*" phase outlines the steps taken by the investigators to achieve their mission. It too is adequate in my view.

There is also a "*Contingency*" section of the Plan. It is important as it orders the execution of the search warrant on the premises regardless of Song's presence and directs the method by which the operation intended to locate Song. The "*Administration*" section refers to exhibits, "Commissioner's Orders" in relation to the use of force. These sections of the Plan too are adequate.

Finally the "*Command and Communication*" part of the Plan designates McAllister as the Case Officer. Use of mobile telephones is outlined in the Communication part of the Plan. The plan as a whole appears to me to be adequate.

A Risk Assessment was also conducted and there were no warnings in relation either to the deceased (for violence) or for the premises. Rather the risk was considered to be in areas of loss of information/evidence, unlicensed firearms and inability to gain entry.

Not only did the AFP not know of any risk of self-harm issues, but also the officer-in-charge of this investigation has been able to find no such issue in his searches after the event.

Police utilised the services of Ms. Louisa Lim, an accredited interpreter in the Chinese languages.

After the briefing, at about 7 am McAllister, Sullivan, Henry, McDonnell and Zappavigna went to Unit 29 where they spoke with the occupant Li Qin WEI and executed the search warrant. They were joined at the premises by Agents Poiner and analyst Webster. Wei was alone in the Unit, which was secured, as is generally standard procedure. A search was conducted and at about 8.30 am Zappavigna left the unit to observe the front of the Units. Shortly afterwards, Sullivan and McDonnell deployed to the streets in an attempt to identify Mr. Song. He was expected to arrive at the premises soon. At about 9.20 am Wei received a 'phone call from Mr. Song. She told McAllister that Song was on his way to the Unit. At about 10.20, McAllister received a 'phone call from Sullivan who told him Song was now in custody in the basement car park. Song was taken to the Unit with his hands handcuffed to the rear. McAllister, Henry, Poiner and Webster were still in the Unit as was Ms. Wei and Louisa Lim. Once custody of Mr. Song was transferred to Mr. McAllister, Sullivan, McDonnell, Poiner and Webster left the Unit to attend the basement car part to search the Honda Civic. Wei was asked to accompany them to view the search, the vehicle being registered to her. McAllister, Henry, Interpreter Lim and Mr. Song remained in the Unit.

Song was seated at a dining room chair. McAllister told Song that he had a warrant for his arrest. Song perused it and it was translated for him into Mandarin. Song would not provide Agent McAllister with details of his home address. Refusal of bail was discussed, and also questioning of Song's family. Song appeared to be calm.

The handcuffs were not removed but Agent Henry held a glass of soft drink so that Song could have a drink. McAllister searched a wallet found on Mr. Song, finding a NSW Driver's License not in Song's name but that of Zhi Min Lan born 3rd April 1962 but bearing a picture of Song, and a Regent's Park address. Further questions were asked but not answered until Song admitted that the licence was fraudulent. Other items were located in the wallet in various names. During this questioning, Song was seated at the dining table, McAllister was about 1.2 metres from him and Henry and Lim were behind McAllister, nearer the kitchen.

Without warning Song stood up and ran towards the balcony. The sliding door was open and Song ran out of the lounge area on to the balcony. The balcony had a wall about one metre high and this wall was about four metres

from where Song had been seated. Song threw himself off the balcony as McAllister, with Henry, ran to stop him. Neither McAllister nor Henry could re-restrain him in time and looked over the balcony to see Song falling towards the pavement below. He hit the pavement headfirst.

McAllister and Henry ran to the lift to get to the basement. McAllister quickly rang for an ambulance. Once in the courtyard he saw Zappavigna and Henry tending to Mr. Song. The handcuffs had been by then removed and were on the veranda of the Unit adjacent to where Mr. Song was lying. The ambulance arrived at about 10.50 but found no signs of life. At about 11 am NSW Police officers arrived and established a crime scene.

A video “walkthrough” was conducted on Friday 18th March 2005 by investigators and Agent McAllister.

The other Agent present in the Unit, Agent Simon Henry generally corroborates Agent McAllister as to the events of the day. He too made a statement to police on 14th March 2005. Moreover on 31st March 2005 Henry underwent an ERISP Record of Interview. He adopted his earlier statement, with minor changes.

Interpreter Louisa Lim made a statement on 14th March 2005 and also underwent an ERISP Record of Interview on 20th May 2005. She is an accredited interpreter with licence number 33975. She assisted firstly with the householder Wei. She was there whilst police searched the Unit. She was there when Song contacted Wei by telephone. She was in the Unit thereafter until Mr. Song threw himself over the balcony wall. Ms. Lim heard loud footsteps followed by one officer saying “shit”.

Importantly she saw the AFP officers *rush onto the balcony and look over the edge*. She had her back to Mr. Song and did not actually see him cross the room and go over the balcony wall, though as I have said she did see the AFP officers running towards it.

There is therefore close corroboration between the police officers as to their versions and very sufficient corroboration of their versions by the independent interpreter Ms. Lim.

I am satisfied that the events occurred as disclosed by Agents McAllister and Henry.

Moreover the physical evidence examination and the observations of Detective Sergeant Coffen show nothing inconsistent with the general version. Coffen for example notes that the alignment of Song’s body on the pavement and its distance from the line of the balcony are consistent with a person rushing through the balcony door and throwing himself off the balcony.

I do not need to detail the versions of those officers not in the Unit at the relevant time.

## Issues.

### Death in Custody Protocols.

Whilst investigating police generally followed Critical Incident Guidelines, there appears initially to have been a misconception amongst NSW Police that this may not have been the type of case to be investigated as a critical incident. Despite a direction from me on 16th March 2005 that ERISPS be taken as soon as practicable from those AFP Officers most closely associated with the incident, they were not quickly taken and in the case of Officer McAllister, were never taken. I am satisfied that the officer later placed in charge of this matter was aware of the guidelines and is not responsible for the failure to promptly obtain ERISP records of interview. Otherwise, I am satisfied that NSW Police followed all relevant Death in Custody protocols. They did promptly separate the involved officers. A crime scene was immediately established. I can see nothing by way of criticism of NSW Police or any of its officers other than as I have stated above. An excellent and very thorough brief of evidence was ultimately compiled by Detective Sergeant Coffen and he is to be commended for it. This has been an open, transparent and thorough investigation of a serious matter.

**Without making a formal recommendation I strongly suggest that all relevant NSW police be reminded of the fact that certain matters, such as this, or for that matter a cross border pursuit, should still be investigated in accordance with the NSW Police Critical Incident Guidelines although those involved may be from another Australian Police Force, including the Australian Federal Police.**

### Section 13A, Coroners Act situations involving non NSW Police.

- 1) NSW Police Critical Incident Guidelines and NSW Police Critical Incident Draft Guidelines set out the types of deaths to be treated as critical incidents. They always involve either death or serious injury and in those circumstances often occur in situations which come within *Section 13A, Coroners Act 1980*.
- 2) Where the critical incident involves a member of NSW Police there is no problem as the guidelines set out in detail the guidelines to be used in investigating such matters, including deaths in custody and deaths as a result of or in the course of a police operation.
- 3) Where there is a death in lawful custody but not that of a NSW Police Officer; or a death in the course of a police operation involving non NSW Police, as here what is the position?

*Section 13A, Coroners Act 1980*, when referring to lawful custody, refers to the custody not only of NSW Police, but also other State Authorities such as Juvenile Justice and Corrective Services.

Surely on a reasonable reading of the section “police operations” and “deaths in lawful custody” can involve police other than NSW Police, provided the operation is within the jurisdiction. Victorian police crossing the border during a pursuit, for example, will be investigated where a critical incident occurs, according to the NSW Police critical incident guidelines.

It follows that a person who dies in the custody of Australian Federal Police, but in NSW; or who dies as a result of or in the course of a police operation conducted by the AFP, but in NSW will also be investigated according to NSW Police Critical Incident Guidelines.

Problems have not occurred in this particular case as the police involved voluntarily submitted, for example to alcohol and drug testing. They made statements when required. They underwent ERISP Records of Interview when required. They underwent video “walkthroughs” when required.

However, it appears that NSW Police investigators cannot force such things to happen if police or other agencies from outside this State do not consent. In such circumstances the investigation by NSW Police, often for the coroner will be hampered and the coronial process will also be hampered.

Cross border police operations have occurred in the recent past. Deaths have occurred in the custody of Department of Immigration and Ethnic Affairs custody and of course there is this death in AFP lawful custody.

In my view it is reasonable that the NSW Police attempts to enter into joint protocols involving such matters with the Police Forces of the neighbouring States and Territory, and with the Australian Federal Police, in order to regularise the investigation of critical incidents which occur in NSW, but involve non NSW agencies, in terms of *extension* of NSW Police Critical Incident Guidelines to those non NSW agencies.

Similarly NSW Police ought to be prepared to enter into protocols with Non-NSW agencies where its police become involved in a critical incident outside this State (for example, by way of cross-border pursuit).

### **Handcuffing.**

This topic has been well covered by Detective Sergeant Coffen and in my view, especially having read the statement of Federal Agent Mark Colbran, it was within the discretion of police to handcuff Mr. Song, and to handcuff him with his hands behind his back. In any event this had no bearing on his actions and if anything rendered them less likely to occur. In any event his actions were entirely unexpected and singular.

### **The Search and Arrest Warrants.**

These appear to have been validly issued and, for that matter, executed. In any event, even were one or other or both of them not validly issued or executed, in terms of the law the issue would be one for a trial judge as to discretion to admit illegally obtained evidence.

Importantly, though the execution of the search warrant in respect of the home unit had concluded prior to Mr. Song returning to Burwood, the execution of the search warrant in respect of the Honda Civic motor vehicle was ongoing at the time of Song's death.

### **Conclusion.**

This is one case where it is difficult to find criticism, other than of the minor nature outlined, of either the police involved in this operation, or the NSW Police involved in attending to the investigation of the incident. Nevertheless, as Ms. England has said, in my view it is timely and desirable to make several broad Recommendations pursuant to *Section 22A, Coroners Act 1980*. They are, I feel self-explanatory. Recommendation Three is included to ensure that NSW Police are in no doubt as to how to handle a case involving death/serious injury of a person in the custody of an external agency.

### **Formal Finding.**

**That Jian Guo Song died on 14th March 2005 at Burwood in the custody of Scott McAllister and Simon Henry, members of the Australian Federal Police, of multiple injuries when he threw himself from the balcony of a 5th Floor home unit at 19 George Street, Burwood, with the intention of taking his own life, whilst the said police were acting in the execution of their duty to execute a search warrant on the said premises.**

### **Recommendations – Sections 22A, Coroners Act 1980 (NSW).**

- 1) That the NSW Police takes the necessary steps to enter into arrangements with bordering Police Forces and with the Australian Federal Police - arrangements that will place officers of those Police Forces and other relevant Agencies, in a similar position to NSW Police Officers involved in a critical incident within the meaning of the NSW Police "Critical Incident Guidelines", where such critical incident occurs within the State of New South Wales;
- 2) That any Memoranda of Understanding formalised by such Agencies and NSW Police closely follow the NSW Police Critical Incident Guidelines;
- 3) That appropriate behaviour of the External Agency, in relation to matters such as incident scene preservation, separation of witnesses and the like, between conclusion of the Critical Incident and arrival of NSW Police, be in accordance with the NSW Police Critical Incident Guidelines;
- 4) That, when finalised, there be a reference to such Memoranda of Understanding in the NSW Police Critical Incident Guidelines themselves.

17.

491 of 2005

**Inquest into the death of Kaylee Rodgers on the 2 May 2005. Finding handed down by Magistrate Milovanovich, Deputy State Coroner on the 3 July 2007.**

**Facts:**

The deceased was a 35 year old transgender male who had been arrested and bail refused on a number of larceny matters. The deceased had a long criminal history and had served terms of imprisonment in the past. The deceased was born and christened with a male name, however, changed his first name by deed poll to that of a female. The deceased had been diagnosed Gender Identity Disorder and depression and had exhibited impulsive behaviour as well as being fearful and withdrawn. The deceased was originally placed in a transgender unit of the prison, however, due to conflict with another prisoner was moved to the protective section. The deceased had complained of mistreatment by prison authorities in relation to comments about her sexuality and had requested that she be transferred back to the transgender unit. This was under consideration at the time when the deceased cut her left wrist. There had not been any prior history of suicidal ideation and it was possible that the cutting of the wrist may have been attention seeking as the prisoner yelled out for help and indicated that she did not want to die to medical staff.

As a result of the wrist injury and following medical consultation a decision was made that the prisoner would require surgery in hospital. On the following day the prisoner was transferred to Auburn Hospital with an escort of two correctional officers and underwent surgery. A direction was given that immediately following surgery and when the prisoner had come through the effects of anaesthetic, that she should be handcuffed.

Evidence has been given that when the prisoner was taken to the recovery ward, her left wrist was heavily bandaged and could not be cuffed and similarly her right wrist had a cannular inserted. Accordingly a decision was made not to handcuff the prisoner until the cannular was removed and she remained under guard with two correctional staff in her presence.

Shortly after being returned to the recovery ward the prisoner was seen to remove the cannula from her left wrist using her teeth. She was informed to stop, however, was able to remove the cannula. One of the escorting prison officers left the room to attend the Nurses station in order to advise them that the prisoner had removed the cannula. At about this time and with only one prison officer present, the prisoner appears to have stood on her bed, stepped onto a meal tray and dived out of the upper portion of an open window. The deceased fell four story's, striking a light pole and tree before impacting with the ground. The deceased had serious injuries and was transported by Care flight to Westmead hospital, however, succumbed to her injuries later that night.

The Coroner identified a number of issues during this Inquest. At the time the prisoner was transferred to Hospital a policy existed that female prisoners are not to be handcuffed on escort, unless they are deemed to be of high risk. Since this incident new procedures have been implemented, however, there remains some ambiguity in relation to anatomically male prisoners who identify as female. The Coroner has requested that the Department of Corrective Services review the policy in regard to male/female escort prisoners and particularly where there is a transgender issue. The Coroner also commented that the two escort officers primary responsibility was to guard the prisoner and it was inappropriate for one officer to leave the guard area to attend the Nurses Station, when a buzzer could have been used to summon nursing aid. The Coroner examined whether the open window should have been identified as a possible security issue and it was determined that as only the top of the window was open, it was unlikely to have been a security risk as it was well above the average height of a person. The Coroner did, however, comment that appropriate guarding and supervision of the prisoner should not have allowed the prisoner the ability to stand on her bed, then onto a meal tray and then dive out of the window. The evidence suggested that there must have been momentary intention to the guarding duties. The Coroner also noted that both escort officers had already completed a full shift and were in their 13th and 15th hours respectively of a double shift.

The did not make any formal recommendations, however, did request that the Solicitor appearing for the Department of Corrective Services bring to the attention of the Commissioner the Coroners comments in regard to this death.

The Coroner was not able to determine whether the deceased dived from the window with a view of escaping lawful custody or whether with a view of taking her own life.

There was no evidence to suggest that the prisoner, having recently come out of anaesthetic was aware that her room was on the 4th floor of the building.

#### **Formal Finding:**

**That Kaylee Rodgers died on the 2nd May, 2005, at the Westmead Hospital, Westmead in the State of New South Wales from multiple injuries. As to whether the injuries inflicted were with the intention of taking her own life or inflicted during an attempt to escape from lawful custody, the evidence adduced does not enable me to say.**

18.

526 of 2005

**Inquest into the death of Ali Chemaissem on the 12 May 2005. Finding handed down by Magistrate Milovanovich, Deputy State Coroner on the 23 May 2006.**

**Facts:**

Two Police Officers while on general patrol duties observed the deceased and a female seated in a motor vehicle and it appeared that they were having a dispute. Police approached the vehicle and spoke to both persons and conducted a search. During the search of the female a prohibited drug, pills and a powder was located. Police were in the process of requesting the deceased to stand near the vehicle for the purpose of a search when he commenced to run away. One of the Police Officers attempted to grab him unsuccessfully and then pursued him. A short distance away, when Police were about 3 metres behind the deceased, he was seen to reach into his trouser pocket and remove an item, which he placed close to his head. Moments later, while still pursuing the deceased, the Police heard what they believed to be two gunshots. The deceased fell to the ground and it was apparent that he had inflicted a gunshot wound to his head. The Police officers immediately rendered first aid and called for assistance as well as Ambulance. The deceased was taken to Liverpool Hospital where he died shortly after from a gunshot wound to the head.

A critical incident investigation team was established on the basis that the death was considered a death in a Police Operation (Section 13A, Coroners Act, 1980). A five shot Smith & Weston revolver was recovered at the scene, partly concealed in a sock. Ballistic tests confirmed the firearm was the weapon used to inflict the fatal gunshot. The firearm had 2 spent and 3 live cartridges within the firing cylinder. An independent witness who was driving past the incident at the time, observed the deceased running with the gun in his hand and firing the fatal shot into his head.

Investigations by Police determined that the deceased had a history of depression, domestic problems and financial difficulties. His criminal history indicated that he had previously served a prison sentence and associates had indicated that he had a fear of going back to prison.

The Coroner was satisfied that all critical incident protocols had been adopted. The Coroner was satisfied that the deceased had taken his own life and that the Police could not have foreseen his actions.

**Formal Finding.**

**That Ali Chemaissem died on the 12th May, 2005, at Liverpool Hospital, Liverpool in the State of New South Wales, from a gunshot wound to the head self inflicted with the intention of taking his own life.**

19.

858 of 2005

**Inquest into the death of Jamie Eduardo Eberlein on the 6 August 2005. Finding handed down by Magistrate Milledge A/NSW State Coroner on the 17 October 2006.**

Jamie Eduardo EBERLEIN was a 36-year-old inmate of the John Moroney Correctional Centre. He was serving a 16-year sentence for murder. With a minimum period of 11 years he was eligible for release on 3 March 2007.

The deceased was being treated for depression, had been diagnosed bi-polar and prescribed lithium.

In 2004, the deceased had undertaken the Violent Offenders Program. It was noted that he was intolerant of criticism, had a grandiose sense of self and lacked empathy.

Mr Eberlein failed to complete Stage 1 and was removed from the program. The Program Manager stated he was removed "due to the inconsistent and contradictory information he provided regarding his life history and in particular his inability to give a comprehensive disclosure of the offence...it is difficult to establish any treatment gains..... and the likelihood of him re-offending has not decreased"

Mr Eberlein was classified accordingly and was anxious to improve his prisoner classification and applied to the Serious Offenders Review Board. He was advised 2 August 2005 that he had been unsuccessful. He then appealed to the Board to reconsider the position.

On 6 August a psychiatrist reviewed Mr Eberlein. The deceased stated he was mildly depressed but did not have thoughts of suicide.

He was assessed as functioning well, however it was intended that his lithium levels be increased over the following 4 weeks.

That day he played cards and interacted with staff and inmates as usual. There was not outward display of depression. There is no doubt that the decision of the Board weighed heavily on his mind.

The following morning, 7 August, he was found dead in his cell with a plastic bag secured over his head.

Whilst fellow inmates expressed surprise he had ended his own life, there were no suspicious circumstances. The Coroner was satisfied he was responsible for his own death.

**Formal Finding:**

**That Jamie Eduardo Eberlein died on 7 August 2005 at Cell 36, Archfield House, John Moroney Correctional Centre, Windsor whilst an inmate.**

**His cause of death is plastic bag asphyxia. I am satisfied on the Briginshaw standard of proof that his death is suicide.**

20.

911 of 2005

**Inquest into the death of Trong Tai Pham on 3 June 2005. Inquest terminated by Magistrate John Abernethy, NSW State Coroner on 26 May 2006.**

**Facts:**

This is an inquest into the death of Trong Tai Pham. It is in the nature of a death pursuant to *Section 13A of the Coroner's Act* and in those circumstances is mandatory. At 6pm on the 3 June 2005 police observed a vehicle being driven along Chelmsford Rd at a speed of 80 to 90 kph in a 50 kph zone.

A subsequent check of the registration plates indicated that they did not belong to the vehicle in question. The driver was informed to stop the vehicle. The vehicle rapidly accelerated into Stanley Street, nearing the intersection of Stacey St, a vehicle carrying Mr Pham in the front passenger seat was reversing out of a driveway the vehicle being pursued at this stage by police collided with Mr Phams vehicle.

Mr Pham received fatal injuries as a result of the collision.

Prior to the inquest commencing a person was charged in relation to Mr Pham's death and the inquest was terminated pursuant to S19, Coroners Act.

**Formal Finding**

**I find that Trong Tai Pham died on 3rd June 2005 at Bankstown.**

**Inquest terminated pursuant to Coroner's Act 1980, S.19.**

21

1007 of 2005

**Aboriginal male died in the Richmond River at Coraki on or about 7 May 2005. Finding handed down by Magistrate Dorelle Pinch, Deputy State Coroner at Ballina on 19 July 2006**

**Facts**

On 22 June 2005 the body of Jack Fisher was recovered from the Richmond River approx. 2.5 kilometres downstream from where he was last seen swimming across the river on the night of 7 May 2005. On that day, Mr Fisher, a member of the local Aboriginal community at Coraki, had been drinking alcohol and had shared at least one joint of marijuana. In the course of an argument with his partner, Ms Gertie Kapeen, he alleged assaulted her with an iron bar. A neighbour reported the matter to the police. Snr Const Duncan and Snr. Const. (then Const.) Smith responded to the call and notified VKG at 9.20 pm that they had arrived at the couple's home at 6 Yabsley Place. Mr Fisher was not present. The police officers followed the ambulance

conveying Ms Kapeen to Lismore base hospital to obtain details of the events earlier that evening. However, just prior to arriving at the hospital, VKG called the officers to return to Yabsley Place because Mr Fisher was threatening the neighbours who had initially telephoned the police.

Although Mr Fisher avoided a meeting with police when they returned to Yabsley Street at 10.30 pm on the second occasion, they heard him scale the fence adjoining the Kurrachee Co-Operative. They then searched those premises before going to the banks of the Richmond River behind. Their initial search was hampered by tangled undergrowth, shrubs and lush vegetation along the river bank. As they reached a cleared area, they saw a figure jump into the water a couple of metres away and swim towards the opposite bank of the river.

Both police officers agree that when Fisher reached the middle of the river he stopped swimming freestyle and, while treading water, called out "Help me, help me". As to what happened after that, the accounts of Snr. Const. Duncan and Snr Const Smith differ. Duncan stated that he gave the keys to Smith to start the police vehicle so they could drive over to the other side of the river. Until that time both he and Smith had their torches illuminating Fisher in the water. When Smith left, his was the sole remaining light.

He said that he never actually saw Fisher's face. Moreover, he left the scene, using his torch to light his way back to the police truck, before he saw whether Fisher commenced swimming again after calling for help.

Smith stated that when Fisher stopped his freestyle stroke he paddled in a 360 degree circle while calling out for help. In the course of that manoeuvre, the swimmer was facing the bank and Smith positively identified him as Jack Fisher. Smith then saw Fisher continue to swim towards the opposite bank. When he left to go to the police vehicle Fisher was about 75% of the way across the river. According to Smith, Duncan told him when he (Duncan) arrived at the vehicle that Fisher was near to the opposite bank. Neither Duncan nor Smith heard any more cries for help.

In Duncan's opinion, Fisher was not in distress. He considered that Fisher was trying to lure the police into the water in order to escape from the opposite bank while they were in the water. Alternatively, he thought Fisher would try to harm them while they were in the water. Smith, on the other hand, thought that the calls were genuine at the time. He stated that he yelled out to Fisher to stay where he was and an SES boat would be called. It was when Fisher recommenced his freestyle stroke, albeit with his head now out of the water, that Smith called for him to come back. Duncan cannot recall Smith mentioning an SES boat. Additionally, he stated that he called out to Fisher to come back at the time when Fisher entered the water, not when he called out for help.

Before moving on from the events in the water, I need to mention the evidence of Casey Hidden and Elisha Locke. Their house backed onto the river. They were awoken by cries for help and also the barking of the neighbouring dogs. According to Hidden, the first cry he heard was very loud – "Help me .....somebody fucking help me." He also described it as 'bone-

chilling". He thought someone was being bashed up in a fight. However, he did not immediately investigate for fear of becoming involved himself and he did not call the police because he was afraid of the repercussions. According to him, it was not unusual for fights to erupt along the river bank on Saturday nights after the local pub closed. He heard another three to four cries for help within the next ten minutes. They diminished in tone until they tapered off completely. Hidden and Locke then turned on their porch light and went into their back yard to investigate. They saw what appeared to be three to four (according to Hidden) and up to six (according to Locke) torches on the opposite bank. Hidden stated that they called out but received no response. Both Hidden and Locke gave evidence that the cries had stopped before they saw the torches on the opposite bank. Kelly Wilson also heard cries for help.

On arriving on the other side of the river, Smith parked the police vehicle just outside a locked gate to a property leading to the river. According to both officers they had made no plan either during the drive or on arrival about what they intended to do. Yet after alighting from the vehicle they went in different directions, Smith towards the Glebe Bridge and Duncan towards a sign adjacent to the river where he thought Fisher would most likely emerge. Neither officer saw Fisher or heard any sounds that could be attributed to him while searching the bank.

In the course of his search Smith located what he considered to be footprints leading from the river. He described the terrain from the water up the embankment as comprising four sections – water, mud, mud/grass, and longer grass. He saw what he considered to be distinct rounded heel prints but no distinct outline of ball of the foot or toe indentations. He saw two such prints just under the water, two to three in the mud, one or two in the mud grass but nothing in the grass leading up to the paddock. Smith stated that he did not consider the marks were stock prints. He drew the marks to the attention of Duncan. Duncan described the marks somewhat differently but was similarly convinced that Fisher had exited the river at that point.

I should note that in the course of the inquest, accompanied by the majority of counsel appearing at the inquest, I inspected the area of the river where the officers had located the prints. At that time there were numerous hoof marks both at the water's edge and extending up the embankment.

Both Duncan and Smith noticed that the cattle by the river were grouped together. Duncan further noted that they were all looking in one direction away from the river. They interpreted this as indicating the direction taken by Fisher. Hence, they abandoned their search, returned to the opposite side of the river and spoke to Kelly Wilson. Subsequently, they drove to a position near the end of the Glebe Bridge where they considered that, owing to the way the bridge was illuminated, they would see Fisher if he tried to make his way back to Yabsley Street. After some 40-45 minutes they left the site and attended to other duties.

Neither officer returned to the river bank the following day to inspect the prints in daylight. There were rumours in the Aboriginal community that Fisher had gone to his family in Cherbourg, Queensland. Both Duncan and Smith accepted this as the most likely possibility. Duncan agreed that he accepted it as a fact. However, neither Smith nor Duncan contacted Cherbourg police to verify his whereabouts.

When a Statement was taken from Ms Kapeen in relation to the alleged assault she mentioned that, when she returned from hospital she found a wet white T-shirt. This was the T-shirt Fisher was wearing when she last saw him. She found no other wet clothes. Police did not inspect the T-shirt nor, prior to finding Fisher's body, did they make further inquiries about the T-shirt. The evidence before me indicates that in the course of their argument Fisher and Kapeen threw milk and water at each other. Ms Kapeen assumed that the T-shirt became wet in the course of this incident. I heard video link evidence from Harold Hopkins, who was staying at 6 Yabsley Street on 7 May. He saw Fisher when the latter returned to the house after Ms Kapeen had been taken to hospital. It was at that time that Fisher changed out of his white T-shirt and into a dark colour T-shirt. According to officers Duncan and Smith, Fisher was wearing a dark coloured top when he entered the water.

A Critical Incident Team was formed to investigate the circumstances of Fisher's death. Those officers concluded that Fisher had not been to Cherbourg after 7 May 2005. His bank account and medical fund had not been accessed after 7 May. Indeed, the last sighting of him was in the Richmond River that night.

### ***Classification***

This matter was appropriately classified as a death in the course of a police operation and investigated accordingly.

### **Post Mortem Examination**

A post mortem examination was conducted by Dr Bottrill, forensic pathologist. His examination was hampered considerably by the advanced state of decomposition of Fisher's body. In this context I note that prior to releasing a body I need to be satisfied of identification. In this case, visual identification would have been unreliable so Fisher was identified by comparison with dental records.

Based on his examination, Dr Bottrill listed the cause of death as "undetermined". However, he stated that he detected no signs of trauma. He also commented that he could not comment on trauma to the hands because they were missing. However, he would not have expected trauma to the hands to be a cause of death. Specifically to exclude the possibility of strangulation, Dr Bottrill had reflected the skin of Fisher's neck and found none of the characteristic marks. Nor were there any of the characteristic marks of suffocation.

In relation to the possibility of a natural cause death, he found no enlargement of the heart or narrowing of the arteries which could be indicia of ischaemic heart disease. While he could not rule out asthma or a seizure on the basis of his examination, he commented that one would usually expect a history of these conditions for them to have caused Fisher's death at this stage.

Drowning is a diagnosis of exclusion. Hence, while Dr Bottrill indicated that drowning was the most likely cause of death, he could not say definitively because the condition of the body precluded him from undertaking an examination for other possible causes. Additionally, the extent of decomposition precluded him from ascertaining any positive signs of drowning such as water in the lungs because the lung tissue had deteriorated.

Toxicological analysis showed a level of blood alcohol of .086mg/L.

Dr Bottrill indicated that alcohol levels could either increase or decrease in the time between death and the recovery of the body. This reading gave no indication of Fisher's alcohol level on 7 May 2005.

According to Dr Bottrill the condition of Fisher's body was attributable not only to immersion per se but also the actions of sea predators. He indicated that the feet were relatively intact because they were covered by socks. The hands being almost completely destroyed was unusual. However, predators were likely to attack those areas of the body where the skin was already broken. It is well known that when bodies float in water the arms hang down and are likely to scrape along the riverbed or against submerged objects. Hence, post mortem injuries could account for the actions of predators in relation to Fisher's hands.

Dr Bottrill could not entirely discount hypothermia as a cause of death. He considered that hypothermia could occur in water temperatures of 15-16 degrees Celsius. He, however, noticed no specific pathological signs. He agreed in cross-examination that he would expect that hypothermia would be more likely if Fisher had been in the water longer. However, the cold temperature would have contributed Fisher's difficulties in the water.

Dr Bottrill indicated that it was not possible for him to provide a definite estimate of how long Fisher had been in the river. However, the state of decomposition was consistent with his being immersed since 7 May 2005.

### ***Cause of Death***

Given the concerns expressed by members of Fisher's family, I want to record specifically that I am satisfied Fisher was alive when he entered the river. Further, on the basis of all the evidence before me, I consider Fisher drowned in the Richmond River probably late on 7 May or the early hours of 8 May 2005 for the following reasons:

1. His swimming ability would have been hampered by the clothes he was wearing, the cold water and his state of intoxication;
2. His cries for help indicated that he was in difficulty;
3. The fact that the cries seemed to taper off at the end is consistent with increasing difficulty staying afloat;
4. That those cries were heard in the distance by Hidden and Locke are consistent with the scenario that Fisher did not reach the opposite bank;
5. The post mortem examination did not reveal any other possible causes of death;
6. He made no contact with any members of his family after 7 May;
7. There is only one eyewitness account that Fisher was seen by anyone after 7 May and, because there is uncertainty about the date, I do not regard that account as reliable;
8. His bank account and medical fund have not been accessed after 7 May 2005.

### **Issues**

As Fisher's death is classified as a death in the course of a police operation it is appropriate that I examine the actions of the two police officers involved. However, my comments should be read in the context that the decision to evade police was made solely by Fisher. The decision to enter the river was made by Fisher. He could have surrendered at any time.

### **Operational Decision**

I am not critical of the decision per se for both police officers to go around to the northern bank. However, regardless of whose version of events I accept, the appropriateness of the timing of the decision is questionable. If I accept Duncan's evidence, he turned the torch off after he heard the call for help and before he saw Fisher recommence swimming. If I accept Smith's version, although he saw Fisher start to swim after the cries for help, he (Fisher) was swimming less strongly than previously and his head was now out of the water as he swam a few strokes. Irrespective of any pro-arrest policy, I do not consider that either officer could be confident that Fisher was safe. I also note that at no time did either call out to ask him what the problem was and how they could assist. I do not intend to speculate on what could have happened from that point onwards. Suffice to note that I do not expect that the police officers should have entered the river to render assistance, even though I am aware that some officers have chosen to do so in similar circumstances in other cases.

While it is possible to speculate about what could have been achieved if Duncan and Smith had taken Fisher's cries for help seriously, I do not consider it reasonable to suggest that they in any positive way contributed to Fisher's death.

### **Notification and Recording**

I am concerned that there does not appear to be any contemporaneous note or notification about the cries for help. Moreover, from reading the COPS entry, one could well form the impression that the officers saw Fisher reach the other side. I consider that where cries for help are made in the course of a police pursuit, albeit on foot, that VKG ought to be informed so that the matter is recorded and may be referred to the Duty Supervisor for attention.

### **Follow-Up**

I consider that where cries for help are made by a person in the course of a police pursuit in a situation that could result in injury or fatality, the police officers should be under a positive obligation to ascertain the safety of that person. In this case much has been said about the reasonable basis of the assumptions made by the officers that Fisher survived. I note that I do not consider the assumptions to have been particularly well-founded:

- The colour of the wet T-shirt did not match the colour of the clothing Fisher was last seen wearing.
- The footprints were never inspected in daylight; and,
- I am still at a loss to understand the assumption that the cattle were spooked by a single figure emerging from the river rather than two men subsequently running across the paddock with torches and the consequent disturbance of wildlife.

However, if there were a policy as I have outlined above in relation to ascertaining a person's safety, I would have expected the following:

- The supposed footprints to have been inspected in daylight the following day;
- The t-shirt to have been inspected;
- Queensland police to have been contacted to make inquiries at Cherbourg;
- Formal inquiries to have made of Fisher's relatives and friends; and
- Objective searches to be made, such as were done by the Critical Investigation Team for this inquest, into bank accounts and medical claims.

## **Formal Finding**

**Jack Warren Fisher died on or about 7 May 2005 by drowning in the Richmond River at Coraki while attempting to evade apprehension by police officers.**

## **RECOMMENDATIONS**

### **To the Minister of Police and Commissioner of Police**

The following policies should be implemented:

1. Where, in the course of a police operation, cries for help are made by a person being pursued, the police officers engaged in the pursuit should contact VKG so that the Duty Supervisor can be alerted.
2. Where cries for help are made by a person in the course of a police operation in a situation that could result in fatality, the police officers should be under a positive obligation to ascertain the safety of that person.

## **22.**

### **1012 of 2005**

**Inquest into the death of John Wayne Glover on the 9 September 2005. Finding handed down by Magistrate Milovanovich, Deputy State Coroner on the 14 September 2006.**

The deceased was sentenced to concurrent terms of life imprisonment for a number of offences of murder. The sentences were imposed by the Supreme Court on the 19th March 1989. The deceased was initially incarcerated at Goulburn Correctional Centre and moved to the Lithgow Correction Centre in 1993. The deceased was housed in a "one out" cell in a non-association wing. Some weeks prior to his death a program called Forensic Investigators was aired on television titled the "The Granny Killer Murders". Inmates who observed the deceased during the period between the program going to air and his death indicated that they observed him to be praying and believed that he was remorseful in relation to the crimes he had been convicted of.

The deceased has requested a transfer to the Long Bay Gaol Hospital and this transfer had been approved on the day of the deceased death, however, he had not yet been informed. On the 9/9/2005, at about 1.25pm a Correctional Officer was handing out paper work to prisoners and when he looked in the deceased's cell and observed him to be hanging by a blue shower curtain attached to the rear door top grill. The deceased was immediately cut down and medical assistance called, however, he was pronounced extinct. There are no suspicious circumstances surrounding the death of the deceased, no suicide note was found. The deceased was a long-term prisoner, who appears to have taken his own life due to depression associated with the airing of the television program. The deceased was not considered a suicide risk and had no prior history of self-harm.

### **Formal Finding.**

**That John Wayne Glover died on the 9th September 2005, at the Lithgow Correctional Centre, Lithgow in the State of New South Wales, from hanging, self-inflicted with the intention of taking his own life.**

23.

1050 of 2005

**Inquest into the death of Hayrani Tabak on the 10 February 2004. Finding handed down by Magistrate Milovanovich, Deputy State Coroner on the 1 September 2006.**

The deceased was sub-contracted by a joint venture organisation (Walter-Vivendi Joint Venture) that had a contract with Sydney Water for the construction of Sewerage works at Port Kembla.

The deceased was required to attend the work site and examine the interior of a large sewerage pit with a view of submitting quotations for the lining and sealing of the interior walls of the pit. On the day that the deceased arrived at the work site, the construction of the pit was almost complete and a number of square and rectangular penetrations had been covered with marine ply. It was a requirement of the building contractors that the penetrations had to be covered and bolted in order to provide a safe working site and avoid persons falling through the penetrations. On the day that the deceased arrived at the site, he was allowed to enter the site and a number of large pieces of marine ply were moved to allow access into the pit via a ladder. The deceased had entered the pit, completed his examination and exited. He was in the company of a co-worker and they decided that they would replace the marine ply over the penetration. From the evidence presented it would appear that the deceased and his co-worker picked up a large piece of marine ply with a view of moving it to cover one of the penetrations and the deceased was not aware that directly beneath this piece of marine ply, there was a small penetration, about 900ml x 900mls. In lifting the marine ply and walking forward, the deceased has fallen through the penetration and landed on the concrete floor below, a fall of some 9 metres.

The death was for all intents and purposes an industrial death on a work site with Work cover involvement and investigation. The matter was deemed to be a death coming within the provisions of Section 13A of the Coroners Act, 1980, due to the fact that the deceased had died during attempts by Police to extract him from the pit.

The Inquest focused primarily on safe work practices and the issue of compliance with contractual obligations by the joint venture company. The role of the Police was examined, as it was apparent that the Larkin Rescue Frame failed to successfully lift the deceased. The Inquest determined that the Larkin Rescue Frame, which is used most successfully on uneven surfaces, such a cliff tops, failed on this occasion as the legs supporting the frame moved on the smooth concrete surface when weight was exerted. It was apparent that guidelines in regard to the use of the Larkin Frame had not

been followed, in particular, the requirement to secure the frames and anchor bolt them when operating on a smooth surface. The Coroner found that while the failure of the Larkin Frame contributed to a delay in having the deceased extricated from the pit, his injuries were such that a successful initial lift may not have resulted in a better outcome. The Coroner was satisfied that NSW Police had introduced appropriate guidelines and training in the use of the Larkin Frame, with mandatory training on its use on flat surfaces and the need to carry suitable drilling and anchor equipment. Accordingly the Coroner made no formal recommendations in regard to the Police involvement.

The primary focus of the Inquest touched upon the failure to provide a safe working environment. These issues were fully investigated by the Work Cover Authority and the Coroner made formal recommendations in regard to industry practices.

#### **Recommendation.**

That the Work Cover Authority of NSW develop effective and practical guidance for the attention of the construction industry which protects workers from being placed at risk of falling through open penetrations.

#### **Formal Finding.**

**That Hayrani Tabak died on the 10th February, 2004, on construction site 797, near Hill 60, Port Kembla in the State of New South Wales, from Right Hemopneumothorax, internal haemorrhage and traumatic injuries to his thorax, abdomen and pelvis when he fell from a height at a construction site.**

24.

1259 of 2005

**Inquest into the death of Graham Charles Waters on the 12 November 2005. Finding handed down by Magistrate Milovanovich on the 10 August 2006.**

The deceased had been celebrating a birthday party with friends at the Kempsey RSL Club on the night of the 11th November 2005. When the function ended the deceased and his friends returned to a home in the Kempsey area where further alcohol was consumed. Some time in the early hours of the 12 November 2005, the deceased and two of his friends made a decision to enter the township of Kempsey with a view of breaking into a bottle shop with a view of obtaining further alcohol.

At 2.26am on the 13/11/2005 an alarm was activated at the Kempsey Hotel, Kempsey. This alarm was monitored back to base and an alert was issued to a private security firm who in turn responded to the alarm and at the same time alerted local Police. The security officer and police attended the area of the security breach and noted that forced entry had been made into the bottle shop area of the Kempsey Hotel. A patrol of the nearby area was commenced by Police and the security officer.

A short time later three Aboriginal males were seen hiding under the bridge, which spans the Macleay River. A pursuit commenced which resulted in one of the males making good his escape. Another entered the waters of the Macleay River and was seen to be clinging to a pylon, which supported the bridge. This person was directed by Police to return to the waters edge and was placed in custody. A third male (the deceased) was observed to be running along the riverbank and pursued by Police. When the deceased was confronted by security officers in front of him he made a decision to enter the Macleay River. Security officers had the deceased under observation and saw him swim out into the river a distance of some 20 metres.

Security officers kept the deceased under observation with a torch and when Police arrived shortly thereafter the deceased was requested to return to the shore. Almost immediately the deceased disappeared from sight and Police immediately entered the water secured by a tie rope in effort to locate the deceased. Despite efforts to reach the deceased, the tie rope was not long enough to reach the area where the deceased was last seen.

Police commissioned the services of the local State Emergency Services and a boat was provided and the river searched without locating the deceased. It was not known if the deceased had drowned at that stage, or made good his escape to the other side of the river, a distance of some 200 metres. On the following day Police divers searched the river in an arc extending some 20 metres from the shore. Searches for the deceased continued for two days without locating him. On the 3rd day it was decided to extend the search to 25 metres and shortly thereafter the deceased was located entangled in weed at a depth of approximately three metres. The deceased's body was recovered, formally identified and a subsequent post mortem determined he died from drowning and had an alcohol level of 0.129gms per/100mls. The deceased was fully clothed when found.

At Inquest the Coroner determined that the Police had acted lawfully in pursuing the deceased. The deceased's next of kin were legally represented at the Inquest and expressed no criticism of the Police action and in fact were appreciative of the efforts made to save and locate the deceased.

### **Formal Finding.**

**That Graham Charles Waters died on the 12th November 2005, in the Macleay River, Kempsey, in the State of New South Wales from drowning.**

The Coroner made a formal recommendation in regard to the weed infestation in the Macleay River. It was apparent that the deceased may have drowned not only due to the fact that he may have been exhausted from running and swimming, alcohol ingestion, but also due to the weeds in the river becoming entangled around his legs. Evidence was given at the Inquest that during certain periods of the year the river is subjected to severe weed infestation, which could create a danger to persons who enter the river to swim. Accordingly the following recommendation was made.

### **Recommendation:**

To: Kempsey Shire Council.

That consideration be given to the erection of an appropriate sign or signs on those parts of the Macleay River where it is likely those members of the public may picnic or enter the river to bath.

Such signs could either in words or signs draw to the attention of the public the possible dangers of swimming in an area of weed infestation.

### **25.**

**1351 of 2005**

### **Inquest into the death of Jeremy Patrick Crean on the 9 September 2005. Finding handed down by Magistrate Milovanovich, Deputy State Coroner on the 30 October 2006.**

The deceased was born in New Zealand, he was single although he had a young child from a former defacto relationship. The deceased had a history of criminal activity involving dishonesty and drug related offences. He had served one prior period of imprisonment in 2004 and during that term had on one occasion expressed suicidal ideation. The deceased came back into custody following his arrest on the 6th December 2005, when he appeared at Sutherland Local Court and bail was refused.

The intake and reception process of the prisoner at Parklea was conducted in accordance with normal procedures. The deceased was processed by a reception officer who searched him and asked him question regarding his state of mind and suicidal ideation. He was then seen by a Registered Nurse who completed the next stage of the intake process. The deceased was questioned in accordance with a pro forma intake document and did not express any concerns regarding self harm. The prisoner was noted not be depressed or despondent. The prisoner was retained in the reception area of the prison until the following day when he was seen by the Welfare Officer, again no suicidal ideation was expressed or concerns noted. The prisoner was assessed for normal cell placement in a two out cell and referred to a Counsellor in regard to alcohol issues.

In the early hours of the 9th December, 2005, the deceased cell partner was removed from his cell due to court commitments. The deceased was observed at that time as being asleep in his bunk. At 8.35am during the morning release of prisoners from their cells, the deceased was found hanging. It was apparent that the deceased had used a disposable razor blade to cut a bed sheet into strips, which he secured to the recessed fire sprinkler outlet located in the ceiling of the cell. Crime scene investigations confirmed that the deceased would have had to stand on the top bunk in order to reach the sprinkler outlet. A suicide note, confirmed to be in the prisoner's handwriting was located in the cell.

There were no suspicious circumstances surrounding the death. The deceased was alone in a locked cell at the time of his death. The duress button in his cell was in working order and had not been activated from within the cell.

The deceased had a conversation with his ex-defacto some 3 days before in which he indicated that he intended to self harm as he did not wish to go back to gaol. This communication was not conveyed to Corrective Services Staff by his ex partner.

The Coroner was satisfied that all the necessary intake procedures had attempted to identify whether the deceased posed any risk of self-harm. It was noted during the investigation that the prior suicidal ideation, expressed by the deceased during his previous period of imprisonment, had not been recorded electronically. Accordingly the intake process was flawed in that the assessment of the deceased was done with no prior knowledge of a previous alert. The Coroner found that this failure was not systemic, however, did request that the Coroner's findings be brought to the attention of the Commissioner for Correctives Services to ensure that all discharge summaries and alerts are placed on the computer system. It was also noted that the internal investigation conducted by the Department had not detected the failure to record the earlier alert.

**Formal Finding:**

**That Jeremy Patrick Crean died on the 9th December, 2005, whilst in lawful custody, at the Parklea Correctional Centre, Parklea in the State of New South Wales, from hanging, self inflicted with the intention of taking his own life.**

26.

644 of 2006

**Inquest into the death of Stuart Cameron Moore on the 3 May 2005. Finding handed down by Magistrate John Abernethy, NSW State Coroner on the 10 August 2006.**

**Circumstances of Death.**

In November 2005, the deceased was diagnosed with an anxiety condition coupled with depression. The illness was long-standing, though successfully disguised by him until perhaps the year before his death. He was a heavy drinker and his alcohol consumption is likely to have negated, or partly negated the beneficial effect of the prescribed drug, citalopram. Further, he was barely compliant on medication and did not, as advised, curtail or cease his alcohol consumption.

He worked on the family property near Werris Creek. His family was particularly concerned about him.

On the night of 1st May 2006, after dinner, the deceased left the family property. His room showed some evidence of his "putting his affairs in order". He left a note suggesting an intent to take his life. His mother immediately rang Werris Creek Police.

The State Coroner was satisfied that the deceased had formed an intention to take his life prior to leaving the family home. He eventually drove to a car park at Apsley Falls via Walcha in his motor vehicle. He took with him a double barrel shotgun.

He attempted to take his own life by placing the muzzle of the firearm under his chin and discharging it at the edge of a Gorge at Apsley Falls, late on 2nd May 2006, receiving quite severe facial injuries. He returned to his motor vehicle and remained in and around it until shortly after 8.45 am on 3rd May 2006.

On the evening of 2nd May 2006, police at Oxley Local Area Command were provided with information from the brother of the deceased as to his possible whereabouts. Walcha Police were not recalled to duty to attend Apsley Falls at that time. Shortly after commencing duty on the morning of 3rd May, two police officers from Walcha Police Station attended the Falls. In the meantime, early that morning the deceased had been noticed by tourists and after attempts by them to engage him in conversation, left his vehicle.

A search was properly carried out but he could not be located. At 2.15 pm a gunshot was heard. The deceased was located at about 3 pm. He had died of shotgun injuries to the head, self-inflicted with the intention of taking his own life.

#### **Issues.**

##### **Adequacy of medical treatment prior to death.**

The parents of the deceased initially had concerns about the one consultation the deceased had with a psychiatrist on 29th November 2005. The psychiatrist was called at inquest and the coroner permitted the family to question the psychiatrist. The inquest then proceeded by way of quite informal discussion and was of clear benefit to the parents and the court. By the end of the inquest they no longer had issues in relation to any medical treatment received by their son prior to death.

##### **Critical Incident Investigation.**

The Region Commander, Western Region correctly assessed the death as warranting a Critical Incident Investigation. Though technical, it was a death “during police operations” within the meaning of *Section 13A, Coroners Act 1980*.

The death was very competently investigated by a Detective Inspector of Police from another Local Area Command, in accordance with NSW Police Critical Incident Protocol. The investigator raised several issues of quite a minor nature. The State Coroner was satisfied that any failings by NSW Police had no bearing on the death itself.

##### **Insufficiency of present model of Computer Aided Dispatch System (CIDS).**

The present system does not allow jobs to be stored for *future broadcast*. Therefore, a broadcast (from Tamworth) at a time when a police station (Walcha) was unattended, would not have reached Walcha Police Station at opening time the following day.

The State Coroner heard evidence and was satisfied that the CIDS system was in the process of being upgraded and that by March 2007 there will be a “future broadcast” facility, resolving this quite important issue.

**Failure by Supervisor, Tamworth to call out Walcha Police on the night of 2nd May 2006.**

The Coroner was satisfied that current NSW Police Standing Operating Procedures in relation to the calling out of police where police stations are closed, are adequate. The decision by the Supervisor Tamworth, not to call out Walcha Police on the night of 2nd May 2006, on receiving a line of inquiry that may have lead to the locating of a missing person was in the view of the State Coroner and the NSW Police Investigator, an inappropriate decision.

The coroner noted however, that arrival of police on the night of 2nd May would probably not have altered the final outcome. The deceased was intent on suicide and would have probably have taken his life on arrival of police.

The Coroner commented that his remarks were to be taken as constructive. He directed that a copy of the summing up and finding be sent to the Region Commander and suggested that he discuss the issue with his Local Area Commanders. The State Coroner saw it as an education issue.

**Formal Finding.**

**That Stuart Cameron Moore died on 3rd May 2006 at Apsley Falls, Oxley Highway, Walcha, in the course of police operations, of shotgun injuries to the head, self-inflicted with the intention of taking his own life.**

27.

934 of 2006

**Inquest into the death of Steven John Green between the 20 September and 21 September 2003. Finding handed down by Magistrate Milovanovich, Deputy State Coroner on the 6 December 2006.**

**Circumstances of death:**

The deceased was arrested on the 12/9/2003 and charged with a number of drug and property offences. He had a lengthy criminal history with past periods of imprisonment. He was bail refused on the fresh charges and was remanded to appear in Court on the 15th October 2003. He was received at the Goulburn Correctional Centre on the 12th September 2003, and an intake assessment was conducted in accordance with normal protocols. The deceased had a history of drug use but had no prior suicidal ideation while in custody and did not present as being at risk of self-harm. The deceased was assessed by a registered nurse and a welfare officer and was considered suitable for placement in a two out cell for a period of seven days with consults arranged with counsellors and the services of a psychologist offered.

The deceased was locked into his cell at 2.50pm on the 20th September 2003, and on the same day his cell partner was moved due to court commitments. The deceased was located deceased at 5.55am on the 21st September 2003, when the cells were opened for morning release. The deceased had torn a piece of bed sheeting, which he fashioned into a ligature, which was secured to the metal bars on the window of his cell. Upon being located medical personnel were summoned, however, it was apparent that the deceased had died some hours before being located. At the time of his death the deceased was alone in his cell and it was apparent that he had not activated the cell alarm button. There was no evidence of any violence and his cell had not been accessed since lock down at 2.55pm on the previous day. Police determined that there were no suspicious circumstances.

The deceased had received visitors the day prior to his death and at the time had indicated that he expected to receive a lengthy sentence of imprisonment and intimated that he “might as well neck himself”. His visitors did not take this conversation seriously, nor was it communicated to any prison personnel.

The Coroner determined that all appropriate risk assessment had been undertaken in regard to the prisoner and that his intended suicide was unexpected. A post mortem examination determined the deceased had died from hanging.

**Formal Finding:**

**That Steven John Green died on the 21st September, 2003, in Cell 43, Unit 4, at Goulburn Correctional Centre, Goulburn in the State of New South Wales, from hanging, self inflicted with the intention of taking his own life.**

28.

1114 of 2006

**Inquest into the death of Stephen James Franks on the 19 June 2006. Finding handed down by Magistrate Milovanovich, Deputy State Coroner on the 19 October 2006.**

The deceased was 60 year old Caucasian male who died in Police custody on the 19th June, 2002. The deceased and two other men were commissioned by a third party to exert pressure on a Mr Kelly in regard to a financial dispute. At around 5.50pm on the 19/6/2002, the deceased and his two accomplices approached Mr Kelly in the driveway of his home and following an exchange of words, the deceased produced a sawn off .22 calibre firearm and discharged to shots towards Mr Kelly, neither of which struck him. Mr Kelly managed to escape, called Police and gave a description of the three assailants and their vehicle.

At about 7.04pm on the 19/6/2002, Sen Constables King and Austin, having heard a VKG broadcast in which the alleged offence and a description of the suspects was given, caused a vehicle to be stopped approximately 18klms north of the township of Gilgandra being in the Orana Police Local Area Command. The deceased and his two accomplices were placed under arrest, they were searched as was their vehicle, and guarded until additional police arrived at the scene. At about 7.26pm Sen Constables Dohnt and Dohnt arrived at the scene at which time the three prisoners were separated and the

deceased was placed in the rear of Gilgandra 25, that vehicle being a caged 4-wheel drive. At this point in time a decision had been made by the four Police at the scene, that they would transport the three prisoners to Gilgandra and they had organised a tow truck to tow the suspects vehicle to Gilgandra for crime scene examination. At about 7.44pm, Sen Constable Darcy, a Detective attached to the Castlereagh Local Area Command arrived at the scene and took over control of the situation. Sen Constable Darcy was a Detective attached to the Local Area Command were the initial offences (the attempted shooting of Mr Kelly) had taken place (Coonamble) and he then made the decision that the prisoners needed to be transported to Coonamble. It would appear that between 7.44pm and about 8.40pm a number of mobile telephone calls and VKG transmissions took place in which the logistics of transporting the prisoners and to which Police Station they should be taken was discussed.

At about 8.43pm, Sen Constable Darcy approached the rear of Gilgandra 25 with a view of speaking to the deceased and upon opening the rear of the caged section, found the deceased hanging by a ligature, fashioned from his shoelaces and attached to the ventilation grill of the caged vehicle.

The evidence would suggest that from the time the deceased was arrested until he was found deceased a time period of 1 hour and 40 minutes had elapsed. The evidence would also suggest that from the time the deceased was placed in the rear of the caged vehicle until the time he was located a period of approximately 1 hour and 5 minutes had elapsed. The evidence confirmed that the deceased was observed on at least two occasions by one Police Officer and that those observations were made via the ventilation grill and that about 15 minutes prior to being found hanging that the deceased was removed from the vehicle in order to urinate.

The Inquest identified a number of issues. The first issue was the delay in transporting the prisoners to a Police Station. The independent Critical Incident Investigation Team Investigator expressed the view that the delay was excessive in the extreme, however, conceded that logistical problems and police resources in transporting three prisoners from a remote location added to the delay. The second issue identified was the issue as to whether the prisoner should have had his belt and shoelaces removed from his person when being placed in the rear of the caged vehicle.

The Coroner made no adverse findings in regard to this issue as it was indicated that persons who are arrested are regularly conveyed in Police caged vehicles without removing belts and or shoelaces. The appropriate test as to whether the laces should have been removed would have been dictated by the demeanour of the prisoner and the evidence presented at Inquest did not suggest that the deceased was observed to be depressed, affected by alcohol nor that he expressed any suicidal ideation.

It was also noted that the prisoner had been checked on at least two occasions and only 15 minutes prior to being found hanging had been allowed out of the vehicle to urinate. At that time the deceased was not observed to be despondent or exhibiting any signs that may have put the Police on notice that he may have been at risk of self harm.

The remaining issue identified at Inquest was the possible conflict that can arise and the competing priorities between a criminal investigation and the Critical Incident Investigation. Sen Constable Darcy when he first attended the location at which the three prisoners were held in custody, assumed responsibility for the crime scene, the transport of prisoners and the investigation into the alleged offences that had taken place earlier in the night at Coonamble. When Sen Constable Darcy found the deceased hanging at approximately 8.43pm, he had assumed responsibility for all three prisoners since 7.44pm.

Having assumed responsibility and having made decisions regarding the transport of the prisoners, he became an involved officer in regard to the death in custody. The question arose, as to whether at that point, he should have been subjected to the critical incident protocols, those being separation from other officers, breath tests etc, and whether he should at that point have stood down from any operational issues associated with the criminal investigation.

On one view it was submitted that he should have been subjected to critical incident protocols and on the other that the criminal investigation and the critical incident investigation could run together. The Coroner was of the view that the critical incident investigation should take priority, particularly as a death in custody would be subject to a mandatory inquest pursuant to Section 13A of the Coroners Act, 1980.

The Coroner elected not to make any formal recommendations, however, indicated that the brief of evidence, transcript and submissions should be forwarded to the Commissioner of Police in order that the identified issues may be examined and guidelines issued.

Pursuant to *Section 22 of the Coroner's Act, 1980*, the Coroner made formal findings that the deceased had died as a result of an intention to take his own life. Evidence was presented of one prior suicidal ideation by the deceased which resulted in his hospitalisation and the Coroner also took into account that the deceased, although not exhibiting outward signs, would have been gravely concerned regarding his predicament in that he was in custody and facing serious indictable offences.

**Formal Finding:**

**That Stephen James Franks died on the 19th June, 2002, near the Curban turnoff, Castlereagh Highway, Gilgandra in the State of New South Wales, from hanging, self inflicted with the intention of taking his own life.**

## Appendix I:

No	Name of Deceased	Case No.	Death in Custody/(DIPO) Death in Police Operation (DIC)	Manner of Death	Date of	Coroner
1	Leonard Lawson	2052/03	DIC	Natural Disease	29/11/03	Abernethy
2	Richard Thomas	1058/03	DIPO	Asphyxia	28/09/03	Milovanovich
3	Tabatha Berg	0059/04	DIPO	M/Vehicle accident	15/01/04	Milovanovich
4	Peter James	60/04	DIPO	M/Vehicle accident	16/01/04	Milovanovich
5	JD	722/04	DIPO	M/Vehicle Accident	21/05/04	Milovanovich
6	Scott Simpson	988/04	DIC	Hanging	07/06/04	Pinch
7	Wendy Hancock	1102/04	DIC	Hanging	03/10/04	Milovanovich
8	Nathan Mazurani	1160/04	DIPO	Shooting	03/07/04	Abernethy
9	Basil Anastasiadis	1649/04	DIC	Natural Disease	20/09/04	Pinch
10	Charles Chenery	1887/04	DIPO	Overdose Drug	03/02/04	Abernethy
11	Thuong Lam	2057/04	DIPO	Shooting	02/12/04	Abernethy
12	Ryan Teaken	290/05	DIC	Hanging	13/03/05	Milovanovich
13	Daryl Duckworth	312/05	DIC	Stabbing	20/03/05	Milovanovich
14	Kah Boo Cheah	343/05	DIC	Natural Disease	26/02/05	Abernethy
15	Andrew Coleman	364/05	DIC	Hanging	28/02/05	Abernethy
16	Jian Song	418/05	DIPO	Fall/Jump	14/03/05	Abernethy
17	Kaylee Rodgers	491/05	DIC	Fall/Jump	02/05/05	Milovanovich
18	Ali Chemaisssem	526/05	DIPO	Shooting	12/05/05	Milovanovich
19	Jamie Eberlein	858/05	DIC	Choking/Suffocation	06/08/05	Milledge
20	Trong Pham	911/05	DIPO	Traffic Accident	03/06/05	Abernethy
21	Jack Fisher	1007/05	DIPO	Drowning	07/05/05	Pinch
22	John Glover	1012/05	DIC	Hanging	09/09/05	Milovanovich
23	Hayrani Tabak	1050/05	DIPO	Fall/jump	10/02/04	Milovanovich
24	Graham Waters	1259/05	DIPO	Drowning	12/11/05	Milovanovich
25	Jeremy Crean	1351/05	DIC	Hanging	09/12/05	Milovanovich
26	Stuart Moore	644/06	DIPO	Shooting	03/05/06	Abernethy
27	Steven Green	934/06	DIC	Hanging	20/09/03	Milovanovich
28	Stephen Franks	1114/06	DIC	Hanging	19/06/02	Milovanovich

## Appendix 2:

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

No.	File No.	Date of Death	Place of Death	Age	Circumstances
1	1433/01	11/08/01	Auburn	39	In custody
2	248/03	16-26/11/01	Unknown	52	In custody
3	1706/03	02/10/03	Leichhardt	31	Police Op
4	2054/03	29/11/03	Narromine	21	Police Op
5	734/04	04/04/04	Royal Adelaide Hospital	41	Police Op
6	845/04 W	01/08/04	Bathurst	34	Police Op
7	1049/04	19/06/04	Goulburn Base Hospital	27	Police Op
8	1107/04	26/06/04	RNS Hospital	27	Police Op
9	1495/04	25/08/04	Barham	39	Police Op
10	1496/04	25/08/04	Barham	46	Police Op
11	1574/04	09/09/04	Grafton Hospital	43	In custody
12	1721/04	01/10-02/10/04	Long Bay	41	In custody
13	231/05 W	25/02/05	Macquarie Fields	17	Police Op
14	235/05 W	25/02/05	Macquarie Fields	19	Police Op
15	249/05	08/02/05	Bellwood	83	Police Op
16	250/05	08/02/05	Bellwood	83	Police Op
17	327/05 W	23/03/05	Bathurst	27	In custody
18	454/05 W	21/04/05	Northmead	31	Police Op
19	497/05	26/03/05	Enfield	25	In custody
20	583/05	10/04/05	Lightning Ridge	14	Police Op
21	744/05	24-25/05/05	Umina Beach	28	Police Op
22	1303/05 W	24/11/05	Campbelltown	53	Police Op
23	1978/05	17/12/05	Marulan	31	Police Op
24	195/06	06/02/06	Darlinghurst	32	In custody
25	366/06	09/03/06	Wagga Wagga	48	In custody
26	367/06	08/03/06	Canberra	56	Police Op
27	666/06	06/05/06	Port Macquarie	29	Police Op
28	944/06	24/06/06	Randwick	44	In custody
29	1081/06	23/07/06	Malabar	36	In custody
30	1136/06	28/07/06	Malabar	19	In custody
31	1304/06	28/08/06	Waterloo	37	Police Op
32	1433/06	18/09/06	Malabar	65	In custody
33	1740/06	09/11/06	Darlinghurst	46	In custody
34	1757/06	11/11/06	Gosford	41	Police Op
35	1834/06	25/11/06	St Leonard's	42	In custody
36	1859/06	30/11/06	Tweed Heads	39	Police Op
37	1883/06	01/12/06	Dubbo	23	Police Op
38	1901/06 W	06/12/06	Westmead	32	In Custody
39	1929/06	15/12/06	Vaucluse	44	Police Op
40	37/06 W	07/01/06	Windsor	64	In custody
41	503/06 W	03/05/06	Berkshire Park	24	In custody
42	510/06 W	05/05/06	Boolaroo	52	Police Op
43	587/06 W	24/05/06	Yanderra	72	Police Op
44	669/06 W	09/06/06	Bathurst	58	Police Op
45	735/06	25/06/06	Lithgow	36	In custody
46	759/06 W	02/07/06	Belmont	41	Police Op
47	1061/06 W	04/09/06	Lithgow	31	In custody
48	1201/06 W	20/09/06	Liverpool	58	In custody
49	1210/06 W	14/10/06	Silverwater	59	In custody
50	1160/06 W	30/09/06	Woy woy	89	Police Op
51	9/07 W	30/12/06	Fairfield	32	Police Op

\* W denotes Westmead Matter

