**CORONERS COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Jack Kokaua |
| **Hearing dates:** | 17-20 September 2019, 24-28 August 2020, 2-5 November 2020 |
| **Date of findings:** | **12 May 2021** |
| **Place of findings:** | State Coroner's Court, Lidcombe |
| **Findings of:** | **State Coroner, Magistrate Teresa O'Sullivan** |
| **Catchwords:** | CORONIAL LAW – malignant ventricular arrhythmia – heart disease – mandatory inquest – positional asphyxia – use of a taser – use of force – supervision - NSW Police Force – Royal Prince Alfred Hospital – Corrective Services NSW – police operation – perceptual distortion - abscond - discharge |
| **File number:** | 2018/54392 |

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| **Representation:** | Dr K Stern SC and Ms S Palaniappan, Counsel Assisting, instructed by Mr J Pender, Crown Solicitor's Office<br><br>Mr P Townsend and Ms C Baxter, Legal Aid NSW, for the Kokaua family<br><br>Ms K E Burke, instructed by S Robinson, Office of the General Counsel of the NSW Police Force, for NSW Commissioner of Police<br><br>Mr B Haverfield, instructed by Mr K Madden, Walter Madden Jenkins, for the involved officers<br><br>Mr P Madden, instructed by K Madden, Walter Madden Jenkins, for the involved officers<br><br>Mr D Nagle, instructed by Mr G Willis, for the involved officers<br><br>Mr J Glissan QC and A Howell for the Police Association of New South Wales<br><br>Mr P Rooney, instructed by Ms K Hinchcliffe, Makinson d'Apice Lawyers, for the NSW Ambulance, South Western Sydney Local Health District, Sydney Local Health District, Western Sydney Local Health District<br><br>Ms A Douglas-Baker, instructed by M Azzopardi, for Corrective Services NSW<br><br>Ms S Goodwin for C Phouisiangiem |

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| **Findings:** | The *Coroners Act 2009* in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death or suspected death. These are the findings of an inquest into the death of Jack Kokaua.<br><br>**Identity**:<br>The deceased person was Jack Kokaua.<br><br>**Date of death:**<br><br>Jack died at approximately 14:28 on 18 February 2018.<br><br>**Place of death:**<br><br>Jack died at Royal Prince Alfred Hospital, Camperdown, NSW<br><br>**Cause of death:**<br><br>A malignant ventricular arrhythmia without myocardial infarction.<br><br>**Manner of death:**<br><br>Jack died by reason of a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors including positional asphyxia, exertion and use of taser, superimposed upon Jack's underlying occult coronary heart disease |
| **Recommendations:** | **Directed to NSW Police and NSW Ambulance**<br><br>1. Consideration be given to modifying the police and ambulance operating procedures and MOU such that police are required, to give active consideration to calling an ambulance at the earliest available opportunity when seeking to arrest or return to detention an individual with a known mental health illness or who has absconded from compulsory mental health detention if it is considered that the use of force may be required or it is considered that the individual is at risk of harming himself or at risk of harming others at the relevant time.<br><br>**Directed to NSW Health and NSW Police**<br><br>2. Consideration be given to expanding the funding for and roll-out of the PACER program. |

**Directed to NSW Police**

3. Consideration be given to:
    a. Developing criteria to determine whether or not a situation requiring police attendance indicates a person of interest with known or suspected mental health problems where those problems may be exacerbating the situation requiring police attendance or may require particular skills to deescalate the situation (**Mental Health Crisis**);
    b. Either making the four day accredited MHIT training package mandatory for all police officers; or in the alternative, developing and implementing a system requiring where possible the dispatch and early identification of four day MHIT accredited officers as first responders in cases which meet criteria indicating possible Mental Health Crisis; and
    c. initiating training and policy provision, to be delivered either in conjunction with or in addition to the STOPAR training for all police officers, for the use of communication and de-escalation after there has been a use of force in a situation involving a possible Mental Health Crisis.

4. Consideration be given to developing and implementing a system to ensure any four day MHIT accredited officers attending in cases which meet criteria indicating a possible Mental Health Crisis identify themselves on arrival as having undertaken the four day training.

5. Consideration be given to MHIT further developing and implementing for all NSWPF officers the "Guardian v Warrior" training currently in the Vulnerable Communities Portfolio.

6. Consideration be given to MHIT and WTPR establishing and documenting a joint review of STOPAR and de-escalation training including after a use of force, and for that training to be integrated in defensive tactics training for situations involving a person of interest with known or suspected mental health problems.

7. Consideration be given to NSW Police Weapons

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| | and Tactics Policy and Review developing and implementing training for those tasked with the role of supervisor including through the use of roleplay.<br><br>8. Consideration be given to requiring:<br>a. one officer to be designated supervisor, and for this to be communicated to other police officers involved in the interaction (including those arriving during the interaction) in any interaction involving 3 or more police officers and the use of, or likely use of, force, with that officer required to undertake overall responsibility for coordinating the police response and for significant events during the course of the interaction, to ensure compliance with NSW Police Policies and with the matters set out below and to ensure that an ambulance is called at the earliest available opportunity if the interaction involves use of force or likely use of force on a person with a known mental health illness or who has absconded from compulsory mental health detention;<br>b. that officers communicate and verbalise significant events in the arrest and detention of a POI including any mechanical restraints applied or the availability of any vehicles or other resources for use during the interaction;<br>c. that officers communicate and verbalise reports as to the status and well being of the POI, the extent of their resistance, and the ongoing need for use of force, including to the designated supervisor;<br>d. that in all cases an officer be tasked to maintain a time log as to when a POI is placed in the prone position to ensure awareness of the period for which the POI is so placed, that this is reported to the designated supervisor, and that an attempt be made to reposition the POI to minimise the risk of positional asphyxia after the expiry of a defined time interval;<br>e. that in all cases an officer be tasked to monitor the breathing of any POI placed in the prone position, and to communicate and verbalise reports as to the status of the POI's breathing, including to the designated supervisor; and |

f. that all officers are trained as to these matters.

**Directed to RPA**

9. Consideration be given to requiring, documenting by way of written procedure and training all ED staff as regards the procedure that:
    a. two or more persons, with the second person being a physician, clinical nurse consultant, nurse unit manager or supervising Registered Nurse, jointly determine, and provide a signed authority for mechanical restraints to be removed even temporarily as regards mental health patients;
    b. the existing patient safety physical restraint order and observation chart be amended to record this; and
    c. this procedure be expressly required as regards temporary relaxation of one or more hand or leg restraints to allow toileting or for any other purpose.
10. Consideration be given to exploring potential alternative options as to how toileting can be effected for a patient who is mechanically restrained, including the availability of security to assist or that another option may be to ensure the attendance of at least two members of clinical staff to provide additional protection against the patient removing restraints or absconding.

**Directed to Western Sydney LHD**

11. On discharge from an inpatient mental health unit where follow up is considered appropriate, consideration be given to introducing a policy, procedure or clinical pathway to seek to ensure that:
    (a) a community mental health team is identified as taking over clinical responsibility for the patient even if the patient will need to access temporary accommodation;
    (b) the Discharge Liaison Officer (if any) or clinician under whose care the person was admitted at the inpatient facility is required to check that the patient is accepted for care by that team.

12. Where an assertive team recommendation has

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| | been accepted in a community mental health setting, consideration be given to introducing a policy or procedure to ensure that that is communicated both to any inpatient facility to which the person is admitted, to Corrective Services if the person is subject to a parole order or community supervision, and that steps are taken to ensure that that be communicated to any subsequent community mental health team to which the person is admitted.<br><br>13. Consideration be given to implementing handover procedures which specifically address the continuation of prescribed medication.<br><br>**Directed to CSNSW**<br><br>14. Consideration be given to introducing a mechanism or procedure to be put in place by CSNSW to assess and act upon any risk when a parolee is not contactable for 7 days.<br><br>**Directed to CSNSW and NSW Health**<br><br>15. Community Corrections and the NSW Department of Health liaise to develop a means to seek to ensure that, as regards offenders where the risk of reoffending has been identified as being linked to their mental health care, discharges from inpatient mental health care are coordinated and subject to ongoing monitoring to facilitate ongoing mental health care, including ongoing provision of prescribed medication, in the community upon discharge, even for those who have access only to temporary (and potentially changing) accommodation and those for whom ongoing accommodation has not been arranged when discharge is being facilitated. |

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| **Non-publication orders:** | Pursuant to s. 74(1)(b) of the Coroners Act 2009, there is to be no publication of the following:<br><br>1. those information and/or documents identified as subject to non-publication in the "Amended short minutes of order" made by State Coroner O'Sullivan on 12 September 2019, which is annexed hereto and marked "**A**"; and<br><br>2. of the fact that an objection pursuant to s. 76 of the Coroners Act 2009 was made (if any), including the identity of the person making the objection. |

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*The Coroner's Act 2009 (NSW) in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

*These are the findings of an inquest into the death of Jack Kokaua.*

## Introduction

1. Jack Kokaua died on 18 February 2018 at the Royal Prince Alfred Hospital (**"the RPA"**) from a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors superimposed upon Jack's underlying but occult coronary heart disease, following a police operation.

2. At the time of his death, Jack was on parole.

3. In the preparation of these findings, I have been assisted by the written submissions of Counsel Assisting, Kristina Stern SC and Surya Palaniappan. I have also been assisted by the submissions of counsel for the interested parties.

4. In making these findings, I extend my sincere condolences to Jack's family, in particular to Queenie who travelled from New Zealand during the COVID-19 pandemic to attend each day of the inquest in person. At all times during the inquest, the family carried themselves with dignity and grace. I particularly wish to acknowledge the family's moving tribute to Jack on the final day of the hearing, which included the performance of a haka for Jack by Jack's family members and a evocative song of farewell to Jack, led by Queenie. Jack was clearly very much loved. He will continue to be missed and mourned by those who loved him.

## The role of the Coroner

5. The inquest is a public examination of the circumstances of Jack's death. Unlike some other proceedings, the purpose of an inquest is not to blame or punish anyone for the death. The holding of an inquest does not itself suggest that any party is guilty of wrongdoing. Rather, the primary function of an inquest is to identify the circumstances in which a death has occurred.

6. The role of a Coroner, as set out in s. 81 of the *Coroners Act 2009* (NSW) ("**the Act**"), is to make findings as to the:

    a. identity of the deceased;
    b. date and place of the person's death;
    c. physical or medical cause of death; and

d. the manner of death, in other words, the circumstances surrounding the death.

7. Pursuant to s. 27 of the Act, a Coroner is required to hold an inquest in circumstances where, as set out in s. 23(1)(c) of the Act, it appears that a person has died (or there is reasonable cause to suspect that a person has died) as a result of a police operation. In this case, Jack died as a result of a police operation conducted on Carillion Avenue, Camperdown, near St Andrews College, University of Sydney.

8. Pursuant to s. 82 of the Act, a secondary purpose of an inquest is for the Coroner to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the person's death. This involves asking whether anything should or could be done to prevent a death in similar circumstances in the future. These recommendations are made, usually to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest.

**The purpose of an inquest**

9. Counsel for the individual police officers relied on the following decisions of the New South Wales Court of Appeal in submitting that it was not the role of this Court to review and comment on actions and decisions of police officers made in the context of a "dynamic situation".

10. First, counsel referred to *Woodley v Boyd* [2001] NSWCA 35 at [37]:

> … The same duties and considerations apply where a police officer is deciding how to effect an arrest. And, in evaluating the police conduct, the matter must be judged by reference to the pressure of events and the agony of the moment, not by reference to hindsight. In *McIntosh v Webster* (1980) 43 FLR 112 at 123, Connor J said:
>
> > "[Arrests] are frequently made in circumstances of excitement, turmoil and panic [and it is] altogether unfair to the police force as a whole to sit back in the comparatively calm and leisurely atmosphere of the courtroom and there make minute retrospective criticisms of what an arresting constable might or might not have done or believed in the circumstances."

11. Secondly, counsel referred to *State of NSW (NSW Police) v Nominal Defendant* [2009] NSWCA 225 at [46]:

> Whilst the reasonableness of the performance of a police officer's duties does not escape judicial scrutiny if damage results, reasonableness has to be

> considered in context. The primary context is the law enforcement role of the police officer. The surrounding circumstances have to be considered, including the nature of the possible offence involved, the need to make quick decisions as to whether to take action and if so, what action to take. Indeed, many such decisions, of their nature, will be almost spontaneously reactive to the circumstances presenting themselves to the police officer. The police officer is also required, in the same short period of time, to weigh up whether, in making a decision to take action, the safety of the public outweighs the need to take action. So far as a decision to engage in a pursuit is concerned, the context will also include the instructions, directions and guiding concepts contained in the Police Service's Pursuit Guidelines.

12. I do not accept this submission. Each of the above cases are appeals from civil claims for damages alleging tortious conduct by police. The jurisdiction of this Court is very different. As described in *Waller's Coronial Law & Practice in NSW* (4th ed) at [23.7]:

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

13. In giving effect to the purposes of s. 23 inquest, any finding that this Court makes must in this case be informed by, as Counsel Assisting put in their submissions:

> the undoubted facts that this was a chaotic and stressful interaction, that Jack was undoubtedly aggressive towards police at times during the incident, and that Jack was a large and strong individual that the officers knew, from the incident in the morning, required considerable force to restrain. Moreover, the evidence of some of the officers was that this was a very difficult encounter, and that it went well beyond the extent of their previous policing experience.

In reviewing the actions of the involved police officers, however, I must also consider, as Counsel Assisting put it, "the importance of safeguarding the welfare of persons such as Jack who are involved in such encounters". In doing this, I must make full use of the benefit of hindsight to work out what could have been done differently, if anything, and to ascertain whether any lessons can be learned from Jack's untimely death.

## The proceedings

14. The hearing of the inquest into Jack's death was held at the NSW State Coroner's Court in Lidcombe in three tranches on the following dates: 17-20 September 2019, 24-28 August 2020, 2-5 November 2020.

15. An issues list was distributed to parties identified as having a sufficient interest in the proceedings, which included the following:

    a. cause of death, including the impact of medication and / or tasers and / or method of restraint on cause of death;
    b. the adequacy and appropriateness of the police officers' response to the second incident;
    c. the appropriateness of the restraint of Jack during the second incident and the position and actions of involved police officers;
    d. methods of restraint that the involved police officers used, all methods of restraint that were available to be utilised and training provided to the involved police officers regarding the use of those methods of restraint;
    e. NSW Police mental health training policies and procedures and the training that was provided to those officers involved regarding the same;
    f. the adequacy of mental health and other support provided to Jack whilst on parole up to the date of his death;
    g. how and why Jack was able to leave RPA; and
    h. whether any recommendations are necessary or desirable, including for the purpose of public health and safety.

## Factual background

16. Following careful review and consideration of the brief of evidence tendered at the hearing, as well as the oral evidence of the witnesses who appeared at the hearing, I make the following findings in relation to the factual background of the inquest.

### *Jack's personal circumstances*

17. Jack was born on 14 March 1987 in Bankstown, New South Wales, to Queenie Kohu Kokaua and Joseph William Kokaua. Both parents were born in New Zealand. Jack's birth certificate also recorded that at the time of his birth he had two older siblings, Adam and Pania.

18. Jack's parents separated when he was young, with his care being split between his parents, which required him to spend time in New Zealand whilst he was in his mother's care.

19. Jack left high school prior to completing Year 10, as a result of being expelled for setting fire to a classroom. Jack later attempted to complete his Year 10 school certificate at TAFE but was ultimately unsuccessful. Jack was then employed for two weeks as an apprentice fitter and machinist, and was not employed following this. He completed certificates in TAFE in dogman and welding.

20. Jack has a daughter, who was born in 2005. Jack was not in contact with his daughter at the time of his death.

***Jack's mental health history***

21. Jack had a long history of mental health issues. These were summarised by Dr Gordon Elliott of Justice Health and Forensic Mental Health Network (**"Justice Health"**) in a report to the State Parole Authority dated 18 December 2017.

22. Jack's mental illness dated from his late adolescence, from around 17 or 18 years of age. His illness required repeated psychiatric inpatient admissions to Concord Hospital, and periods of non-compliance with medication also necessitated his treatment in the community under the conditions of a Community Treatment Order and utilising a long-acting injectable antipsychotic.

23. When unwell, Jack's illness was characterised by auditory hallucinations, passivity phenomena (or a sense that his feelings and volition were being controlled by some external power), and referential ideas from television and radio.

24. Jack's illness was exacerbated by co-morbid substance use disorders, in particular the use of cannabis and methamphetamines. Dr Elliot's report identifies that Jack had a history of aggression when unwell and that his offending behaviour was attributed to substance-induced exacerbation of his underlying illness. Jack was also noted to have given Dr Elliot a convincing account of experiencing psychotic symptoms.

***Jack's medical history***

25. Jack had a number of electrocardiograms (or "**ECGs**") leading up to his death.

26. On the following dates, Jack was the subject of an ECG which indicated the following results:

    a. 27 November 2014: “normal” and overall cardiovascular risk recorded as “low”;
    b. 14 April 2016: “abnormal ECG”;
    c. 3 and 23 November 2017: “Borderline ECG”; and
    d. 18 February 2018: “Abnormal Rhythm ECG”.

***Jack’s criminal and parole history***

27. Jack had extensive contact with NSW Police, dating back to 2002. There are 154 events linked to Jack on the NSW Police COPS system, with Jack being charged with criminal offences on 13 occasions.

28. Relevantly, on 11 November 2015, Jack was sentenced to four years’ imprisonment for robbery in company, with a two-year non-parole period. Further, whilst in custody, in January 2016, he was convicted of assaulting a correctional officer. For the latter offence, on 27 February 2017, Jack was sentenced to three months’ imprisonment, commencing 30 January 2017.

29. In a pre-release report dated 6 September 2017, it was noted that if Jack was to be released to parole he would be:

> … subject to new parolee supervision level during the first eight weeks of release, which will include a field contact visit each four weeks and then as per the approved case plan …

30. Community Corrections in that same report, however, recommended against Jack being released to parole, noting that Jack’s suitability for offender-targeted programs was unknown and his mental stability and post-release accommodation were yet to be confirmed.

31. In a pre-release supplementary report dated 3 January 2018, Community Corrections recommended that Jack be released to parole, noting the following:

    a. Jack had an assessed risk rating on release of “T3/Medium-High”;
    b. Jack “presents as an isolated individual with limited family support”;
    c. “It is positive that he is compliant with his medications and this continued compliance with be imperative to his stability in the community”;
    d. “following a review of notes from the Mental Health Nurse Practitioner, there is no intention to apply for a Community Treatment Order to

manage [Jack's] compliance with medication prior to his release on parole";

e. a referral had been submitted to the Campbelltown Integration Support Centre, given Jack was unable to provide any options for post-release accommodation;
f. Jack would be required to accept the supervision of a Community Corrections Officer in accordance with CSNSW policy and guidelines;
g. "[g]iven [Jack's] issues relating to mental health and drug use, his case management in the community will focus on engaging him with services to help manage these concerns … Contact with Campbelltown Community Corrections confirmed the availability of services from the Campbelltown Community Mental Health Team …"; and
h. Jack would require "ongoing support regarding reintegration into the community, including focus on his associates".

32. On 8 January 2018, Justice Heath Mental Health Nurse Min Jiang authored a letter noting that Jack's next depot injection was due on 16 January 2018.

33. On 11 January 2018, the State Parole Authority made a Parole Order that Jack was to be released from custody not later than 18 January 2018. Jack was subject to 18 conditions, which included, amongst others, that he:

a. must, until the order ceases to have effect or for a period of three years from the date of release, submit to the supervision and guidance of the Community Corrections Officer assigned the supervision of Jack for the time being and obey all reasonable directions of that officer;
b. not be in possession of a prohibited drug or substance and must, at the direction of the officer, undertake alcohol and drug testing;
c. participate in mental health intervention, if so directed; and
d. must comply with directions of the mental health team, including treatment and medication.

34. On 16 January 2018, Justice Health Nurse Practitioner Chris Muller faxed "Campbelltown COMET" (namely, the Campbelltown Community Mental Health Team, also known, and will be referred to here on in as **"Macarthur COMHET"**) to advise that she was concerned that without assertive follow up Jack "may well become non adherent with treatment and exacerbate". She also noted that his next depot injection was due on 30 January 2018.

***Registration with Macarthur Community Mental Health Team***

35. On 16 Jan 2018, a Macarthur COMHET nurse completed a Mental Health Triage form noting the referral from Justice Health to Macarthur COMHET. The Mental Health Triage form noted that Jack's current medications were:

    a. Zuclopenthixol 300mg IMI "every 2/52. Next LAI due 30/01/18"; and
    b. Quetiapine 200mg nocte, "Jack will be released with a 1/52 supply of oral medication".

***Jack on parole – 17 January 2018 to 18 February 2018 at 2.40am***

36. On 17 January 2018, Jack was released on conditional parole to reside at Campbelltown Integration Support Centre (**"ISC"**). A CSNSW Community Corrections Officer ("**the Community Corrections Officer**") was allocated to supervise Jack while on parole. At that time, the Community Corrections Officer was a Trainee Community Corrections Officer based at Campbelltown Community Corrections office.

37. On the same day, the Community Corrections Officer met with Jack. The Community Corrections Officer's notes on the Offender Management Integration System (**"OIMS"**) record that the following took place during that meeting:

> The parolee was given documentation from Justice Health to take to his GP regarding his MH medication, Seroquel XR 300mg, and also that he has been referred to Campbelltown Community Mental Health for his next depot injection due on 30/1/18.
>
> …
>
> Action – follow up on engagement with MH service provider/GP, medication and commence OIDF.

38. On 18 January 2018 at 8.00am, Jack signed out of the ISC and failed to return at his allocated return time.

39. On 19 January 2018 at 12.19am, an ISC staff member telephoned Jack to ascertain his whereabouts, noting that Jack had not returned to the ISC the previous night. During that telephone call, Jack became "agitated, argumentative and offered a myriad of excuses" upon being questioned about his failure to return on time.

40. At around 6.55am on the same day, Jack returned to the ISC. He advised ISC staff that he had not taken his medication the previous day and that he had been up all night. Jack also participated in a drug test which returned a negative result. It was later noted during a meeting between ISC staff and

Jack at 2.00pm on the same day that Jack's speech was slow and he was blinking profusely.

41. On 19 January 2018, the Macarthur COMHET also assessed Jack. In a MH Discharge/Transfer Summary form that the Macarthur COMHET completed on 28 January 2018, it was noted that Jack had indicated at the assessment that he was "wanting case management", that he was "[w]orried about running out of medication" and that he was "[w]orried about getting his depot; reassured that this is not due until Tuesday 30/01/2018".

42. Jack took his medication on 19 January 2018.

43. On 20 January 2018, Jack was observed to be singing at the ISC during the residents' hour (around 12.25am), then walking around talking loudly on his phone. Later, he left the ISC without signing out and then returned in the evening and was observed again to be yelling and singing loudly.

44. On 21 January 2018, Jack assaulted an ISC staff member. According to the attending police officers, the CCTV footage of the ISC showed Jack attempting to start fights with other residents at the Centre. Jack was informed that afternoon that he could no longer be a resident at the ISC and the Campbelltown Police were later contacted at 4.30pm following Jack's refusal to leave the Centre. Upon the police arriving at 6.30pm, Jack agreed to leave, complied with verbal directions from police officers, and was transported to his aunt's home.

45. On the same date, Jack participated in a DrugWipe test at the ISC. The test returned a positive result for amphetamines/methamphetamines. However, Jack denied using drugs. According to Jack's aunt, this failed drug test also contributed to the ISC's decision to remove Jack as a resident.

46. On 22 January 2018, Jack's aunt telephoned the Community Corrections Officer and advised that she was uncomfortable with Jack's behaviour in her home as she had young children residing there.

47. On the same day, Jack met with the Community Corrections Officer at the Campbelltown Community Corrections office. His aunt also attended. OIMS notes in respect of that meeting record that Jack was directed to make contact with Linked2Home, a service that provides temporary accommodation. To assist Jack's referral to Linked2Home, the Community Corrections Officer gave Jack a copy of his mental health and parole documents. Jack's aunt indicated during the meeting that Jack was not able to reside with family due to his behaviour and safety concerns for the family's children.

48. On the same date, a Macarthur COMHET staff member also telephoned the Community Corrections Officer and recommended that Jack be instructed to report to the COMHET. The staff member also advised that Jack's aunt had been informed that the COMHET would not be able to conduct a home visit on Jack until 24 January 2018 and that, given Jack's temporary accommodation was due to end on that date, the home visit was unlikely it would go ahead. The staff member further advised that Jack was to be referred for case management to the Macarthur Community Mental Health team and that "it will be hard to attain a residential MH facility as Jack's situation is more related to accommodation issues".

49. The Macarthur COMHET also discussed Jack's case on the same date, noting that Jack needed medication, that he would be provided with a script for Quetiapine and that he was due for his depot injection. Dr Karthik Modem made an entry in the clinical records that the script was prepared for Quetiapine with five repeats.

50. On 22 January 2018, Jack's aunt also contacted Macarthur COMHET as she was concerned about Jack's mental state and his unstable accommodation. Notes in relation to the phone call record the following plan:

> Aunty to pick up script [for Seroquel]
> MDT on 23/01/2018.
> Organise depot – due on 30/1/18

In accordance with the plan, Jack's aunt picked up Jack's script for Seroquel.

51. Following Jack's aunt contacting Macarthur COMHET, the COMHET telephoned the Community Corrections Officer. In a clinical record created in respect of that telephone conversation, it was noted that the Community Corrections Officer had indicated that he "[w]ould like CoMHET to review [Jack] due to concerns expressed by aunty". The plan was listed as:

> 1. [Discuss with team] on 23/01/17 ? the need for face to face review at ?Minto office or his temporary accommodation at 28 Angle Rd Leumeah
> 2. Organise depot chart
> 3. Refer to CC.

52. Jack was then accommodated for one night through Housing NSW at Dignity House, Leumeah. He was subsequently requested to attend the Campbelltown FACS Housing office on 23 January 2018 and advised that Dignity House would no longer accommodate him due to behavioural concerns, including threatening other guests, stealing a mobile phone and exhibiting paranoid and aggressive behaviour consistent with drug use.

53. On 23 January 2018, Jack failed to report to the Community Corrections Officer. At a team meeting at Macarthur COMHET on the same day it was noted that the Jack's plan was "PLAN: Assessment completed by CoMHET. Chronic issues with D&A use and non-compliance to medication. To discuss at Intake Meeting for CC/MATT follow up".

54. On the same date, a Macarthur COMHET clinical psychologist made an entry in the clinical records in relation to a multidisciplinary team meeting. It was noted that, amongst other things, "COMHET to ascertain client's whereabouts and short term accommodation/location" and "MATT to follow up if consumer is in area long term".

55. Late that afternoon, Jack self-admitted to the mental health ward at Cumberland Hospital, accompanied by his sister-in-law

56. Following Jack's admission, a Registered Nurse drew a mental health progress note recording a telephone call that had been received from Jack's aunty. She reported that Jack was known to "Macquarie mental health" and that his contact person was Rachel. A number for Macarthur Mental Health was noted. the Community Corrections Officer's contact number was also recorded.

57. On 24 January 2018 at 10.33am, Drs Graeme Sampson and Manoj Narayanan saw Jack at Cumberland Hospital. Dr Narayanan noted in a mental health progress note of the same date that "[a]s per patient he is on Seroquel, and Zuclopenthixol injection before. Last injection 300 mg last week". It was also noted that Jack "was upset and wanted to leave because he was not allowed to smoke" and the plan was to "[c]ontinue Clopixol and Seroquel".

58. On 24 January 2018 at 11.45am, mental health progress notes record that Drs Sampson and Narayanan had a telephone conversation with the Community Corrections Officer. According to the progress note, the Community Corrections Officer confirmed that Jack had received his depot injection from the Macarthur Community Mental Health Centre. The same telephone conversation is recorded in OIMS. According to the Community Corrections Officer, "the service provider is aware of [J]ack's parole order, writer requested to be contacted if day leave is granted and prior to discharge. Discussed Jack's medication and previous engagement with Macarthur Community MH".

59. As a result of Jack's conduct from 17 to 24 January 2018, the Community Corrections Officer submitted a breach report to the State Parole Authority on

25 January 2018. This report was noted by the Authority on 7 February 2018. The breach report stated that Jack appeared to be in breach of his parole order due to failure to comply with condition (3), namely "[t]he offender must, while on release on parole, adapt to normal lawful community life". Given Jack had been admitted to Cumberland Hospital, the Community Corrections Officer recommended that Jack's matter be stood over for a period of two weeks pending the outcome of mental health observation.

60. Between 25 and 27 January 2018, progress notes record that Jack was continuing to appear psychotic.

61. On 28 January 2018, RN Lawrence Zimbudzana authored a "MH discharge/Transfer summary" on behalf of the Macarthur COMHET. RN Zimbudzana noted in the "Summary of Care" that the COMHET plan had been to "administer depot due on 30/01/18". It was noted, however, that:

> COMHET received phone call from P & P Officer on 24/01/18 advising that client was admitted at Cumberland Hospital, Paringa Ward. COMHET MDT resolved to discharge client from service as client was admitted to hospital.

RN Zimbudzana noted that Jack's discharge medications were Quetiapine 300mg nocte and Clopixol 300mg IMI 2/52, and that the discharge plan was "[a]dmitted in Cumberland Hospital". Following from this "MH discharge/Transfer summary", there are no further records from the Macarthur COMHET that evidence any contact between the service and Jack.

62. Dr Modem gave evidence in the inquest that:

> … the policy is that even if he is admitted to the Campbelltown Hospital which is still in our area we still discharge them because he can't have two active running notes – two, when's not part of the service so we can't keep him as an open patient when he's part of a different service so that's procedural – that's a policy that we stick to, yes.

63. On 29 January 2018, Registered Nurse Bahaa Al Yawafi recorded in Cumberland Hospital progress notes that Jack had "express[ed] bizarre thoughts of a religious nature, and was identified as being delusional and at high risk of aggression".

64. There is no record of Jack receiving his scheduled depot medication on 30 January 2018.

65. On 1 February 2018, Jack was discharged from Cumberland Hospital.

66. On the same day, OIMS records that Dr Sampson telephoned the Community Corrections Officer. The OIMS notes of that telephone call indicate that the following was discussed:

> Dr Samson [sic] diagnosed Jack with a personality disorder which affects his conduct. He feels that Jack's condition is not a treatable illness that requires ongoing observations or admission with his acute service at the hospital. He recommended ongoing case management with a community MH service provider. It is noted that Jack was referred to Macarthur MH for case management prior to his admission. Dr Samson [sic] disclosed that Jack was not given a depot injection during his stay as it was not due, his medication is of some benefit, however believes that his behaviour will not improve and that he may get into trouble in the community and suggested that gaol may be a better place for him due to community safety concerns.

67. Dr Sampson's "MH Discharge / Transfer Summary" of the same date notes that Jack "was treated with Seroquel 300mg nocte ,& Clopixol IMI , which was given [to] him prior to his arrival here. He has been seen in the community at McCarthur [sic] Area Health Centre". Dr Sampson also noted that Jack's diagnosis was "? Schizophrenia, Personality Disorder, & Substance Abuse".

68. In respect of the telephone conversation described at paragraph 66 above, Dr Sampson denied having stated to the Community Corrections Officer that Jack's depot was not due, as he said that he did not know when it was due. He also gave evidence that he did not think that Jack needed the depot medication because Jack had a personality disorder and not schizophrenia, and that, even if Macarthur COMHET had decided on a specific treatment plan, the Hospital could do otherwise. Despite this evidence, Dr Sampson ultimately accepted that Jack's depot medication was important but stated it was up to the consultant to find out, and that it was not necessarily due on 30 January because Macarthur COMHET said it was due on that date.

69. Dr Sampson accepted that the plan for Jack as recorded in the "MH Discharge / Transfer Summary" was to continue the depot injections and Seroquel. He also accepted that it was a problem that someone receiving the discharge summary would not know when the next dose of Zuclopenthixol was due. Contrary to his evidence, there is no evidence to support Dr Sampson's suggestion of any clinical decision to discontinue Zuclopenthixol. He ultimately accepted that, if it had been his view that Zuclopenthixol was no longer needed, he would have stated as much in the discharge summary, and it follows that he did not decide that Jack should not receive Zuclopenthixol.

70. Jack was re-admitted to Cumberland Hospital as a voluntary patient, however, the same day, in the company of his sister. It was noted in the "MH Review" form that:

> Seroquel and clopixol charted as regulation medications
> Depot dose and next due to be clarified by the team

71. On 5 February 2018, Jack was discharged from Cumberland Hospital for the second time.

72. On the same day, OIMS records that someone called "Wayne" from Cumberland Hospital telephoned the Community Corrections Officer and informed him that Jack was being discharged and that he would be referred to Parramatta Housing for accommodation.

73. The "MH Discharge / Transfer Summary" noted that Jack presented to Cumberland Hospital with a "reported history of schizophrenia and want of accommodation". It was also noted that "[o]n the day of discharge, he did not have any psychotic or mood symptoms/ suicidal intent or plans" and his discharge medication was recorded as "[m]edication information has not been updated for this patient, during this visit".

74. There is no record of Jack receiving depot medication during his second admission at Cumberland Hospital.

75. Upon being discharged from the Cumberland Hospital on 5 February 2018, Jack was provided temporary accommodation through Bankstown Housing at the Banksia Motel in Bass Hill. Jack's temporary accommodation at the motel was extended until 14 February 2018.

76. It appears that the Western Sydney Local Health District Community Mental Health team attempted to contact Jack following his discharge from the Cumberland Hospital. On 6 February 2018, a progress note records that Sue Boyd of the Western Sydney Community Mental Health team "tried to contact patient for seven day post discharge follow up. Patient has no fixed address or phone. There is a number for his father which is not answering". On 9 February 2018, a further progress note records that Ms Boyd had "made numerous attempts to contact [patient's] relatives, as patient doesn't have a phone. File now closed".

77. There is no further evidence of any contact made between Jack and a community mental health team after Jack's release from Cumberland Hospital.

78. On 8 February 2018, the Community Corrections Officer telephoned Cumberland Hospital and was advised that Jack had been discharged from hospital on 5 February 2018. the Community Corrections Officer requested a copy of the discharge summary. There is no evidence to suggest that the Community Corrections Officer ever received the requested document.

79. On the same date, the Community Corrections Officer made four telephone calls – to Banksia Motel, Jack's sister, Jack's brother and Banksia Motel – and requested assistance from Housing and Jack's sister in making contact with Jack.

80. On 9 February 2018, the Community Corrections Officer telephoned Community Corrections officer Peter Fitzgerald (**"CCO Fitzgerald"**) at the Bankstown Community Corrections office. During that telephone call, the Community Corrections Officer advised that the Campbelltown Community Corrections office had had minimal contact with Jack and that Jack had not been in contact with CSNSW since his discharge from Cumberland Hospital.

81. On the same day, Bankstown FACS Housing telephoned the Community Corrections Officer and advised that Jack had been compliant with his obligations with Housing during his stay at the Banksia Hotel. Jack had therefore been allocated an appointment by Housing for a mental health assessment on 13 February 2018 to determine if he was able to live independently and his eligibility for the disability support pension.

82. Following the telephone call from Bankstown FACS Housing, the Community Corrections Officer directed Jack to report to the Bankstown Community Corrections office. Jack complied with the direction and was seen by CCO Fitzgerald. CCO Fitzgerald's notes of the meeting record Jack's medication as "said he is prescribed Seroquel only and takes it faithfully". During the meeting, Jack also "acknowledged that he needs to be connected with MH services".

83. On 12 February 2018, Jack visited a brothel in Bankstown. The manager remembers that Jack's tongue was very white and that "he kept sticking it in and out of his mouth like a dog". Jack's behaviour led the manager to believe that Jack was "very high on something".

84. Jack failed to report to CCO Fitzgerald on 13 February 2018 and did not attend his mental health assessment.

85. On 14 February 2018, the Community Corrections Officer telephoned Jack's sister, who advised that she had not seen Jack for a few days. She indicated that she was unsure as to whether Jack was still residing at the Banksia Motel

and advised that she would go to the motel to see Jack that night or the following evening.

86. On the same date, Jack visited a pawn shop and sold a gold necklace that he had been wearing for $90. To complete the transaction, he was required to provide proof of address. He visited the Centrelink office next door to the pawn shop and returned with a payment summary which listed his address as a Punchbowl address. It is not clear from the material contained in the brief of evidence who in fact resided at this Punchbowl address.

87. On 15 February 2018, police officers were called to attend the Marrickville Tavern in response to a job relating to "a large islander male, who is possibly intellectually impaired, failing to leave the pokie area upon request". One of the attending officers, Constable Peter Treacy, now believes the relevant male to be Jack. Constable Treacy stated that Jack appeared angry because he felt that he had won a game on a slot machine but it had not been paid out. Constable Treacy did not form the view, however, that Jack was adversely affected by drugs or alcohol, but rather "it was apparent that he may have an intellectual disability". Whilst Jack did not initially comprehend what was communicated to him, he ultimately complied with the police officers' directions.

88. On 16 February 2018, police officers were called to attend a 7/11 store in Marrickville due to a "Male POI inside store refusing to leave and harassing customer". The attending police officers – Leading Constable Sarah Jessup and Constable Cameron Edwards – now believe the relevant male to be Jack. Upon arrival, Constable Edwards completed checks via the police radio using Jack's ID and, at that time, Leading Senior Constable Jessup heard on the police radio that Jack had previous reports for mental health. That night both police officers formed the view that Jack was not, however, displaying signs of mental health issues. Jack was provided with a banning notice and moved along. The police officers inadvertently retained Jack's ID and they later located him while on patrol on 17 February 2018, at which time it appeared to them that Jack seemed in good spirits and did not appear to be under the influence of any drugs or alcohol.

89. Constable Edwards indicated that Jack advised them that he was staying at a boarding house in Marrickville. Whilst there is no evidence that this was the case, Jack had previously stayed in a boarding house in Marrickville in 2017.

90. On 18 February 2018, between the hours of 1.30am and 3.00am, Jack buzzed the door at the Song Hotel in Chippendale. The night auditor opened the door and Jack pushed past him. He noticed that Jack's "eyes were very red and he smelt like alcohol". Jack appeared to be angry, and the night

auditor thought Jack "was drunk or on some type of drugs". He asked Jack to leave but Jack refused and used the bathroom. The night auditor then called Redfern Police but, as he did so, Jack left.

91. At 2:40am on the same day, police officers were called to a licensed venue in Chippendale where Jack was reported as loitering in the vicinity of the premises after he was refused entry. When approached by police officers, Jack agreed that he had been drinking and had attempted to gain access to the venue by avoiding security. Jack ultimately complied with the move on direction.

***First incident***

92. On the morning of 18 February 2018, a witness observed Jack on Bridge Road, Glebe, "babbling about the fact that he owned this land". He also saw Jack arguing with a friend about giving sunglasses to "Johnny" that Jack had sold to him. During the argument, Jack appeared to be interchangeably crying and then becoming aggressive.

93. Another witness heard Jack call out, "Hey boss," and saw Jack pick up a hire bike and attempt to ride it, even with its back wheel locked. (It appears that the bicycle that Jack was using the morning of 18 February 2018 was a rental bike. When a rental bike has been rented, a mechanism releases the back wheel of the bike so that it can be ridden. As it appears that Jack had not paid to rent the bike, its back wheel remained locked.)

94. Further witnesses observed Jack riding a bicycle in the middle of the road near Allum Place, Glebe. One witness stated that Jack appeared to be sweating a lot, which seemed to that witness to be unusual as it was not a hot day and it was still early in the morning. Other witnesses described Jack as unsteady on the rental bike, having trouble peddling and falling off multiple times in the path of oncoming traffic. Jack did not appear to the witnesses to be trying to stop himself from falling off the bicycle, and he yelled at passers-by in what was perceived as an aggressive tone. A number of the witnesses called the police expressing concern for Jack's safety.

<u>Arrival of police</u>

95. Following police being contacted about Jack, Constables Jessica Guthrie and Sam Marshall responded urgently under lights and sirens. Constable Marshall was wearing a taser that day, which he had booked out and appeared to be in working order.

96. Constables Guthrie and Marshall spotted Jack at 9.40am “at the cross of Allum St”. Constable Marshall noted on the radio that Jack appeared “quite intoxicated”.

97. Upon arrival, Constable Guthrie noted that Jack was a large Islander male, who was extremely sweaty and unsteady on his feet. She formed the view that “he clearly wasn’t sober”, and “was either drunk or on some other type of drug or something”. She recalls that she “[p]ossibly” had concerns as to Jack’s mental health.

98. Constable Guthrie was the first to approach Jack. He was on the footpath and she “kind of pushed him” further onto the footpath to get him out of the way of oncoming traffic. Jack then “kind of stood there for a little bit” and Constable Guthrie introduced herself to him. Jack was compliant during the initial conversation but then started to walk away, still straddling the bike.

99. Jack attempted to ride away from the police officers but “started kind of wobbling around and … stumbling over the bike as if to fall or try and run away with it between his legs”. As a result of Jack’s movements, Constables Guthrie and Marshall tried to hold Jack’s arms to steady him on the bike. Constable Guthrie stated that both officers lost their grip on him as he was “extremely sweaty”. She viewed this as an “indicator” that Jack was “on something other than alcohol”. Constable Marshall also observed Jack to be “a little unbalanced, a bit dazed” and talking in incoherent sentences.

100. Constable Guthrie recalled that Constable Marshall then said he would call Jack an ambulance. Constable Guthrie thought it was appropriate to call an ambulance because she was concerned about Jack’s state of intoxication and the potential risks arising from that. Constable Guthrie noted that it was after Constable Marshall referred to calling an ambulance that Jack began tensing his arms and saying, “Let me go”.

101. Constable Marshall recalls Constable Guthrie then “gripped [Jack’s] shoulder ... put her hands on him,” and said, “Look, mate, you’ve got to, got to stop”. It was at this point that Constable Marshall believed Jack’s behaviour escalated and that Jack started to “sort of thrash his arms around”.

102. Constable Guthrie reported that she took the bike about five to ten metres away from Jack, as she was concerned that Jack, who had a “very solid build” and weighed at least 130 kilograms, might use the bike as a weapon and possibly try to get away. Constable Guthrie recalls that Constable Marshall then used the police radio to call for an ambulance. Constables Guthrie and Marshall each took one of Jack’s wrists to keep him on the footpath until the ambulance came, but Jack started to become quite aggressive, trying to

break free and was displaying aggressive body language, which included tensing his body and balling his fists.

103. Jack then broke Constable Guthrie's grip and took a swing at her, connecting with her right thigh. She then stepped back in to assist Constable Marshall and fell to the ground together with Jack, trying to hold onto him as tight as she could, "bear-hugging him from the back … holding on to his … chest". As a result, Constable Guthrie and Jack were "rolling around on the ground", with Jack "continuously try[ing] to … shake [Constable Guthrie] off his back".

104. According to Constable Guthrie, it was at this time that Constable Marshall made an urgent radio call. Recordings of the police radio indicate that at 9:42am a radio call was made stating, "Leichardt one seven urgent". This was the first "urgent" radio call that Constable Marshall had ever made. He recalls however that the call was made before Constable Guthrie pulled Jack down. Sergeant Jacqueline Buchanan recalls hearing Constable Guthrie on the radio "very distressed … she was screaming".

105. Constable Guthrie gave evidence that Jack then relaxed "a bit" and she let go, leaving both herself and Jack sitting on the ground. While Constable Guthrie was moving to stand up, she felt like Jack was going to punch her, at which stage Constable Marshall grabbed hold of Jack's arm. After a further struggle, Constable Marshall sprayed Jack in the face with OC spray for a one second burst. When Jack continued to resist, Constable Guthrie also sprayed Jack with OC spray in a short, one second burst but this had little to no effect on him. Constable Guthrie managed to restrain his legs, but felt that Jack was "still extremely strong" and that it was unlikely they would get the cuffs on him. When Jack tried to push his body away from the ground in a push up position, she used her whole body weight to pin his hip to the ground. Constable Guthrie recalls striking Jack five or six times on his thigh with a baton while directing him to "get your arm out". The VKG recorded at 9:43am a repeated "Leichardt one seven urgent" call and a further call stating "POI's resisting".

106. Constable Guthrie reported being fearful at this time that Jack would assault her or Constable Marshall and that "he just wanted to walk away from us at all times". Constable Guthrie believed Jack could potentially overpower the officers and "knock me unconscious". When asked what she believed would happen if Jack was left unrestrained, Constable Guthrie stated that she feared he would continue to run into traffic, possibly be hit by a passing car or potentially lash out and hurt the officers.

107. Sometime after 9:44am, Detective Sergeant Stephen Sutherland, who was an Inspector at the time, and Constable Patrick Pike arrived on the scene. Detective Sergeant Sutherland was also the Acting Duty Officer on this day.

Sergeant Buchanan, who was an Acting Sergeant at the time, also arrived on the scene around the same time.

108. Constable Guthrie recalls that, once Constable Pike arrived, he assisted in pinning Jack onto his stomach and getting the cuffs on him. She also recalled that Detective Sergeant Sutherland did not get involved in the scuffle. This is inconsistent with Constable Marshall and Detective Sergeant Sutherland's evidence. They indicated that it was Detective Sergeant Sutherland who became physically involved and it was his handcuffs that were used to secure Jack.

109. After Jack had been handcuffed, Constables Guthrie and Marshall's car (a caged truck) was moved and Jack was placed in the back.

110. At 9:45am, a police radio call was made noting that Jack was "restrained, he's in cuffs". Detective Sergeant Sutherland radioed at 9:46am for an ambulance for decontamination as Jack was affected by OC spray.

111. Jack then showed signs of settling down. Sergeant Buchanan and Constable Pike opened the door to the truck in order to pour some water on Jack's eyes but, when he tried to get up, they pushed him back into the truck and closed the door. They decided to wait for the ambulance to arrive before releasing Jack from the truck. Whilst Jack was in the truck, he kicked the back of the cage door.

Arrival of the ambulance

112. The ambulance received the call for assistance at 9.51am, it was dispatched at 10:06am, and reached the scene at 10:12am.

113. Following the arrival of the ambulance, police officers opened the door to the cage on the truck and explained to Jack that the ambulance was there to help. Detective Sergeant Sutherland describes that Jack "virtually threw himself out of the truck onto the ground".

114. NSW Ambulance Officer Alexander Brooks also saw Jack attempting to jump out of the caged truck. When he saw Jack's behaviour, NSW Ambulance Officer Brooks became concerned that Jack might have been mentally disturbed or suffering from excited delirium. He tried asking Jack some questions but Jack's responses were nonsensical.

115. With Jack lying on his right side on the ground, one police officer was crouched down and trying to hold down his legs. Jack was calm for short periods and then would unexpectedly kick out with one of his legs and try and

roll onto his back and move around. Jack told police that he loved them. While ambulance officers were assisting Jack, he appeared to speak incoherently and often in the third person, saying, “I am the God, I am the best…Jack is the boss”. Jack also made a number of sexual comments to Sergeant Buchanan, including telling her he loved her and asking her to “touch my dick”.

116. Constable Guthrie recalls the paramedics lying Jack on his side and squirting a sedative up his nose, whereas Constable Marshall, Detective Sergeant Sutherland and Sergeant Buchanan recall it being injected into his upper arm. NSW Ambulance Officer Brooks’ statement confirmed that he administered Droperidol, a sedative, by injection for Jack’s safety and the safety of others in attendance.

117. NSW Ambulance Paramedic Tristan Mercer, who was at the time a paramedic intern, noted that, after Jack received the Droperidol, the police officers present continued to restrain Jack by holding his arms and legs and “[s]everal minutes later it was apparent that the Droperidol had been effective and [Jack] was much calmer”. Sergeant Buchanan described the effect that the Droperidol had on Jack as “it was just like an instant sort of change in his whole demeanour”. She said between the administration of the injection and Jack getting into the ambulance, “I don’t think there was anything more in terms of aggression there”. Constable Guthrie said Jack was “quite calm and compliant with the … paramedics. So whether the sedative was involved with that then, yeah, possibly”. Detective Sergeant Sutherland recalled that the sedative caused Jack to calm down “within maybe a matter of minutes”.

118. Detective Sergeant Sutherland also recalled that, whilst the ambulance officers were engaging with Jack, they were reassuring him. He stated further:

> … I think there were police officers there too who were also speaking to Jack, and he, he seemed to calm with having that reassurance with that conversation. Even though Jack wasn’t saying anything directly to us that I could comprehend, I think he calmed considerably when, when the ambulance officers and police were talking to him when he was basically laying on the stretcher.

119. Jack was able to walk to the stretcher when asked. An ambulance officer placed restraints on his arms and legs. Jack was observed to be compliant. The handcuffs were removed from Jack when the ambulance restraints were secured.

120. Jack was loaded into the ambulance at 10:28am.

121. While he was being loaded into the ambulance, Sergeant Buchanan asked Jack what drugs he had taken. Initially Jack responded: “oh no miss, I don’t do drugs”. However, when pushed, Jack claimed to have had “some weed” (or “some pot”), “some coke” and “some ice”. Sergeant Buchanan says she had believed Jack to be drug affected as he was aggressive, sweating, manic, agitated, nonsensical, frothing and drooling. Constable Guthrie also believed that Jack was drug affected because of his excessive sweating and bloodshot eyes. Paramedic Mercer stated that, “[f]rom my experience, [Jack] appeared to be drug affected and later he admitted that he had recently used ‘heaps of ICE and marijuana’”.

122. Ambulance officers noted that during post-decontamination Jack denied all other pain, had “no difficulty breathing, was speaking in full sentences, chest sounds were clear and equal bilaterally, nil obvious head, neck, thoracic or long bone trauma, nil neck pain on palpitation”. Jack’s Glasgow Coma Scale remained at 14 during transport to the hospital and there were nil changes in his sinus rhythm.

123. It was discussed between Constable Guthrie and Detective Sergeant Sutherland at the scene that while there may be future charges laid against Jack, he should go to the hospital for a mental health assessment under the *Mental Health Act 2007* (NSW).

***Admission to and absconding from RPA***

Arrival at the RPA

124. The ambulance left the scene at 10:28am and arrived at the RPA at 10:36am. Jack was transferred from the ambulance stretcher to a hospital bed at 11:12am.

125. Constables Guthrie, Marshall and Pike and Sergeant Buchanan followed the ambulance to the RPA. Upon arrival, Constable Guthrie washed the abrasions on her arms out of fear of contamination from Jack.

126. During triage, Jack’s prior medical history was listed as schizophrenia, depression and polysubstance abuse. Sergeant Buchanan recalled Jack continuing to make sexual comments during triage. Sergeant Buchanan also recalled a security guard from the hospital who was present during triage. She says that the paramedic with Jack commented to the security guard that Jack would need care. The security guard allegedly said, “I don’t give a fuck,” and walked out the door. The last that Constable Guthrie saw of Jack was him sleeping on the stretcher. She believed that he had been given more

sedatives as he slowly became “more and more drowsy”. Sergeant Buchanan recalls Jack asking for “more ice” from the doctors at the hospital.

127. There is no evidence that security was notified of Jack’s admission by any nursing or medical staff upon his entry into the hospital.

128. Constable Marshall recalls completing s. 22 paperwork to schedule Jack, namely a “Request by a member of NSW Police Force for assessment of a detained person” form. The form that Constable Marshall completed identified the following information:

    a. Jack’s current behaviour was “Intoxication (Drugs/Alcohol)” and “Attempted self-harm”;
    b. “Any other relevant information” pertaining to Jack was “Significant criminal history including numerous serious offences”;
    c. police intervention included “Appointments” and “Weaponless control”; and
    d. the description of the circumstances that led to apprehension of Jack was:

> About 10:30am police responded to Bridge Rd, Camperdown, following numerous reports from the public regarding a male attempting to run into traffic moving at approx. 60kmph.
>
> On arrival police located the above named person who appeared heavily affected by drugs and/or alcohol. Whilst police were speaking with the person his behaviour became aggressive and erratic. This person attempted to leave the scene prompting police to detain him. Due to his highly aggressive state, police were required to deploy OC spray, batons and strikes in order to subdue him.
>
> Due to his behaviour police believe that he posed a significant risk to both himself and members of the public.

129. Once the s. 22 paperwork was completed, all four police officers present left the hospital.

130. Jack was first seen by Registered Nurse Joceli (Joy) Cabides (“**RN Cabides**”) in the Resuscitation Bay, which is a three bedded area in the Emergency Department where one nurse is allocated to each of the three beds. As Jack was a scheduled patient and in the Resuscitation Bay, he was automatically allocated 1:1 nursing.

131. Jack was already physically restrained to the hospital bed when RN Cabides saw him. She received a verbal handover from the ambulance officers, who

advised that Jack was a scheduled patient. She was also advised that Jack had been running through traffic, had been "capsicum sprayed" by police officers and had been administered Droperidol. As part of taking on Jack's care, RN Cabides recalls having a "brief look at" the s. 22 form that Constable Marshall prepared in respect of Jack. At the time of giving evidence at the inquest, she was unable to remember what was recorded on that form.

132. Dr Dawn Cutler, an Emergency Department Consultant, was also asked to review Jack in the Resuscitation Bay around about the time that Jack was being transferred from the ambulance stretcher to the Resuscitation Bay bed. Dr Cutler obtained Jack's history from the two police officers and two ambulance officers present. She recalled that they advised her that there was concern for Jack as he had been found walking on the road, became aggressive when police officers arrived and it had taken a number of police officers to restrain him. The ambulance officers advised that Jack had been sedated with 10mg of Droperidol. Dr Cutler understood at the time that Jack had apparently taken ice and cocaine within the 24 hours prior to presentation. Dr Cutler also accessed Jack's powerchart, which indicated that he had had previous admissions for drug-induced psychosis and a forensic history, and arranged for a request for Jack's Cumberland Hospital records.

133. Dr Cutler then conducted an examination of Jack. He had abrasions to his feet and "it looked as though he had been walking around without shoes for a while". He advised he was not in pain and was unable to provide any further information or medical history. Dr Cutler described Jack's presentation as "[o]verall, … quiet and drowsy, but cooperative". Given he was drowsy and still affected by the sedative, Dr Cutler did not consider that Jack could properly be assessed (that is, a mental health assessment) at that time.

134. Finally, Dr Cutler arranged for an ECG to take place as she considered it necessary given Droperidol can affect a person's heart rate.

<u>"Emergency Department Request for Nurse Special" form</u>

135. At around 10:45am, Nurse Unit Manager Jessica Francis ("**NUM Francis**") completed an "Emergency Department Request for Nurse Special" form. NUM Francis identified the following information on the form she completed:

    a. Jack was scheduled;
    b. the "Nurse Patient Ratio" was 1:1;
    c. the reason given for "special" was "sedated aggressive";
    d. Jack's diagnosis was "MH" (mental health);
    e. Jack's behaviour was "violent";
    f. "yes" was circled next to the words "Attempting/Wanting to Leave"; and

g. a male nurse was requested.

136. In her statement, NUM Francis explained that she had completed the above form "in case [Jack] was transferred from the Resuscitation Bay" to another ward. The nursing care provided in the Resuscitation Bay, as noted above, was 1:1, regardless of whether a patient was scheduled or not.

137. In giving evidence, NUM Francis explained that she had requested a male nurse because often assistants in nursing are "young 18 year old female, 19 year old female nursing students". As Jack "was quite a large man", she thought that those female nurses may "feel intimidated by him". She also explained that "often the boys [i.e. the male nurses] seem to have a better rapport" with male patients.

138. In respect of NUM Francis having circled "yes" next to "Attempting/Wanting to Leave", she gave evidence at the inquest that the basis for this answer was that she believed Jack had "said at some stage that he wanted to go". She also agreed that she circled this answer as she thought there was a risk that Jack would attempt to abscond from the hospital.

139. The "Specialling Patients in the Emergency Care Setting" policy sets out the systematic approach that should be provided to "at risk patients whom require a higher level of supervision in the ED". The role of the Emergency Department NUM is to liaise closely with members of the Emergency Department team to ensure the individual assessment and needs of the patient are met. The policy identifies that patients, staff and the general public are entitled to be protected from harm or injury and that patients may pose a risk to themselves and to others. If a patient is at risk of absconding the medical team must review the patient as soon as practical or allocate a senior medical officer or Mental Health Nurse practitioner who has the necessary skill set to provide such a review.

140. Despite the fact that NUM Francis identified Jack as at risk of absconding, it does not appear that NUM Francis took any action consistent with the abovementioned policy.

<u>Use of restraints</u>

141. At 11.00am, RN Cabides completed the "Patient safety physical restraint order and observation chart" form. She noted on the form that a restraint order had been made on 18 February 2018, and that Jack was being checked every 15 minutes, that his temperature was warm, that his pulse was present and his skin condition "normal". The form was not signed by a medical officer, nor did it identify the "Duration and reason required" for the restraint.

142. When asked who had made the restraint order, RN Cabides initially responded that:

> [t]he medical officer and the ambulance … it's a collaborative team decision. This gets filled out with the signature by the medical officer. We, the special nurse or the resus nurse fills up the, the restraint, the time, the type and the area that, all of that observations.

She later clarified that she was unable to recall who specifically authorised the restraint.

143. In respect of the information missing from the form, the following exchange took place between Counsel Assisting and RN Cabides:

> Q. Surely when you were completing this form, you should have spoken to the medical officer in order to ask how long should this patient be restrained and what is your reason for restraining him?
> A. I did ask the medical officer about this. I said 'You have to sign the order' and I did remind her and she knows about it. I'm not sure what happened in between that and she told me 'We will just keep him under restraint until we properly assess him' and I said 'Okay' and yep that's it.
>
> Q. So now you say that, is that Dr Cutler?
> A. Yes.
>
> …
>
> Q. Is your evidence that you recall Dr Cutler saying to you "Keep him restrained until he's been properly assessed'?
> A. Just Dr Cutler just told me just to keep him as it is. Sorry wordings are not proper. Because I've asked her 'What's the plan?' And she asked me, 'Is he vitally stable?' I said 'Yes, but still uncooperative with the questioning and all that and won't even let me do some bloods on him.' And she didn't give me a direct order to keep him on restraint. She said 'We'll just wait until we get the medical records and so we can properly assess him.'

144. The restraints used on Jack were "posey" restraints. The Sydney Local Health District Policy Directive, "Restraint Policy" (**"2014 Restraint Policy"**), which was in place at the time, provided that restraints could be used to protect the safety of a patient and staff from immediate risk. Restraints were to be used for the shortest period necessary.

145. The 2014 Restraint Policy relevantly provided:

a. the clinical team will determine the need to include restraint in a patient's management plan;
b. the decision to restrain a patient must always be a team decision;
c. the authorisation of restraint must be by the person who made the decision to use the intervention, often the senior nurse who leads the response team;
d. the use of restraint must also be authorised by the medical officer; and
e. a coordinator, usually the nurse in charge or other qualified health professional must accept the responsibility for initiating and coordinating the restraint.

146. It is not immediately apparent who formally authorised the use of the restraints on Jack.

147. The hospital copy of the Ambulance Electronic Medical Record noted that restraints were applied at 10:35am for the following reasons: "mental health, drug affected, [violent], in police custody".

148. Paramedic Mercer recalls that the soft restraints that the ambulance officers used "were removed from [Jack] and he was transferred from our stretcher onto a Resus bed. Hospital soft restraints were then immediately applied to [Jack] by nurses with the assistance of security staff". It is likely that the nurse involved in this process was Registered Nurse James Churchland ("**RN Churchland**"). In his statement, RN Churchland recalled:

> A short time after [Jack] arrived in the Resuscitation Bay, the Ambulance restraints were removed from him and he was transferred to Resuscitation Bay Bed 1 and restrained to the bed with Hospital restraints. I was involved in this restraint process by attaching the Hospital restraints to the Resuscitation Bay bed. The Paramedics then moved Mr Kokaua from the Ambulance stretcher to the Hospital bed and applied the Hospital restraints.

149. In his evidence at Court, RN Churchland advised that he could not recall who authorised the use of the hospital restraints. He noted however that:

> So I think in practice … if somebody comes in, in restraints then it's normal practice to keep them restrained. Until they've had a proper medical evaluation, we can decide whether the restraints are appropriate to come off or not. If someone doesn't come in restrained and we decide to restrain them once they're in the department, that's a medical decision.

150. RN Churchland's comments referred to immediately above appear to be consistent with Dr Cutler's evidence.

151. In contrast, NUM Francis stated that she "believed" it was Dr Cutler who had authorised the restraint because she remembered Dr Cutler "talking about restraints being on" and Dr Cutler was the medical officer looking after Jack on the relevant day. She stated however that she was not aware of any discussion amongst the clinical team about the use of restraints on Jack.

152. Whilst Dr Cutler initially commented that Jack "came in with ambulance restraints on, so the decision was made prior to him coming to hospital", she went on to state:

> I asked that the restraints were left on and that was [in] discussion with the team that were looking after [Jack] so there would've been a nurse there, which I think was [RN Churchland], possibly more nurses. I seem to remember there was [RN Churchland], two paramedics and two police officers.

153. Dr Cutler also agreed that she had spoken to RN Jecky Soni about the restraints.

154. In her statement, Dr Cutler said that her plan in respect of the use of restraints on Jack was that "once the effects of the Droperidol had worn off and [Jack] was able to be assessed by a Mental Health clinician, a decision could be made as to the removal of the restraints". Dr Cutler conceded in her evidence that her plan was not articulated in the restraint order form, but that she had advised the nursing staff that Jack should remain restrained until he was awake. She also said that her usual practice was to complete the form when conducting a comprehensive review of the patient, which she was intending to complete when the effects of the Droperidol on Jack had started to wear off. As Jack had absconded, this review was unable to take place.

<u>Observations of Jack</u>

155. Between 11:00am and 12:30pm, RN Cabides filled in information on an "Emergency Department Mental health and delirium risk assessment" form on four occasions at roughly 30-minute intervals. The risk assessment form indicated that Jack's total mental health and delirium risk assessment score was 9 or 10 on each occasion. There was no notation made against the criteria "NUM/In-charge notified if risk assessment score>8", as required.

156. RN Cabides clarified in her evidence that she had verbally advised Dr Cutler and RN Churchland of the risk assessment scores, and that she must have forgotten to make a notation on the form regarding the same.

157. According to the "Specialling Patients in the Emergency Care Setting" Policy Directive, a score of nine to 15 on the risk assessment form indicated a "medium risk". This required that the following was to take place:

a. the patient be assessed every 15 minutes;
b. that the patient be placed in the department for easier observation;
c. that the patient be considered "special";
d. the NUM or a more senior officer be referred to; and
e. the medical and nursing staff needed to consider escalation of treatment such as oral medication.

158. At 11:59am, Dr Cutler reviewed the results of Jack's ECG. The results indicated that Jack had an abnormal rhythm, suggestive of sinus tachycardia. Otherwise, his vital signs were within normal range, although his heartrate was slightly elevated. According to Dr Cutler, this was consistent with Jack having taken illicit drugs.

159. At 12:01pm, Dr Cutler completed an entry in Jack's electronic medical record. It noted, amongst other things, the following:

a. Jack "[b]ecame aggressive and rambling on arrival of police";
b. he "[r]equired manual restraint and 10mg IM droperidol";
c. Jack's medications included "Depot" and "? Quetiapine"; and
d. Dr Cutler's plan was that a psychiatric review would be conducted on Jack.

160. At 12:30pm, RN Cabides made a note that Jack was taking off his monitoring leads every now and then and was unable to keep still so as to allow RN Cabides to safely take bloods. She also included in the note that the medical officer (or "MO") was aware, presumably, of these observations.

<u>Removal of Jack's restraints</u>

161. At approximately 12:40 pm, Jack asked to use the toilet. RN Cabides advised Jack that, as he had been scheduled, he would have to use a bottle and was unable to go anywhere without an escort. RN Cabides then gave Jack a bottle and he asked for privacy. He then indicated that he could not use the bottle because he was restrained. RN Cabides loosened Jack's left hand restraint and undid his ankle restraints, so that he could use the bottle. In her statement, RN Cabides indicates that she had some concerns about loosening Jack's restraints as he "was a big man and it would have been difficult to re-restrain him, however he had been compliant and cooperative up to that point".

162. RN Cabides had not been advised that it had taken seven police officers to restrain Jack. While she agreed that increased the likelihood of his absconding, she gave evidence that if he did abscond, all they could do was to ask him to come back. She accepted that the information from the ambulance service ("mental health, drug affected, violent, in police custody") suggested that Jack may be unpredictable when the Droperidol wore off. However, she maintained that even if she knew that due to Jack's highly aggressive state, police were required to deploy OC spray, batons and strikes in order to subdue him, this would not have made any difference to her decision to release Jack's restraints to enable him to go to the toilet. She explained, "I'm rendering care to him and according to our policy, if we are rendering care to our patient and it, the initial risk that he came in and has gone off, we can take off the restraint". She later accepted, however, that when she loosened Jack's wrist restraint she did have a concern that she may have to re-restrain him.

163. The 2014 Restraint Policy in place at the time provided no allowance for a restraint to be removed because a patient currently restrained requested to use the toilet.

164. RN Churchland gave evidence that it was the practice in the Resuscitation Bay to remove restraints to allow for a patient to use the toilet and if there was a high risk of aggression then security might be called to assist. Consistently, RN Cabides indicated that she would call security to supervise a patient's use of a bottle for urination if there was risk of danger were the patient to be unrestrained. RN Churchland and RN Cabides each gave evidence however that the risk of a patient absconding or becoming aggressive would not have changed their decision to remove restraints so that a patient could use the toilet.

165. NUM Francis stated that if a patient was calm and compliant, there would be no reason to not let them go to the bathroom. She would, however, tell a colleague that she was going to be releasing restraints so that "they could give you a hand". She said if Jack had become non-compliant, the plan was always to call security. Security could not have performed a controlled take-down of Jack however should he have tried to leave the hospital.

166. The 2014 Restraint Policy provides that a "mechanical restraint can be ceased by the senior nurse or MO at any time if the reason for the intervention has ended".

167. When asked about the above aspect of the 2014 Restraint Policy, RN Cabides said that she was a "senior nurse" for the purpose of that policy

and that it allowed her to temporarily release (rather than cease altogether) Jack's restraints so that he could go to the toilet.

168. Dr Cutler stated that it was a "nursing decision" regarding a person who was restrained needing to use the toilet, and she would not normally expect the nursing staff to involve her in that decision. She said later, however, that she discussed with RN Jecky Soni the policy that the restraints needed to be removed as soon as they could but that she never made a decision to take them off.

169. RN Jecky Soni, CNC, accepted that if it was possible, it would be a good idea for him to be consulted as to the decision whether to release restraints.

170. Each of NUM Francis, RN Cabides, and Dr Cutler gave evidence that the plan was to follow the "Absconded Patient Policy" and to press the duress alarm if Jack's behaviour escalated.

Jack absconds

171. Following the loosening and removal of Jack's restraints, RN Cabides then left Jack alone behind the curtains. She later "peeked" around the corner of the curtains, at which time she saw Jack remove his other hand restraint and so she pressed the duress alarm.

172. RN Cabides said that she used de-escalation techniques once it became apparent that Jack had loosened his restraints. She said that she had developed a rapport with Jack and that when he began loosening his restraints "she offered him if he wants to go to the toilet, [she] can walk him to the toilet … And [she] even led him …"

173. In response to the duress alarm, a male nurse spoke to Jack behind the curtain. A short time later, security, NUM Francis and other nurses arrived in the Resuscitation Bay. According to RN Cabides, Jack then became angry. A staff member told Jack that he could use the toilet in an isolation room but he said he did not want to. Jack then moved into the emergency department corridor, where he was followed by staff. He was directed to a "quiet room". Jack came out of the "quiet room" by which point there were three security officers present. He then walked through the ambulance bay, jumped over a stretcher with another patient in it and exited the hospital.

174. The RPA "Absconded Patient Policy" identifies that there are a number of factors that may indicate that there is an increased likelihood that a patient will abscond and that those factors should be taken into account to implement appropriate strategies to minimise the risk of absconding. The factors which

are said to increase the risk of absconding include a history of mental illness, delirium, agitation, being held involuntarily under the *Mental Health Act* and a history of drug and/or alcohol misuse/intoxication. It is apparent that Jack had a number of risk factors that may have indicated an increased likelihood of absconding.

175. The strategies to minimise the risk of absconding, as set out in the "Absconded Patient Policy", include identification and de-escalation of potential stressors, inclusion of details in clinical notes, location in an area of the ward where direct observation is easier, specialling of the patient and timely communication with security about the patient.

176. The "Specialling Patients in the Emergency Care Setting" policy also states that "[s]ecurity should receive a verbal report regarding any patient who is at risk of absconding and a plan of escalation is discussed including any potential risks for patient or staff".

177. As a scheduled patient, Jack was at high risk of absconding. As noted above, there is no evidence to support that security were advised that Jack, a scheduled patient, had been admitted to the RPA. On the evidence it appears that the first time that security was notified about Jack was after the duress alarm was pressed. Further, no plan was ever discussed or put in place as to how to respond if Jack were to become confrontational or violent.

178. A Registered Nurse also in attendance on the day indicated that usually when a patient comes in with police, the nurse triaging the patient or the nurse receiving the patient in the Emergency Department would contact security. In contrast, RN Churchland gave evidence that, while it would have been best practice for security to attend when a scheduled patient arrived, there were only four security officers available to the whole hospital and it was not feasible for security to be contacted to attend the Emergency Department every time a scheduled patient arrived.

179. Further, the 2014 Restraint Policy provides that, if restraint has been used repeatedly, a patient's medical records must include a management plan for recurring disturbed behaviour. There is no evidence that any management plan was specifically created for Jack.

180. The "Absconded Patient Policy" also includes a post-absconding protocol. This requires that staff must never place themselves at risk of harm in order to return a patient to the ward, although security can "encourage the patient to return voluntarily". According to the policy, security officers do not have the authority to force a patient to return to the ward. Instead, they are to contact police for assistance.

181. When asked whether she had given any thought to what she would do if Jack attempted to abscond, RN Cabides stated that "it came to my mind" and that she had the duress alarm at hand and was confident security would be there to stop Jack from leaving.

182. I accept that RN Cabides should have given more careful consideration, including consulting with someone else or more senior, as to the release of Jack's restraints. Although she did so for the purpose of allowing him to urinate, there was practically no difference to the restraints being temporarily or permanently removed. Where there remained a risk that Jack would be non-compliant, I find that RN Cabides should have considered having security present.

183. The "Absconded Patient Policy" also requires that any scheduled patient be identified as "high" risk once absconded and that certain processes be followed when a high-risk patient absconds.

184. At 12:50pm, following Jack absconding, RN Cabides prepared an "Absconded Patient Report to Police". The report identified that Jack's risk level of absconding was "high", and that the action taken by the ward to locate the patient was "[p]olice called".

185. RN Cabides explained in her evidence that she had assessed Jack's risk post-absconding as "high" because:

> … at the time when he absconded, we still didn't have his bloods, only the ECG as an assessment or is observations, blood pressure, heart rate. We haven't fully had a conversation to him with regards to his medical history. Why is he running the streets. So we don't have that assessment still, that's why it's on high.

186. RN Cabides then clarified:

> He, because of, because we haven't really completely assessed him. The time that he was, that he did abscond he, his – we, the risk of him injuring himself or others might, is still in there, because he absconded. If he didn't abscond then you would assume that he is still cooperative and still wants to stay in the hospital and be assessed. But because he did run away, he did abscond, then that changes.

<u>Notifying NSW Police that Jack had absconded</u>

187. Following Jack absconding, NUM Francis spoke to security staff and advised them that Jack was a scheduled patient. The security staff indicated they did not feel it would be safe to attempt to get Jack back into the Resuscitation Bay

physically. Security officer Danilo Sotelo noted that Jack was very aggressive and security did not have enough "man power" to deal with him. It is consistent with the policy at the RPA, to which I have already referred, for security not to seek to detain a patient.

188. NUM Francis called the police and advised that Jack had absconded from the hospital. Constable Pike recalled receiving a phone call to this effect. Sergeant Buchanan and Constables Guthrie and Marshall later advised over police radio that they were looking for Jack.

***St Andrew's College, University of Sydney***

189. Shortly after absconding, CCTV footage shows Jack scaling a wall into the St Andrew's campus.

190. At approximately 1:30 pm, Jack walked into one of the seminars at the College and said: "I am an angel". He walked around the classroom saying, "bless you, bless you," to a number of students. Jack's voice was observed to be at a normal level but some witnesses perceived that he had some form of mental health illness. Jack had also gone into another seminar room and it was observed that he was mumbling strange, incoherent sentences. When the lecturer tried to remove him, Jack grabbed the lecturer around his chest. Jack then attempted to remove the lecturer's shoes. He later left the seminar.

191. Prior to entering one of the classrooms, Jack told a student, Alexander Wright, that he was hungry and needed water and shoes. Mr Wright described Jack as looking disorientated and his speech as being slightly slurred. Mr Wright observed Jack to be quite subdued and passive, but uncooperative.

192. Mr Wright then called campus security. Greg Charlesworth, a security guard, attended the College and found Jack in the laundry room, wearing some small white square stickers, indicative of those used at a hospital. Jack told Mr Charlesworth that he was washing his clothes and asked whether it was time to go. The security guard recalled Jack leaving without incident and stated that he was not threatening, aggressive or intimidating at any time. Mr Charlesworth described Jack's demeanour as calm, polite and respectful, with Jack speaking clearly and coherently in a calm tone. Mr Charlesworth did not believe Jack to be mentally ill, but more like a recently homeless person looking for somewhere to wash his clothes.

193. Jack then exited the College onto Carillion Avenue.

***The second incident***

194. At 13:21:07, Sergeant Buchanan located Jack and parked vehicle LE14 near the entrance to St Andrews College on Carillon Avenue, Camperdown. Ten seconds later she exited the car, and 20 seconds after that, Sergeant Buchanan crossed the street and started speaking with Jack.

195. At no point during the process of her arrival did Sergeant Buchanan make a call for an ambulance. In her evidence, she explained that generally you need to have control of the situation before calling for an ambulance. Further, she considered that, at that stage, she did not have sufficient information to call an ambulance and there was no time to call the ambulance in any event. Sergeant Buchanan's plan was to locate Jack, detain him and then call an ambulance. She was hopeful that Jack would cooperate, having regard to his earlier demeanour after sedation. In evidence on 3 November 2020, she elaborated and explained that her plan was that Jack would be returned to RPA, preferably in an ambulance, but if there was violence then in a police car. Sergeant Buchanan was hopeful that Jack would cooperate, having regard to his earlier demeanour during the first incident after sedation. However, in evidence on 3 November 2020, she said she knew something was going to happen "and it's not likely to be good".

196. In evidence, Sergeant Buchanan did not describe any plan as to how she would respond in the event that Jack did not cooperate as she hoped save that, on 3 November, she identified that she would use the options available as per the tactical options model.

197. At 13:21:35, Constables Guthrie and Marshall arrived and stopped vehicle LE17 opposite the driveway to St Andrews College.

198. Constable Marshall said that prior to their arrival he and Constable Guthrie had reached a "[g]eneral consensus, he's absconded, we'd like to stop him and get him back to hospital". Constable Guthrie's evidence on 4 November 2020 was that the plan was that Jack should be located and returned to hospital.

199. Constable Marshall also gave evidence that he had a general discussion with Constable Guthrie before they arrived about different tactical options and "what might most be suitable, given the circumstances". He said he discussed the use of the taser "because of the ineffectiveness of OC spray. He's a very large gentleman, stronger than both of us, it would be very difficult to deal with him hands on, if he became aggressive". He also said, "If we were engaged in a violent confrontation, they're very useful in helping to protect yourself and control people". Constable Guthrie gave evidence on 4 November 2020 that there was no time to call an ambulance when she and Constable Marshall arrived.

200. At 13:21:42, Constable Marshall alighted from the vehicle and Constable Guthrie walked around the car shortly thereafter. Constables Guthrie and Marshall joined Sergeant Buchanan and crossed the road in an attempt to stop Jack from walking away.

201. Sergeant Buchanan described Jack on approach as being agitated, shouting and repetitively saying, “do you wanna fight me”. She said that she advised Jack, “no, we don’t want to fight you”, and that, in response, “he was saying things and doing things, which I guess are responses, but he was not responding to what I was saying”. When asked what view she formed as to Jack’s mental health at that particular point in time, she said “he was obviously unwell, which is why we put him in the hospital”.

202. When Jack first saw the police approach, Constable Marshall described Jack’s demeanour as, “he appeared to get a bit agitated”. Constable Guthrie said that Jack was saying things like, “Fuck off. Leave me alone. I’m not going anywhere,” and rambling things. She said, “[h]e was looking away from us a fair bit so in my experience that usually means people are trying to look for a space to get away. Like maybe, generally people do that before maybe foot pursuits start… Then, he started kind of clenching his fists a little bit and just he had a bag in his hand… he was just kind of essentially arguing with us to leave him alone”.

203. Constable Sam Marshall said the officers “were trying to stop him walking away”.

204. At approximately 13:22:16, Constable Guthrie put her left hand out towards Jack and touched Jack’s chest, applying some force. She said, “Jack, stop, please. You need to go back to hospital”. Constable Guthrie described Jack as quite agitated, he seemed a bit annoyed but not violent. Her evidence is that Jack was verbally resisting.

205. At 13.22.41, Constable Marshall activated, or armed, the taser and the taser video footage with audio commenced. Constable Marshall said he activated the taser as a precaution so it was ready. He believed that there might be a violent confrontation.

206. At 13.22.47, Sergeant Buchanan discharged OC spray in Jack’s face as she felt there was a threat of violence from Jack, namely, “he’d gone to run from me, he’d gone to shape up, he was frothing at the mouth, he’s sweating, he’s saying he wants to fight”. She did not verbally warn him that she was going to use the spray but had told him to “stop”. Constable Guthrie’s evidence was that after the OC spray Jack became physically aggressive and violent. The

OC spray also affected Sergeant Buchanan as she had to run through it. She said she had difficulty seeing, “and breathing, talking and everything else”.

207. Constable Marshall gave evidence that, prior to Sergeant Buchanan discharging the OC spray, Jack “shaped up a bit towards us”.

208. At 13:23:00, Constable Marshall is seen on CCTV to kick at Jack’s thigh area. As a result of the kick, Jack slipped but regained his balance. Constable Marshall said his reasons for the kick were “Two fold, I didn’t want him to have his bag with him and I wanted to push him off balance. I was hoping he would fall onto his back”. He said, “He was already down low. We could safely restrain him at that point, potentially”.

209. At 13:23:02, Jack is seen to run towards Constable Marshall.

210. At 13:23:04, Constable Marshall fired his taser for the first time. Constable Marshall said “[h]e was charging towards me, at a fraction of a second, I was concerned for my safety, that and [Sergeant] Buchanan who was standing next to me. I deemed it was appropriate to use the taser”. Constable Marshall gave no warnings to Jack before firing the taser. He said, “[i]t happened quite suddenly”.

211. Following the deployment of the taser, Jack fell to the ground immediately.

212. Constable Guthrie gave evidence that after the taser was deployed and Jack was on the ground, she ran towards him and applied pressure to his back. He was face down but possibly trying to bring his hands up under him. She said, “[m]y intention was to place my body weight onto his trunk or arm or…, to restrain him on the ground and prevent him from getting back up again to possibly further assault me or Jacqui or Sam”.

213. In the period 13:26:09 to 13:23:22, Constable Guthrie remained straddling part of the left side of Jack’s upper body. She said, “I believe possibly my, my left hand may have been on his left shoulder or possibly on his left arm as he was trying to pull them in, thrash around a little bit”.

214. At 13:23:14, Sergeant Buchanan reported to police radio, “Fourteen, need further cars urgently”.

215. At 13:23:19, Constable Guthrie used a number of elbow strikes to Jack’s upper back. She said she was yelling, “get your arms out. Release your arms”. She said she was striking “the areas of his lat [sic] to have a response for him to bring his arm down”. That is, she was striking just under his

shoulder. At around the same time, Constable Guthrie says Jack was starting to grab her ankle and leg.

216. At 13:23:50, the taser log records the second depression of the trigger. Constable Marshall had fired the taser for the second time. At that time, Jack was on the ground and three officers were behind him. Constable Marshall said, "[h]e was violently resisting us, and there was a danger, we could have been overpowered".

217. At 13:24:03, Constable Guthrie said she had her right arm around Jack's chest area. She does not recall whether her arm was around his neck. Her intention was not to be around his neck at any time. In the period 13:24:05 to 13:27:15, Constable Guthrie remained in the same position.

218. At 13:24:25, Jack is seen rolling onto his back.

219. At 13:25:10, the taser log records the third depression of the trigger. Constable Marshall fired the taser for the third time and Jack fell to the ground. After this, Constable Marshall kept the taser on standby.

220. At 13:25:17, Jack stood up with Sergeant Buchanan on his back.

221. At 13:25:22, Jack fell over again.

222. I find that the evidence establishes that all three applications of the taser resulted in charge being applied to Jack, even if, as outlined in the statement of Senior Armourer Halbmeier, that charge was erratic at times.

<u>Arrival of Senior Constable Oscuro, and Constables Macsok and Harris</u>

223. At 13:25:32, Senior Constable Susan Oscuro, and Constables Cameron Macsok and Jodi Harris arrived in vehicle IW18. Around this time, Constable Guthrie said she was taking control of Jack's legs and lower portion of his body: "[s]o I believe I'd actually wrapped my legs around his legs". She said she was also reaching above his head to hold the second cuff of the handcuff.

224. By 13:27:39, Constable Harris agreed in evidence her position was over Jack's hip and lower back area. She said her mid-section was on his hips. She was "trying to plank and keep him down." She had weight on his hips to try to restrain him. In Constable Harris' notebook, she stated, "I was reaching holding down the male at his back". In evidence, she said, "[w]ell, I was over his hips and his lower back, like his hips". She also said she didn't apply pressure the whole time, "I was applying pressure when I felt him resisting… So it was when he was trying to get up we'd apply pressure and then alleviate

that pressure with the mount of force that he was trying to resist and get up". She said Constable Macsok was to her right, towards Jack's upper body and head. She could not remember Constable Macsok lying across Jack's upper body. She was aware of him being close but could not recall the position he was in. Constable Harris remained in position over Jack's hip area, with intermittent pressure in a planking position, until Jack's breathing was checked. In evidence, she agreed that Jack was in the prone position.

225. Constable Macsok wrote in his notebook, "I ran over and put my body weight onto the males upper body. The male was violently resisting". In evidence, he described this as "[s]o as I ran over, I was trying to secure his right arm, he was in the process of pushing himself up…. He's laying across the footpath, I've run over and the sort of left side of my chest is sort of on his shoulders. So he has pushed himself up, I've sort of side straddled". He said it would have been on the back of his right shoulder. He was pushing himself up. Once on top of him, with Jack facing the ground, he said it pushed Jack down "slightly".

226. Constable Macsok's evidence was that from the time he put weight on the back of Jack's right shoulder until he was rolled over, Jack remained in a position facing the ground. He said in his notebook, "I put my left forearm on the males upper hand and moved his head away from the male officer." In evidence, he describes this as, "at that stage Jack was looking towards Constable Marshall on his left, so I put my hands on the side of Jack's head, so it would have been on the left side of his head to control it, to keep it in a position where he couldn't keep turning and spitting". He confirmed he turned Jack's head away from the officer. Constable Macsok described his position on Jack as, "[s]o I wasn't lying across the upper, his upper body. I was… sort of side straddle, so the left side of my chest would have been on his right shoulder, and again my left forearm was, was near his, the left side of his head".

227. Constable Marshall agreed that the weight of several police officers was used to subdue Jack. He could not recall how many. He also recalled a point after Jack was handcuffed, where "I do recall seeing some officers on top of him, yes".

228. As noted earlier, Sergeant Buchanan's vision was affected by OC spray as she had run through the spray. She was unable to say whether the police officers present were using their weight to restrain Jack. She stated, "I don't know, … I can't say whether officers were using their weight. I don't know that". She also said:

> I'm certain that, obviously, because it was a physical confrontation, we would have been using our weight in the same ways he was using his weight. So, yep, weight would have been involved. It's important to know and I was aware of it, but I couldn't tell you to the degree with which each officer was using weight at any given time in that wrestle through the entire period.

229. Constable Harris in evidence agreed that Jack in this period was in the prone position. Constable Macsok gave evidence that, from the time he put weight on the back of Jack's right shoulder until Jack was rolled over, Jack remained in a position facing the ground. He was trying to roll Jack over onto his right side. He agreed he didn't succeed in rolling Jack over.

230. In the period 13:26:31 to 13:26:57, Constable Guthrie says she believes her left shoulder was pinned underneath Jack's bottom portion. She was bear hugging his legs and her legs can be seen in the air. Senior Constable Oscuro sought to pull Constable Guthrie to free her from under Jack's legs.

231. Following this, Constable Guthrie returned to applying pressure with one or two hands to Jack's lower body, his hip or side of the thigh area.

232. At 13:26:09, CCTV footage shows Constable Macsok on top of Jack's torso area, Constable Guthrie and Sergeant Buchanan on his legs, and Constable Marshall holding Jack's head.

233. At 13:26:11, Senior Constable Oscuro said in evidence that there were two or more officers lying across Jack's upper body.

234. At 13:26:21, Constable Macsok confirmed from taser frame "Image Y" from the taser footage that he had his hand on one side of Jack's head with his ear between his fingers and at that point Jack had both shoulders on the ground.

235. About 10 seconds later, at 13:26:41, Constable Macsok confirmed in evidence that at that time, from taser frame "Image EE", he had his left arm underneath Jack's chin. He had his left forearm on the side of Jack's head. Jack was pushing himself up. He said "he again spat. So the first thing I did, reacted and put my hands around his chin so I could pull him back away from Constable Marshall".

236. Senior Constable Oscuro assisted with handcuffing Jack. After he was handcuffed, she said that Jack was on his side and waiting for the caged truck. She accepted after seeing the taser footage however that he was not lying on his side at that time and was face down resting on his elbows. It is clear that Jack had been handcuffed by 13.26.42 on the VKG timings, as both handcuffs applied to his wrists can be seen on the taser footage at that time.

237. Based on the available evidence, the time period between the handcuffs clearly being on (and it is possible that they were on a little earlier) and the officers starting to get up is 3 minutes and 10 seconds.

238. Various officers report Jack spitting after being handcuffed.

239. Sergeant Buchanan's evidence was that she didn't know he was ever handcuffed.

240. Constable Macsok confirmed in his notebook and evidence that Jack's arms were extended in front of his head and he was cuffed towards the front. In evidence, he said:

> … whenever he was trying to push himself up, obviously I had concerns that he was going to get up and overpower us and possibly hurt others and the public there, so that was the sort of safest position. So whenever there is resistance I would obviously put a bit of weight there.

His evidence was he was side on, with his upper body weight resting on Jack's right shoulder and his legs/the lower half of his body on the ground.

241. Constable Macsok agreed he effectively remained in that position throughout, until he was notified that Jack seemed to have stopped moving.

242. At 13:28:45, Senior Constable Oscuro tasked other police officers to go and get the caged truck.

243. In evidence, Senior Constable Oscuro confirmed she observed officers lying on Jack. In respect of the number of officers lying on Jack, she said, "I wrote in three or four on my notebook but, but ... I can't say where, how … they were restraining him…"

244. The evidence given regarding the officers restraining Jack, includes:

    a. Constable Marshall recalled having one hand on Jack's shoulder and, after he holstered the taser, two hands. At one point, he was crouched down in front of Jack with both hands on his head to stop him spitting on other officers: "I was trying to stop him turning it to spit at the officers". His head was facing the ground. He agreed that, at that time, no one would have been able to see Jack's face, his nose, or mouth, in that position.

b. Constable Marshall agreed that in the period 13:27:18 to 13:27:38 he remained in position with his arm extended down onto Jack's body. He agreed he would have been putting some weight through his arm on Jack's upper body but, "I can't recall how much. He agreed he was seeking to keep Jack pinned down to the ground, as "he was still struggling". He said he "would have had to" use some force with his arm against Jack's shoulder. At 13:30:49, Constable Marshall stood up. He said at 13:31:01 he spoke with Sergeant Buchanan who was "holding onto his lower legs, or his legs somewhere". He believed her position was "[o]n top of him". At around 13:31:42, he returned to holding Jack's shoulder, he used both hands and he believed he was using some force. He remained for some period with both hands on Jack's upper body somewhere, applying some force. Constable Marshall described at this point "There were several officers there, there were some that were on, on top of him, yes". By this, he meant their bodies were at least partially across his. He agreed it was across his back. When asked whether it was one or more than one officer lying with their bodies across his back, he said "[i]t was more than one. I'm not sure how many".

c. Senior Constable Oscuro in evidence said there were maybe three of four officers restraining Jack in the period between handcuffing him and the administration of CPR. She described the positions of the officers as Constable Marshall at his upper body, Constable Macsok at the upper body, Constable Harris on his body somewhere and the two female Leichhardt officers on his legs.

245. It difficult to reach precise findings as to the exact location of each of the officers who were restraining Jack. However, the evidence does appear to establish that each of Constable Macsok, Harris and Marshall applied weight to the Jack's torso, and Constable Macsok and Marshall to his upper torso for periods of time during the operation, including in the period leading up to when Jack was identified as not breathing.

<u>Arrival of Senior Constable Johnson and other police officers</u>

246. At 13.28.10, Senior Constable Brendan Johnson arrived with Constables Burke and Oxley in vehicle IW17.

247. Senior Constable Johnson recalls that when he arrived on the scene Jack was being held down on his stomach. He observed three police officers on Jack's legs, three on his torso and one at his head. The officers were lying across Jack with the top part of their bodies pushing down on Jack with their bodyweight; it was like "a bit of a stacks on". He later confirmed that he could

not see Jack's body "because there were cops all over him" and that he was "effectively covered by police", but that he could tell that Jack was exhausted.

248. Another officer asked Senior Constable Johnson to hold Jack's head as he had been apparently spitting on other officers present. At 13.28.17, Senior Constable Johnson is seen in CCTV footage crouched near Jack's head, holding Jack's head. Jack was resisting and trying to move his head and Senior Constable Johnson could hear him making spitting sounds. Approximately 15-30 seconds later, Senior Constable Johnson recalled that there was no resistance from Jack's head, and he asked if he was still breathing. His evidence was also that there was not a great deal of resistance when he was holding Jack's head. Upon Senior Constable Johnson querying whether Jack was breathing, the other officers released their grip and rolled Jack over.

249. Senior Constable Johnson accepted in evidence that he was asked to hold Jack's head and remained in that position from the time he got there until he noticed that there was no resistance from Jack's head. He then asked if Jack was still breathing. That period on the CCTV from Senior Constable Johnson arriving to officers standing up is 13:31:34 to 13:33:15. Therefore, approximately 1 minute and 41 seconds passed from the time that Senior Constable Johnson arrived until the other officers present began standing up.

250. Senior Constable Johnson observed Jack's lips change colour and instructed an officer to check whether he was breathing. At this point, he stated an officer commenced CPR.

251. Senior Constable Johnson gave evidence that Jack was on his stomach from his arrival to when Jack was turned over after he asked if Jack was still breathing. Senior Constable Johnson gave evidence that at least when he was present, Jack's spitting was more likely an attempt to clear his mouth of saliva. He also said that it was his impression that Jack was not getting much air but that he did not turn his mind to why that was so. He also said that Jack was not really moving much for the entirety of the time that he was holding his head. His evidence was that he did not try sitting Jack up as he was not the officer in charge, and he did not know what had gone on previously. His concern was to get Jack in the back of the truck and off the ground as quickly as possible. Moreover, his background was in highway patrol.

<u>Arrival of other police officers</u>

252. At 13.29.15, Senior Constable George Raffoul, Constable Lachlan Dally and Probationary Constable Kristian Bodell on LE36 also responded. Upon his arrival, Senior Constable Raffoul observed three officers lying on Jack in a

prone style position, spread out across him. It appeared that they were each controlling a different area. Senior Constable Raffoul noted that the "positioning of the deceased meant that his head was raised off the ground slightly and no one was putting any pressure on his head or neck" that he could see.

253. At 13.30.09, Detective Sergeant Sutherland and Constable Pike arrived.

254. Police officers recall saying, or hearing someone say, "[w]atch his breathing," on at least one occasion before Jack was rolled over and his breathing checked.

255. When Jack's breathing was checked, Senior Constable Oscuro "saw the froth in his mouth".

256. Constable Bodell noted in evidence that about 15 seconds after he arrived Jack had stopped resisting and that his body wasn't moving when he had arrived (it was 30 seconds from when he arrived before officers stood up).

257. Constable Dally said when he arrived (he arrived with Bodell) he could see Jack moving, but not violently, maybe a shuffle.

<u>The officers notice that Jack has stopped breathing</u>

258. At 13.29.33, NSW Ambulance was contacted for decontamination. That call was made by LE14, which was Sergeant Buchanan's vehicle

259. At 13:29:53, officers appear to begin standing up. Three seconds later, Jack looks to be partially rolled over and then, six seconds after that, fully rolled over. At 13:30:10, VKG records lW17: "can I get an ambulance to my location. Male is um, not conscious."

260. Sergeant Buchanan's evidence was that one of the officer's said "is he breathing", that that was "such a sobering comment" that she said they should check, and at that point someone checked a pulse and checked if he was breathing and Jack was not breathing. Constable Marshall recalled Sergeant Buchanan asking that they check if he was okay. The officers "climbed off, he was rolled over and I remember seeing his lips were blue".

261. Constable Guthrie said that it was when Jack stopped moving and resisting as strongly that she walked up towards his head. Jack was rolled over and she saw officers checking his breathing.

262. In evidence, Constable Harris said the time between her noticing Jack resisting less and her realising he was unconscious was a "split second… it was a really quick turnover". At the point where Jack stopped resisting, Constable Harris confirmed that she was still lying across his hips and lower back, that Constable Macsok remained to her right and at least one other officer was to her left. She stated, "because at that time, up until that point he was violently really resisting us".

***Administration of CPR and the arrival of ambulance***

263. At 13:30:30, CCTV footage shows that Constable Guthrie began conducting chest compressions on Jack.

264. At 13:30:40, IWI7 advises the police radio, "I need an ambulance to my location immediately. The male is unconscious and not breathing at this stage". At 13.30.57, the NSW Ambulance log records "NSWPF< AMBOS REQ MALE IS UNCONSCIOUS AND NOT BREATHING". This is the first time that Jack's consciousness and breathing is noted in the NSW Ambulance log.

265. At 13.31.11, the NSW Ambulance log records "NSWPF< POLICE HAVE COMMENCED CPR".

266. Dr Sophie Unell, an off-duty medical officer, came upon the scene whilst Jack was receiving CPR. Dr Unell identified herself as a doctor to police and supervised the police officers during resuscitation and encouraged the pads of the defibrillator to come on. Dr Unell noted that Jack appeared to be frothing at the mouth, and that as a result she advised the police officers to continue administering CPR without doing breaths.

267. At 13.37.49, an ambulance arrived and Jack was transported to the RPA. He arrived at the RPA at 13.57. He was triaged as Category 1 and directed to the Resuscitation Bay.

268. CPR was discontinued at 14.28, and Jack was pronounced deceased. Dr Cutler completed a "Report of death to the Coroner" form at 15.30 and the "Apparent Cause of Death" was recorded as "Critical incident – Taser discharge and OC spray. Apparent cardiac arrest on scene and transported to hospital".

***Autopsy and expert opinions regarding the cause of Jack's death***

269. On 12 and 20 February 2018, Dr Jennifer Pokorny completed an autopsy of Jack. Her report was completed on 11 May 2018. The autopsy report

concluded that the direct cause of Jack's death was "unascertained", but that there were several possibilities suggested by the findings, including:

a. sudden death, given that Jack's coronary arteries were severely narrowed (noting that there was no evidence of myocardial infarction);
b. the possibility of neck compression or mechanical asphyxia contributing to the cause of death could not be excluded;
c. it appeared unlikely that the use of the taser or OC spray contributed significantly to the cause of death;
d. the use of antipsychotics such as Zuclopenthixol may be associated with QT prolongation and may cause sudden death by triggering lethal arrhythmia; and
e. schizophrenia may be associated with sudden death due to "excited delirium", typically in the setting of police restraint.

270. Dr Mark Dooris, a Senior Staff Cardiologist at the Mater Hospital in Brisbane, Queensland, provided expert opinion on the cause of Jack's death. He opined that Jack died from a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors superimposed upon Jack's underlying but occult coronary heart disease. The relevant factors he identified were:

a. sympathetic activation from exertion/agitation in relation to the physical struggle during the second incident;
b. possible positional asphyxia, having regard to the video and still images and that the autopsy did not exclude this, noting that, in circumstances of an underlying cardiac disease and the increased myocardial demand of the struggle, a lower degree of hypoxia may have been sufficient to precipitate a malignant arrhythmia; and
c. the application of the taser three times prior to the cardiac arrest, noting that electronic control devices such as tasers may lead to electric cardiac capture and may cause precipitate malignant arrhythmias, and that the time of onset of malignant arrhythmia to the time of diagnosis of cardiac arrest is not necessarily instantaneous or a matter of seconds.

271. Dr Dooris labelled the above factors as a "perfect storm". In his view, the most likely factors were the sympathetic activation and agitation, but the role of positional asphyxia and the administration of the taser were not excluded. He indicated, however, that it was inappropriate to attribute Jack's death solely to his underlying coronary heart disease.

272. In evidence, Dr Dooris confirmed that "it's very uncommon for coronary heart disease in a person [Jack's] age" to be sudden cardiac death, but that rather,

it was a “complex interaction of factors”, including the vulnerability Jack’s mental health placed him in.

273. Two factors Dr Dooris also considered in his report but ultimately excluded as factors of relevance as regards causation of Jack’s death were:

a. the presence of drugs that may precipitate malignant arrythmia; and
b. excited delirium, noting that Jack had features consistent with this syndrome including active psychiatric illness, agitated behavioural, tachycardia and he was observed to be sweaty.

274. Dr Pokorny agreed in evidence that mental illness is one of the factors that makes it a higher likelihood that a person will be vulnerable to sudden cardiac arrest or sudden death, and agreed with Dr Dooris as to the multifactorial aspects of Jack’s death, preferring however, the term “mechanical asphyxia“ to “positional asphyxia”.

275. In respect of the role that the taser had in Jack’s cause of death, Dr Pokorny stated that her opinion in her report may have differed from Dr Dooris because she did not have the taser timings, and “that regardless of whether the use of the taser precipitated a lethal arrythmia it would certainly have contributed to the sympathomimetic excitatory effects that were going on with the deceased and put … him at increased risk”.

276. Both Drs Pokorny and Dooris stated that the prior administration of Droperidol and possible impact it had on QT prolongation was “unlikely” or “far less likely” to be a contributing cause.

277. Dr Pokorny was asked about the bruising on Jack’s neck. She stated that bruising is an indication of a blunt force applied to the region, but that she could not be certain as to what the force was caused by. She noted that the bruising to Jack’s neck would have been “recent” and could have been minutes or up to a few hours before his death.

278. Dr Dooris was also asked about the bruising to Jack’s neck and, whilst he deferred to Dr Pokorny’s expertise, he opined that he could not be sure if the bruising occurred prior to resuscitation or as a result of resuscitation. In that regard, he departed somewhat from the finding in his second report that “post-mortem bruising around the neck seems inconsistent with the subsequent CPR resuscitation attempt” on the basis that there was a lot more uncertainty than he had acknowledged in the second report, even though it would be unusual for the neck to be involved in CPR.

279. In addition to the above evidence and given that Jack's failure to take his prescribed medication appeared to be a critical factor in Jack's mental health decline, a forensic toxicologist report was obtained from Dr Michael Robertson. Dr Robertson confirmed that, when it is assumed that Jack's last dose of Zuclopenthixol was possibly four or more weeks prior to his death, it is likely that the concentration of Zuclopenthixol had fallen to the extent that it would have been less effective and possibly not effective at managing his condition.

**Issues**

***Identity***

280. The deceased is Jack Kokaua.

***Date of death***

281. Jack died on 18 February 2018 at 14:28pm.

***Place of death***

282. Jack was pronounced deceased at the RPA.

***Cause of death***

283. I refer to the expert evidence summarised at paragraphs 269 to 279 above.

284. I accept Drs Dooris and Pokorny's evidence that Jack died by reason of a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors including positional asphyxia, exertion and use of taser, superimposed upon Jack's underlying occult coronary heart disease.

***The manner of death***

285. I accept Counsel Assisting's submissions in respect of the manner of Jack's death. Jack died by reason of a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors including positional asphyxia, exertion and use of taser, superimposed upon Jack's underlying occult coronary heart disease

286. Further, I find that if those factors had been ameliorated at some point prior to when the involved police officers identified that Jack had stopped moving and breathing, then it is probable that Jack's prognosis may have improved.

### *The adequacy and appropriateness of the police officers' response to the second incident*

Reliability of the police officers' accounts

287. Before I make any findings as to the adequacy and appropriateness of the police officers' responses to the second incident, it is appropriate to deal first with the reliability of the evidence of the involved police officers.

288. In written closing submissions, Counsel Assisting submitted that an overarching difficulty with the nature of the evidence of the involved officers was that none of Sergeant Buchanan, Senior Constable Oscuro and Constables Marshall, Guthrie, Harris or Macsok gave any directed interview in relation to the second incident nor did they give a witness statement outlining their recollection of the same. This was because each of these officers invoked their common law right to avail themselves of the privilege against self-incrimination and to therefore participate (or not) in aspects of their respective directed interviews. Of the directly involved officers, only Senior Constable Johnson gave a directed interview in relation to the circumstances leading to Jack's death and he was present for only part of the incident. Senior Constable Oscuro and Constables Guthrie and Macsok made entries in their police notebooks but these were very much in summary form.

289. As a result, it was not until the first tranche of the hearing of this inquest in September 2019, some 19 months after Jack's passing, that six of the involved officers gave their first accounts of the second incident. Counsel Assisting submitted that the passage of time would have inevitably impacted on the police officers' memories.

290. In these circumstances, I have accepted Counsel Assisting's submission that I give the greatest weight to the most contemporaneous accounts of the second incident, and to those that were corroborated by others.

291. Further to the issue of contemporaneity, the Court also heard evidence regarding the role of perceptual distortion in accurately recalling events experienced under stress.

292. In his evidence, Sergeant William Watt opined that those under stress may suffer from perceptual distortions. These distortions include tunnel vision, time dilation or compression, inattentional blindness and looming. By way of example, Senior Constable Johnson's evidence that Jack was not moving much whilst he was holding Jack's head differs significantly from the evidence of other officers that Jack was violently resisting throughout the incident.

293. Professor Geoffrey Alpert gave evidence, consistent with Sergeant Watt, that:

> Our research has shown that people react differently and … a lot of these issues vary among officers and between them as well. Someone may see something that another didn't see. Or someone may perceive something another didn't see even though they're … looking at the same incident. To support that, we've done a lot of research where we've looked at the officer's statement, interviewed the officer and then looked at the body worn video and … it's incredible to see some of the differences that the body worn video might show that the officer's didn't see and didn't remember.

294. Professor Alpert went on to describe an experiment he had conducted in Queensland, which was then replicated in the United States of America. According to Professor Alpert, the results of that experiment indicated that "it is better to interview officers immediately after the incident rather than wait two sleep cycles that some people suggest … So my … opinion would be that, yes, it is better to interview them sooner than later".

295. In light of this evidence, Counsel Assisting submitted that, whilst the involved officers' actions in declining to give a contemporaneous account by reason of a claim of privilege against self-incrimination was readily understandable, it was highly undesirable that there be no means of giving a certificate to offer protection in the circumstances.

296. Counsel Assisting therefore proposed that I recommend that:

> Consideration be given, through legislative amendment if appropriate, to abrogating the right of involved officers from claiming the privilege against self-incrimination for the purposes of a critical incident or coronial investigation or, alternatively, providing for the availability of a certificate to involved officers who seek to claim such privilege for the purposes of a critical incident or coronial investigation, such certificate not precluding the evidence being available for use in any coronial investigation.

297. Ms Bourke took issue with Counsel Assisting's submissions. Ms Bourke further submitted that it was "unrecognised particularly in these court proceedings, that the jobs those police officers undertook was dangerous". I find these submissions unhelpful. They do not address the substance of the proposed recommendation nor do they accurately reflect the tenor of Counsel Assisting's submissions (see for example paragraph 13 above) or the views of this Court.

298. Mr Haverfield submitted that I should not make the proposed recommendation. He submitted that the delay in giving evidence was not the fault of the involved police officers and that it would be unfair to make the

recommendation given the circumstances of this matter. He noted that s. 61 of the Act presently allows this Court to compel a witness to give evidence in circumstances where a witness objects to giving evidence as a result of a claim against self-incrimination.

299. Mr Glissan QC for the NSW Police Association submitted that the proposed recommendation set out paragraph 296 above was "defective" for two reasons. First, "it places and creates a serious risk of injustice to the police officers involved". Secondly, "it is not needful because the power to obtain the evidence in a timely way already exists".

300. In support of the first proposition, Mr Glissan QC referred to principle enunciated by the High Court in *Lee v The Queen* (2014) 253 CLR 455; [2014] HCA 20 at [32]-[33]:

> The companion rule to the fundamental principle is that an accused person cannot be required to testify. The prosecution cannot compel a person charged with a crime to assist the discharge of its onus of proof. Recognising this, statute provides that an accused person is not competent to give evidence as a witness for the prosecution, a protection which cannot be waived. [citations omitted]

301. He submitted that the proposed recommendation was directly offensive to the principle in *Lee*.

302. Mr Glissan QC then directed the Court's attention to existing mechanisms available in the Act to compel police officers to give evidence, whilst noting that the Act also preserves the principles of self-incrimination.

303. Messrs Haverfield and Glissan QC's submissions, in my view, go beyond the premise of Counsel Assisting's proposed recommendation. As Counsel Assisting noted in reply, I have not been asked to further abrogate the rights of police officers to avail themselves of the privilege against self-incrimination. Rather, I am being asked to make a recommendation that consideration be given through legislative amendment, if appropriate, to either the abrogation of the right of involved officers to claim privilege or to provide for the availability of a certificate.

304. There is significant public interest in there being effective and prompt information taken from involved police officers, particularly in circumstances where a person has died as a result of a police operation. It is concerning that it took 19 months for the involved police officers' accounts of the second incident to be taken – such a large gap has impacted on the memories of the involved police officers and, as a result, somewhat diminished the ability of

this Court to examine in depth the events that took place in the lead up to Jack's death.

305. I am however not minded to make the recommendation at this stage without further consideration of how other statutory mechanisms might be able assist, and what if any reform is proposed including the review of the Coroners Act (NSW) 2009.

Police officers' response to the second incident

306. I refer to my summary of the events that transpired during the second incident at paragraphs 194 to 268 above, which set out this Court's findings regarding police involvement in the second incident.

*Information as to Jack's presentation and symptoms*

307. First, Counsel Assisting submitted that there was no dispute that the involved police officers made no attempt to seek information as to Jack's mental health presentation as at the time he absconded, or the circumstances of his absconding from the RPA.

308. The NSW Police Force Handbook provides:

> Upon receiving notification that a person has absconded from a Mental Health Facility, speak with the Hospital Manager and ascertain as much detail as possible. Create a missing persons event where appropriate. Manage the missing person as per existing SOP's and the level of risk communicated by the reportee …

309. In his expert report, Professor Alpert opined that, in light of the NSW Police Force Handbook, it would have been appropriate for the police to call the hospital and attempt to contact NUM Francis. Consistently, Sergeant Buchanan agreed in evidence that, in hindsight, it could have been useful if she had tried to get as much detail as possible about Jack's mental state before approaching Jack. She stated however that the attending police officers had already been exposed to Jack that morning and so they "had some awareness of the range of [Jack's] mental scope just hours before". In his report, Professor Alpert said, "While this was a technical policy violation, a call made by [Sergeant Buchanan] may or may not have reached the appropriate person". Professor Alpert ultimately made a similar qualification in his evidence, stating that he was "not sure what difference it would have made" if the NSW Police Handbook was complied with.

310. Sergeant Watt gave evidence that the “more information that [police officers] have is always the better”, and that the information that police officers have about an abscondee will impact their level of response. For example, if someone who was a voluntary patient had left the hospital, the level of resources to be allocated to locating that person would be different to someone who had absconded from the hospital and was a high suicide risk or currently experiencing a psychotic episode. He nevertheless qualified his evidence similarly to Professor Alpert, stating:

> Generally I would prefer to rely on what information I am seeing directly in front of me to make a determination as to police tactics. And one could equally argue that based on his behaviour prior to sedation that may have an effect on how I'd approach and both of them should. But I would be more, more willing to rely on my own judgement as I approached the individual 40 than rely on information that with a completely different organisation in a completely different circumstance, he behaved in a completely different fashion.

311. Mr Dunne also agreed that “it's important to have that background knowledge of a subject, particularly a mental health patient if you're going to search for them.” Again, he qualified his evidence, noting, like Sergeant Buchanan, that in this case the attending police officers had previous experience with Jack during the first incident, that calling the hospital may have delayed the police officers’ response and would not necessarily have provided the police officers with any insight into Jack’s movements in the period between absconding from the RPA and his appearance on Carillion Avenue.

312. Consistent with Mr Dunne’s opinion that calling the hospital would have delayed the police response, Constable Marshall’s evidence on 4 November 2020 was that getting information from the hospital may have taken some time.

313. Sergeant Buchanan also gave evidence that in any event it was the role of the station constable at the relevant station to find out more information about abscondees. Her role was to “keep a lookout for, for this patient, so it’s an entirely different process”.

314. Given the expert opinion and the police officers’ evidence, Counsel Assisting submitted that attempts should have been made to acquire more information about Jack’s mental health presentation and symptoms at the time of his absconding through the police radio controller, rather than by direct attempts to contact the hospital.

315. Mr Haverfield, with Mr Madden adopting his submissions, submitted that, in this case, the police officers had done all that they could to acquire information about Jack's mental state at the time of his absconding. Namely, the hospital had made a report to the station constable and information from that report had been forwarded to the attending police officers. In any event, Mr Haverfield said, the police officers were already aware of Jack's mental state given their interactions with him that morning.

316. I accept that while attempts should have been made to acquire more information about Jack's mental health presentation, I consider that such information may well not have changed the outcome of the second incident.

317. At the same time, if a call had been made to the hospital, it might have been the case that police officers were advised that Jack was largely compliant with hospital staff and that at the time of his absconding he was not violent. Knowing this information, attending police officers might have been in a better position to plan how they would approach Jack if they found him.

318. Counsel Assisting's proposed recommendation overcomes any limitations on time faced by attending police officers by proposing that the radio controller make the call to the hospital. I find that, in the present case, if the radio controller had made the recommended call to ascertain more information about Jack's mental health presentation, then Sergeant Buchanan and Constables Guthrie and Marshall could have continued their search for Jack without being hampered by making telephone calls to the hospital.

*Calling for an ambulance*

319. There is no dispute that the involved police officers made no attempt to call an ambulance either at the point that Sergeant Buchanan and Constables Guthrie and Marshall arrived at Carillion Avenue and after OC spray was deployed and Jack was tasered.

320. <u>Arrival at Carillion Avenue:</u> Each of the involved officers gave evidence that they did not call an ambulance to attend the second incident when they first attended the scene because they either did not have time to make such a call or it did not cross their mind to do so (see paragraphs 195 and 199 above).

321. Each of Sergeant Buchanan and Constables Guthrie and Marshall gave evidence that their respective plans upon arriving at Carillion Avenue were to locate and detain Jack, and then facilitate his transport to hospital (see paragraphs 195 to 196 and 198 to 199).

322. Given this evidence, Counsel Assisting submitted that if an ambulance were to be required in any event to enable transportation of Jack back to hospital, there was good reason to seek to have an ambulance available as soon as possible. This was for the following three reasons.

323. First, ambulance officers have specific training in dealing with mental health patients and, as Paramedic Mercer indicated, "it would normally be a constructive part of [an ambulance officer's] role to deal with some rapport with a patient in an incident like this, to at least start the process of de-escalation and at least initiating that clinical relationship which is the, the main focus of [their] role. This is recognised in the Memorandum of Understanding between NSW Health, Ambulance Service of NSW and NSW Police Force, "Mental Health Emergency Response" (July 2007; **the Mental Health Emergency Response MOU**). The MOU provides that the role of the ambulance service can include clinical stabilisation and behavioural management.

324. Secondly, each of the officers gave evidence that ambulances can take some time to arrive at an incident.

325. Thirdly, during the first incident, the evidence disclosed that Jack's sedation by an ambulance officer had a good and prompt effect. That meant that sedation, rather than ongoing physical restraint, potentially after Jack was physically restrained by police to enable safe administration, was one possible way of securing a safe return of Jack to hospital through the use of less force.

326. Further, Counsel Assisting drew the Court's attention to the following policies, which they submitted were consistent with the calling an ambulance at the earliest opportunity:

    a. The Mental Health Emergency Response MOU, which provides that the use of police vehicles to transfer individuals with mental illness should only occur in extreme situations. In addition, where police suspect that an individual is mentally ill they are to contact mental health services, and the ambulance service is to stand by "for transport and medical assistance".
    b. The Memorandum of Understanding, "Incorporating provisions of the Mental Health Act 2007 (NSW) No 8 and the Mental Health (Forensic Paitents) Act 1990 (NSW)" (March 2018; **the Mental Health Legislation MOU**) provides that when agencies attend a mental health related incident they should have a discussion regarding the resources that are currently available and those that could become available, and the harm that could arise in the absence of another agency attending.

327. Mr Haverfield submitted that ambulance officers could not be called to attend until such time as the police officers had control of the situation. He further submitted that during the second incident no control was attained. In support of his submissions, Mr Haverfield referred to Constable Marshall's evidence that he did not have time to call an ambulance. Constable Marshall stated that calling an ambulance required a conversation that he did not have time to participate in and which would have necessarily required Constable Marshall to have information that could only be obtained after locating and detaining Jack.

328. Mr Haverfield also referred to the expert evidence of Sergeant Watt. When asked whether Sergeant Buchanan should have called an ambulance once Jack was located on Carillion Avenue, Sergeant Watt answered:

> No, I do not. And that's based on operational experience. How Jack was going to react at that stage wasn't known. The ambulance will require certain information in order to prioritise the dispatch of an ambulance. So the typical information we need to provide is sex, age, age of the individual, whether they're conscious and breathing, and a brief overview of the circumstances so they can - they can appropriately task an ambulance to the location. So if I have an unconscious not breathing patient then that's going to be a higher priority than something else. Based on a review of [Sergeant] Buchanan's transcript, she indicated that she was more concerned about getting to Jack and stopping him before she concerned an ambulance - contacted an ambulance.

329. Sergeant Watt then went on to opine that:

> I, I don't know that the, the arrival of an ambulance would have resulted in less use of force. It may have shortened the amount of time but essentially before they can sedate or provide any medication to anyone that subject is going to need to be controlled and [to] some extent the level of control is going to need to be higher because now I have non-police officers involved, I'm responsible for their safety as well. And we have sharps … out. Having them available, would it have been an option? Yes it is. Is it necessarily - the decision as to when to call the ambulance is always going to be at the discretion of the officer there. It, it unfortunately, it has to be.

330. Similarly, Sergeant Buchanan gave evidence that generally a police officer has to have control of the situation before calling for an ambulance. She also gave evidence on 3 November 2020 that there was not enough time to radio for an ambulance when she first arrived at Jack's location, and that she would not have been able to give the necessary information to the ambulance operators as she needed to assess the situation. Similarly, Constable Guthrie gave evidence on 4 November 2020 that there was no time to make such a call.

331. Having regard to the evidence and policies, and in particular that the police officers' experience with Jack earlier that day should have informed their assessment of Jack during the second incident, I am of the view it would have been at least beneficial for the police officers to contact, or request that contact be made with, the NSW Ambulance service at the earliest opportunity.

332. Though Sergeant Buchanan and the other officers' evidence was that they considered that Jack needed to brought under control before an ambulance could be called, Counsel Assisting suggested that a recommendation be made that, in situations where it is known a mental health patient has absconded, an ambulance be called at the earliest available opportunity. Chief Inspector Matthew Hanlon, the Manager of the NSW Police Force Mental Health Intervention Team (**MHIT**), said he saw no downside in a recommendation that officers be required to give early consideration to the calling of an ambulance.

333. As noted, calls were made over the police radio for assistance throughout the second incident. There is no good reason why such calls could not have included a request to secure the attendance of an ambulance to assist with returning Jack as a mental health abscondee. As NSW Ambulance officer Mercer made clear, this was a call that the NSW Ambulance service receives on a regular basis. Further, the involved police officers' experience earlier that day during the first incident should have informed their assessment of Jack.

334. <u>After deployment of OC spray and taser:</u> As noted above, at 13:22:47, Sergeant Buchanan deployed OC spray, and, at 13:23:04, Constable Marshall fired the taser for the first time.

335. According to the CCTV footage, from the arrival of the first officer on the scene until OC spray was used, one and a half minutes had passed, and from the time that OC spray was used to the first taser deployment a further 17 seconds had passed.

336. The taser was then deployed a further two times.

337. Despite the above, no police officer made a call for an ambulance until 13:28:58, when Sergeant Buchanan radioed for an ambulance for sedation and decontamination.

338. In her evidence on 3 November 2020, Sergeant Buchanan said that she was not in a position to call an ambulance prior to this point because she was "pinned down under a 140kg man. I feared for my life. I didn't have a chance. I

was terrified when I realised that back up was far away. In those moment, it just couldn't happen. And even if it could, nothing would have changed".

339. Constable Marshall gave evidence that he did not arrange an ambulance after using the taser because he did not think he had time to ask someone to radio for an ambulance.

340. Constable Guthrie stated that she did not contact an ambulance because:

> It all happened quite fast and it - Jack certainly wasn't as calm as the beginning of the first incident. So it certainly started off quite intense. So my focus was on working as a team with [Sergeant Buchanan] and [Constable Marshall] to try and get, get the situation to a level where we could assess properly and have the chance to get an ambulance to arrive, yeah.

341. Part 10 of the NSW Police Force "Use of Conducted Electrical Weapons (Taser)" policy provides that "Ambulance personnel are to be called on ALL occasions when a subject has been Tasered. Failure to do so may be considered a breach of the SOPs".

342. It was inconsistent with this policy for the police officers to have failed to call for an ambulance until 13:28:58.

343. Further, consistent with Counsel Assisting's submissions, I am of the view that that from the point when Jack was on the ground and restrained by the three police officers a call for an ambulance could have been made. In particular, at 13:24, when Sergeant Buchanan made a radio call for assistance as the taser "was not working", equally a request could have been made for an ambulance to attend the incident for decontamination. Had an ambulance attended before Jack stopped breathing, it is possible that the outcome for Jack would have been different, but it would be highly unlikely that an ambulance could have been available within that short time frame. I accept the submission of Counsel Assisting that this underscores the importance of early calls for the attendance of an ambulance, and of taking all available precautions to maintain the safety of a person of interest being restrained in a prone position.

344. Conclusion: It is accepted that on the available evidence, the involved police officers did not seek (whether themselves or by tasking others to call) the prompt attendance of an ambulance. This was in spite of Jack's mental health presentation, his having been sedated with good and prompt effect during the first incident and at least some of the involved police officers knowing that Jack had been the subject of OC spray, had been tasered, and an ambulance was the preferable mode of transportation back to hospital for a mental health patient.

345. In light of the above evidence, Counsel Assisting proposes that I make a recommendation that consideration be given to modifying the police and ambulance operating procedures and MOU such that:

a. police radio operators are tasked with calling an ambulance if it is identified to the radio operator that a taser has been discharged; and
b. police radio operators are tasked with calling an ambulance if it is identified to the radio operator that police are attending an incident involving a person with a known mental health illness or involving a person who has absconded from compulsory mental health detention;
c. police are required, if it is considered that any use of force may be required to effect arrest or to return to detention, to consider calling an ambulance at the earliest available opportunity when seeking to arrest or return to detention an individual with a known mental health illness or who has absconded from compulsory mental health detention; and
d. police are required, if it is considered that an individual is at risk of harming himself or at risk of harming others at the relevant time, to consider calling an ambulance at the earliest available opportunity when seeking to arrest or return to detention an individual with a known mental health illness or who has absconded from compulsory mental health detention.

346. In response, NSW Ambulance submit that requiring NSWPF radio operators to call an ambulance in circumstances proposed by Counsel Assisting's above recommendation would result in an increased strain on NSW ambulance resources and/or the inappropriate use of NSW ambulance resources.

347. It is accepted that implementing a blanket requirement that NSW Ambulance paramedics attend all incidents involving persons with a mental health issue or those who have absconded from a mental health detention facility would likely place an undue strain on the resources of NSW Ambulance. It is further accepted that the primary role of NSW Ambulance paramedics is to respond to medical emergencies, albeit, that this may well on occasion include mental health emergencies.

348. The closing submissions on behalf of NSW Ambulance refer to the Police, Ambulance, Clinical, Early, Response ("PACER") program, which is designed to provide a specialist mental health early response to people experiencing a mental health crisis by placing mental health clinicians in police area commands. NSW Ambulance submit that it would be more appropriate to for mental health clinicians engaged under the PACER program to attend situations involving persons with a mental health issue or those who have absconded from a mental health detention facility. This submission is not without merit. However, it is noted that the PACER program is still in a pilot

phase, having only been rolled out in 12 police area commands across NSW. The PACER program is addressed further at para 458 of these findings.

349. For the above reasons, I am not minded to make the recommendation set out at paragraph 345a and 345b.

350. In response to the recommendations proposed at paragraph 345c and 345d, NSW Ambulance submit that NSW Ambulance paramedics are not required to enter a scene until it is safe to do so, and as such, will not attend to a patient in circumstances where the use of force is required or the individual is at risk of harming themselves or others. In these circumstances, NSW Ambulance submit that it is the responsibility of NSWPF to subdue the individual prior to paramedics attending the scene.

351. With respect, the recommendation proposed by Counsel Assisting would simply require a police officer to give active consideration to calling an ambulance at the earliest available opportunity when seeking to arrest or return an individual with a known mental illness or who has absconded from compulsory mental health detention in circumstances where it is considered that the use of force may be required to or where the individual is at risk of harming themselves or harming others. The requirement, in my view, is not burdensome, but would ensure police officers actively turn their mind to the need to a paramedic in potentially violent situations involving an individual with a mental health issue.

352. For the above reason, I am minded to make the recommendation that consideration be given by NSWPF and NSW ambulance to modifying the police and ambulance operating procedures and MOU such that police are required, to give active consideration to calling an ambulance at the earliest available opportunity when seeking to arrest or return to detention an individual with a known mental health illness or who has absconded from compulsory mental health detention if it is considered that the use of force may be required or it is considered that the individual is at risk of harming himself or at risk of harming others at the relevant time.

*The lack of any plan as to how Jack should be returned to the RPA*

353. Each of the plans formulated by the police officers in respect of locating and detaining Jack, and then transporting him to the RPA, are summarised at paragraphs 195 to 196 and 198 to 199 above.

354. Mr Haverfield submitted that Sergeant Buchanan's and Constable Guthrie and Marshall's plans were appropriately detailed in the circumstances. According to Mr Haverfield, force is fluid and is not a factor that can be planned for.

Rather, reliance must be place on the tactical operation model in circumstances where force is required.

355. Whilst the situation was necessarily fluid and plans may have needed to be adapted, Sergeant Buchanan and Constables Guthrie and Marshall should have had a detailed plan in place before approaching Jack. Such a plan should have accounted for the following:

    a. how Jack would be returned to the RPA in the event that he was not compliant;
    b. when they would call an ambulance, as that would be the preferable mode of returning Jack to hospital (noting Sergeant Buchanan's evidence referred to above at paragraph 195 above and the Mental Health Emergency Response MOU referred to at paragraphs 323 and 326 above);
    c. in addition to, or in the alternative to b., when they would call a police truck so that it could provide a means of containment of Jack pending the arrival of an ambulance; and
    d. if physical restraint was necessary, then whether an officer should, if possible, be responsible for monitoring Jack's breathing, and to evaluate if and when restraint should be ended.

356. Counsel Assisting submitted that no plan was made in respect of any of the factors listed immediately above.

357. Whilst planning for these factors would have led to challenges in circumstances where only three police officers were present, once more officers attended the location, those officers could be allocated with any of the above planned roles so as to ensure that Jack's safety was protected and so to minimise the period for which Jack was subject to restraint.

358. A plan may also have obviated the problems occasioned by each officer during the struggle that eventuated focussing upon their own particular role rather than evaluating the situation as a whole, and forming an informed view as to whether or not it would be safe to seek to roll Jack over or otherwise to seek to move him to minimise the risk of positional asphyxia. It would have given some protection to Jack's safety and welfare, in a situation where in fact the focus of officers was on control of the situation rather than on Jack's welfare.

359. As noted above, Sergeant Buchanan and Constables Marshall and Guthrie should have developed some plan to cater for the real possibility that Jack may not return in a compliant fashion to RPA that afternoon. Such a plan

could have been developed on arrival or by communication as the incident unfolded.

*Informed evaluation and consideration of risk and safety, including monitoring of Jack's breathing*

360. Sergeant Watt gave evidence that police officers should make a "continuous series of evaluations during any use of force, considering the possibility of the technique causing injury versus the need to obtain and then maintain control".

361. Counsel Assisting submitted that I might find that the involved police officers did not continuously evaluate whether force was necessary during Jack's restraint and, in particular, that they did not adequately turn their minds to:

a. the risks to Jack of positional asphyxia; and
b. Jack's breathing.

Rather, Counsel Assisting say that the focus was on gaining control of Jack and maintaining Jack in what was considered to be a safe position for the police officers and not Jack.

[redacted] <u>The risks to Jack of positional asphyxia:</u> According to the NSW Police Force Handcuffing Manual (2014), [redacted]

[redacted]

363. NSW Police policies require that police officers should be mindful of the risks associated with positional asphyxia when dealing with subjects, and must ensure a subject is not restrained or conveyed in any manner that may induce positional asphyxia.

364. Sergeant Watt confirmed the current police training treats positional asphyxia as a significant risk and that prone restraint with weight on a subject's back poses a risk of sudden death. He also stated however that the NSW Police's position on positional asphyxia is under review.

365. Whilst most involved police officers gave evidence that they knew about the risks of positional asphyxia, none of the officers appeared to specifically turn their minds to those risks during the second incident or sought to change their actions so as to reduce those risks, save for possibly Sergeant Buchanan who gave evidence on 3 November 2020 that she said, "Watch his chest, get him on his side".

366. Sergeant Buchanan said that she was aware of the risks of positional asphyxia and accepted that Jack had most if not all the risk factors (see above). Sergeant Buchanan said that:

> … so we are trained in something called positional asphyxia or learning to be wary of that as a risk. Having said that it's not always completely avoidable, to completely avoid those areas when detaining someone … I remember saying out loud to "make sure that he's breathing" and to try and get him on his side because I was conscious of when there was - because, you know, when more police come you always think everyone just wants to come in and get involved and that's when the risk, I suppose, heightens in terms of stuff like positional asphyxia, and that's when I was just blindly kind of calling out, you know, make sure, "make sure that he's breathing, make sure he's on his side".

367. Constable Guthrie could not recall participating in any specific courses relating to positional asphyxia, but agreed that Jack exhibited all of the risk factors. On 4 November 2020, Constable Guthrie clarified that although the risk factors were "certainly there" at the time, she was thinking of the situation at hand and not those risks. She agreed that "potentially, yes" she should have considered the risk factors of positional asphyxia.

368. Constable Marshall gave evidence that he was trained in the risks of positional asphyxia and agreed that all of the risk factors were present in respect of Jack during the second incident. When he gave his first account of the second incident, Constable Marshall said that positional asphyxia was something in the back of his mind, but that he could not recall any actions taken to avoid positional asphyxia. On 4 November 2020, Constable Marshall gave evidence that it was only once the subject was under control that steps could be taken to reduce the risk of positional asphyxia. He accepted, however, that with the benefit of hindsight he should have considered the risk factors associated with positional asphyxia.

369. Senior Constable Johnson was trained in positional asphyxia and was aware of the risks associated with an individual being restrained in the prone position. He noted however that he did not turn his mind to the risks of positional asphyxia at all during the second incident. On 5 November 2020, he clarified this evidence, saying that he did consider that Jack was at risk in the prone position because he was more likely to suffer from breathing difficulties. Senior Constable Johnson gave evidence that this was why he asked for the caged vehicle to be brought closer so that Jake could be moved out of the prone position. In hindsight, he accepted that he should have communicated this awareness of the risks of positional asphyxia to the other officers who were present.

370. Constable Harris also stated that the risks of positional asphyxia were in the back of her mind and that, although she was always making an assessment, she had to balance this against being in a wrestle with a violent person in the middle of the street. When she was asked why she did not try to minimise the risk factors, she said, “In that situation – couldn’t have happened”.

371. Constable Macsok stated that he did not turn his mind to the risk factors for positional asphyxia, and when asked, “Do you think you should have?” He replied “No, it was constant, it was dynamic”.

372. It appears that the involved police officers undertook no evaluation of the methods of restraint used and the risks that those methods posed to Jack in respect of positional asphyxia. Whilst the situation was certainly dynamic and Jack appeared to the police officers to be resisting (discussed further below), there was a real need for Jack, as a restrained person, to be protected. Instead, the involved police officers focused on gaining control of Jack, rather than considering the risks of positional asphyxia and seeking to obviate that risk.

373. <u>Jack’s breathing:</u> NSW Police policies provide the following warnings that breathing should be monitored when force is used to restrain an individual:

[redacted]

[redacted]

374. Sergeant Buchanan says that she made at least three calls to the police officers present during the second incident to check Jack's breathing and to make sure Jack was on his side. She said she was relying upon feedback from others as to his breathing, and accepted that no one was tasked with monitoring Jack's breathing. Sergeant Buchanan also indicated that she was not aware of where other officers were during the period of restraint.

375. In support of Sergeant Buchanan's evidence, Senior Constable Oscuro gave evidence on 20 September 2019 that she heard someone say to watch Jack's breathing but she couldn't say if it was more than once. Senior Constable Oscuro's contemporaneous notebook entry recorded that someone said, "Be careful about sitting on Jack's chest". Constable Harris recalled hearing a female voice at one stage say, "check whether he's breathing," but that she only heard that on one occasion.

376. It appears therefore that on at least one occasion Sergeant Buchanan called for someone to check whether Jack was breathing. It is not clear how often this call was made, or when. It also appears that on one occasion a call went out to be careful about sitting on Jack's chest. Beyond this, there does not appear to have been any instruction to monitor Jack's breathing during the incident nor was anyone tasked with undertaking that role. Sergeant Buchanan said in evidence on 5 November 2020 that "in hindsight, [she] probably should have. But [she] was monitoring his breathing, and at the time that's why [she] didn't say anything". Moreover, the evidence indicates that Senior Constable Johnson who was in a position to monitor Jack's breathing and who listened for Jack's breathing did not communicate to others that he observed that Jack did not seem to be getting much air and sounded like he had lots of saliva in his mouth and could not swallow. Senior Constable Oscuro, albeit not physically involved in the restraint beyond handcuffing Jack and releasing Constable Guthrie's leg but who was standing back and observing, also did not herself monitor Jack's breathing but instead assumed others were doing so.

377. Professor Alpert opined that although multiple officers were present during the second incident, it is not clear from the CCTV footage who was watching Jack's breathing and communicating it to the other officers.

378. Each of Professor Alpert and Sergeant Watt, however, gave evidence that Jack's breathing need only have been monitored once Jack was "under control".

379. In his expert report, Professor Alpert stated that:

> A contested policy violation is the speed at which officers recognised Jack's compromised breathing and turned him over to remove pressure from his abdomen (to prevent positional asphyxia). *This manoeuvre is not required, however, until the subject is under control.* [emphasis added]

380. He also indicated that:

> The officers had the duty and responsibility to provide Jack appropriate care and turn him to his side as soon *as he was under control and quit resisting. Being handcuffed in front does not equate to being controlled* … [emphasis added]

381. When asked whether the officers should have sought to have freed Jack from their weight at the first opportunity, Sergeant Watt answered, "Yes, and that would be once they have gained control of Jack". Further when asked whether there should be a time limit on the use of prone restraint, Sergeant Watt opined:

> I would prefer that rather than have a time limit the police focus on the need for the restraint to continue. Unfortunately in the - in a hospital environment, they have methodologies that are not available to police in the field. They can use chemical restraint. We, we don't have that capability. It's a different - it is a different environment and there are different risks and different considerations. Would consistently monitoring, tasking somebody to continually monitor the individual while we are restraining him. If possible, yes, we should be doing that. But again it's difficult to maintain. Yep, I want you to stand there and at the one minute mark, I want you to check. At the two minute mark, I want you to check. At the three minute mark, I want you to check.
>
> I would rather they examine the need for the restraint and whether or not it's successful.

382. Mr Dunne also agreed that mandating a time for the use of the prone restraint position was "not possible".

383. In his expert report, Mr Dunne concluded that the guideline to closely monitor and assess breathing was only followed after Sergeant Buchanan gave the instruction for this to occur, although it could be assumed that if Jack was resisting then he was breathing and had a pulse.

384. The assumption/connection that Mr Dunne made between Jack's supposed resisting and his breathing was shared by some of the involved police officers. On 4 November 2020, Constable Harris gave evidence that she assumed Jack could breathe because he was moving, and that, by reason of his conduct when she was trying to handcuff him, he was violently resisting. Constable Macsok was unwilling in oral evidence to even consider the possibility that Jack may have been moving by reason of pain or difficulty breathing, or that he was spitting because he was trying to clear his mouth of saliva.

385. In my view, Mr Dunne's assumption referred to immediately above and in the evidence of Constables Harris and Macsok is merely that, an assumption. It likely reflects misunderstanding as to whether Jack was in fact moving because he was struggling to breathe as opposed to "resisting".

386. I accept the evidence of Senior Constable Johnson. He indicated that, at least when he was present, Jack's spitting was more likely an attempt to clear his mouth of saliva than a sign of resistance. Senior Constable Johnson also gave evidence that there was not a great deal of resistance when he was holding Jack's head, and that he had the impression that Jack was not getting much air but that he did not turn his mind to why this was so. His evidence was that he did not try sitting Jack up as he was not the officer in charge and did not know what had occurred previously during the second incident. His concern was to get Jack into the back of the truck and off the ground as quickly as possible.

387. Conclusion: Finding: I accept Counsel Assisting's submission, given the above evidence, that none of the officers, other than Senior Constable Johnson, turned their minds to the fact that Jack's spitting was on account of anything other than aggression. In those circumstances, the Court is unable to place any real weight on their evaluation that his spitting was necessarily motivated by aggression throughout.

388. It may be, as Counsel Assisting suggested, that the officers involved were experiencing perceptual distortions (see paragraphs 291 to 293 above) such that they were not in fact looking beyond the circumstances of their own actions, nor able to evaluate whether Jack continued to be out of control or at risk of escaping if they tried to turn him over or move his position so as to lessen risk.

389. In any event, Sergeant Buchanan, Senior Constable Oscuro, and Constables Guthrie, Marshall, Harris and Macsok did not engage in any evaluation of whether continuing force was necessary during Jack's restraint, given the risks of positional asphyxia and the impact of force on Jack's ability to

breathe. Rather, Jack remained restrained in the prone position pending a police truck being moved to a position close to Jack, in circumstances where it may have been possible for Jack to be rolled over into a safer position. Sergeant Watt's proposed continuous assessment and evaluation did not take place.

390. Moreover, no police officer undertook responsibility to monitor Jack's breathing or focused upon Jack's safety or wellbeing during the period of prone restraint, until Senior Constable Johnson arrived at which time he focused on Jack's breath. Rather, the focus was upon gaining control of Jack and maintaining Jack in what was considered to be a safe position for the police officers involved.

391. In respect of Senior Constable Oscuro, given her evidence on 5 November 2020 that she saw that the police officers had control of Jack after handcuffs were applied and she was not involved in the struggle, she was in a position to evaluate the risks to Jack and the benefits of trying to move him out of the prone position. Whilst Senior Constable Oscuro indicated that she considered Jack was in a safe position, she did not herself monitor his breathing nor was she aware of anyone else in fact undertaking that task. Further, she ultimately accepted by reference to the taser footage that at the point when Jack had had handcuffs applied he was face down resting on his elbows and therefore in the prone position.

392. In the light of his evidence, Senior Constable Johnson was ideally placed to perform the necessary evaluations referred to above. No-one tasked him however to do anything more than hold Jack's head and when he arrived there were six police officers, including two senior constables, involved in the incident.

*Supervision*

393. Professor Alpert, in his evidence, stated that "command and control is so important". He elaborated, "That someone is keeping an eye on what's going on if possible and, and that's why I mentioned the, the requirement to intervene if another officer sees something then, then he or she must do something". Sergeant Watt gave evidence however that it was difficult to mandate "command and control" in "specific actions at specific times".

394. Sergeant Buchanan, who as noted above was in an Acting Sergeant role on 18 February 2018, was the most senior officer in attendance during the second incident. There is limited evidence from the involved police officers however that Sergeant Buchanan acted in the role of supervising officer,

including giving instructions to other officers as to their roles or steps they should take, during the second incident.

395. Constable Marshall gave evidence that he understood that Sergeant Buchanan was in charge on the afternoon of the second incident but that she gave no “specific instructions” to him. Similarly, Constable Guthrie said that Sergeant Buchanan was the “sergeant, external sergeant at that stage so I believe she would be the most senior officer in charge of this”. She indicated however that Sergeant Buchanan did not communicate any plan to Constables Guthrie and Marshall. She stated:

> Yeah, so, but there was no specific instructions between me, [Sergeant Buchanan] and [Constable Marshall], okay, like as to the plan. There was no, I guess, plan. We were just, our sole focus was just to locate Jack and make sure he was okay and, as requested, return him back to the emergency department, the mental health ward.

396. Constable Bodell indicated that when he arrived at the second incident he was aware that Sergeant Buchanan was the supervisor on the day. He stated however “But being a dynamic incident, sometimes it might be necessary for a lower and ranking officer to make an observation or take a certain action but I recognised that she had the highest rank at that time”. He then elaborated that “if [Sergeant Buchanan] was to make – to direct me to something, then I would be required to do it, but it was a very dynamic situation”. When asked however whether he had turned his mind to who was in charge when he turned up at the second incident, he answered, “probably didn't if I'm actually turning my mind back to that situation and being only eight weeks policing experience. It probably wasn't something I turned my mind to. My mind was on the situation at hand”.

397. Senior Constable Johnson and Constables Harris and Macsok gave evidence that they could not recall who was in charge when they arrived at the second incident. Senior Constable Johnson and Constable Macsok indicated that they could not recall receiving any instructions from Sergeant Buchanan during the second incident, and Constable Harris recalled being given instructions on four occasions but was unable to identify who it was that she received instruction from.

398. As noted at paragraph 206 above, Sergeant Buchanan also gave evidence that during the second incident she was affected by the OC spray as she had to run through it. She said she had difficulty seeing, “and breathing, talking and everything else”. On 3 November 2020, when asked whether she would accept that she was in no position to exercise the role of supervisor given she was exhausted, in pain and experiencing difficulties with her vision, she

answered that she did not accept that. She also indicated that she was unsure as to whether she could have tasked someone to take over. She stated:

> But I think that the danger in assigning any one person to do any task is that if they – if that one person is the only one doing the task and they miss it then, you know, its kind of ineffective tasking. Whereas if everyone is putting in that collective input to collectively work out when the situation's safe or, you know, if there is an issue with anything …

399. In my view, whilst placed in a very difficult situation in which she was at times pinned under Jack's body, Sergeant Buchanan failed to exercise her supervisory role and did not take up opportunities to delegate the role to others in circumstances where there were six police officers present during the second incident. Senior Constable Oscuro, for example, could have been delegated a supervisory role, particularly in circumstances where for much of the time that she attended the second incident she can be seen on the CCTV footage standing back and observing the melee. Sergeant Buchanan was in a position where she was unable to properly monitor the actions of the involved police officers – she was unaware that the taser had been deployed or that Jack had been handcuffed.

400. If Sergeant Buchanan had delegated supervisory capacity to Senior Constable Oscuro, or had Senior Constable Oscuro stepped up and taken on that role, this may have allowed the supervisory officer to monitor the safety of the police officers and Jack.

401. This view is consistent with Mr Dunne's expert evidence. In his expert report, he identified that, given the number of officers that later arrived at the scene, it would have been preferable if Sergeant Buchanan had directed one of them to replace her as this would have enabled her to deal with the overall management of the incident.

402. Ms Bourke submitted that there was no requirement for a supervisor to assume a supervisory role in the course of the circumstances that occurred in respect of Jack.

403. During the inquest, Sergeant Watt gave evidence that those under stress may suffer from perceptual distortions. His evidence was that such perceptual distortions can include tunnel vision, time dilation or compression, inattentional blindness and looming. It is plain from the differing accounts of the six primarily involved officers as to Jack's condition and movements on 18 February 2018, and as to timing during the incident, that their own perceptions were likely impacted by these factors.

404. I accept the submission of Counsel Assisting that this underscores the importance of planning, supervision, and allocating an officer to monitor, evaluate, de-escalate through communication and give instructions, if that is reasonably practicable. The consequence of this not occurring is that matters set out in policies, and about which officers are dutifully trained, offer little or no protection in times of stress and apparent chaos, as, on the basis of the available evidence, was the case in the incident involving Jack on 18 February 2018.

*Communication*

[redacted]The NSW Police Force "Weapons & Tactics, Policy & Review, Close Quarter Control" policy provides a clear mandate for communication between police officers involved in a physical confrontation, in particular to "[redacted]

406. Further, in the chapter "Mentally Ill People" in the NSW Police Handbook, it is noted that:

[redacted]

407. Further, expert evidence at the inquest emphasised that, where possible, communication between police officers and persons of interest is important and should be undertaken. The experts also supported the importance of communication as between officers, for example as to whether the person of interest was having breathing difficulties or had been handcuffed.

408. Counsel Assisting submitted that there were deficiencies both in respect of both communication between the involved police officers and communication between the involved police officers and Jack.

409. Communication between the involved police officers: The evidence establishes that the involved police officers were not aware of key matters during the second incident, including:

a. whether Jack was handcuffed;
b. the positions of police officers relative to Jack whilst the police officers were struggling to get Jack "under control";

c. who had control over what part of Jack's body;
d. the level and nature of Jack's resistance;
e. Jack's mental health issues and mental health presentation;
f. whether any attending officers had completed the four-day mental health training course (see paragraphs 433 to 452 below);
g. Senior Constable Johnson's evidence as to Jack's shallow breathing, the minimal amount of effort it took to hold Jack's head and that Jack was not moving much at the time; and
h. whether it might be safe to roll Jack over or move him to his side.

410. The police officers' lack of awareness as to these key matters, in my view, is to be attributed to their lack of communication. This lack of communication was inconsistent with NSW Police policy. Moreover, their failure to communicate with each other impacted on their ability to properly assess the incident as it unfolded, likely impacted on their sense of safety and wellbeing and, in turn, prevented them from properly evaluating and assessing Jack's safety and wellbeing. I note Professor Alpert's view in this regard that "[a]s communication among the officers was lacking and violated policy, it is a question as to whether this lack of communication created a gap in time between Jack being controlled and turning him onto his side to avoid positional asphyxia".

411. Mr Haverfield submitted that, from the moment containment of Jack did not work, the involved police officers were hands on. He referred to the evidence of Sergeant Watt that, "part of the purpose of training is so that everyone knows what everyone else's job is and they move through and do that," and submitted that consistency in training of police officers means that they can work together as a unit even if the police officers are not actively communicating with one another:

412. I do not accept Mr Haverfield's submission. The involved police officers' failure to communicate was inconsistent with NSW Police policy and was contrary to their training.

413. Communication between the police officers and Jack: There is no evidence to suggest that, even after their arrival, Jack was speaking to the involved police officers.

414. Constable Macsok recalled that Jack "didn't speak, so he didn't say words. It was more making noises and, and grunting". He described the noises as, "He was sort of yelling and making, I can't really explain. So he was grunting, just yelling out noises".

415. Constable Harris on 4 November 2020 said that, whilst she has no recollection of doing so, she would have said to Jack words to the effect of, “stop pulling your arm away” and “please stop resisting”. She also indicated that she “wasn’t getting any response in regards to my communications with him”, but went on to say that she had no actual recollection of this. She also answered in response to the question, “Did you ask if he was ok?”, “No – it [was] hard when he [was] spitting”.

416. In her evidence on 5 November 2020, Senior Constable Oscuro stated that she directed Jack to “stop resisting”. She said that this direction would have been “reassuring to [Jack] to listen to police to follow instructions”. She said that there was no attempt to communicate with Jack regarding his welfare because there was no opportunity for the police officers present to make those enquiries.

417. The evidence establishes however that no attempt was made to meaningfully communicate with Jack in order to build a rapport, save for Constable Macsok’s limited attempt during the struggle where he “asked what’s his name. I said Jack just relax we are trying to help you stop resisting. He was non verbal – he didn’t respond”. Rather, police officers appear to have only given Jack directions.

418. Further, no attempt was made to reassure Jack, or to determine whether he was in pain, having difficulty breathing or moving for any reason other than violent resistance to a police arrest. Regarding this, Senior Constable Johnson said that despite the fact that he had been trained in relation to communicating with people with mental health conditions, including building a rapport and offering communication, he did not inform Jack what was happening and that in hindsight he should have.

419. Chief Inspector Hanlon gave evidence that once the use of force commences, although communication and de-escalation remain an option, it is unlikely to be successful as any rapport that the person of interest has developed with police officers is tarnished. Further, police officers will become increasingly adrenalized and will focus on the techniques related to and the physicality and effectiveness of the use of force. In this case, as both the police and Jack had converged in a fight, this meant that the focus was no longer on de-escalation. He stated however that communication should be used continuously where possible, and that, absent violence (even after there is violent resistance), there would be an opportunity to de-escalate.

420. Messrs Haverfield and Madden’s submitted that because of both who Jack was, this presumably being a reference to his mental health presentation, and

his failure to appropriately respond to the limited efforts made to communicate with him, the police officers did all that they could to communicate with Jack and to try to de-escalate the situation.

421. I do not accept the above submissions. Sergeant Buchanan, Senior Constable Oscuro and Constables Guthrie, Marshall, Harris and Macsok's failure to communicate with Jack for the purposes of reassurance and de-escalation was inconsistent with NSW Police policy and Chief Inspector Hanlon's evidence as to best practice. Given Jack's mental health presentation, which was known to at least Sergeant Buchanan, and Constables Guthrie and Marshall, such communication should have been attempted notwithstanding the struggle in which they were engaged.

422. In light of the above evidence, I am minded to make the recommendation proposed by Counsel Assisting, namely, that consideration be given to requiring:

a. one officer to be officially and verbally designated supervisor in any interaction involving 3 or more police officers and the use of force, with that officer required to undertake overall responsibility for significant events during the course of the interaction, to ensure compliance with the matters set out below and to ensure that an ambulance is called at the earliest available opportunity if the POI has a mental health history and force is at risk of being, or is being, used;
b. that officers communicate and verbalise significant events in the arrest and detention of a POI such as any mechanical restraints applied or the availability of any vehicles for use;
c. that officers communicate and verbalise reports as to the status of the POI and the extent of their resistance, including to ensure the designated supervisor is aware;
d. that an officer to maintain a time log as to when a POI is placed in the prone position to ensure awareness of the period for which the POI is so placed, requiring an attempt that the POI be moved at a certain defined time interval;
e. that an officer be tasked to monitor the breathing of any POI placed in the prone position, and to verbalise the status of the POI's breathing, including to ensure the designated supervisor is aware; and
f. that all officers are trained as to these matters.

423. As already noted above, in reviewing the actions of the involved police officers, I am to consider the particular circumstances of Jack's death but also the importance of safeguarding the welfare of persons involved in similar encounters. In doing this, I make no apology for making full use of the benefit of hindsight to work out what could have been done differently, if anything, to

prevent Jack's death, and to ascertain whether any lessons can be learned from the circumstances examined in this particular inquest. It is through learning lessons from the past that we can hope to meet one of the fundamental purposes of this jurisdiction, namely, the prevention of tragic deaths occurring in similar circumstances.

424. It was initially proposed by Counsel Assisting that I make a recommendation that NSWPF consider implementing a "lessons learned" unit to review critical incidents and to identify what, if any changes could be made to avoid such incidents occurring in the future. However, counsel for NSWPF has informed the Court that NSWPF already has such a unit – the Research and Policing Practice Unit – which is responsible for the development of research that informs the principles and practice of policing in NSW. On the basis that this reach includes reviewing critical incidents to identify what, if any, changes can be made to avoid similar incidents occurring, I am not minded to make the recommendation proposed by Counsel Assisting.

***Methods of restraint that the involved police officers used***

425. The issue of restraint and the involved police officers' evaluation of the methods of restraint used on Jack are referred to at paragraphs 203 to 262 above.

426. It is clear from the evidence referred to above that up until Senior Constable Johnson arrived at the second incident:

a. at least five police officers placed significant weight on Jack over the course of the second incident, for varying durations, in varying positions, and all whist Jack was held in the prone position;
b. those police officers did not communicate with each other about the positions that they were in relative to Jack's body and what they were experiencing (e.g. whether Jack was resisting and the manner of his resistance) or whether Jack was breathing; and
c. there was no police officer who took on a supervisory role, and nor was there any police officer who was monitoring Jack's breathing.

427. In light of the above, Counsel Assisting submitted that the police officers should have at least tried to sit Jack up once he was handcuffed.

428. Counsel Assisting's submission is consistent with the expert evidence.

429. In his report, Mr Dunne opined, "In the period after the other police arrived and as the activity between them and Jack reduced, there may have been an opportunity to consider reducing the weight applied to him". Sergeant

Sutherland gave similar evidence in relation to the first incident, where he regarded it as likely that once he had got handcuffs on Jack, that enabled him to exercise necessary control.

430. I accept Counsel Assisting's submissions that the involved police officers should have made an assessment as to the method of control used and given consideration to other methods of restraint and whether Jack's breathing was monitored, particularly when six officers were involved. This was not done here. There is currently no training in relation to a police officer being assigned to monitoring a persons' breathing when that person is in the prone position. The Court heard evidence however that it would not be a significant issue to add something like that to training. Indeed, evidence heard from Dr Cutler in relation to practice in a hospital setting is that she has never restrained anyone prone, and that she would almost err on not restraining a person if she had to place them in the prone position.

431. To accept the tactical experts' evidence that the subject has to be under "control" before any assessment as to the safety of the chosen method of control/restraint is unsatisfactory.

432. I also accept Counsel Assisting's submission that, in particular once handcuffs were on Jack, there should have been clear supervision, command and control, and communication and careful monitoring of breathing. Moreover, an ambulance should have been engaged, at least as early as when Constable Marshall's taser was deployed for the first time. As Professor Alpert stated, in relation to the United States, the police force there has moved to a requirement for officers to intervene if they see something that should not be happening, based on the concept of active bystandership, whereby everyone is tasked with the duty to intervene.

***NSW Police mental health training***

433. NSW Police mental health training is currently developed and implemented by the MHIT. According to Chief Inspector Hanlon, the Manager of MHIT, the aims of MHIT are to:

a. reduce the risk of injury to police and mental health consumers when dealing with mental health related incidents;
b. improve awareness amongst frontline police of the risks involved in interaction between police and mental health consumers;
c. improve collaboration with other agencies and non-government agencies in the response to, and management of, mental health crisis incidents; and

d. reduce the time taken by police in handover of mental health consumers into the health care system.

434. MHIT has developed and implemented an intensive four-day training course for frontline police officers. The course involves 21 lectures on different facets of mental health and suicide awareness with a focus on communication and de-escalation techniques. Amongst other things, the course covers role plays where participants are assessed on their ability to communicate to resolve set scenarios, including a suicide intervention, a domestic situation where an involved person is experiencing mental illness and a mental health consumer who is in crisis in a busy community setting.

435. Between 4 February 2014 and December 2015, MHIT implemented a One Day Mental Health Workshop Program. This involved providing a one-day mental health awareness training package to all sworn police officers who had not completed the four-day program. It was effectively an abridged version of the four-day training course referred to immediately above.

436. Following the initial rollout, the One Day Mental Health Awareness Program was integrated into the core curriculum for recruits at the NSW Police Academy in Goulburn.

437. The following involved officers completed mental health training on the following dates:

a. Senior Constable Oscuro: four day training commencing on 11 July 2011;
b. Constable Harris: one day on 25 June 2014;
c. Constable Guthrie: one day on 9 November 2014;
d. Detective Sergeant Sutherland: one day on 11 September 2015;
e. Senior Constable Johnson: one day on 2 April 2015;
f. Constable Marshall: one day on 2 April 2016;
g. Constable Macsok: one day on 23 July 2016;
h. Sergeant Buchanan: four day training commencing on 9 March 2018 (after the events the subject of this inquest).

438. The involved police officers had the following recollection of their mental health training.

439. Constable Marshall could not recall having completed any courses that covered mental health specifically and surmised that it had been covered in the academy.

440. Constable Guthrie remembered attending a one-day lecture, during which she was told that when encountering a situation where a person of interest appears to be both drug affected and potentially suffering from some sort of mental health problem, keep the situation as calm and neutral as possible until medical help in the form of an ambulance has arrived. She said there was no requirement to have someone with four day training attend the scene.

441. Detective Sergeant Sutherland confirmed in evidence that whether someone is:

> having a mental health episode or in a drug-induced psychosis, the methods [to] restrain an offender, a person, a member of the public or whoever they may be, don't particularly differ. If, if a person is violent and they need to be restrained, they'll be restrained.

442. Detective Sergeant Sutherland stated that the one-day mental health training was:

> more focussed on the problems that, or the issues that arise when dealing with people who are having mental ill, mental illness episodes, and perhaps they're more so their perspective and how, how these sort of things affect them rather than how the police deal with them holistically.

443. Senior Constable Johnson stated that he had never had any training regarding detention or restraint to people with mental health issues, nor any training in respect of communication with individuals with mental health issues.

444. Gaps in mental health training: Chief Inspector Hanlon's evidence on 5 November 2020 was that that the mental health training described above does not deal with situations in which force has been applied. Counsel Assisting submitted that this is a significant and undesirable gap in the NSW Police training and policies.

445. In light of the above, Counsel Assisting proposed that the importance of communication and attempting de-escalation if possible even after force has been used in an incident involving a person of interest with known or suspected mental health issues be included in relevant NSW Police training and policies. As noted by Ms Bourke in submissions, Chief Inspector Hanlon stated that he could see the benefit of such a recommendation being considered by this Court.

446. I accept Counsel Assisting's submission that in the present case where there were police officers such as Senior Constable Oscuro and Senior Constable

Johnson who were present during the second incident but who were not physically involved in the restraint or likely adrenalized, it would be highly desirable for them to attempt communicate with Jack. I note the expert evidence summarised at paragraphs 407, 410 and 419 above regarding the importance of communication.

447. Benefits of mental health training: At the time of the second incident, Senior Constable Oscuro was the only involved police officer who had attended the four-day mental health training course. She did not however announce her training status on arrival and, in evidence, she said that she did not know Jack's mental health history, that he had any mental health presentation or that he had absconded from the RPA. Further, at no time during the mental health incident did she become aware that Jack was believed to have mental health issues.

448. Senior Constable Oscuro's evidence was not unique. Constables Harris and Macsok similarly gave evidence that they were not aware of Jack's mental health presentation.

449. Although Sergeant Buchanan agreed that she didn't take any steps to ensure an officer with four-day mental health training could attend to Jack, she said that she was certain, having now done the course, that there was nothing that could have been done differently. Her evidence was that the four-day mental health training course was "more beneficial for junior constables to give them some perspective. For me, who's worked thousands of mental health jobs, there was nothing on the course that having known that then would have changed anything".

450. When asked however, "do you accept that you should have got someone to attend who had done the four-day MH training?" Sergeant Buchanan answered, "Sure, why not".

451. Counsel Assisting submitted that NSW Police offers mental health training for a reason, and accordingly proposed that a recommendation be made that consideration be given to implementing a system whereby certain MHIT accredited officers who attend cases which meet criteria indicating a possible mental health crisis identify themselves on arrival as having undertaken the relevant training.

452. I also do not accept Sergeant Buchanan's evidence that it would have made no difference for a police officer who had completed the four-day mental health training to attend nor that it would have made no difference if Senior Constable Oscuro had been told and intervened with the benefit of that training. Rather, that is a matter which is simply unknown.

453. In light of the above evidence, I am minded to make the recommendations proposed by Counsel Assisting in relation to mental health training for police officers. Accordingly, I recommend that consideration be given to:

a. making mandatory the four day accredited MHIT training package for all police officers; or;
b. in the alternative, developing and implementing a system requiring the dispatch where possible and early identification of four day MHIT accredited officers as first responders in cases which meet criteria indicating possible mental health crisis; and
c. initiating training and policy provision for the use of communication and de-escalation even after there has been a use of force in a situation involving a person of interest with known or suspected mental health problems to be delivered either in conjunction with or in addition to the STOPAR training for all police officers.

454. Further, I recommend that consideration be given to:

a. developing and implementing a system to ensure any four day MHIT accredited officers attending in cases which meet criteria indicating a possible mental health crisis identify themselves on arrival as having undertaken the four day training.
b. NSW Police Weapons and Tactics Policy and Review to develop and implement training through the use of roleplay where, in cases where there are multiple officers, one is tasked with the role of supervisor.
c. MHIT and WTPR establishing and documenting a joint review of STOPAR and de-escalation training including after a use of force, and for that training to be integrated in defensive tactics training where mental health is likely to be a relevant factor.

<u>The “Guardian versus Warrior” training module</u>

455. Chief Inspector Hanlon gave evidence that NSWPF currently provide a training module referred to as “Guardian versus Warrior”. Chief Inspector Hanlon explained that the training module is conducted under the Vulnerable Communities Portfolio and is specifically aimed officers dealing with vulnerable individuals, specifically those with autism. The Court understands that the training module is not currently provided to all general duties policemen as part of their basic training.

456. Chief Inspector Hanlon explained that the training is aimed at assisting officers to transition from a warrior mentality, where the use of force or a restraint might be necessary, to a guardian approach, where the vulnerability

of the person is prioritised. It was put to Chief Inspector Hanlon that the Guardian versus Warrior module would appear to be highly relevant and beneficial as regards the de-escalation of violent interactions between police and those with a mental illness. Chief Inspector Hanlon accepted in evidence that, in principle it would be valuable and that consideration could be given to introducing the Guardian versus Warrior module into NSWPF's mental health training program.

457. In light of the above, I am minded to make the recommendation proposed by Counsel Assisting, namely that consideration be given by NSWPF to MHIT further developing and implementing for all NSWPF officers the "Guardian v Warrior" training currently in the Vulnerable Communities Portfolio.

The PACER Program

458. The Court heard evidence regarding the NSWPF's PACER program, which is designed to provide a specialist mental health early response to people experiencing a mental health crisis by placing mental health clinicians in police area commands. Chief Inspector Hanlon gave evidence that the program is still in a pilot phase and that at the time of giving evidence, 36 clinicians had been recruited to work in 12 chosen high-risk area commands across New South Wales.

459. Chief Inspector Hanlon gave evidence that under the PACER program, a mental health clinician could attend a situation where an individual was experiencing a mental health episode. Chief Inspector Hanlon explained that that, once police had rendered the situation safe, the mental health clinicial would be encouraged to engage with the individual to conduct an assessment of that individual's mental health condition to determine how best to assist the individual. Chief Inspector Hanlon accepted in evidence that, once police had rendered a situation safe, whether that be through verbal communication or physical restraint, mental health clinicians may also have a role in de-escalating the situation.

460. In light of the above evidence, I am minded to make the recommendation proposed by Counsel Assisting, namely, that consideration be given by the NSW NSW Health and NSWPF to expanding the funding for and roll-out of the PACER program.

***The adequacy of mental health and other support provided to Jack whilst on parole***

461. I refer to paragraphs 32 to 91 of the findings above.

462. I accept Counsel Assisting's submission that, from an examination of the medical and parole records, it appears that for the period of time between Jack's release to parole and his death Jack:

a. had no stable housing and there was some uncertainty as to his accommodation in the future;
b. for considerable periods, including the days leading up to his death, the Community Corrections Officer, amongst others, did not seem to know where Jack was staying;
c. had observed psychiatric symptoms of varying degrees, and yet appears to have missed his two scheduled doses of fortnightly depot medication such that he had not had depot medication since 16 January 2018;
d. had a positive drug test;
e. had no known contact with any community mental health service after his discharge from Cumberland Hospital, and
f. had failed to report to the Community Corrections Officer on 13 February 2018.

463. Before I deal with the adequacy of the steps taken CSNSW and the Community Corrections Officer as regards Jack while he was on parole, it is necessary to first deal with counsel for CSNSW's submissions that neither CSNW nor the Community Corrections Officer were afforded procedural fairness in these proceedings.

*Procedural fairness as regards CSNSW*

464. In written closing submissions, counsel for CSNSW submitted that CSNSW was not afforded procedural fairness in these proceedings as "CSNSW was not informed of the content of either the proposed adverse findings or the draft recommendations prior to the close of evidence before the Court concerning."

465. In a letter dated 28 August 2020, CSNSW were notified of a sufficient interest in these proceedings. The letter specified that:

> "While the Coroner has not formed any concluded views in relation to the various issues raised in the subject matter of this inquest, it is likely that Corrective Services' conduct will be a subject of the inquiry and, possibly, of adverse comment."

466. On 28 August 2020, an application was made by CSNSW seeking that the evidence of Mr Phouisangiem be held over until the third tranche of the

hearing in order to allow CSNSW time to review and adequately consider the brief of evidence. This application was granted.

467. On 5 November 2020, CSNSW was provided with a copy of Counsel Assisting's closing submissions, which included proposed adverse findings and draft recommendations. The purpose of circulating those adverse findings and draft recommendation was to assist parties in preparing closing submissions.

468. The following day, 6 November 2020, the Court heard oral closing submissions on behalf of the remaining interested parties.

469. On 6 November 2020, following an application by CSNSW, the Court granted CSNSW the opportunity to provide written closing submissions in response to the adverse findings and draft recommendations proposed by Counsel Assisting.

470. On 20 November 2020, CSNSW provided written closing submissions.

471. In this jurisdiction, there is no requirement that Counsel Assisting must notify parties of proposed adverse findings or draft recommendations prior to the closing of evidence. What is important is that parties have the opportunity to respond to any adverse findings or recommendations proposed by Counsel Assisting as part of closing submissions.

472. I am satisfied that CSNSW has been afforded such an opportunity in these proceedings and for that reason I do not accept counsel for CSNSW's submission that CSNSW was not afforded procedural fairness in these proceedings.

*Procedural fairness as regards the Community Corrections Officer*

473. In written closing submissions, counsel for CSNSW and counsel for the Community Corrections Officer each submitted that the Community Corrections Officer was not afforded procedural fairness in these proceedings. The basis for the submission appears to be twofold, namely:

    a. that the Community Corrections Officer was not notified prior to giving evidence that he may be the subject of adverse comment; and
    b. that the Community Corrections Officer was not represented during the course of his evidence, and as such, did not have the opportunity to

cross-examine or otherwise test the evidence of witnesses in the proceedings.

474. As noted at paragraph 82 of these findings, in a letter dated 28 August 2020, CSNSW was notified of a sufficient interest in these proceedings. The letter also referred to the fact that the Community Corrections Officer was Jack's parole officer at the time of his death, and as such had been subpoenaed to give evidence in these proceedings.

475. On 2 November 2020, the Community Corrections Officer gave evidence. the Community Corrections Officer was asked questions as part of examination in chief by Counsel Assisting, and was subsequently cross-examined by counsel for the family, and counsel for CSNSW.

476. On 4 November 2020, prior to the conclusion of evidence in the proceedings, the Community Corrections Officer was notified of a sufficient interest in the proceedings, including that his conduct may be the subject of adverse comment.

477. On 5 November 2020, the Community Corrections Officer obtained separate legal representation.

478. On 6 November 2020, counsel for the Community Corrections Officer was in attendance to hear the submission of the various parties.

479. On 27 November 2020, counsel for the Community Corrections Officer provided written closing submissions.

480. I want to make it clear at this point that any adverse comment directed to the Community Corrections Officer is a comment against CSNSW as opposed to him personally. With that in mind, I am satisfied that procedural fairness has been afforded.

Commissioner of Corrective Services NSW (CSNSW)

481. At the hearing of the inquest, the Community Corrections Officer accepted that the purpose of parole was as set out in chapter "D5 Supervision" of the "Community Corrections Police and Procedures Manual" namely, "to reduce the impact of crime on the community, primarily through the reduction of reoffending and provision of cost effective and efficient alternatives to custody". Although he stated he sought to act consistently with that purpose in his dealings with Jack, Counsel Assisting submitted that there were aspects of his evidence, as set out below, that leave room for improvement.

482. First, a difficulty that the Community Corrections Officer encountered as Jack's probation and parole officer was that he could breach report Jack, but, short of doing that, he only had available to him making referrals for Jack to Housing and encouraging Jack to engage in mental health services, without necessarily "holding his hand".

483. Secondly, the Community Corrections Officer said he was limited in what assistance he could provide when Jack was living in a different area to that covered by the Community Corrections Officer's office. For example, he said that to have visited Jack at the Banksia Motel would have been beyond the scope of his duties (as Jack was outside the purview of the Community Corrections Officer's office), but he could have visited Jack if he had remained at the Campbelltown ISC.

484. The Community Corrections Officer also indicated that he could not have arranged for another officer the Bankstown area to visit Jack because Jack had not been officially transferred to that area. When asked if he could have affected an urgent transfer, he said yes but Jack had no rapport with any other office so it would have been inappropriate. Notwithstanding this evidence, however, as noted above, Jack did attend an appointment at the Bankstown office and appears to have had some discussion with the CCO Fitzgerald there.

485. Thirdly, he clearly suffered from the fact that he was also supervising a number of other parolees and had responsibilities to them in addition to Jack.

486. Fourthly, the Community Corrections Officer agreed that he was not in a position to know whether Jack was complying with his parole conditions following Jack's discharge from Cumberland Hospital on 5 February 2018 as he could no longer get in contact with him.

487. In light of the above I am minded to make the recommendation proposed by Counsel Assisting, namely that consideration be given to some mechanism or procedure to be put in place by CSNSW when a parolee is not contactable for 7 days.

488. Counsel Assisting submitted the effect of the four factors identified above was that Jack was effectively left in a situation where he had one officer who had rapport with him, but could not get in touch with him and felt it outside of his scope to go see him. And yet, that same officer did not transfer Jack's supervision to another office. Further, whilst Jack was in contact with the Bankstown office, it appears that they did not undertake any overarching supervisory role. This meant, they say, that it was easier for Jack to then fall

through the cracks and not receive the mental health care and treatment that he required.

489. Ms Douglas-Baker, counsel for CSNSW, submitted that:

> On a fair reading of the factual timeline, the relevant period to be examined in this inquest is not 5 February 2018 to 18 February 2018, but 13 February 2018 (the day of Jack's second appointment with community corrections and the day Jack failed to report) to 18 February 2018 (the date of Jack's death). The relevant time period is further reduced from 13 February 2018 (the day Jack failed to report) to Friday 16 February 2018 (being the last weekday of the week prior to Jack's death on Sunday 18 February 2018). The period during which Jack was not apparently engaged with community corrections was 13 February 2018 to 16 February 2018 – a mere four days.

490. The evidence revealed, according to Ms Douglas-Baker, that during the totality of the time Jack was released to parole:

a. Jack was released to parole for a period of 33 days;
b. Jack's accommodation was unstable "due to Jack's non-compliance with the rules of the house";
c. Jack was twice admitted to Cumberland Hospital, which represented a total of 13 of his 33 days released to parole; and
d. notwithstanding Jack's admissions to Cumberland Hospital, the Community Corrections Officer met Jack twice and spoke with him once in the period 17 January to 23 January 2018, then CCO Fitzgerald met with Jack once but Jack missed his following appointment.

491. Ms Douglas-Baker then referred to the following terms of the "D5 Supervision" chapter of the "Community Corrections Police and Procedures Manual":

> The authority for a CCO's involvement in an offender rests in the legal document offering supervision. The extent to which a CCO can become involved in an offender's life is limited by the conditions of the legal document, legislation governing breach procedures, and the nature of the offence …

It was submitted that this, along with relevant legislative provisions, indicates that the role of a CCO "is to supervise a parolee (by encouraging, engaging, monitoring and referring) the parolee, not to intervene generally in the parolee's life". Given this role, Ms. Douglas-Baker submitted that the CCO "stands as neither nanny nor gaoler in relation to the parolee".

492. Ms Douglas-Baker then proceeded to respond to Counsel Assisting's submissions as follows.

a. The Community Corrections Officer's evidence was consistent with parole condition 3: "The offender must, while on release on parole, adapt to normal community life".
b. In respect of Counsel Assisting's submissions summarised at paragraph 482 above, the Community Corrections Officer's evidence was that his role was an overseeing role which involved encouraging Jack to take positions steps in self-care and referring Jack to services such as Housing from whom Jack would then receive assistance with accommodation. It was not the Community Corrections Officer's role to appropriate day-to-day responsibility for Jack but to supervise, encourage and refer Jack to services that would facilitate his independence and reintegration into the community. Only if such measures failed, or Jack was non-compliant, would the Community Corrections Officer breach Jack. Further, if Jack posed a risk to himself or others, and that because known to the Community Corrections Officer, he would "have the obligation to inform the relevant authorities to prevent that from happening".
c. In respect of Counsel Assisting's submissions summarised at paragraph 484 above, the Court's attention was drawn more fully to the Community Corrections Officer's evidence regarding whether Jack could be transferred to the Bankstown office:

> It could have been done but Jack had no contact with them, so they had no rapport with them [sic] and the accommodation itself was temporary so he could have been relocated to a different location and then again transferred to another office. So because I've had that initial carriage and had that initial contact with him and also tried to contact family and so forth, I've already had that, I guess some rapport. It would have been difficult for the office to again start from scratch, so it's be going back to square one, then transfer him to someone else. So that's why because he wasn't formally transferred, he wasn't – yeah – things just weren't ready.

It was submitted that the above evidence should be interpreted as meaning that, in circumstances where Jack's accommodation remained temporary, it was by no means certain that Jack would remain resident outside of the Campbelltown office area and a relationship had been commenced with the Community Corrections Officer at that office, so it was inappropriate – practically or otherwise – to transfer Jack to another CCO office.
d. In respect of Counsel Assisting's submissions summarised at paragraph 485 above, it was noted that, whilst the Community Corrections Officer's evidence was that his office had a high workload (being allocated responsibility for 30-40 parolees), it was also his

evidence that he and his colleagues worked the hours necessary to get the work done over the course of a five-day working week. the Community Corrections Officer also gave evidence that, although parolees are prescribed a specific number of hours of supervision depending upon their level of risk, in practice "basically whatever needs to be done we just do it as part of the supervision". It was submitted that Counsel Assisting's submission was not consistent with the Community Corrections Officer's evidence and that had another CCO been supervising Jack there would not have been a different outcome.

e. In respect of Counsel Assisting's submissions summarised at paragraph 488 above, it was noted that the Community Corrections Officer directed Jack to report to CCO Fitzgerald and that Jack met with CCO Fitzgerald directed. Whilst the Community Corrections Officer might not have known "personally" whether Jack was complying with his parole conditions, there were appropriate supports in place that were in effect standing in for the Community Corrections Officer and monitoring Jack's compliance with parole conditions.

493. Counsel Assisting also submitted that, on discharge from Cumberland Hospital, those responsible, including the Community Corrections Officer, were well aware of when the next depot injection was due and that it had not been administered during his stay at Cumberland Hospital.

494. In response, Ms Douglas-Baker submitted that, in circumstances where the Community Corrections Officer is not a medical practitioner, and in circumstances where he received advice from Dr Sampson that the depot injection was not due (see paragraphs 57 to 69 above) and was, in Dr Sampson's expert opinion, not connected with his behaviour, "it is manifestly unfair and inappropriate to suggest that the Community Corrections Officer had any responsibility to ensure that a parolee was receiving his or her medication from treating medical practitioners". This was particularly the case in circumstances where the Community Corrections Officer did not have access to Cumberland Hospital's medical records (see paragraph 520 below) and where it was Jack who bore the responsibility of complying with the treatment regime prescribed.

495. I am mindful of the very relevant points raised in submissions of counsel for CSNSW and counsel for the Community Corrections Officer, namely that:

a. at the time, the Community Corrections Officer was a trainee officer with a high workload;

b. The Community Corrections Officer acted within the nature and scope of his powers as per CSNSW policies;

c. The role of a Community Corrections Officer to engage with parolees, supervise them, encourage them and monitor them to facilitate their adjustment to life in the community after release from prison,
d. A Community Corrections Officer is not able to compel parolees to attend appointments or comply with medication;
e. Jack was difficult to contact and was at times reticent to engage with services, including failing to attend meetings that the Community Corrections Officer had arranged;
f. CSNSW, like any other organisation, has limited resources;

496. However, the facts in this matter suggest that the Community Corrections Officer, was in a unique position, in that he was aware of Jack's mental health and medication needs. He knew that Jack's compliance with medication was a critical factor in maintaining his mental health. He knew that Jack needed a depot medication at the end of the month. And he knew, following his conversation with Dr Sampson on 1 February 2018, that Jack had not received a depot injection at Cumberland Hospital.

497. Although he tried to re-engage Jack by contacting Jack's family and the Banksia motel, more needed to be done to ensure that Jack was referred to a community mental health care team. the Community Corrections Officer conceded in evidence, properly in my view, when asked whether it was part of his responsibility to engage with Community Mental Health, that is, whether he should have checked with the hospital "are you going to refer him or should I?", that he could have asked that.

498. Although the Community Corrections Officer stated that "even if there were another officer supervising Jack, there wouldn't have been different outcome. Little we can do if there is no engagement", I find that he could have done more to support Jack, including engaging with COMHET.

<u>South Western Sydney LHD and Western Sydney LHD</u>

*Continuity of mental health care for Jack on parole*

499. Dr Modem gave evidence that Jack had been approved through the Macarthur COMHET for the Macarthur "MAT" (or, "Macarthur Assertive Team"), where he would be given assertive follow up including home visits. When Jack was admitted to Cumberland Hospital, however, he was discharged from Macarthur COMHET including the MAT referral because he could not have two active services.

500. Dr Modem said that the onus was on Cumberland Hospital to call the appropriate intake line when Jack was being released, and that the Hospital

would have known that the reference to “MAT” in the Macarthur COMHET discharge summary was a reference to the Macarthur Assertive Team as this is a well-recognised term and not all geographical areas have an assertive team, including those within the same local health district.

501. Mr Parker, Director of Community Mental Health Partnerships for the South Western Sydney Local Health District, confirmed Dr Modem’s evidence.

502. Dr Modem could not answer Counsel Assisting’s question as to how continuity of care could be ensured in circumstances where a person was staying in temporary accommodation, as he said it was outside scope. Mr Parker, however, stated that within the same local health district there are instances where persons can stay with their existing treating team even in circumstances where, for example, a person moved from Liverpool to Campbelltown, as opposed to moving from Liverpool to Bowral where that would not be possible. He said they would need to be able to practically provide a service in the latter example.

503. In respect of continuity of care, Dr Sampson of Cumberland Hospital said variously that it was not his responsibility to facilitate continuity of care for Jack because it was the treating team’s responsibility. He also indicated that there were limits as regards Jack’s ongoing management because he had no accommodation and so Dr Sampson would not have known where to send the Cumberland Hospital discharge summary.

504. Mr Parker stated that instability of accommodation was something that was common to people managed by their service. He said the COMHET could identify housing issues and work with housing to assist in finding accommodation. Had Jack been referred back to Macarthur COMHET by Cumberland or the Community Corrections Officer, on Mr Parker’s evidence he would not have to have been triaged again and the referral to the MAT would have remained in place. Macarthur COMHET may then have assisted in finding Jack accommodation in area.

505. In circumstances where Cumberland Hospital was aware of Jack’s prior referral to the Macarthur COMHET, including a referral to the MAT, I consider that attempts could have been made to engage with Macarthur COMHET prior to Jack’s discharge from Cumberland Hospital in order to seek their involvement in arranging temporary housing within their area to seek to ensure continuing of community mental health care.

506. Further, I consider that Cumberland Hospital could have taken steps to ensure that there was continuity of mental health care for Jack by either raising this with the Community Corrections Officer or by liaising directly with

housing to seek to arrange emergency housing prior to discharge so that a community mental health team could be available from the point of discharge.

507. In order to address this issue of continuity of care, Counsel Assisting proposed the following recommendation directed at Western Sydney LHD:

508. In closing submissions, counsel for the Western Sydney LHD informed the Court of Western Sydney LHD's Mental Health Discharge Liaison 7-day follow up process, and the role of the Discharge Liaison Clinician, who is responsible for conducting the 7-day follow up.

509. Relevantly, progress notes from Cumberland Hospital record that a Nurse Boyd made two attempts to contact Jack following his discharge.

510. In exhibit 5, there are two notes, one on 6 Feb and one on 9 Feb. The first states "I tried to contact patient for seven days post discharge follow up. Patient has no fixed address or phone. There is a number for his father which is not answering." The second states "as per the seven day post discharge follow up, I have made numerous attempts to contact patient's relatives, as patient doesn't have a phone. File now closed".

511. Nurse Boyd does not appear to have contacted Jack's parole officer. In closing submissions, counsel for the Western Sydney LHD submitted that the Discharge Liaison Clinician is reliant on the contact information provided by the treating team. In Jack's case, counsel submitted that Jack's father was the only listed contact on patient management. Counsel for the Western Sydney LHD submitted that the Discharge Liaison Clinician would have had to have conducted a search of the progress notes in order to locate the Community Correction Officer's contact details.

512. Accordingly, in closing submissions, counsel for Western Sydney LHD proposed amending Counsel Assisting proposed recommendation as follows:

> On discharge from an inpatient mental health unit where follow up is provided by the Discharge Liaison clinician, consideration be given to introducing a policy, procedure or clinical pathway to ensure that concerns post discharge (including persons who are unable to be located) is communicated both to the inpatient facility to which the person was discharged from, to Corrective Services if the person is subject to a parole order or community supervision, and that steps are taken to ensure that that be communicated to any subsequent community mental health team or other healthcare provider to which the person had been referred to (or receiving care from) at that time."

513. With respect, it appears that the recommendation proposed by counsel for the Western Sydney LHD may be broader than what is proposed by Counsel Assisting in that it would require any concerns post discharge to be communicated to CSNSW and any future community mental health team or healthcare provided.

514. In light of the above, I am minded to make the recommendation as proposed by Counsel Assisting, namely that, where an assertive team recommendation has been accepted in a community mental health setting, consideration be given to introducing a policy or procedure to ensure that that is communicated both to any inpatient facility to which the person is admitted, and to CSNSW if the person is subject to a parole order or community supervision, and that steps are taken to ensure that that be communicated to any subsequent community mental health team to which the person is admitted.

*Jack's Depot Injection on 30 January 2018*

515. In respect of the administration of Jack's depot injection, I refer to the evidence of Dr Sampson summarised at paragraphs 57 to 69 above.

516. Jack's failure to receive the scheduled depot injection on 30 January 2018 was seemingly a critical factor in his decline.

517. A forensic toxicologist report obtained from Mr Michael Robertson has confirmed that when it is assumed that Jack's last dose of Clopixol was possibly 4+ weeks prior to his death (i.e. 16 January 2018), under these circumstances, it is likely that the concentration of zuclopenthixol had fallen to the extent that it would have been less effective and possibly not effective at managing his medical condition.

518. It was clearly noted in the Macarthur discharge that Jack should receive clopixol and Jack himself expressed a concern about getting it, and yet he was not given it at Cumberland Hospital – despite the fact that his medication was not changed by that facility.

519. I find that this was a failure on the part of Cumberland Hospital and that steps should have been taken to ensure that Jack's clopixol was administered as due.

*Follow-up about Jack's Depot Injection*

520. Dr Sampson also gave somewhat confused evidence as to whether the Community Corrections Officer had "available" to him Jack's discharge summary from Cumberland Hospital, which clearly noted that Jack should

receive a depot injection. In the end, it was clarified that it could have been provided to the Community Corrections Officer had he requested it (which he had). It appears on the available evidence however that the Community Corrections Officer never received that the discharge summary. Dr Sampson could and should have done more to ensure that the Community Corrections Officer received the discharge summary.

521. In light of the above, I am minded to make the recommendation proposed by Counsel Assisting and directed to Western Sydney LHD that consideration be given to implementing handover procedures which specifically address the continuation of necessary medication.

522. I am further minded to recommend that CSNSW and the Department of Health liaise to develop a means to dealing with those with mental health needs linked to re-offending, in particular, to ensure that discharges from inpatient facilities are coordinated so as to ensure ongoing mental health care, including medication, in the community upon discharge, even for those who have access only to temporary accommodation.

***How and why Jack was able to leave the RPA***

523. I refer to paragraphs 124 to 188 of the findings above regarding the factual background to how and why Jack was able to abscond from RPA.

524. In Counsel Assisting's closing submissions, Counsel Assisting proposed two recommendations aimed at addressing how and why Jack was able to leave RPA.

525. The first proposed recommendation is that consideration be given by RPA to requiring, including documenting this by way of written procedure and training all ED staff, that:

a. two or more persons, with the second person being a physician, clinical nurse consultant, nurse unit manager or supervising Registered Nurse, jointly determine, and provide a signed authority, that it is appropriate for mechanical restraints to be removed even temporarily as regards mental health patients;

b. a form be developed to record this;

c. this procedure be expressly required as regards temporary relaxation of one or more hand or leg restraints to allow toileting or for any other purpose.

526. The second recommendation proposed by Counsel Assisting is that consideration be given by RPA to potential options available as to how toileting can be effected for a patient who is mechanically restrained, including the availability of security to assist or that another option may be to ensure the attendance of another member of clinical staff to provide additional protection.

527. In closing submissions, counsel for the Sydney Local Health District did not indicate any objection to the above proposed recommendations, save to indicate that the RPA has already developed a patient safety physical restraint order and observation chart, and suggest that rather than "developing" a form, the existing physical restraint order and observation chart could be "amended" to address the matters in the first recommendation.

528. Accordingly, I recommend that consideration be given by RPA to requiring, including documenting this by way of written procedure and training all ED staff, that:

    a. two or more persons, with the second person being a physician, clinical nurse consultant, nurse unit manager or supervising Registered Nurse, jointly determine, and provide a signed authority, that it is appropriate for mechanical restraints to be removed even temporarily as regards mental health patients;

    b. the existing patient safety physical restraint order and observation chart amended to record this;

    c. this procedure be expressly required as regards temporary relaxation of one or more hand or leg restraints to allow toileting or for any other purpose.

529. Further, I recommend that consideration be given by RPA to exploring potential alternative options as to how toileting can be effected for a patient who is mechanically restrained, including the availability of security to assist or that another option may be to ensure the attendance of another member of clinical staff to provide additional protection.

**Conclusion**

Jack was someone who could become distressed, resistant and ultimately violent when non-compliant with psychiatric medication, or under the effects of drugs or alcohol. However, there appears to have been many occasions on which a different intervention on the part of police, doctors, nurses, mental health service providers or his parole officer might have prevented Jack's ultimate fate. I hope that lessons have been learnt.

I would like to express my sincere condolences to those who knew and loved Jack. Jack's family showed their profound love and respect for him when they performed the haka for him on the last day of the inquest. Throughout these proceedings, Jack's family has displayed enormous dignity and grace and I thank them.

I also extend my thanks to the counsel assisting team, Kristina Stern SC, Surya Palaniappan, Johanna Geddes, James Pender and Emily Azar.

I close this inquest.

**Teresa O'Sullivan**
State Coroner
Lidcombe

Date: 12 May 2021