INQUEST INTO THE DEATH OF NATHAN DOHERTY

DEATH IN CUSTODY – In custody; Police shooting.

Coroners Act 1997 (ACT) ss 3, 3C, 52(4) and 74
Mental Health (Treatment and Care) Act 1994

Licciardello v The Queen [2012] ACTCA 16
Eatts v Dawson (1990) 21 FCR 166

No. CD 44 of 2011

Chief Coroner: L A Walker
Coroners Court of the ACT
Date: 25 June 2012

IN THE CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY))) No. CD 44 of 2011

F I N D I N G S

Chief Coroner:	Lorraine A Walker
Date:	25 June 2012
Place:	Canberra

THE COURT FINDS THAT:

Nathan Doherty, born [redacted] March 1983, late of Fraser in the Australian Capital Territory, died at 5:46 am on Sunday 13 February 2011 at the intersection of Dyte Place and Wheeler Crescent, Wanniassa in the Australian Capital Territory. He died as a result of a single gunshot wound to the chest fired by Sergeant Matthew Gale of the Australian Federal Police, in defence of himself and others, in the course of his duty.

THE COURT RECOMMENDS THAT:

Recommendation 1: The AFP, in consultation with ACT Mental Health, develop a protocol for the exchange of information in respect to ACT Mental Health consumers.

Recommendation 2: That ACT Ops and ACT Mental Health staff be trained in this protocol.

Recommendation 3: That the embedded ACT mental health worker in ACT Ops continue.

Recommendation 4: That consideration be given to increasing the periods during which an ACT mental health worker is embedded in ACT Ops.

Nathan's History

1. Nathan Doherty battled with mental illness even as a child. The night he died, weakened by the effects of alcohol, illness got the better of him; his reason was overthrown and he brought his death about by his own irrational actions.
2. Nathan's mother, Sandra (Sandy) Doherty, gave evidence that he had experienced behavioural and mood difficulties even as a child. Various diagnoses were applied but no definitive diagnosis had been arrived at even by the time Nathan died. His symptoms certainly included depression, anxiety and alcohol abuse. Nathan's use of alcohol complicated both diagnosis and treatment.
3. In 2007, Nathan was involved in an incident which lead to him being shot in the leg by SGT Gregory Booth of the Australian Federal Police. Nathan had been drinking. The police attended, including general duties officers, specialist negotiators and a police team. Nathan advanced on the police brandishing a knife. He refused to stop. SGT Booth, backed up against a fence, shot. Nathan was hit in the leg. This incident lead to criminal charges. Whilst Nathan recognised that he had a second chance at life following this event, he told those close to him that he wished he had died in that incident. He subsequently wrote a letter of both apology and thanks to SGT Booth.

4. Subsequently, Nathan attended a rehabilitation program at Karralika for 15 months. This programme, although not without setbacks, resulted in a radical change for Nathan, including him staying off alcohol for a considerable period of time. He continued to receive psychological support after Karralika, from his longstanding general practitioner, Dr Petelcyzk, and from a psychologist, Vicki Walmsley, whom he first connected with through Karralika.

5. Whilst at Karralika, Nathan met Kylee-Lea Dowell (Kylee). After their exit from the program they formed an intimate relationship, which continued intermittently until Nathan's death. Nathan lived with Kylee at times and otherwise with his parents, Sandy and Michael.

6. In June 2010, Nathan took an overdose of prescription medication. He was taken to Calvary Hospital and treated for the physical effect of the drugs. There was some psychological follow up but otherwise Nathan resumed his usual level of treatment, seeing his GP and his psychologist intermittently.

7. On 16 January 2011, Nathan again took an overdose of prescription medication. This resulted in referral for psychiatric assessment by Dr Annita Paull, along with arrangements for support from his local mental health team. He saw Dr Paull soon after leaving hospital.

8. On 24 January 2011, Sandy was concerned about Nathan's mental state and raised this with his support team. That team responded by bringing forward a further assessment by Dr Paull. At Nathan's last appointment Dr Paull noted that he was feeling better than he had been for the last week, had a drinking period but stopped, was comfortable with the end of his relationship with Kylee and happy to wait for his next appointment in February.

9. Nathan was last seen by medical practitioners on 27 January 2011, being both Dr Paull and Ms Walmsley.

Events leading up to the shooting

10. As at 12 February 2011, Nathan was back living with his parents, having been separated from Kylee for about a week. Kylee was pregnant with Nathan's child, who has since been born. Sandy observed that her son appeared to be "over the top" happy on the 12th. However, he received a text message from Kylee which was not intended for him later in the day. It noted that Kylee was aware that Nathan had formed a relationship with another woman but that she felt that their relationship was not finally over. It upset him. A further exchange did not improve the situation and Nathan determined to go out drinking.

11. Sandy tried to dissuade him from going but he insisted, so she drove him to his local club rather than risk having him drink and drive. Nathan exchanged texts with Kylee during the evening. Whilst her responses were placating, his were increasingly aggressive. He arrived back at his parents' home at about 4 a.m. Sandy was awake and spoke with him. He appeared calm. Following a telephone call to Kylee, his mood darkened and he determined to go to Kylee's home. Despite ugly threats having been made earlier, Kylee became frightened of Nathan for the first time in their relationship during this phone call because of Nathan's tone.

12. Nathan demanded his car keys from Sandy. She stalled a little but then handed them over. Sandy saw Nathan take a meat cleaver with him. Disturbed by his altered appearance, that he simply did not look himself, Sandy, with Michael driving, set out after Nathan. They were headed to 11 Riddell Court, Wanniassa, Kylee's address. Sandy made several phone calls on the way.

13. The first call was to Kylee to warn her that Nathan was on his way bearing a meat cleaver. Sandy asked what Kylee wanted to do. Kylee wanted Sandy to try to get assistance from ACT Mental Health first and to hold off calling the police for Nathan's sake. Sandy kept two phones operating whilst in the car, one to speak with Kylee and the other to make calls for assistance.

14. Sandy had a card that she had been given and tried to call the Belconnen Mental Health Team, which she understood had responsibility for Nathan's care. She got a recorded out-of-hours message which purported to provide another number to call. That number was too muffled for Sandy to hear.

15. Sandy then called the Crisis and Assessment Team (CATT) hotline. Her call connected and, having explained what was happening, she was told that she needed to call the police as no-one from CATT would attend. This call was not recorded in ACT Mental Health's record keeping system, known as MHAGIC.

16. At the inquest, the refusal to send a mental health worker out was explained by Anna Stevens (the CATT Clinician on that night) and Wendy Kipling, Acting Operational Director of Access and Acute Mental Health, on the grounds that there was only one CATT worker available to perform a wide range of functions between 11pm and 7.15 am. Those functions included manning the 1800 number which includes receiving calls from the police, performing telephone triage or counselling; undertaking face to face assessments at the Mental Health Assessment Unit (a 5-6 bed Unit) (MHAU) of the Canberra Hospital and at Calvary Hospital and the police Watch House; assisting the registered nurse allocated to care for occupants of MHAU; and attending with the police to assist a mentally ill person, at the police's request. It was also explained that CATT workers would not attend during this

period without police because of the heightened risk of attending at night and, necessarily, alone.

17. After calling CATT, Sandy could hear that Nathan had arrived at Kylee's. She heard the car pull up and loud music. Sandy overheard some of the exchange between Kylee and Nathan. Kylee asked Nathan what was in his hand and asked him to put it down. At this point Kylee told Sandy to call the police.

18. Whilst Sandy was calling police, Kylee was engaging with Nathan who was threatening her including saying that, although he loved her, he was going to have to kill her. Kylee escaped from the house in to the street.

19. Meanwhile, whilst hearing this through one phone, Sandy called the AFP via the 000 line on the other.

20. Her call was answered at 4.56 am. Sandy told the call-taker that police were needed to attend a domestic and that her son was very drunk. The call-taker immediately called for Domestic Violence Crisis Support assistance and initiated inquiries as to person and place.

21. The call to the AFP was automatically allocated a "category 2" priority for the computer aided dispatch (CAD) system. AFP policy as to response time for such an incident is that 60% of such matters will be responded to in 8 minutes and 90 % in 12 minutes**.**

22. At 4.57 am, Renee Fleming of ACT Police Operations (ACT Ops) dispatched Tuggeranong Patrol (TP) 42, consisting of PCs Bolton and Yates, to the address saying that Nathan was "going off".

23. At 4.58 am TP 40, consisting of SGT Gale, was also dispatched to the scene.

24. Between 4.58 and 5.02 am, a series of alerts about Nathan was broadcast over the radio by Jerry Heraid from ACT Ops. These were obtained from the PROMIS

system and included the fact of him suffering mental illness, being aggressive when affected by alcohol, and having been shot by police in 2007.

25. At 5.04 am, Sandy called 000 again and added that Nathan had a meat cleaver. She also notified of their arrival at Riddell Court and that Kylee and her dog were now with her in the car. The Doherty's then withdrew to the mouth of the street, where they remained until later told by police to leave.

26. SGT Gale arrived by 5.06 am, that is within nine minutes of dispatch being called, thus within category 2 response time. He had heard the alerts broadcast by Jerry Heraid. He waited in Annand Place, around the corner from Riddell Court. For obvious safety reasons, AFP policy is that a police officer should not attend such an incident alone. He saw TP 42 arrive.

27. TP 42, comprised of PC Yates and PC Bolton, arrived at 5.10 am. Their car stopped in Riddell Court almost opposite No. 11.

28. At 5.11 am, SGT Gale drove into the street, passed TP 42 and turned his car around in the cul de sac at the bottom of the street. As he did so, he saw a person which must have been Nathan go back into No. 11. SGT Gale spoke to TP 42 and told them to put on their ballistic vests and back further up the street towards Wheeler Crescent. SGT Gale moved his car further back up the street.

29. A further patrol, Woden 42 (WP 42) arrived at 5.19 am. This patrol consisted of PCs Robinson, Hocking and Alexander. SGT Gale broadcast the order for them to "vest up" also.

30. Meanwhile, SGT Gale went to Sandy, Michael and Kylee who were at their car on the corner of Riddell Close and Wheeler Crescent. He confirmed that no-one but Nathan was in No.11. Sandy told him that Nathan had mental health issues. Kylee was speaking to Nathan on her telephone and he told her that he had put cling wrap

around his face as protection against Oleisin Capsicum (OC) spray. Kylee conveyed to SGT Gale that Nathan had entered her house with a meat cleaver and had now put gladwrap around his face. At 5.14 am, SGT Gale broadcast a situation report to this effect.

31. SGT Gale asked PC Robinson to initiate contact with ACT Mental Health for more information which she did at 5.16 am. This was done through Neil Ericson at ACT Ops. Mr Ericson called the CATT number at 5.17 am. The police take their place in line along with others users of this after hours facility. He connected after 17 seconds and spoke with Anna Stevens, the duty psychologist. Mr Ericson asked whether mental health had had any dealings with Nathan and noted that he was being a "little challenging". He asked for details of "recent dealings". Ms Stevens advised that Nathan had seen a doctor a couple of weeks ago and was back drinking. She noted relationship issues and associated mood disturbance and treatment for depression. Mr Ericson brought the call to an end at 5.21 am. It was related back to PC Robinson that Nathan was "travelling ok".

32. At 5.19 am, SGT Gale was speaking with Nathan on the sergeant's phone for nearly four minutes. Nathan said that he had been shot by the police before and was not afraid to be shot again. SGT Gale indicated that he had no intention to shoot Nathan and that if Nathan would come out unarmed and talk, he expected that he would go to hospital for treatment. Nathan seemed interested in speaking to mental health and SGT Gale formed the view that he may come out and the matter be peacefully resolved. SGT Gale communicated this and noted his intention to speak to Nathan again after Nathan had spoken, at his request, with Kylee.

33. Nathan and Kylee spoke on Kylee's phone from 5.24 am for over 16 minutes, that is until 5.40 am.

34. At 5.36 am, SGT Gale reported to AFP Ops that Nathan appeared open to negotiation and that he make contact with Nathan again after Nathan and Kylee finished speaking.

35. During that phone call, Kylee said that she needed to use the bathroom; Nathan asked her to go back into the house. SGT Gale made it clear that that would not happen. SGT Gale eventually told Kylee to end the call.

36. Whilst Kylee and Nathan were speaking, SGT Gale spoke to Sandy and explained what might happen, consisting of effectively a three point plan: if Nathan cooperated, he would be taken for treatment; if he did not come out of the house, the negotiators would be called; if he came out armed, the police would retreat and call on tactical response to attend.

Direct engagement with Nathan

37. At 5.41 am TP 42 broadcast that they thought that Nathan had left the house as they had heard a door but had not yet seen him.

38. SGT Gale heard this as he was moving from the family back towards the other officers. As he arrived alongside the other police, they all became aware of a figure outside No. 11.

39. There is some discrepancy as to what was originally observed by officers. This is hardly surprising given the poor artificial lighting, their relative positions, the sudden appearance of Nathan and the vagaries of human perception.

40. The six police officers gave evidence as to the events from Nathan's emergence from the house until he was shot. All were walked through the scene and interviewed after the event. All also gave oral evidence at the inquest. There were

minor variations in the descriptions given as one might expect in the circumstances, but no significant discrepancy.

41. SGT Gale flashed a light at Nathan; he responded with a demand that the light be moved from his eyes.

42. The light allowed a number of the police officers to see a solid looking man wearing only trousers, with a knife in one hand, possibly something in the other, face covered as to the bottom with something dark and cling wrap around his eyes.

43. SGT Gale adopted a placatory tone and stance, hands up, palms out and spoke to Nathan. He told him that he was the person he had just been speaking to on the phone and asked him to put the knife down.

44. Nathan began to approach the police. SGT Gale either verbally ordered or otherwise indicated for the police group to fall back, which they did, in a rough line formation. When this process commenced, Nathan was about 10 to 15 metres away from SGT Gale who was the nearest of the police, maintaining as he did his position at the front of the line. PC Bolton was to SGT Gale's left, PCs Hocking, Alexander, Yates and Robinson to his right.

45. PC Robinson was despatched by PC Yates to direct Nathan's family to leave the area, which they did. This officer had time to run up to the family, then run back down, securing SGT Gale's police vehicle on the way.

46. The officers described Nathan as extremely aggressive and abusive from the outset. He appeared to be goading the police. Amongst the things he was heard to say were "I've been shot before"; "Come on shoot me" and "You're going to fucking die. Let's go".

47. Although no officer could remember the exact exchanges which took place, a recording from SGT Gale's 'open microphone' from the point when he drew his

firearm provided a snapshot of the interaction. At that stage, Nathan was about 7 metres from SGT Gale. Initially the firearm was pointing to the ground.

48. The harrowing recording discloses that SGT Gale continued to implore Nathan to drop his weapon.

49. At the intersection of Riddell Court and Wheeler Crescent, the police group became divided with two officers at the far right of the line, PCs Yates and Robinson, dropping off as the line effectively right wheeled into the intersection. The two then removed themselves from the potential line of fire. At this point Nathan directed his attention briefly to PC Hocking. SGT Gale drew Nathan back to him though and the retreat continued.

50. The officers describe a tactical retreat characterised by increasing speed and decreasing distance between Nathan and the police. The officers described the difficulty in maintaining the retreat because of having to move backwards, without proper vision of their path, increasingly faster and with increased fatigue, in part related to the weight of protective clothing they were wearing, which, along with accoutrements, was over 13 kgs. The whole retreat covered about 220 metres.

51. During the retreat, at one stage PC Alexander drew his firearm. He was at that time an inexperienced police officer, only months out of recruit training. PC Hocking told him to reholster the firearm, which he did. PC Hocking did this in part because he considered himself to be in the line of fire.

52. PC Hocking took the safety catch off his firearm as the police were retreating into Wheeler Crescent. This was at the time that Nathan's challenge to the police to shoot him was more directed towards PC Hocking. When SGT Gale drew Nathan's attention back, PC Hocking resecured his weapon.

53. PC Bolton drew his baton. He was concerned what effect the drawing of a second firearm may have on Nathan. He did not think the baton would be of much use but felt he had no other real option in the circumstances.

54. By the time the police and Nathan reached the intersection of Dyte Place and Wheeler Crescent, Nathan was about 2 metres from SGT Gale and was lunging at him.

55. SGT Gale fired one shot. Nathan fell to the ground. A knife and a meat cleaver fell from his hands; it was only later that some of the officers realised that Nathan had been brandishing both of these weapons.

The aftermath

56. Other officers immediately attended to Nathan, applying first aid, speaking with him and attempting to make him comfortable. PCs Hocking and Bolton applied cardio-pulmonary resuscitation for an extended period.

57. The ACT Ambulance Service were called at 5.47 am and arrived at 5.57 am. Attempts at resuscitation were ceased as Nathan was dead by then.

58. A post-mortem report prepared by Dr Lavinia Hallam opined that the cause of death was a gunshot wound to the chest.

59. Toxicology disclosed the presence of alcohol at the level of 0.160 grams of alcohol per 100 millilitres of blood, consistent with Nathan's drinking that night. Olanzapine was present at 0.15 milligrams per litre of blood, which Dr Paull opined indicated Nathan's compliance with his prescribed medication.

Death in Custody – s3C

60. I find that Nathan's death was a death in custody as defined in s3C(d) of the *Coroners Act.*

61. I am assisted in reaching this determination by the recent decision of *Licciardello v The Queen* [2012] ACTCA 16 in which the Appeal Court noted at [35]:

"The fact that the appellant was not physically restrained is not determinative of the issue of whether or not he was in custody". This is consistent with a long line of authority. It is not an essential that a person be aware that they are in custody for them to be so (see *Eatts v Dawson* (1990) 21 FCR 166).

62. Nathan was not free to leave and, had circumstances not developed as they did, was to be detained in accordance with the police's powers pursuant to the *Mental Health (Treatment and Care) Act* 1994. Alternatively, his "voluntary" attendance would nonetheless be required. Although it may not have been necessary to take Nathan involuntarily to the hospital, SGT Gale had conveyed to Nathan that he needed to speak to police rather than simply leave or be left alone. This was sufficient to create a situation in which he was being taken in to custody.

63. I am therefore required to make findings about the quality of care, treatment and supervision of Nathan whilst in custody which contributed to his cause of death.

64. ACT Ops responded quickly, efficiently and effectively as a team to the situation presented to them. The incoming calls from Sandy were received, researched and actioned quickly, calmly and effectively.

65. There have been two matters considered arising from the role of ACT Ops.

66. The first is the exchange between Neil Ericson to ACT Mental Health.

67. ACT Ops staff are given a six week initial training and that training is regularly refreshed. However, there is no particular protocol for a request of the type Mr Ericson was required to make. It would not be desirable to attempt to create a formulaic request as this is highly unlikely to address all circumstances. However, it would be helpful if a protocol could be developed which allows for a brief outline the presenting problem which has created the need for the call. Here, the observation that Nathan was being "challenging", whilst correct, underplayed the seriousness, or at least the potential seriousness, of the circumstance. A simple statement of the facts, such as "Nathan has entered his ex-partners home uninvited, with a knife, is drunk and threatening harm to her or himself", might have allowed a more directed response from Ms Stevens, as well as providing a clear basis for her to apply the legislative exemption allowing her to divulge personal information. Whilst Ms Stevens observed that there is something of an assumption that when the police call requesting information, there is a need for it which satisfies the exemption, the above summary would have made that clear and provided a basis for Ms Stevens to sift the information available to her in a more informed and directed way.

68. Ms Stevens did not convey one of the more relevant pieces of information to Mr Ericson, that is Nathan's recent suicide attempts. In evidence she said that this was because she had not found reference to them in the short time she had, brought to a close by Mr Ericson. Had she been aware of the gravity of the situation, her response may have been more thorough.

69. As it was, the potentially misleading notion that Nathan was "travelling ok" did not even make it to SGT Gale before Nathan came out of the house, himself changing the direction of events irreversibly. SGT Gale also made it clear that this misinformation would not have altered his approach to the situation.

70. This imperfection in communication, and I put it no higher, thus had no impact on the outcome in this situation. It may nonetheless be useful for those responsible for training ACT Ops staff and ACT Mental Health staff to consider how such exchanges can best elicit relevant information.

71. I note that, unrelated to this matter, an ACT mental health worker has been embedded in the ACT Ops area for certain peak periods since late 2011. The consensus from those involved in this trial is that it is very helpful; that although only a short amount of time is gained in accessing relevant information, the fact that the mental health worker is present allows them to have a more ready appreciation of the situation. It also means that that person is available, without other demands on them, to speak to either the officer or the mentally ill person, on the ground. I understand that this trial has been funded by ACT Mental Health and is currently under review.

Recommendation 1: The AFP, in consultation with ACT Mental Health, develop a protocol for the exchange of information in respect to ACT Mental Health consumers.

Recommendation 2: That ACT Ops and ACT Mental Health staff be trained in this protocol.

Recommendation 3: That the embedded ACT mental health worker in ACT Ops continue.

Recommendation 4: That consideration be given to increasing the periods during which an ACT mental health worker is embedded in ACT Ops.

72. The inquest received evidence from SGT Booth. Since his involvement in Nathan's first shooting in 2007, SGT Booth has been involved in developing and implementing a training program for ACT police in relation to mental health issues. The consistent evidence from those officers present at this incident was that they had received some mental health training during their time at police college but that it was relatively superficial. All agreed that they had learnt much more since, on the job. SGT Booth's program appears to be more in depth training, utilising mental health professionals and people who have suffered mental illness to create a greater understanding of the mental illness experience and how to interact the mentally ill. This program has been provided to about one quarter of all ACT police officers and that roll-out is continuing. His efforts, and the support of the AFP, are commended.

73. A second issue explored in evidence was that fact that the Duty Operations Manager (DOM) turned off the radio channel on which Nathan's incident was being broadcast so as to concentrate on what appeared at the time to be a more pressing issue of explosions in Civic nightclubs. I am satisfied that, whilst this clearly occurred, this was a reasonable response to the competing demands facing the DOM. There is no basis to conclude that the deployment of further resources, which is the DOM's primary function, would have assisted Nathan's situation. Further, I am satisfied that ACT Ops staff were aware of the need to draw significant matters to the DOM's attention and that, when Nathan's situation escalated, Jerry Heraid did just that.

74. No question arises as to the attending police officers currency in use of force training. I do note that there were two very junior officers present, only months out of police college, who acquitted themselves well.

75. The physical tools available to the police to deal with the situation that night, described by police as their *accoutrements*, included, relevantly, a short baton, a can of OC spray and a pistol.

76. Police Guidelines as to the use of lethal force are detailed in Commissioner's Order 3. The basic precept is that the force used must be proportional to the circumstances. Alternatives to lethal force, negotiation, withdrawal and non-lethal options must first be considered.

77. SGT Gale tried negotiation and indeed was initially optimistic of a negotiated outcome. He continued to use negotiation, including de-escalation and other psychological tactics until just before he fired.

78. Withdrawal was vigorously pursued.

79. Although PC Bolton drew his baton, it was considered ineffective against a knife due to the proximity required to use it. OC spray was considered but the use of plastic wrap would, as intended, prevent it reaching its intended target.

80. Prior to discharge of his firearm, SGT Gale gave repeated warnings in as timely a manner as circumstances permitted as to his intention to use it.

81. Sergeants of the AFP have since been issued with the electrical shock device known as a Taser. The use of Tasers is highly controversial. No doubt their introduction has been very carefully considered. SGT Gale said that had he had a Taser available that night he would have used it. These weapons apparently have a 30% failure rate. Whilst they are more effective on bare skin than through clothing, one can do no more than speculate as to what the outcome would have been in these circumstances had a Taser been deployed. In any event, it was not an option then available.

82. There was some exploration as to whether other police resources should have been called on and whether they would have been available in time.

83. As to whether, had they been available, these options would have altered the outcome, I note that all were available in 2007 when Nathan was shot, without avoiding that event. Further, as to negotiation, the specialist negotiator who gave evidence, having reviewed the case, concluded that SGT Gale did all his team would have done on those facts any way.

84. I note that the AFP Practical Guide to calling out the police negotiation team (PNT) is to the effect that the on call PNT team leader is to be notified as soon as practicable of a number of circumstances including where there is a person threatening suicide or suffering mental health issues and believed to be at risk. On the face of it, that Guide was breached here. The evidence was that compliance with this Guide is practically impossible. One can only assume that it is intended that the DOM will exercise some measure of discretion as to application of this Guide, although that is not extant. This has the potential to create confusion in the mind of the DOM as to just what discretion he or she does have.

85. In terms of the effect on the outcome of not calling on other police resources, the simple answer is that dogs, police negotiators and tactical response simply would not have been capable of deploying in the time this incident took to unfold. SGT Gale took a steady approach, noting that time was on his side in circumstances where no-one else was at immediate risk of harm. However, the accelerated time frame was ultimately determined by Nathan himself.

86. The six police officers who attended in response to this situation acted professionally in execution of their duty when faced with a dangerous situation. The police response was timely and appropriate to the circumstances. Information was sought and provided in a timely manner. SGT Gale demonstrated considered,

compassionate and intelligent leadership. The command structure operated effectively; the team responded appropriately.

87. SGT Matthew Gale acted in defence of himself and others; he used no more force than was reasonably necessary in the circumstances.

88. I am satisfied that there was no material deficiency in the quality of care, treatment and supervision of Nathan whilst in police custody. No unreasonable action or inaction of any member of the AFP contributed to Nathan's death.

Comment pursuant to s.52(4)

89. I referred above to the provision of information to ACT Ops by ACT Mental Health. There is in fact a script for mental health workers when providing information to the police. It aims to address the requirements of Privacy Principle 10 (2)(d) which states that:

"Where the record keeper believes, on reasonable grounds, that the disclosure is necessary to prevent or lessen a serious and imminent risk to the life of physical, mental or emotional health of the consumer or someone else",

information may then be disclosed.

90. The script is unwieldy legalese and would take quite some time to recite in what are often pressing circumstances. The evidence is that the script was not generally used. That is perfectly understandable.

91. There is no suggestion that Ms Stevens ought not have provided the information she did to ACT Ops. The concern is how a person in her position is to properly identify what may be significant in the context of AFP/ACT Mental health communications. Ms Stevens had no idea why the police needed information. On top of that, it was not easy for her to quickly identify relevant information given the structure of the

MHAGIC notes. ACT Mental Health do not collect information about a person for the benefit of the AFP. The reality is, though, that it is the officers of the AFP who are the first line of defence in respect to acutely, and sometimes dangerously, psychologically unwell people. Consideration should be given to an exchange of information protocol that would allow a more effective process in emergency situations. We know they are sufficiently common for this problem to warrant consideration.

92. ACT Mental Health may also consider the addition of an "alerts" tab to the MHAGIC screen, in consultation with the AFP, in which a summary of the type of information which may be relevant to police interactions could be highlighted. This tab could be the responsibility of the case manager allocated to the mentally ill person's care. It could be used as a first port of call for information in emergency situations.

93. The adequacy of overnight staffing of ACT Mental Health was touched upon in the inquest. Certainly, the practitioner allocated to the 11pm to 7.15 am shift appears to have a wide range of duties, some of which must inevitably conflict. However, any further comment is outside the scope of this inquest.

94. Finally, there is no evidence that the delay in contacting mental health occasioned by Sandy first calling Belconnen Mental Health, contributed to Nathan's death. Nonetheless, consistent with the "no wrong door" policy, and recognising the stress experienced by those needing to contact mental health services in crisis situations, I strongly recommend that a call forward system is put in place so that those contacting the regional mental health teams after hours are connected immediately to another limb of the mental health service.

In conclusion

95. The investigation undertaken for this inquest was extremely thorough. The diligent work of DSGT Sarah Casey and Counsel Assisting, Mr Gill, was of great assistance in making events transparent and comprehensible.

96. The open and proactive involvement of the parties, and the cooperation of their counsel, facilitated an expeditious process.

Findings

97. Nathan Doherty, born [redacted] March 1983, late of Fraser in the Australian Capital Territory, died at 5:46 am on Sunday 13 February 2011 at the intersection of Dyte Place and Wheeler Crescent, Wanniassa in the Australian Capital Territory. He died as a result of a single gunshot wound to the chest fired by SGT Matthew Gale of the Australian Federal Police, in defence of himself and others, in the course of his duty.

98. These findings will be reported as required by s75 of the *Coroners Act.*

99. To those who loved Nathan, and who struggled with him, the Court offers its deepest condolences.

I certify that the preceding ninety nine (99) numbered paragraphs are a true copy of the Reasons for Judgment herein of her Honour, Chief Coroner Walker.

Associate: Abdullah Swaiti
Date: 28 June 2012

Counsel Assisting:	Mr Shane Gill
Counsel for the Australian Federal Police:	Mr Steven Whybrow
Counsel for ACT Health:	Mr Brian Meagher SC
Counsel for SGT Matthew Gale et al	Mr John Purnell SC
Date of hearing:	14, 15, 16, 17, 18, 21, 22, 23, 28, 29, 30 May and 7 June 2012
Date of Decision:	25 June 2012