SUMMARIES OF INDIVIDUAL CASES COMPLETED IN 2009.

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 **2009.** These findings include a description of the circumstances surrounding the death and any recommendations that were made.

INQUESTS UNDERTAKEN IN 2009

	Case No.	Year	Name	Coroner
1	248	2003	Falconer	Magistrate Dillon
2	1136	2006	Cameron	Magistrate MacMahon
3	1757	2006	Wilson	Magistrate Milovanovich
4	759	2006	Hare	Magistrate Dillon
5	1782	2007	Walmsley	Magistrate MacMahon
6	2172	2007	Tupou	Magistrate MacMahon
7	2195	2007	Kennedy	Magistrate McPherson
8	2357	2007	Garner	Magistrate Dillon
9	58	2008	Cyprien	Magistrate Milovanovich
10	166	2008	Kentwell	Magistrate Milovanovich
11	167	2008	Shipley	Magistrate Jerram
12	400	2008	Jacobs	Magistrate MacPherson
13	529	2008	Whitton	Magistrate Dillon
14	595	2008	Puckeridge	Magistrate Milovanovich
15	669	2008	Pham	Magistrate Milovanovich
16	773	2008	Drage	Magistrate MacMahon
17	1047	2008	Paterson	Magistrate MacMahon
18	1048	2008	Paterson	Magistrate MacMahon
19	1137	2008	Turner	Magistrate MacMahon
20	1247	2008	Hapi	Magistrate MacMahon
21	1582	2008	Shaw	Magistrate Milovanovich
22	1012	2008	McEwen	Magistrate Milovanovich
23	2219	2008	Nguyen	Magistrate Milovanovich

1. 248/03 Terrence Falconer

Inquest into the death of Terrence Wallace Falconer at Port Macquarie on the 26 November 2003. Inquest suspended by Deputy State Coroner Dillon on the 24 April 2009.

The death of Terrence Falconer was deemed to be a death resulting from a police operation. Following advice from investigating police a known person was charged with an indictable offence arising from the death. The NSW Deputy State Coroner in accordance with the Coroners Act suspended the inquest. No formal finding other than identity date and place of death was made.

2. 1136/06 Joshua Paul Cameron

Inquest in to the death of Joshua Paul Cameron at Long Bay Gaol on the 28 July 2006. Finding handed down by Deputy State Coroner MacMahon on the 6 February 2009.

This is an inquest into the death of Joshua Paul Cameron. Joshua was born on 2 July 1987. He died on 28 July 2006. He was nineteen years of age at that time, having turned nineteen less than four weeks prior to his death. . Joshua died at the Long Bay Prison facility conducted by the Department of Corrective Services. Before I take the matter any further it is important that

I outline what the role and function of a Coroner is, though that role and function is set out in s 22 of the Coroner's Act and the Coroner investigating the death of a person is to be firstly - determined that a person has died. Secondly, determine that person's identity, and, thirdly, determine the date and place of their death and, finally, to determine the cause and the manner of their death.

The ability of a Coroner to make such a determination is of course dependent on the evidence which is available to him or her, if no evidence - or insufficient evidence is available, then the Coroner cannot make a finding as to a particular matter of which s 22 speaks. The Coroner's jurisdiction is not an adversarial jurisdiction like the criminal courts or the civil courts. The Coroner is conducting an inquiry into a particular matter; it is the Coroner's inquiry or investigation. The parties who are given leave to appear are there for the purpose of assisting the Coroner to undertake their statutory role, which is imposed upon him or her.

The Coroner's function is therefore to examine evidence available, to make findings of fact, if not to do - attribute blame, is not to adjudicate between parties. It is not to find people guilty of any criminal or civil wrong. It is simply for the purposes of, if possible, findings of fact.

The Coroner's jurisdiction - the Coroner makes such findings in accordance with the law and the test which the Coroner must provide is not the criminal test of beyond reasonable doubt, and it is not a simple civil test of on the balance of probabilities, it is what is commonly referred to as a **Briginshaw Test**, that test comes as identified and outlined by the High Court in the case of **Briginshaw v Briginshaw** many years ago.

In short, and without using legalese, the Coroner must be comfortably satisfied that the evidence available allows him or her to make a particular finding. It is not whether or not such a finding is more likely than not to do more than that. The finding must be made. The Coroner must be comfortably satisfied of a particular fact. In this case there are a number of matters, which are not in dispute, and it is appropriate to identify them.

Firstly, it is not in dispute that Joshua was in cell 52 room 10 at Long Bay Prison facility on 28 July 2006 - sorry, he was placed in that facility on 27 July 2006 and at that time he was alive. It is also not in dispute that on 28 July 2006 he was found in that facility and he was deceased. It is not in dispute that it was Joshua who was so found. As to the issue of identity, date and place of death are not disputed, and I can be comfortably satisfied on the evidence, which is available to me as to the matters. That is that Joshua Paul Cameron died on 28 July 2006 in cell 52, room 10 at Long Bay Gaol.

Before I proceed further, it is important to be aware that because Joshua died when he was in custody, he was serving a sentence of imprisonment at the time of his death, it is mandatory under the **Coroner's Act**, that an inquest be conducted into his death, and it is mandatory that such inquest be conducted by a Coroner who holds the office of State Coroner or Deputy State Coroner.

The reason why that is the case is because Joshua's liberty had been taken away from him by the state and it is incumbent on the state having taken away his liberty, he was not free to leave, that he be properly cared for, and with his medical and other needs were provided for, and that he was provided appropriate protection if that were necessary.

It is therefore incumbent on the Coroner who is conducting such an inquest where it is mandatory and where there are obligations on the state to examine closely the circumstances of his death so that it can be determined whether or not there was any failing on the part of the state authorities to provide proper care and protection to him whilst his liberty was removed.

Following his death Joshua was the subject of an order for an autopsy or post-mortem examination in order to determine what caused his death, and Dr Matthew Orde, an expert forensic pathologist attached to the Department of Forensic Medicine had undertook such an autopsy and provided an autopsy report, and Dr Orde - that report is contained within exhibit 1.

Dr Orde examined Joshua and found that in terms of the physical examination he did not suffer from any medical or neurological illnesses or injury, which could have caused his death.

Dr Orde ordered the undertaking of a toxicological assessment and the Division of Analytical Laboratories at Lidcombe performed such a test.

It found that within Joshua's system were a number of drugs. Dr Orde, examining that, it was as a result - and considering the levels of those drugs concluded that the most likely cause of Joshua's death was multi-drug toxicity, in using his language. Put simply, found within Joshua's system at the time of his death were levels of Codeine, Morphine, Paracetamol and Panadol and the interaction of those drugs between them was a fatal concoction, which caused Joshua's death.

Having regard to the evidence and taking into account Dr Orde's opinion, the findings of the Division of Analytical Laboratories in taking into account the evidence of Dr Perl, which I will come to shortly, I am satisfied that that indeed was the cause of - I have come to be satisfied that that indeed was the cause of Joshua's death.

Dr Judith Perl is an expert pharmacologist, gave a report and gave evidence that is in court as exhibit 11. In the report of the Division of Analytical Laboratories they identified the various drugs, which I have outlined and they also indicated that in respect to the Codeine that was found there was less than the reported drug fatal level, but it was greater than the reported liver fatal range. As far as the morphine was concerned, the level found was in fatal range.

As far as the Paracetamol was concerned, it was less than the blood fatal range but above the reported liver fatal range, and as Paracetamol works on attacking the liver, that was a significant finding. The Tramadol did not have indications as to the level, which had come to - in the fatal range in the reported literature.

Dr Perl, exercising her expertise, indicated however that each of the drugs found were at a level that by themselves could have resulted in Joshua's death, but combined they - in the concoction that they were found - they were certainly at a fatal level. The evidence available was that some of - I go back - Joshua, as I have already indicated, was at that level at the time in 10 wing at the Long Bay facility and that is a specific wing used for specific purposes, principally but not necessarily uniquely for specific purposes to enable the provision of medical care to inmates.

Joshua was there, it seems, principally or it is inferred from the evidence that he was there because the classification that he had received was for him to be at Lithgow Correctional facility but there were no vacancies and has Bathurst, which is where he went to following him being sentenced in Dubbo, was not an appropriate facility for a person of his classification. He was transferred to Long Bay and the place that he was. He was on some medication, or he was prescribed some medication, and it would seem that perhaps the thinking was that the location was one, which was appropriate whilst he was waiting for placement at Lithgow, but really nothing turns in particular on that issue other than that is how he got to where he was.

He, however, was found after he was deceased to have drugs in his system, which he did not receive by legitimate means. That raises the issue of course because as I have already indicated, a person whose liberty has been deprived from them is entitled to protection and care of the state, and that raises the question of whether or not or how he came to have in his system the drugs, which I have outlined. Now, of course there are two ways in which drugs can be in the system. That is they can be self-administered or they can be forced.

The examination of Joshua following his death did not indicate any evidence of a forcible administration of drugs. There were no assaults, no evidence of assault or force. On behalf of Mrs Cameron, the mother of Joshua, she accepts that the drugs were self administered, and I think that that is an appropriate acceptance. Indeed, Mrs Cameron gave evidence that Joshua had a history of administering drugs, which she said he - from a young - from being a young person, which she put down to attention seeking.

There was other evidence that Joshua was involved in the - what could be described in lay terms - the drug scene. Mrs Cameron suspected that that was the case and that - but that he did not talk to her about it because he did not want her to get upset. No doubt if he talked about it to her she would have told him that he was treading on a very dangerous path, but it was his history - his sister, Amanda, confirmed and that his involvement in that scene, as did in fact his history in the Juvenile Justice - in the commission of offences which brought him into the Juvenile Justice system and resulted in him receiving a detention order.

There is some evidence that even the offence, which brought him into the Correctional facility, may have been committed whilst affected by substance, but that is not the finding, which I am to determine before me. That is just anecdotal material, which is consistent with other evidence, which is before me. I am satisfied that the self administration - that Joshua administered the drugs to himself and that is consistent with his prior history, it is consistent with these prior actions to try and obtain what could be described as a “high”.

Joshua was a young man with a troubled history. He had been - as I have already indicated - involved in the Juvenile Justice system for offences he committed as a juvenile and then he was incarcerated in the adult system for a very serious offence he committed and that brought him eventually to Long Bay in July 2006. I am satisfied that he himself administered the drugs, which caused his death. That raises the question of course of whether or not of his intention at the time of that self-administration that is did he intend to take his life by the administration of the drugs that he did.

He did have previous episodes in which he had factored in a way, which appeared to indicate an intention to self-harm, and that of course raises the question whether or not on this occasion he intended to self-harm. That is did he intend to commit suicide by taking the drugs? I do not believe that there is sufficient evidence for me to be comfortably satisfied that he intended to take his life when he took the drugs that he did.

As I have indicated, to make a finding one has to be comfortably satisfied, that that is that the finding is correct and as a matter of fact.

Joshua at the relevant time appeared to have settled in to prison life. There is no evidence that he had made enemies in prison. He had lodged an appeal against his sentence. Who is to know what would have resulted from that. He, as I have already indicated, was classified to be at Lithgow Correctional facility, which was closer to home.

One does not know - the evidence does not tell me that he knew that that was where he was ending up, but there is - there must be some possibility that he did know that that is the case. More importantly, however, he appeared to have had a good relationship with his mother and sister. They were in communication with him and he was expecting a visit from his mother.

He had previously indicated from time to time to his sister that he felt depressed and he had indicated to his sister not so long before his death that he had felt depressed, but whether or not that translates into an intention to self harm, that is a leap which is too much, and not to my mind, particularly as his mother had arranged for - had made arrangements to visit him. In addition There is no evidence, apart from the throwaway line to the sister, that he was at the relevant time suffering from any psychological distress and nothing was observed by any of the witnesses, whether or not they be Correctional officers or inmates, that he had any intentions to self harm.

In addition, very persuasively, Joshua had a history of using substances to get high and had a history of lack of self-control. In both of those circumstances it seems to me that - well I am satisfied that it is more likely than not that his intention to - when taking the substances that he did - was not actually to take his life but simply to achieve the benefits that he had previously experienced from substance abuse. I use the word “benefits” in inverted commas. He clearly took a lot of tablets. Dr Perl estimated that he would need to have taken somewhere between twenty and thirty tablets in a variety of configurations to have achieved the outcome which occurred.

So when did he take those tablets? Mr Pritchard, who was his cellmate, made a statement but did not give evidence at the inquest, I excused him from giving evidence because of the material which was before me, which indicated that he suffered from a significant medical condition which could have been aggravated by his giving of evidence, but he gave a statement which I can take into account. He indicated that Joshua took some substances prior to - in the morning of the 28th. His indication as to the amount of that substance was the subject of comment by Dr Perl who indicated that the effect on him would have been such that he is almost certain that he would have been observed to have been affected when he returned to his cell after the morning period let out.

That raises the question as to the credibility of Mr Pritchard’s evidence, which would mean that all of his evidence would need to be examined carefully.

Of course I do not have the benefit of that, and so therefore I have to treat warily the evidence from Mr Pritchard about what else happened on 28 July, particularly what happened after Joshua returned to his cell for the night. Mr Pritchard gives a history of what he observed - of what occurred that night and what he observed. That may or may not be the case, but it seems to me on the evidence it is more likely than not that the substantial number of substances which led to Joshua's death were taken after he was locked in for the night.

Whether or not he had taken substances before that, and how much, is another thing, but - which is something which I cannot determine - but I am satisfied that the assertions of Mr Pritchard as to what was taken cannot be corrected. What else happened that night, we do not know. I am satisfied that Joshua took the substances, that there were a significant number of tablets taken and that those tablets taken caused his death. How they occurred throughout the night I cannot be satisfied with the statement.
I cannot accept the statement of Mr Pritchard as to what he observed and so therefore I cannot make any findings other than that which I have already outlined.

As I have indicated, the substantial - the most important drugs, which caused his death, were drugs for which he did not obtain by legitimate means. He must have obtained by illicit means. There is evidence before me from various witnesses that as to the trading of prescription drugs by inmates. I am satisfied that inmates do trade prescription drugs and do divert such drugs by various means. That is how Joshua got the drugs, which resulted in his loss of life. The question arises of course as to whether or not it can be determined as to who Joshua got the drugs from.

There was no suggestion from any of the advocates that there is sufficient evidence to meet the standards set out in s 19 for the referral of a known person to the Director of Public Prosecutions in respect to an indictable offence. That is an attitude, which I concur with. Ms Graham on behalf of the family made a detailed submission as to whether or not there is evidence from which I could make a finding, that the person of interest Mr Spinks, who was before the court and gave evidence, was the source of some, if not all, of the said drugs.

Mr Pritchard, who I have already mentioned, was also linked or indicated as being a person who was involved in that supply or may have been involved in that supply. As I have indicated, Mr Spinks did not give evidence and did not appear at inquest - sorry, Mr Pritchard did not give evidence and did not appear at inquest. Mr Spinks did appear at inquest and did give evidence. He denied under oath that he was involved in such a trade. Ms Graham argued assiduously that I could be satisfied that the evidence of a number of the witnesses was credible and that I could be satisfied to the relevant test that Mr Spinks did have such an involvement.

The difficulties with making such a finding - there are a number of difficulties with making such a finding. Firstly, Mr Spinks did give evidence and did deny under oath that he was involved in such a trade.

Secondly, the various - Mr Spinks was not represented at inquest and the various witnesses who indicated or gave evidence, which was contrary to what Mr Spinks asserted under oath, were not tested on his behalf on that point.

Thirdly, and has been acknowledged by the advocates, that in respect of each of the various inmates who gave evidence, there were issues which gave - raised questions as to the credibility.

Given that they were not tested on this point it would have, in my mind, be unjust to make a finding against Mr Spinks, particularly as he had given evidence under oath as denying the various allegations and had not had the opportunity to have the alternative, the allegations put against him, tested in the witness box, and that would be contrary to our notions that justice in my mind - the **Briginshaw Test** means that I have to be satisfied or comfortably satisfied in what really amounts to an unjust situation.

I would have to take into account the restriction on Mr Spinks' vulnerability to protect his interests in making a determination as to whether or not I was comfortably satisfied. I cannot be comfortably satisfied that he was involved. It may well be that he was. It may well be that he did tell the truth when he gave his evidence, and it may well be that the various witnesses who nominated him in that activity are telling the truth, but in the circumstances, I cannot make a finding that I am comfortably satisfied that he in fact was the supplier or involved in the supply of these drugs.

The role of the Coroner, as I have indicated, is not to attribute blame but to find facts and having found facts, found out what happened and the Coroner can look at what happened and determine whether or not some recommendations of improvement can be made the way - the circumstances of the person's death can contribute in a positive fashion to the future. Ms Graham on behalf of Mrs Cameron has made a number of recommendations.

The first, which might be adopted, the first of which was that the medical records of the Department of Juvenile Justice should be transferred to Justice Health if a juvenile enters into a Corrective Services environment. I am told, and I accept, that since Joshua's death that has in fact occurred, that recommendation is therefore not necessary. She has also recommended that training occur for Corrective Service officers as to various matters associated with the abuse of medication, that - and before me I have the training protocols and it seems to me that those issues are dealt with in those protocols.

The third recommendation is that there be random personal searches at lock in. There are such searches at release. That recommendation - and Ms Graham submits that if that recommendation were made, there were random personal searches, that perhaps that would attribute towards protecting people such as Joshua from taking illicit substances into their cells and abusing them. The evidence is that prisoners secrete illicit substances, which are to be diverted in a variety of creative ways.

It may well be that a random personal search at lock in might identify - however, of course, if there were such searches, prisoners would no doubt act in a way which tries to avoid detection.

The Department of Corrective Services have argued that such searches would be detrimental in that firstly they would be of limited benefit. Secondly, they would delay the time of prisoners out of cell, and that would be negative. I do not consider that it is appropriate for me to make such a recommendation having regard to the fact that I agree that such searches would be of limited value or limited effectiveness.

The fourth recommendation by Ms Graham was that inmates when called for muster respond by stating their names rather than they just simply acknowledging that they are there. The reason for this is that it is thought that if a person were to speak more than simply, “Here” or “Yes”, it might be more likely that the prison officer would identify if substances affected them.

We had the benefit of a view and we had the benefit of observing how this process of muster occurs. We were able to observe that the muster officer has available for him or her both the names of the various inmates and a photograph of the inmate.

Observing the process myself I was able to observe that the officer called a name, appeared to look at the documents in front of them and then appeared to look in the direction of the various inmates. I am told that the purpose of that is to examine whether or not the person who is acknowledging is the person whose photograph is in front of the officer, not - it appeared that that was in fact what was occurring, but of course I cannot be definitive as to what the officer did, had to look at - be that as it may, the prisoner would be then moved past a number of other officers from the muster, from the yard, into the cell block.

It is argued that in moving past a number of other officers is a more effective way of determining whether a person is affected by substances than simply speaking their name and whilst the effort by Ms Graham to come up with a practical recommendation to assist in this area is a worthy effort, it seemed to me that the process which currently is in place is in fact a more effective process. Therefore I do not wish to propose to make such a recommendation. There was also a recommendation that the number of Panadeine type products be reduced to inmates.

That is argued against by Justice Health on the basis that there has to be some responsibility taken by inmates and to remove - reduce the number of such medication would be a disadvantage to those who suffer from chronic illnesses, which require the availability of such products prior to that of clinic hours. The number of such items, which are available, appears to be modest and having regard to the recommended doses which are contained in such products and which are freely available at supermarkets and chemists, seem to me that the levels currently available as takeaways are not excessive.

That does not appear to have been a contributing factor to Joshua's death. The way Paracetamol affects a person would not have - sorry, I will go back - an overuse of Paracetamol, even with Codeine in the form of Panadeine, is such that an overdose by Joshua was even of significance, would not necessarily have caused his death because in the time which it was resulted in. (not near microphone). Because of the effect on the liver - takes a significant period of time before the liver function begins to be disrupted in a legal fashion.

In those circumstances the recommendations of Ms Graham, I do not propose to make the recommendations, which Ms Graham has submitted, that they ought be made, but I do appreciate her efforts in that regard. There are a number of other subsidiary issues which were raised in these proceedings, which - perhaps if one was to undertake written findings that might be dealt with as well, but it seemed to me that it was in the interests of justice and the interests of the family of Joshua that particularly given that where they reside, that this matter be concluded today. I therefore turned my attention only to the matters, which I considered to be of greatest significance.

Formal Finding:

That Joshua Paul; Cameron date of birth 22 July 1987 died on the 28 July 2006 in cell 52 of 10 wing, Long Bay Gaol, Maroubra. The cause of death was multiple drug toxicity, codeine, morphine, paracetamol and tramadol, which were self-administered without the intention to cause his death.

3. 1757/06 Peter Gordon Wilson

Inquest into the death of Peter Gordon Wilson at Gosford Hospital on the 11 November 2006. Finding handed down by Deputy State Coroner Dillon on the 25 August 2009.

Senior Constable Peter Gordon Wilson was a Highway Patrol officer engaged in speed law enforcement using lidar on the F3 freeway near Somersby on 11 November 2006 when he was struck by an out-of-control car travelling at high speed and so badly injured that he died of the effects of those injuries in Gosford Hospital later the same day.

He and his partner were operating on a section of road known by police as "the flight deck" because it was a long straight section on which motorists frequently travelled at very high speeds. They were operating from the wide, heavily vegetated median strip between the two section of divided road. A motorist exceeding the speed limit was apparently signalled by Senior Constable Wilson to stop. She was taken by surprise when she saw the police officer and braked heavily but was hit from behind by another vehicle also probably exceeding the speed limit. As a result, the first motorist lost control of her vehicle, which then struck Senior Constable Wilson as he tried to run out of its path.

DSC Dillon in Gosford conducted a mandatory inquest. The focus of that inquest was on the issues of the safety of police officers undertaking stationary speed law enforcement duties. This in turn raised questions concerning the identification and evaluation of the risks involved in this inherently dangerous activity, the capacity of police to control and minimise those risks, and the techniques used by the Police Force at the time of Sen Constable Wilson's accident and afterwards to minimise the risks. The inquest also considered whether the Police Force has addressed the questions of risk satisfactorily.

The inquest identified eight factors that contributed to the fatal accident: the vulnerability of police officers on foot beside high speed roads; the fact that the road was a freeway which, in effect, encourages high speed driving; excessive speeds by some motorists using the freeway; difficulties for motorists in interpreting signals used by Highway Patrol officers; motorists' surprise at presence of police of which they got no early warning; police operating from the median strip compounding the surprise factor; inadequacy of police training in assessing "human factors" or the tendency of motorists to make errors of judgment under pressure; and overconfidence in the Highway Patrol.

DSC Dillon concluded that, although the Police Force had considered the risks involved in speed law enforcement by officers on foot on high speed roads, it had failed to give adequate weight to the several risk factors that combined to cause the accident which resulted in this officer's death and that, because of the inadequacy of the assessment of the risks, a culture of over-confidence in their ability to avoid the risks had developed in the Highway Patrol.

Formal Finding:

That Peter Gordon Wilson died on 11 November 2006 at Gosford District Hospital of the effects of multiple injuries inflicted when he was hit by a motor vehicle on the F3 freeway near Somersby.

The following recommendations pursuant to s.22A of the Coroners Act:

To the Commissioner of Police

1. That the Commissioner has the current SOPs subjected to a full risk assessment by an independent expert or organisation.

2. That when the Police Force conducts its review of the current SOPs, it considers relevant and comparable international practice and gauge them in the light of *best* international practice.

3. That consideration be given to modifying the SOPs so as to prevent police from working on roadways unless protected by police vehicles or other stationary protective barriers placed in suitable positions by police.

4. For the purposes of this recommendation, a civilian vehicle temporarily stopped by police in a traffic lane is not considered a “stationary protective barrier” placed in a suitable position.

5. That consideration be given to the amendment of SOPs to make clear that as much warning as possible is to be provided by stopping police to targeted vehicles by using the warning lights on their police vehicles once a speeding vehicle is detected.

6. That the SOPs be amended to incorporate an *express* operating assumption that every time an officer attempts to stop an oncoming vehicle, he or she is exposed to a person who may deliberately, negligently or accidentally drive at them.

7. That all safety procedures referred to in the SOPs, including site assessment, escape routes, directions concerning walking on roadways, use of signals and so on, be based on the premise in Recommendation 5 and the exposure of officers to such drivers be reduced to the minimum necessary to conduct operations in accordance with that premise.

8. That consideration be given to eliminating traffic law enforcement operations by police on foot at multi-lane sites where the speed limit is 80 kph or greater and their replacement with other alternatives such as mobile speed cameras and vehicle-based lidars or other instruments.

9. That consideration be given to including within the Highway Patrol Education Program at Goulburn Police College, training dealing with the role of “human factors” in road accidents and in “danger experience” dealing with the police officer’s perception of particular dangers which arise in stationary speed enforcement operations.

10. That consideration be given to expanding the Highway Patrol annual radar assessment to include education of a practical nature reinforcing the importance of “human factors” in road accidents and traffic law enforcement operations to counter any tendency to over-confidence in “danger perception”.

11. That consideration be given to the creation within the Traffic Services Branch of a database recording information about sites used for stationary traffic law enforcement operations, including details such as incidents, accidents and “near-misses” at such sites.

12. That, if established, the database be used to review and increase the safety of police methodology, for improvement of training of Highway Patrol officers and for the dissemination of relevant information to Highway Patrols in NSW.

To The Minister for Roads

13. That the Roads and Traffic Authority consider locating fixed speed cameras on freeways and motorways and other high-speed roads in areas (such as the "flight-deck" at Somersby) identified by the Police Force as being used regularly by motorists travelling at dangerous speeds whether or not they are also identified as accident "black spots".

14. That the RTA place on its website detailed information, especially for inexperience drivers, about the potential hazards of approaching police traffic operations sites and the motorists' responsibilities when doing so.

4. 759/06 Mark Ian Hare

Inquest into the death of Mark Ian Hare on the 2 July 2006 at Belmont. Finding handed down by Deputy State Coroner Milovanovich on the 29 July 2009.

The death of Mark Ian Hare was reported to the Office of the New South Wales State Coroner (Magistrate Milovanovich, Deputy State Coroner) on the evening of the 2nd July 2006 following the death of Mr Hare earlier on the same day.

The death of Mark Ian Hare was identified by Police as falling within the provisions of Section 13A of the Coroners Act 1980, that being that Mr Hare had died in the course of a Police operation or died while in Police custody.

Mr Hare's death was also a reportable death under the provisions of the Coroners Act for other reasons, that being that (a) his death was sudden, unexpected, the cause of his death was unknown and a medical practitioner was prohibited from issuing a death certificate and (b) at the time of his death, Mr Hare was an involuntary patient having been scheduled under the Mental Health Act and having been subject to an order by a Magistrate under the provisions of the Mental Health Act.

New South Wales Police had identified that Mr Hare's death was a reportable death under Section 13A of the Coroners Act 1980 and invoked critical incident investigation protocols. The Coroner directed that the Police critical incident Investigator ensured preservation of the crime scene, the separation of the involved officers and the mandatory requirements for the testing of involved officers for alcohol or drugs be undertaken. In addition the Coroner directed that tests be undertaken in regard to whether capsicum spray had been used and that a video re-enactment be done with the involved officers. In addition the Coroner issued an order to Dr Nadesan, Forensic Pathologist, to undertake a post mortem examination and for the Police to prepare a brief of evidence for the Coroner.

THE ROLE OF THE CORONER.

As Mr Hare's death fell within the provisions of Section 13A of the Coroners Act 1980 an Inquest into the manner and cause of his death is mandatory.

The Coroner has a statutory obligation pursuant to Section 22 of the Coroners Act 1980 to examine the evidence and make findings as to the identity of the deceased, the date and place of death and the manner and cause of death.

The Coroner is also required, in appropriate cases, to examine the evidence to determine whether any known person or persons have committed an indictable offence in relation to the death of the deceased (Section 19 Coroners Act 1980). The Coroner also has the power under Section 22A of the Coroners Act 1980 to make recommendations. Any such recommendations are usually made on issues identified that may impact on public health or safety.

BACKGROUND AND ESTABLISHED FACTS.

Mark Ian Hare was born on the 27th October 1964 at the Salvation Army Hospital, Merewether in the State of New South Wales. His natural mother was Janice May Smith who was unmarried and Mr Douglas Allan Hare and his wife Norma Maureen Hare who passed away around 1986 subsequently adopted the child.

Mr Hare's adoptive father has provided a history of the deceased's formative years and up until he left home at the age of about 24 years in 1988. That history includes a reference to the deceased contracting measles and encephalitis at the age of 2 years, which may have resulted in some brain damage. Mr Hare describes his adoptive son as being "a little slow" as well as being a slow learner. Mr Hare also describes that the deceased left school at the age of 16 years and worked in various manual-labouring jobs. He also described Mark Hare as being a big man with a large build.

Mr Hare states that Mark Hare married not long after leaving home and that he fathered a daughter, Naomi. At the age of 26 years Mr Hare states that his adoptive son was diagnosed with schizophrenia and that he received treatment at Cairns and Townsville Hospitals. According to Mr Hare it was not long after his diagnosis that his marriage failed. Mr Hare also provides a history of further admissions, including a lengthy admission of 3 years at Townsville Hospital in relation to his mental health.

Mr Hare states that around 1998 his son returned to the Newcastle area and was employed in a number of labouring jobs and had a keen interest in his religion and was always involved in some form of church activity. Mr Hare outlines a history of further admissions at James Fletcher Hospital and a half way house at Wickham in the years around 2000. Mr Hare has also stated that his son moved into a house in Belmont around 2001 and that at about this time he took up a job as a taxi driver.

Mr Hare recalls that his son had a period of approximately 4 years when he appeared to living a normal life, however, believes that problems with his work resulted in a return of his depression and further admissions to James Fletcher Hospital. Mr Hare has described his son as being a quiet and non-aggressive man who would avoid confrontation.

Mr Hare found the actions of his son when first scheduled and his behaviour on the day of his death as being out of character.

Mrs Smith (Mark's natural mother) re-established contact with her son around 1999.

In her statement to Police Mrs Smith has indicated that she became aware of her son's mental health issues and was provided information from his adoptive parents. Mrs Smith's son Gavin, who was born in 1973, was also diagnosed with schizophrenia and he died as a result of a self-harm incident in 2001. Mrs Smith has stated that after 1999 she kept in regular contact with Mark Hare and was aware of his family situation, his work, his interest in religion and the fact that he had been admitted to hospital on a number of occasions due to mental illness.

On the 16th June 2006 Mr Hare came under Police notice as a result of information provided by the public. At about 4am on the 16th June Constables Pike and Chivas attended 26 Victoria Street, Belmont and observed Mr Hare in the driveway of those premises. At the time he was holding a knife and a small iron bar. After a short period of interaction with the Police, Mr Hare placed the knife and iron bar on the ground and was eventually taken into custody by the Police following the use of capsicum spray and a short struggle. The Police would have been entitled to charge Mr Hare with summary offences, however, it is apparent that they determined that his behaviour was unusual and that he may be suffering from a mental illness. To their credit they made the decision to transport Mr Hare to James Fletcher Hospital for admission and assessment under the provisions of the Mental Health Act.

On the 22nd June 2006 Janice Smith travelled to the Newcastle area with her brother Warwick Coles to visit his wife who was recovering from a medical procedure. Mrs Smith has stated that it was her intention to visit Mr Hare while in Newcastle. On or about the 26th June 2006 Mrs Smith attended Mr Hare's home at 23 Victoria Street, Belmont and could not locate him. She then made some enquiries and eventually ascertained that he had been admitted into James Fletcher Hospital. Mrs Smith visited Mr Hare on the following day in the company of her brother. She formed the opinion that he was not well. Mrs Smith asked her son if they could stay at his home and he agreed. On entering the home Mrs Smith observed that the home was not well kept and also noticed correspondence, which suggested that his rent was overdue.

On or about the 29th June 2006 Mrs Smith had a discussion with Dr Tan regarding her son's admission. She has stated that Dr Tan was not able to provide her with any detailed information due to privacy reasons. Mrs Smith made enquiries as to whether her son could be allowed to leave the hospital over the weekend in order that he could arrange to pay his outstanding rent and also attend church. The nursing notes confirm that this request was made and approved by the Hospital.

On Friday the 30th June 2006 Mr Hare was released from the hospital into the care of his mother. At the time of his release he was an involuntary patient and accordingly his release was classified as being "escorted leave". Permission was granted for Mr Hare to remain away from the hospital on Friday and Saturday evening on the proviso that he took his medication and that he would be returned by around 5.00pm on Sunday 2nd July 2006.

Mr Hare's movements over the weekend from Friday night (30th June) to Sunday 2nd July are known only to the extent of the evidence given by Mrs Smith, her brother Warwick Cole, Mr Gary Inwood and Mr David Hewing. According to the evidence of Mrs Smith on the day of his release (Friday 30th June) they arranged to pay his rent and then returned to his home where they had dinner, Mr Hare played his piano and retired to bed. On the following day, Saturday 1st July the evidence from Mrs Smith was that Mr Hare basically stayed around the house and tinkered with his motor vehicle in the company of a friend. There was no evidence that Mr Hare left the house during the day, however, Mrs Smith became aware that he had left the house sometime during the late evening and she observed him returning about 2.00am. It is apparent that Mr Hare attended a sausage sizzle, one which he had wanted to attend and had raised the issue with his mother earlier. Mr Inwood who was at the sausage sizzle has confirmed that Mr Hare did attend late in the evening. Mr Inwood stated that Mr Hare was non violent when he observed him.

On Sunday the 2nd July 2006 Mrs Smith and her brother left the house around 9.00am to visit the relative in hospital. Mrs Smith has stated that she was aware that her son Mark intended to go to church that morning and believed that arrangements had been made for him to be picked up. Mr David Hewing, a church member recalls seeing Mr Hare at church and provided him with a lift back to his home. Mr Hewing believes that he dropped Mr Hare off at about 11.45am. Very little is known of Mr Hare's movements after 11.45am, although Mrs Smith believes that a telephone call on her mobile around 1.15pm was probably Mr Hare ringing. She stated that his voice sounded muffled. Mrs Smith returned to her son's home and when she ascertained that he was not home she rang James Fletcher to see if he had returned. He had not. Some short time later Police arrived at Mr Hare's home and informed Mrs Smith that her son had been arrested and that he had passed away.

The events that took place between approximately 3.30pm and 5.00pm are well documented in the brief of evidence and require only a brief summary.

It is known that Mr Hare was driving his motor vehicle at around 3.30pm and was seen by Mrs Berzins walking in traffic and attempting to enter a stopped 4 Wheel Drive vehicle driven by Maryann Gale. He is then seen to drive off in his vehicle. At about 3.50pm Mr Hare enters Kerry's Takeaway and attempts to enter behind the counter. An altercation takes place during which Mr Berzins is pushed and Mrs Berzins is punched in the chest. Mr Hare is described at this time as being uncommunicative.

At this time, Mr Johnson and Mr Rudd, both Firemen, attempt to intervene and a short struggle takes place during which Mr Hare struggles free and gets into his vehicle and drives away.

A short time later a further altercation takes place at the Newcastle 4 Wheel Drive Centre at Belmont between Mr Hare, Mr Sorrenson (a customer) and Mr Raymond an employee at the Car Yard. During this altercation Mr Hare is again described as being uncommunicative and uncoordinated and some pushing and shoving takes place before Mr Hare is physically taken off the premises and was being escorted away from the premises. It is at about this time that Sen Constable Chafey and Constable Liston observe Mr Hare walking along the Pacific Highway with Mr Raymond a short distance behind him. The two Police Officers respond to the scene and approach Mr Hare and he states, "Nothing is wrong". The two officers having been informed of earlier events make the decision to take Mr Hare into Police custody and attempt to restrain him and move him away from a plate glass window, which was considered as posing a danger. Mr Hare is described by the Police Officers and Mr Raymond as struggling against the Police efforts to restrain him. Eventually the Police are able to manoeuvre Mr Hare into a prone position with a view of securing his arms and handcuffing him.

Police called for back up and at 4.04pm Constable Newton arrived at the scene. The evidence would suggest that at about the time of the arrival of Constable Newton, Officers Chafey and Liston had been able to handcuff Mr Hare, with the assistance of Mr Raymond, in the prone position. It is at about this time, that all Police present observed Mr Hare's colour to change and he was immediately un-cuffed and placed in the recovery position. CPR was commenced immediately by Constable Newton using a Laerdel mask and shortly thereafter Constable Pike arrived at the scene and CPR continued on rotation between Officers Chafey, Newton, Pike and Liston until the arrival of the ambulance at 4.21pm. Upon Ambulance arrival CPR was continued and eventually Mr Hare was transported to Belmont Hospital with CPR continuing on route. He was pronounced life extinct at Belmont Hospital.

CORONERS SUMMARY AND FINDINGS.

This Inquest had identified a number of issues that impact on the Coroners responsibility in regard to making findings as to manner and cause of death and also in regard to the discretion a Coroner has to make recommendations pursuant to Section 22A of the Coroners Act 1980.

The identified relevant issues are as follows;

The cause of death.

Police training and protocols in regard to restraint and or positional asphyxiation.

Issues of Privacy and disclosure to prospective Carers.

Policies associated with the granting of escorted leave.

Recommendations.

I will deal with each matter in turn.

Cause of Death.

The Post Mortem examination of Mr Hare was conducted by Dr Kevin Lee, Senior Specialist, Forensic Pathologist at the Department of Forensic Medicine at Newcastle. Dr Lee in his final post mortem report (Exhibit 1) expressed the view that his examination of Mr Hare, together with the known circumstances surrounding his death, showed features of excited delirium. Dr Lee further states that such a finding is a complex field in which there is acute behavioural disturbance on the part of the person involved, and where they appear to be paranoid, psychotic and agitated, often fleeing from imaginary threats. He further stated that factors that increase the chances of sudden death include fear, panic and aggression, each of which will tend to increase the overall stress level. He further stated that exhaustion; exertion and restraint are also likely to increase the chances of death occurring.

Dr Lee also stated that in cases of death due to excited delirium, the individuals involved are restrained, and shortly after being restrained, or whilst being taken into custody, will cease being agitated and suddenly become quiet and that death occurs shortly afterwards. Dr Lee expressed the view that the cause of Mr Hare's death was directly caused by excited delirium and that the other significant condition contributing to death was due to obesity.

A finding that a person has died from Excited Delirium is a finding of exclusion, in other words, if the facts and circumstances support this finding and in the absence of other factors that may have caused death, the finding may be appropriate. There is also no doubt that amongst the forensic medical fraternity, the finding is viewed with some caution, notwithstanding that a number of studies and texts (predominately in the United States) support it as a primary cause of death. For those reasons it was considered appropriate that the facts associated with Mr Hare's medical history, his admissions and the circumstances surrounding his death be reviewed in conjunction with the post mortem findings. Accordingly the Coroner requested that Dr Timothy Lyons, Senior Forensic Specialist at the Department of Forensic Medicine, Newcastle undertake a thorough review of the post mortem findings. Dr Lyons has given evidence at this Inquest.

By way of summary Doctor Lyons is of the view that the primary cause of death was due to a cardiac arrhythmia. Doctor Lyons explained the mechanism of death and how a cardiac arrhythmia occurs when electrical impulses from the brain cause the heart to beat in an irregular pattern and may cause it to stop beating. Doctor Lyons was of the view that a number of factors, either individually or in conjunction with each other, most probably caused the cardiac arrhythmia.

Those factors included Mr Hare's medical diagnosis of schizophrenia, his obesity, mild coronary heart disease and that he had exerted himself and was under restraint at the time of the arrhythmia. It is not possible for this Court to determine which of the possible factors (individually or on conjunction) caused the arrhythmia, however, death as a result of a cardiac arrhythmia is more probable than death due to Excited Delirium. I propose to return a finding that Mr Hare died as a result of a Cardiac Arrhythmia.

Police Restraint, Protocols and Training.

At the outset is should be said, that this Court finds no grounds to be critical of the Police Officers involved in their attempt to restrain and handcuff Mr Hare. It is clear that a large man, who appeared aggressive, confronted the Police and they had little knowledge of his past medical or mental illnesses. Counsel for Mr Hare's mother in his written submission has stated "it is difficult to envisage what they (the Police) could have done differently to control the dangerous and immediate situation". I agree with these comments.

It is apparent from the evidence that the Police considered it a priority, particularly in view of the location, to restrain Mr Hare after he exhibited signs of aggression. Police are trained to make an effort to get an aggressive person to the ground for two reasons, control and self-preservation. It is the accepted and appropriate manner in which a person can be de-mobilized and secured. The evidence would suggest that Officers Chafey and Liston managed to get Mr Hare to the ground fairly quickly, however, due to his size and struggle it became difficult for him to be handcuffed and he was resisting those attempts. There is no doubt from the evidence that it was during this period and very shortly after Mr Hare was handcuffed that the first signs of him not being well were observed. The Police moved quickly to remove the handcuffs and put him into the recovery position and commence CPR. The assistance of Mr Raymond was an appropriate attempt by a member of the public to assist Police overwhelmed by Mr Hare's size and strength.

I do not propose to make any formal recommendations in regard to the Police action, as I do not believe it is required. I do, however, request that Counsel appearing for the Police report the findings of the Coroner and the circumstances of Mr Hare's death to the Commissioner of Police. In so doing it may be prudent to re-enforce what the Coroner said in his findings into the death of Richard Thomas (Ref 1058/2003) and also re-enforce existing training material that highlights the dangers of positional asphyxiation, particularly in persons affected by alcohol or drugs, following exertion, persons who are obese and persons who are placed in the prone position following restraint and struggle.

Issues of Privacy and Disclosure to prospective Carers.

At the time of Mr Hare's admission the relevant privacy legislation was as outlined in Section 289 of the Mental Health Act 1990. That section states;

A person must not disclose any information obtained in connection with the administration or execution of this Act or the regulations unless the disclosure is made:

With the consent of the person from whom the information was obtained, or
In connection with the administration or execution of this Act, or
For the purposes of any legal proceedings arising out of this Act or the regulations or of any report of any such proceedings, or
In accordance with a requirement imposed under the Ombudsman Act 1974, or
With other lawful excuse.

My interpretation of the legislation in force at the time is consistent with the submission put to this Court by Mr Beckett, Counsel for the family and in particular as set out in Paragraphs 20 and 21 of the written submission:

"Where a person has been detained under the Mental Health Act 1990 they were subject to the leave provisions of the Act. Section 71 allowed the medical superintendent to grant leave. The disclosure of information obtained in connection with the administration of the Act by Dr Tan with respect to Mr Hare's admission to hospital fell clearly within the exception at s.289(b) because it concerned the granting of leave and the arrangement of care by a carer while he was on that leave.

The NSW Health Privacy Manual (Ex 20) which covered the relevant period of time also provides a clear basis for disclosure against consent where "disclosing information to another person or organisation involved in the ongoing care of the client/patient" at [11.2.1.1] p 28 dot point 2. Mr Hare was being cared for by Mrs Smith while he was on weekend leave from the hospital."

I believe, should there be any disagreement on this issue, that a broad interpretation should be given to Section 289(b) of the Mental Health Act 1990. It is impossible to envisage how the words "in connection with the administration or execution of this Act" could not be interpreted as placing an obligation to disclose relevant information to a proposed Carer. In addition, we should not lose sight of the fact that at the relevant time, Mr Hare was subject to a Magistrates Order under the provisions of the Act to remain in hospital for care and treatment.

Mrs Smith was entitled to know the circumstances surrounding her son's admission and in particular whether those circumstances may have impacted on her decision to volunteer as a carer.

In addition, had she been aware of Mr Hare's behaviour at the time he was taken into Police custody, it may have made her more acutely aware of her obligations to keep Mr Hare under observation and ensure his compliance with medication.

In the event that it needs to be said, Area Health Services have an obligation to disclose relevant information to prospective Carers.

Policies Associated with Granting Escorted Leave.

This Inquest has identified that the procedures and practices in regard to granting escorted leave may firstly not have complied with hospital protocols and secondly should be the subject of some form of review in order to put place uniform systems in all Area Health Services.

I concur in the submissions made by Mr Beckett for the family, that Dr Tan should have consulted her supervising or Consultant Psychiatrist on the issue of granting leave.

It would appear confirmed from the evidence of Dr Newnham that the policy now at James Fletcher Hospital is to seek approval from the supervising Psychiatrist before granting leave.

The Inquest has also identified that it may be prudent to have a system in place, uniformly across the State of New South Wales, of protocols and documentation in regard to granting escorted leave. While in Mr Hare's case his release on escorted leave was during a period that he was an involuntary patient, there are many parallels and similar considerations that apply to discharge.

My experience as a Coroner suggests that the period immediately after discharge or release on leave is a critical period. Sadly, too many cases come to the attention of Coroners where patients die, often due to self-harm, in that critical period. The death of Culum John Nugent (File No. 1004/2006) following his discharge from Banksia House, Tamworth, resulted in the New England & Hunter Area Health Service introducing a Northern Action Plan. In short that plan was designed to ensure that there was effective communication between the relevant agencies and family in regard to discharge. That Action Plan post dated the death of Mr Hare, however, the Court has been told that it has only been implemented at Banksia House and not other Mental Health facilities in the Area Health Service area of responsibility.

I would like to see a consistent and uniform approach across the State of New South Wales on this issue of leave and or discharge. The period after release on leave or discharge is a period when the patient may be most at risk. I support the submissions made by Mr Beckett, Counsel for the family, that an appropriate form of checklist should be put in place.

Such a checklist should be prepared and a copy given to the carer (whether release is on escorted leave or discharge). The checklist should include vital information such as;

Amount of medication to be taken and frequency.

The necessity to monitor and ensure that medication is actually taken.
Highlight the possible risks and the need to ensure that medication previously dispensed is not accessible as it may compromise the current medication regime.

That Carers (particularly with escorted leave) understand and acknowledge their obligations in regard to supervising the patient. It should include a signed declaration that the Carer will be responsible for the supervision of the patient's medication.

Contact telephone numbers in the case of an emergency, eg Police, Community Mental Health Team etc. and advice to Carer's to bring the patient back to the hospital if behaviour changes significantly.

Date and time when patient must be returned (escorted leave).

Copy of the checklist to be signed by the Carer and original placed on the patient's medical file.

I propose to make a formal recommendation on the above issue to the Minister for Health. I do not propose to make a formal recommendation on the issues associated with Privacy and disclosure. My reasons being, that I believe the current legislation and its proper interpretation should result in disclosure in appropriate circumstances. I note section 189(1)(c) of the Mental Health Act 2007 creates an exemption for the offence of disclosing information under the Act where that information is provided to a Carer.

There is merit, however, in drawing to the attention of the Director General of Health that guidelines may need to be considered and sent to all Area Health Services on the issue of Privacy. The Registrar to the State Coroner forwarding a copy of the Coroners findings to the Director General can achieve this.

RECOMMENDATION.

1. **To the Minister for Health.**

That consideration be given to implementing on a State wide basis an appropriate protocol that deals with issues associated with the release of a Mental Health patient on escorted leave or the discharge of a Mental Health Patient.

Such protocols should also consider the formulation of documentation by way of a checklist, which should be signed and provided to prospective Carers.

A proposed checklist should include, but not be limited to, the matters identified by the Coroner and referred to in the submissions by Counsel for the family.

The Minister may consider that the discharge procedures as set out in the Hunter and New England Area Health Service's Northern Action Plan (currently applying only to Banksia House, Tamworth) be considered as a template in the formulation of a State Wide policy.

FORMAL FINDINGS.

That Mark Ian HARE died on the 2nd July 2006 at Belmont Hospital in the State of New South Wales from a Cardiac Arrhythmia which he sustained earlier on the same date at Belmont in the State of New South Wales, while lawfully in Police custody.

5. 1782/07 Desmond Walmsley

Inquest into the death of Desmond Walmsley between the 27th and 28 September 2007 at Long Bay Gaol. Finding handed down by Deputy State Coroner MacMahon on the 21 August 2009

Background:

Desmond Gielen Walmsley (Born 11/01/1975) in September 2007 was a thirty two year old man on remand at the Long Bay Correctional Centre. He had been charged with the murder of his former girlfriend on 24 May 2007. He had also attempted to take his own life but due to the intervention of police had not been successful. Prior to 24 May 2007 Mr Walmsley had no history of prior incarceration or adverse contact with police. He also had a stable employment history.

Following his arrest he was admitted to the Liverpool Hospital for treatment and remained there until 8 June 2007. He was then transferred to the Long Bay Hospital where he remained until 3 July 2007.

On discharge form the Long Bay Hospital Mr Walmsley was considered to be a high risk of self-harm. Because of this he was admitted to the Acute Crisis Management Unit (ACMU), a part of the Metropolitan Special Programs Centre (MSPC) at Long Bay Correctional Centre. The ACMU provides specialised safe and humane crisis intervention, coordinated case management, and progression planning for inmates at risk of self-harm and /or suicidal behaviour.

On 17 September 2007 Mr Walmsley was discharged from the ACMU and transferred to MSPC 9 Wing, a part of the mainstream prison. At the time discharge from the ACMU Mr Walmsley denied having any thoughts of suicide or self-harm and had not displayed any behaviour whilst in the ACMU that suggested he was an acute risk. He was, however, assessed as being a high chronic risk of self-harm.

On his transfer to 9 Wing Mr Walmsley shared a cell with David Valiukas, an inmate whom he had met and become friends with in the ACMU. Mr Walmsley had requested that he share a cell with Mr Valiukas and Mr Valiukas and the prison authorities had agreed to.

On 27 September 2007 Mr Walmsley and Mr Valiukas were locked in their cell about 3.30pm. That evening they were watching the *'Footy Show'* during which Mr Valiukas fell asleep. Early the next morning Mr Valiukas woke to go to the toilet and found Mr Walmsley hanging from bars that formed part of the window. Mr Valiukas called for assistance from prison staff however Mr Walmsley was found to be deceased.

Function of the Coroner:

The role and function of a Coroner is found in Section 22, Coroners Act 1980. That section, in summary, provides that at the conclusion of an Inquest the Coroner is required to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

Section 22A provides that a Coroner conducting an inquest may make such recommendations as he or she considers necessary or desirable in relation to any matter connected with the death with which the Inquest is concerned. The making of recommendations is discretionary and relates usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way the coronial proceedings can be forward looking, aiming to prevent future deaths. It is not the role of the Coroner to attribute blame.

Mr Walmsley was a person who died whilst in custody. He had been in custody since his arrest on 24 May 2007. Section 13A provides that where that occurs it is mandatory for an inquest to be conducted by either the State Coroner or a Deputy State Coroner. At such an inquest the Coroner is, in general terms, in addition to the matters set out in Section 22 also required to be satisfied that the circumstances of Mr Walmsley's incarceration did not cause, or materially contribute, to his death.

Date, Place, Manner and Cause of Death

The date and place and manner and cause of Mr Walmsley's death were not in issue at the inquest. The circumstances in which Mr Walmsley was found and the post-mortem examination conducted by Dr Botterill established that the direct cause of his death was hanging.

Mr Valiukas, Mr Walmsley's cellmate, made a statement to police and gave evidence at the Inquest. His evidence was that during the time that they shared a cell Mr Walmsley did not indicate to him that he had any intention to harm himself and that on the evening of 27 September 2007 everything appeared to be normal. He said that they were watching the *Footy Show* on television and he fell asleep before the end of the show. It was when he woke about 2am to go the toilet he found Mr Walmsley. Mr Valiukas denied assisting Mr Walmsley to hang himself and denied knowing of his intention to do so.

Detective Constable David McAvoy, the officer in charge of the investigation into the death of Mr Walmsley, gave evidence as to the manner in which Mr Walmsley was hung and was of the opinion that Mr Walmsley would have had little difficulty in doing so without assistance. I accept the evidence of D/S McAvoy and that of Mr Valiukas. I am comfortably satisfied that Mr Walmsley took his own life and that he had no third party assistance in doing so.

I am satisfied that Mr Walmsley died at the Long Bay Correctional Centre between 11pm on 27 September 2007 and 2am on 28 September 2007. I am also satisfied that the cause of his death was hanging and the manner of his death was suicide.

Issues for Inquest

The death of a person due to suicide is always a tragedy. Where the person is incarcerated and has been assessed as being a chronic suicide risk, as Mr Walmsley was, it is necessary that the circumstances of the death be examined to ensure that appropriate steps were taken by the relevant authorities to ensure that the recognised risk of self-harm was mitigated. In respect of Mr Walmsley the matters that were the subject of examination were:

1. The existence of an obvious hanging point in a cell in which a person recognised as being at risk of self-harm was placed,
2. The psychological and other support services provided to Mr Walmsley following his discharge from the ACMU into the general prison population,
3. The response of Department of Corrective Services (DCS) officers to concerns for Mr Walmsley's well being communicated to them by members of his family, and
4. The preservation of relevant evidence.

Hanging Point:

On discharge from the ACMU it was recognised that Mr Walmsley was a person who was to be considered a person with a high risk of self-harm. The discharge summary from the ACMU prepared by Kirk Stenhouse, the acting Therapeutic Manager of the Unit, makes this clear when it records that:

> *'Mr Walmsley is considered a high risk of self harm due to the following factors:*
>
> - *Recent serious attempt to kill himself.*
> - *Charged with capital crime of murdering his partner.*
> - *History of recent suicidal ideation.*
> - *Recent incarceration, on remand, and first time in custody.*
> - *Few social supports in community and custody.*
>
> *Although Mr Walmsley denies current plans or intentions of ending his life his acute risk is likely to increase around time of court as the full emotional impact of his current circumstances bears down on him. His acute risk may also increase if his cousin withdraws his support or if he has association problems.'*

Mr Walmsley was transferred to 9 Wing following his discharge from the ACMU. This was a considered decision to which I will return later. On his transfer to 9 Wing he was placed in a cell with an obvious hanging point. It appears that no consideration was given to the physical suitability of the cell for a person who was recognised as being a high chronic risk of self-harm and who, with change of circumstances, could become an acute risk. The ready availability of the means to take his life was thus a contributing factor to Mr Walmsley's death.

Mr Stenhouse gave evidence as to the options available for Mr Walmsley on his discharge from the ACMU. He was of the opinion that 9Wing was the best option available. He said that on discharge from the intensity of the ACMU a stepped approach to the integration of an inmate into the general prison population was preferable and that with the closure of the Kevin Waller Unit, which had served this purpose, 9 Wing had become a defacto alternative. There was no evidence before me as to the availability of obvious hanging points in the Kevin Waller Unit however it would seem that if 9 Wing is to serve as an alternative for a step down unit then an audit of 9 Wing should be undertaken in order to ensure that it is safe for the purpose for which it is being used. I propose to make a recommendation in accordance with Section 22A in respect of this matter.

Psychology Support Services:

Mr Walmsley was held in the ACMU in accordance with the DCS protocol *"RIT Protocol for the Management of Inmates 'At Risk' of Self-Harm or Suicide"*. This protocol is commonly referred to as a RIT.

The protocol requires that the actions of DCS officers be focused towards the development of a management plan for the care of inmates at risk.

DCS recognises that suicide and self-harm prevention is the responsibility and obligation of all DCS staff as part of their duty of care.

On Mr Walmsley's discharge from the ACMU and the release from the RIT the management plan developed included a number of specific recommendations. Those recommendations were that he was:

1. *"To be managed in shared cell accommodation with a specified inmate,*
2. *To be seen regularly by Justice Health and psychology staff to monitor his mental state, particularly on arrival and around court appearances, and*
3. *To be provided with access to educational resources."*

Mr Walmsley entered 9 Wing on 17 September 2007 and died some ten days later. In the time he was housed in 9 Wing he was located in a shared cell but in that time he did not receive a psychological assessment by DCS staff. In addition the only evidence of contact with Justice Health appeared to be the provision of prescribed medication. It would be anticipated that the early period of transition from the intense supervision of the ACMU to the mainstream prison would be likely to be the time of greatest need for an inmate who is at risk of self-harm and as such Mr Walmsley ought to have been reviewed during that time.

The evidence available at inquest indicates that by the weekend of 22-23 September 2007, and most likely before then, Mr Walmsley had developed a specific intention to take his life. His conversations with his cousin and his sisters' partner that weekend were such that they became sufficiently concerned about his intentions to contact the Gaol. In addition the diary that he had been keeping, which became available after his death, showed that he had been struggling to deal with the fact that he had killed his girlfriend and believed that his death was necessary 'to restore the balance'. An assessment by a psychologist during this period may have identified factors that suggested Mr Walmsley risk of self harm had moved from being at a chronic to acute and allowed the reactivation of the Department's RIT procedure. Unfortunately such an assessment did not take place.

Mr Stenhouse was the manager responsible for the provision of psychological services to inmates in 9 Wing, the ACMU, the Kevin Waller Unit and a number of other Wings within the Gaol. When asked why Mr Walmsley had not been assessed during the period he explained that at the time there were six psychologist positions to undertake the work in the areas that he was responsible for and that at the time only two of those positions were filled. He stated that he had intended to make contact with Mr Walmsley himself following his discharge from the ACMU but due to the enormous workload that had fallen to himself and the other psychologist he did not have the opportunity to do so.

The fact that Mr Walmsley was not assessed in the period following his discharge from the ACMU thus appears to have resulted from the Department's failure to adequately staff the psychologist positions it had considered were appropriate. It will never be known whether an assessment would have identified the change in Mr Walmsley's risk status however having identified Mr Walmsley to be a person at-risk the Department had the responsibility and obligation to take all reasonable action necessary to mitigate that risk. In Mr Walmsley's case this did not occurred. This failure may have been a factor that contributed to Mr Walmsley's death occurring when it did.

On 6 June 2009 the State Coroner, Magistrate Jerram, in her findings following the Inquest into the death of Adam Shipley, recommended:

> *"That the Department of Corrective Services review the systems and protocols in place for inmates known to be at-risk, to determine whether these presently provide a coordinated and pro-active management plan for such inmates (including involving Correctional Officers and mental health professionals) particularly following a release or discharge from a RIT protocol."*

This recommendation appears to apply equally in the case of Mr Walmsley. I propose to make similar recommendations in this case.

DOC's Response to Family Concerns for Welfare:

Eric Houmate was Mr Walmsley's cousin and had provided him with support following his incarceration. They were in regular contact by phone and through Mr Houmate's visits to Long Bay. Mr Walmsley had told Mr Houmate as early as 8 September 2007 that he wanted to kill himself and asked him to obtain cyanide tablets for him. Mr Houmate refused and Mr Walmsley became angry and aggressive towards him. Mr Houmate did not tell anyone about Mr Walmsley's request because he was asked not to.

On Saturday 22 September 2007 Mr Houmate visited Mr Walmsley. He was once again asked for the cyanide tablet. Mr Houmate told him that he was not going to get the tablets and Mr Walmsley became angry. He then yelled at Mr Houmate "I'm going to hang myself."

On Sunday 23 September 2007 Lee Williams, a friend of Mr Walmsley and partner to Mr Walmsley's sister Ana Walmsley, also visited Mr Walmsley. During the course of their conversation Mr Walmsley indicated that he was ashamed of his actions and believed that the only way he could restore his honour was to die. He also mentioned that another person in the Gaol had committed suicide by hanging. Mr Williams formed the view that Mr Walmsley was seriously considering committing suicide by that method.

After returning from his visit Mr Williams and Mr Houmate discussed their fears. Following their discussion it was agreed Mr Houmate would inform DCS of their fears. Mr Houmate did so that afternoon. This information resulted in a DCS officer and a Justice Health nurse interviewing Mr Walmsley that evening. The progress note recorded by the Justice Health nurse is as follows:

> *"Informed by officers this PM that pts. Relative who visited on 22/9/07 had contacted them this PM to inform them that they believed pt was @ risk of 'committing suicide.' Both officers and myself interviewed pt. Re same who denied any intention of self-harm and guaranteed safety pt was responsive and co-operative and is in two out cell placement. Nil changes to current placement were decided."*

I am satisfied that the DCS response to this call was both timely and appropriate.

Mr Houmate remained concerned and contacted the Gaol again on Monday 24 September 2007. Being unable to speak to an officer he left a message on voicemail about his concerns for Mr Walmsley's welfare. Manuel Rodigues, a welfare officer, received this message on 25 September 2007 and referred the concern to Donna Brotherton, another welfare officer. Ms Brotherton decided to interview Mr Walmsley.

Ms Brotherton's notes as to her actions are as follows:

> *" Welfare: Welfare Officer Manuel Rodiguez received a phone call from Eric Houmate, Desmond Walmsley's cousin yesterday afternoon 24/9/07Mr Houmate had apparently visited Desmond on Sunday 23/9/07 and phoned welfare to express his concerns about Desmond's mental state, depression and possible risk of self harm.*
> *Inmate seen in 9 Wing area as there was a lock-in this afternoon. Made eye contact, denied any risk of self-harm. Became a little frustrated and angry when I said his cousin was concerned for him – saying 'don't listen to him, I'm Okay' Desmond said that custodial staff had also checked on him on Sunday evening and that he had been trying to make contact with his cousin as he wasn't happy with him.*
>
> *Said he now has his sister here for support. Has court coming up? 3rd occasion. I advised Desmond re referral process to welfare and OSP services. He is 2-out. Will f'up again this week."*

Following speaking to Mr Walmsley Ms Brotherton contacted Mr Houmate. She recorded her conversation as follows:

> *Contacted Mr Houmate at 3.15pm 25/9/07. Advised that I had seen Desmond and that he appeared Okay. Eric conformed that he had been contacted by another friend of Desmonds who had also visited over the weekend and was concerned about Desmonds mental state. Eric confirmed that he made contact with custodial staff on Sunday afternoon. Discussed same and encouraged Eric to make contact with staff if he had any further concerns"*

Ms Brotherton gave evidence at the Inquest. She stated that when she was informed of the concern for Mr Walmsley's welfare she acted on it. During her interview with Mr Walmsley she looked for any signs that would suggest he was suicidal. She did not identify any such signs. She asserted that she was qualified to undertake such a risk assessment and that it was part of her duties as a welfare officer to do so. She indicated that she was familiar with the RIT Protocol of the Department and believed that in dealing with Mr Walmsley she had followed that protocol. She stated that she had invoked the RIT protocol in the past and that had she believed Mr Walmsley was at acute risk of self-harm she would have invoked it in his case.

Ms Brotherton also gave evidence that the next day she had the opportunity to talk with Mr Walmsley's cellmate Mr Valiukas and asked after his wellbeing. She received a positive response and this reassured her as to her assessment of Mr Walmsley from the day before.

Ms Brotherton was an impressive witness who appeared to take her duties seriously. I accept that as a welfare officer she was qualified to make an assessment of risk of self-harm and that having interviewed Mr Walmsley she formed the opinion that his level of risk was not acute. I accept that her assessment was appropriate having regard to the information she had available at the time she interviewed Mr Walmsley. Ms Brotherton acknowledged that at the time of the interview she had not read the discharge summary from the ACMU and as such she did not take into consideration the information contained therein in forming her views. It is hard to know whether or not, had she been aware of that information, she would have come to a different conclusion. On balance, however, it seems unlikely as at the time of her interview she was dealing with the situation that existed at the time. As such I doubt that it would have made any difference to her decision.

It would seem that Mr Houmate did not tell Mr Williams of his conversation with Ms Brotherton. Mr Williams had expected the welfare officer to phone him. As this had not occurred by Thursday 27 September 2007 he phoned Ms Brotherton from work during the course of the day. She did not answer her phone so he left a message on her voicemail.
Mr Williams' memory of the message he left was that he reiterated what he had asked Mr Houmate to tell her about Desmond. He also remembered telling her that Desmond was "100% adamant about killing himself, and that at the first opportunity he would try." Mr Williams gave evidence at the Inquest and had no doubt that the message he had left indicated that Mr Walmsley had the intention to kill himself and had a plan for doing so.

Ms Brotherton received the message from Mr Williams at about 4pm that day. Her recollection of the receipt and content of the message was recorded in her note made 28 September 2007. That report was as follows:

> *"On Thursday afternoon 27th September 2007 a message was left on my answering machine at approximately 12.58pm from an unknown person who failed to disclose his name or full contact details, perhaps due to the answering machine cutting out through the conversation.*

This call was not retrieved until approximately 4pm as I was attending to duties in the Kevin Waller Unit. The caller did not call back.
The caller made reference to Eric Houmate and re-iterated concerns of Mr Walmsley's self harm ideation. At no point during the message did the caller state that Mr Walmsley had a plan, which he was going to follow through with in the immediate future.
Due to the nature of the call and the advice to Mr Walmsley that I would see him at the end of the week to follow up his progress, I had anticipated seeing him today"

Ms Brotherton's response to the message that was left by Mr Williams was to follow up Mr Walmsley the next day. She did not consider that the message provided any additional information to that which Mr Houmate had already provided to her. She specifically denied that there was any information that suggested Mr Walmsley had an immediate intention or plan for taking his life. Ms Brotherton accepted that that information was important and that had she received such information she would have interviewed Mr Walmsley again and would have probably invoked the RIT protocol.

The evidence of Ms Brotherton and Mr Williams on this point cannot stand together. One of them must be mistaken. The difference could have been resolved by reference to the voicemail message. This was not available for reason to which I will return. Both Ms Brotherton and Mr Williams were impressive witnesses and I accept that each was endeavouring to assist the Inquest to the best of their ability. Were Ms Brotherton's recollection to be correct I am satisfied that her response would have been appropriate however, as Ms Brotherton acknowledged, if Mr Williams recollection were correct that would not be the case. On the evidence available however, because of the unavailability of the voicemail recording I am unable to determine who is mistaken and consequentially I am unable to determine whether or not Ms Brotherton's response to Mr Williams message on 27 September 2007 was appropriate.

Preservation of Relevant Evidence:

The message left on Ms Brotherton's voicemail was obviously relevant and important in the investigation of Mr Walmsley's death. Ms Brotherton recognised this and archived the message expecting that DCS staff investigating Mr Walmsley's death would request it. They did not.

Mr Williams also knew that the message was important. When identifying Mr Walmsley to Detective McAvoy at the Department of Forensic Medicine at Glebe he asked Detective McAvoy to ensure that it was preserved. Unfortunately Detective McAvoy was delayed in trying to retrieve the message and when he did try it had been automatically deleted from the system. Detective McAvoy when giving evidence explained that he was unable to attend to the matter due to other pressing duties.

This is a most unsatisfactory situation. The importance of the conversation was obvious. It should have been retrieved and preserved as a matter of course. I propose to make recommendations to both the Commissioner of Corrective Services and the Commissioner of Police that the relevant policies and procedures for investigating deaths in custody be reviewed to ensure that relevant physical evidence be immediately preserved so that it is available when required at Inquest.

Formal Findings:

Desmond Gielen Walmsley died on or about 28 September 2007 at the Long Bay Correctional Centre. The cause of his death was hanging and the manner of his death was suicide.

Section 22A Recommendations:

To the Commissioner for Corrective Services

1. That cells occupied by inmates identified as being at risk of self-harm or suicide be audited for obvious hanging points before occupation and where such hanging points are identified they be eliminated.
2. That a review of the systems and protocols of the Department of Corrective Services be undertaken to ensure that they provide for a coordinated and pro-active management plan for inmates identified as being at risk of self-harm or suicide particularly following the release or discharge of such inmates from a RIT Protocol.
3. That a review of the policies of the Department of Corrective services be undertaken to ensure that such policies require the preservation of all relevant physical evidence relating to the death of all inmates in NSW Correctional facilities.

To the Commissioner of Police

1. That the policies of the NSW Police Force be reviewed so as to emphasise that the investigation of the death of a person in the custody of the NSW Department of Corrective Services be sufficiently resourced so as to ensure that all relevant physical evidence is obtained and preserved in a timely manner.

6. 2172/07 Manoa Tupou

Inquest in to the death of Manoa Tupou on the 28 November 2007 at Silverwater Gaol. Finding handed down by Deputy State Coroner MacMahon on the 4 September 2009.

Background:

Manoa Tupou (Born 25/05/1981) was, in November 2007, a twenty six year old man on remand at the Metropolitan Remand and Reception Centre (MRRC) at Silverwater. Mr Tupou had been arrested on 24 November 2007 at Mt Druitt for the offences of Common Assault and Stalk/Intimidate Offences.

Correctional staff identified Mr Tupou as being at risk of self-harm or suicide. He was consequently placed in a *"safe cell"* that was supposed to be camera monitored by correctional staff. At 10.50pm on 28 November 2007 he was located hanging from the light fixture in his cell when staff were conducting rounds of each cell.

Ambulance officers were contacted and Mr Tupou was found to be deceased. An autopsy subsequently conducted by forensic pathologist Dr Szentimary found that the cause of Mr Tupou's death was due to hanging.

Function of the Coroner:

The role and function of a Coroner is found in Section 22, Coroners Act 1980. That section, in summary, provides that at the conclusion of an Inquest the Coroner is required to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

Section 22A provides that a Coroner conducting an inquest may make such recommendations as he or she considers necessary or desirable in relation to any matter connected with the death with which the Inquest is concerned. The making of recommendations is discretionary and relates usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way the coronial proceedings can be forward looking, aiming to prevent future deaths. It is not the role of the Coroner to attribute blame.

Mr Tupou was a person who died whilst in custody. He had been in custody since his arrest on 24 November 2007. Section 13A provides that where that occurs it is mandatory for an inquest to be conducted by either the State Coroner or a Deputy State Coroner. At such an inquest the Coroner is, in general terms, in addition to the matters set out in Section 22 also required to examine whether or not the circumstances of Mr Tupou's incarceration caused, or materially contributed to, his death.

Date, Place, Manner and Cause of Death:

The date and place and manner and cause of Mr Tupou's death were not in issue at the Inquest. The evidence tendered establishes to my satisfaction that Mr Tupou died on 28 November 2007 at the Silverwater Correctional Centre. I am also satisfied that the cause of Mr Tupou's death was hanging and that Mr Tupou took his own life.

I am further satisfied that there is no evidence to suggest that Mr Tupou was assisted by a third party in his actions.

Issues for Inquest:

At the time Mr Tupou was taken into custody he was identified as being at risk of self-harm. Where, less than four days later, he commits suicide, the question that must be answered is whether or not the Department of Corrective Services (DCS) fulfilled its responsibilities towards him. The answer in this case must be in the negative.

Mr Tupou came into DCS custody on 24 November 2007. He was interviewed for placement and assessed as being at risk and a mandatory notification form was activated. He was placed on 15-minute observations in a camera cell.

On 25 November 2007 an intake screening form was completed. The screener identified that Mr Tupou had mental health issues, schizophrenia and drug induced psychosis, and past admissions to Psychiatric Hospitals. It was also noted that Mr Tupou had self harmed a week prior and had suicidal thoughts since his arrest. It was observed that Mr Tupou presented as being anxious, very confused, scattered, paranoid suspicion and not coping too well.

Later on 25 November 2007 Mr Tupou was seen be a registered nurse and an immediate support plan was developed. The plan recommended that Mr Tupou be placed in an assessment cell, camera observations no sharps, minimal clothing and a safe blanket.

The Risk Assessment Intervention Team (RAIT) interviewed Mr Tupou on 27 November 2007. Although he denied current thoughts of self-harm/suicide he was considered to be a high risk to self and others. The arrangements previously recommended were continued and arrangements were made for Mr Tupou to be assessed by a psychiatrist. He was to be reviewed on 29 November 2007.

On the evening of 28 November 2007 the evidence is that Mr Tupou appeared normal. He used the cell alarm to request cigarettes on a number of occasions. The evidence shows that at about 9 pm a correctional officer opened his cell and he was provided with a cigarette. Nothing untoward was noted about Mr Tupou at the time. The cell was secured at 9.01pm. This was the last time Mr Tupou was seen alive. He was subsequently found hanging in his cell at 10.45pm.

The question that must be asked is how a man who had been assessed as being at a high risk of self-harm, was allocated to a *'safe'* cell, was to be monitored on a 15-minute basis was able to hang himself in the *'safe'* cell at all and then this fact did not become known in the hour and forty minutes between 9.01pm when he was given a cigarette by a correctional officer and 10.45pm when he was found hanging?

Sandra Steel a Senior Investigator attached to the DCS Investigations Branch undertook a review of the circumstances of Mr Tupou's death on behalf of the Department. She identified a significant number of failings on the part of the Department that were associated with the circumstances of Mr Tupou's death.

Some of those matters were:

- Mr. Tupou covered the lens of the monitoring camera in his cell with wet toilet paper thus blocking the ability of officers to monitor his actions.
- It was not possible to establish when this occurred and the fact that it was covered was not discovered until after Mr Tupou's death. Ms Steel's investigation found that DCS procedures for CCTV observation of assessment cells were random and there was no certainty that Mr Tupou's cell was monitored during any specified period or at all.
- There was no correctional officer who was specifically designated to monitor the safe cells. There were officers who might but their doing so could be interrupted by other responsibilities.
- One officer, who might have monitored the cell, was not in the room in which the monitors were located for an extended period of time.
- One officer, who might have monitored the cell, was playing table tennis with an off duty officer during the period during which Mr Tupou took his life.
- DCS officers had previously identified the light fitting in the cell as a hanging point. This had occurred on 8 August 2006 and 20 February 2007. Following those reviews it had been recommended that the internal light fittings be sealed with impact resistant Perspex. This recommendation was not accepted. The O H & S Committee reviewed the suitability of the light fitting in April 2007 and found that: *'all hanging points had been removed.'* Whether this was the case could not be determined because the light had been damaged in June 2007 and it appears that in repairing the damage the hanging point may have resulted in the hanging point being created. No O H & S or other review had occurred following repair of the light.
- On the night of Mr Tupou's death the DCS staff underwent random breath testing at about the time of the change of Watch. This reduced the number of officers available to monitor the safe cells for a period of time.

Ms Steel's investigation, including its breath, the nature of its findings and its recommendations was thorough. Because of this I do not consider it necessary for me, on this occasion, to undertake a detailed review of the circumstances

I am satisfied that the evidence given at inquest establishes that DCS has taken action in response to each of the shortcomings identified by Ms Steele. The DCS is to be commended for the quality of her investigation and the response to her recommendations.

The fact that such failings occurred is of course completely unacceptable. The DCS had a duty of care towards Mr Tupou. Their policies and procedures

recognise that duty. The DCS protocol *"RIT Protocol for the Management of Inmates 'At Risk' of Self-Harm or Suicide"* requires that the actions of DCS officers be focused towards the development of a management plan for the care of inmates at risk. It emphasises that suicide and self-harm prevention is the responsibility and obligation of all DCS staff.

In the case of Mr Tupou DCS was on notice that he was at risk. It was part of the risk mitigation action that DCS had developed that required him to be placed in a *'safe'* cell and monitored on a regular basis.

It abundantly clear that he was neither monitored in accordance with the plan developed nor was the cell that he was placed in safe. I propose to make recommendations pursuant to Section 22A dealing with these two issues.

These failings of the Department of Corrective Services were a significant contributing factor to Mr Tupou's death. The evidence available does not allow me to conclude that the Departmental officers involved in the supervision of Mr Tupou on 28 November 2007 did not treat the issue of providing proper care to Mr Tupou with appropriate seriousness however the actions and inactions of the officers involved are certainly suggestive of such an attitude. It would be appropriate for the obligation to be emphasised in the training that corrective service officers receive and I propose to make a recommendation pursuant to Section 22A that this occur.

Formal Finding:

Manoa Tupou died on 28 November 2007 at the Metropolitan Reception and Remand Centre, Silverwater Correctional Centre. The cause of his death was hanging and the manner of his death was suicide.

Section 22A Recommendations:

To the Commissioner of Corrective Services:

That Departmental Policies and Procedures be reviewed so as to ensure that cells occupied by inmates identified as being at risk of self-harm or suicide are audited on a regular basis for obvious hanging points and where such hanging points are identified they are eliminated.

That Departmental Policies and Procedures be revised to provide that where an inmate is placed on an observation regime, due to their risk of suicide or self-harm, the time and other details of such observations be recorded in an auditable fashion by the officer/s undertaking such observations.

That the educational programs provided for corrective services officers by the Department emphasise to the duty of care that the Department, and it officers, have towards inmates who are assessed as being at risk of self-harm or suicide.

Section 44(4) Order:

Having regard to the circumstances of Mr Tupou's death in custody I consider that it is desirable in the public interest to allow a report of the proceedings of the inquest to be published. I therefore make an order permitting the whole of the proceedings, other than that evidence the publication of which was specifically prohibited during the course of the inquest, to be published.

7. 2195/07 Glen Robert Bruce Kennedy

Inquest into the death of Glen Kennedy on the 3 December 2007 at Randwick. Finding handed down by Deputy State Coroner MacPherson on the 26 June 2009.

BACKGROUND

On 28 November 2007 Glen Robert Bruce Kennedy flew to Sydney from Adelaide to visit his sister Cheryl Kennedy at her unit 218/232 Malabar Road South Coogee. Sadly, he never returned alive because in the early hours of Monday the 3 December 2007 he jumped from the balcony of his sister's unit and sustained fatal injuries.

Glen's sister Gail Kennedy said in her statement that she was shocked by the circumstances of Glen's death and that he would not have ended his life in his sister Cheryl's home because he always loved and protected her and was extremely sensitive to her psychiatric condition. There is also evidence that he had organised medical appointments in Adelaide to address his liver problems so his actions on the 3 December were totally out of character and unexpected.

Cheryl says that Glen was fine when he arrived on the Wednesday but on Saturday when they were supposed to go the Flight Centre to get Glen a ticket to return home she started to notice that he didn't seem quite right and she thought he was becoming paranoid.

Cheryl described in the transcript of interview Glen's possible mental state in answers to questions 297 and 298, referring to him saying he was feeling 'iffy' and to her it meant being bothered by the voices.

Things progressed to the Sunday night when Glen and Cheryl Kennedy were watching television and Glen said to Cheryl at the end of the show that she shouldn't be there. He produced a knife and said, "I can't do it anymore I'm doin' myself."

As a result Cheryl left the unit, closed the front door and then locked the screen door and eventually went to a neighbours and the police were called.

I will deal with the police operation shortly as it is the focus of this Inquest but suffice to say that two police units arrived initially, followed later by Sergeant Davis, the mobile supervisor. Sergeant Davis and Sergeant Montgomery entered Cheryl's unit after getting the keys for the screen door from Cheryl Kennedy. Both sergeants commenced negotiating with Glen Kennedy to put the knife down, come inside from the balcony and be treated by ambulance officers.

Approximately two and a half hours later, after the arrival of the Duty Officer Inspector Davis, whereupon a call was made to the Duty Operations Inspector to call out the State Protection Group Officers containing the Negotiators, Glen went over the balcony of the unit.

THE ROLE OF THE CORONER

At the commencement of this Inquest, Counsel Assisting stated that the primary role of a Coroner in regard to a death is to determine the identity of the deceased, the date of death, the place of death and the manner and cause of death.

Under Section 22 of the *Coroners Act 1980* ("*Coroners Act*"), a Coroner is required to make formal findings. In regard to a death, the formal finding will be recorded on the deceased details at the Registry of Births Deaths and Marriages.

Coronial proceedings are inquisitorial and they are neither criminal nor civil nor adversarial. It is not the role of the Coroner to attribute fault or make findings in relation to negligence or duty of care, they are issues that sit more comfortably in the civil jurisdiction.

It was important for Counsel Assisting at the commencement of this Inquest to set out the role and functions of the Coroner and for me to restate them, not so much for the benefit of learned counsel, but more for the benefit of Glen's sister, Gail and his family who may not always appreciate and understand that while Coroners do have wide powers they are limited by the very statute (the *Coroners Act*), that empowers them.

However, as Counsel Assisting stated in his opening submissions, another important function of an inquest is that provided for in s 22A of the *Coroners Act,* namely to consider whether there are recommendations which are necessary or desirable in relation to any matter connected with the death with which this inquest is concerned. It is in this respect that the coronial jurisdiction differs from other court proceedings. That is, because of the function of making recommendations, coronial proceedings can be forward looking, aiming to prevent future deaths, rather than allocating blame.

In relation to the death of Glen Kennedy, Section 13(1)(a) of the *Coroners Act* provides that a coroner has jurisdiction to hold an inquest if it appears to the coroner that a person has died *a violent or unnatural death.* Section 13A(1)(b) provides that a coroner, who is the State Coroner or a Deputy State Coroner, has jurisdiction to conduct an inquest where it appears that the deceased *has died, or there is reasonable cause to suspect that the person has died, as a result of or in the course of a police operation.*

Glen's death is one that comes within the meaning of section 13A(1)(b) because it occurred during a police operation and is mandatory and must be dealt with by either the State Coroner or a Deputy State Coroner.

Also of relevance are section 44(3) and 44(4) of the *Coroners Act* which provide, in summary, that where at the conclusion of an inquest findings are made that a death was self-inflicted no report of the proceedings shall be published unless the coroner holding the inquest is of the view that it is desirable in the public interest to permit a report of the proceedings to be published and that is in addition to the non publication orders that have already been made in this inquest relating to material and evidence supplied by Detective Chief Inspector Graeme Abel.

THE ISSUES

Counsel assisting indicated four issues to be explored in this inquest prior to the inquest commencing and in his opening and a couple of further issues arose during the course of the inquest.

- Training of officers as to their obligations and options in high-risk situations. How much do the officers know? How much did they know then?

- The role of Inspector Davis the Duty Officer in calling out the State Protection Group/Tactical Response Group (SPG/TRG).

- The role of other general duties officers in not calling the Duty Operations Inspector to call out SPG/TRG.

- The role of Sergeant Davis in becoming involved in negotiation when perhaps he should have retained Command position and delegated negotiations. His role in the negotiations did he make the comment alleged by Sergeant Montgomery just before Glen Kennedy exited the balcony.

During the inquest an issue arose as to whether the inside door to the unit was opened by Glen at some stage and Sergeant Davis had a conversation with Glen who was sitting on the floor.

The submissions made by Ms. O'Sullivan on behalf of Glen's sister Gail and the family were measured and considered. Ms. O'Sullivan articulated the issues they were concerned with fewer than three headings.

Firstly, the delay in calling for negotiators; secondly the lack of leadership displayed and finally the lack of training in relation to the officers who attended the unit.

Apart from the issue of whether the door was opened or not those three headings encapsulate, in my view, the issues raised by counsel assisting at the commencement of this inquest and I will deal with the issues under each of those headings.

Delay in Calling in the Negotiators and Lack of Leadership

Sergeant Montgomery told the inquest that she entered the unit because she heard Probationary Constable Amy Robertson say over the police radio "There is a person on the balcony".

Sergeant Davis, the Mobile Supervisor and the most Senior Officer at the scene at the time said that he entered the unit because of the time that had gone by trying to get Glen to open the door.

The fact that each had a different view of why they entered is not the point, in my view. The important point was that both felt, for different reasons that the situation was urgent and they needed to enter the unit and speak to Glen directly.

The fact that they gave differing reasons for entering the unit can be put down to the stressful situation that they were facing at the time. They had been told that Glen was armed and threatening self-harm.

There was some suggestion that it would have been better for Sergeant Davis to have remained outside to set up a command post and let Sergeant Montgomery go in and handle the negotiations.

Firstly I could not see Sergeant Davis allowing his partner Sergeant Montgomery to enter a room on her own where there was a man armed with a knife. As he told the inquest when they both entered they adopted a triangle of safety where each could cover the other in the event they were put in danger.

Although they did not have their guns drawn upon entering the unit, Sergeant Davis said that he had the safety cap off and after they had entered the unit, he had the capsicum spray in his hand behind his back in the event that he needed to use that.

In the circumstances I cannot see that any criticism should be leveled at either Officer for entering the unit and both had clearly built up a rapport with Glen prior to entering the unit.

The other reason for not criticising Sergeant Davis for not remaining outside and setting up a command post was the opinion expressed by Detective Chief Inspector Abel, a very impressive witness in terms of dealing with siege situations.

He would not criticise Sergeant Davis for making the decision to enter the unit.

Once in the unit it was difficult for either officer to leave because they were fully engaged in trying to coerce Glen into coming inside from the balcony and put the knife down. In this situation there clearly needed to be someone senior called to take charge and be able to make intelligent decisions because the evidence of the constables at the scene was that Sergeant Davis was still in charge. Inspector Davis did attend but that was some time after he initially tried to make contact with Sergeant Davis.

As far as delay in calling in negotiators it was also the only adverse comment expressed by Detective Chief Inspector Abel that in hindsight his team could have been called to the siege earlier.

Training for Police in dealing with High Risk situations

With the exception of Inspector Davis all other police involved at the unit had a poor understanding of when a matter became High Risk and the consequences of that.

Most had difficulty recalling the training they undertook in relation to dealing with mentally ill persons and that is a concern as each of the officers that gave evidence said they deal with persons threatening self harm and who are sometimes armed, almost daily. It is important that we arm our front line police with tools they can use when faced with these serious and stressful situations.

The fact that most are resolved peacefully by the general duties officers is a testament to them. If that were not the case then you would see more cases coming before the State Coroner and Deputy State Coroners and that is simply not the case.

However, officers should at the very least be able to recognise when they are getting out of their depth and be aware that they can call on the excellent resources of Detective Chief Inspector Abel and his teams of negotiators around the State.

This was a terrible outcome particularly for Sergeants Davis and Montgomery. Both felt, although some two and a half hours had passed, that they were making headway and both were shocked that he jumped, although they expressed their feelings differently.

Words allegedly spoken by Sergeant Davis

It should not be forgotten that Sergeants Montgomery and Davis entered the unit where Glen was armed with a knife. They spent the next two and a half hours talking calmly to Glen trying to get him to come inside from the balcony. There is no suggestion, apart from the last words spoken by Sergeant Davis before Glen jumped, that either had raised their voices or were acting inappropriately in their dealings with Glen

Just before he jumped over the balcony Sergeant Montgomery says in her second statement made on 21 December 2007, that she told Sergeant Davis, “The negotiators are here”.

She goes onto say that Sergeant Davis' tone changed as he said to Glen something like, “You’ve been arsing around too long you need to come in if you don’t come in I’m going to come over and get you”.

Even if one accepts that Sergeant Davis said the words in a changed tone it is unlikely that that was the trigger that caused Glen to jump. The fact is we will never know why he chose that moment to jump.

In resolving the issue it is important to remember that because this was a ‘critical incident’ certain protocols had to be observed and were observed. The officers were separated and statements obtained separately. There was no opportunity for any collusion or contamination of their evidence.

Sergeant Davis agrees that he could have said words to the effect of, “Stop arsing around you need to come in”, but denies the balance of the words ascribed to him by Sergeant Montgomery.

In her first statement on the 3 December 2007 she said that she informed Sergeant Davis that the negotiators had arrived and that Sergeant Davis said to Glen words similar to, “Well you have been thinking for a while, come inside” then Glen turned around and jumped over the balcony.

Senior Constable Jacqueline Barlow said in her second statement of 28 December 2007 that Sergeant Davis’s tone changed and he said words to the effect of, “this has gone on long enough, you’ve just got to drop the knife and come inside.”

Constable Amy Louise Robertson says in her statement of the 3 December 2007 that she heard Sergeant Davis say to Glen "Given you lots of time now" and Glen said something and Sergeant Davis said "Stop arsing about drop the knife and come inside". After that Glen jumped over the balcony.

Given the stressful situation the officers were in and the terrible outcome resulting in the death of Glen Kennedy, although Sergeant Montgomery obviously believes that Sergeant Davis said the words "…if you don't come in I'm going to come over and get you", I form the view that she was mistaken.

Was the door open by Glen before the officers entered?

This issue arose after Ambulance Officer McNeill gave evidence. He said Glen opened the door and police spoke to him through the security door. It is suggested that his evidence is supported by Ambulance Officer Houston, who was not called, who says,

> "…A short time later the front door opened from the inside. I did not see the person that opened it. But it was not the police that opened the door. The police were standing away from the door when it opened. A male police officer wearing a crown had arrived and entered the premises with the original blonde Sergeant behind him. I could no longer see the police, they did not close the door behind them."

There is no mention of any conversation between Sergeants Montgomery and Davis and Glen. What Ambulance Officer Houston says in effect is that the door opened and the police went in. That is correct. What he has confused is that it was the police who opened the door and not Glen. It has to be remembered that Ambulance Officer Houston's statement was not given until 3 January 2008.

Ambulance Officer McNeill in his statement of the 14 January 2008 says that he "saw the police open the screen door and then obviously the wooden door." I have no doubt he was doing his best to recall events but is confused about what happened which can be put down to the vagaries of human recollection.

Memorandum of understanding between police, ambulance and mental health

It was clear that as far as Police and Ambulance are concerned the memorandum only applies to who transports mentally ill clients. It seems to be a sad fact that a lack of resources means that it is difficult to obtain assistance from mental health crisis teams after hours and in relation to armed persons threatening self-harm the team either calls the police or leaves it to the police to contain and negotiate.

I do not propose to make any recommendations in relation to the interactions of these agencies except to say that the memorandum appears to be a fairly useless document in how these agencies interact in these sorts of situations. Perhaps they should go back to the drawing board.

CONCLUSION

There is no issue as to time, date, place and cause of death; they are clear. What is not clear is whether Glen intended to take his own life. He had said to Sergeants Davis and Montgomery that the balcony was not high enough to kill himself and that he would only injure himself.

Self-harm is never to be presumed. It must be affirmatively proved to justify the finding (Sellers LH in *re Davis (deceased) 1967 All ER 688)*. To make a finding that he intended self-harm I would have to be satisfied to the *Briginshaw* standard, that is comfortably satisfied, and I'm not.

Formal Finding:

I find that GLEN ROBERT BRUCE Kennedy died on 3 December 2007 at the Prince of Wales Hospital from multiple injuries sustained when he jumped from the third floor balcony of Unit 218 at 232 Malabar Road, South Coogee, but the evidence does not enable me to say whether he intended to end his own life of not

SECTION 22A RECOMMENDATION

Mr. Biggins counsel for the Commissioner of Police has indicated that there will not be any opposition to a sensible recommendation with respect to the training of police in responding to high risk incidents as set out in the 1999 training package.

> **To the Minster and Commissioner of Police I recommend that the training package developed by Detective Chief Inspector Graeme McLeod Abel in 1999 and entitled "Responding to High Risk Incidents" be included in the Mandatory Continuing Police Education Scheme.**

It should not be forgotten that police every day are out on the streets protecting not only the public but also people like Glen. Sergeants Davis and Montgomery did there very best to bring the stand-off with Glen to a satisfactory conclusion and that should be recognised.

Finally I extend the court's sympathies and mine to Glen's sisters Gail and Cheryl and Glen's family on their tragic loss.