CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of B W
Hearing dates:	17,18,19 and 21 July 2023 (sitting at Parramatta District Court Complex)
Date of findings:	8 September 2023
Place of findings:	NSW Coroners Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – self-inflicted death; death after emergency removal of child by NSW Police pursuant to to *Children and Young Persons (Care and Protection) Act*; adequacy of Police response to person in emotional distress; adequacy of Department of Communities and Justice response to risk of significant harm reports; adequacy of Police policies, procedures and training dealing with emergency removal of children; adequacy of Police policies and procedures dealing with reports of threats of suicide or self-harm; recommendations made.
File Number:	2020/116336

Representation:	Sian McGee, Counsel Assisting instructed by Rosanna Muniz of the Crown Solicitor's Office. Sarah Talbert, Counsel for L C, instructed by Andrew Marriott of Legal Aid NSW. Emma Sullivan, Counsel for the Department of Communities and Justice, Shalu Ahuja and Ashwini Thakur, instructed by Darren Chennell of the Department of Communities and Justice. Gillian Mahoney, Counsel for the Commissioner of NSW Police, Detective Inspector Andrew Mackay, Constables Katerina Nedelkovska and Jorja Rostek, instructed by Rebecca Atherton of the NSW Police Force, Office of General Counsel. Timothy Lowe, Counsel for Sergeant David Sommerville and Constable Alexandra Halls, instructed by Warwick Anderson of Anderson Boemi Lawyers.
Non publication orders:	Non-publication orders made on 21 April and 19 July 2023 prohibit the publication of various persons personal information and particular evidence in the brief of evidence. The orders can be obtained on application to the Coroners Court registry.
Findings	**Identity** The person who died was B W **Date of death** B W died on 17 April 2020 **Place of death** B W died at Westmead Hospital, Westmead NSW **Cause of death** B W died of hanging **Manner of death** B W's death was intentionally self-inflicted. It occurred shortly after NSW Police officers conducted an emergency removal pursuant to *Children and Young Persons (Care and Protection) Act*, of his daughter A W. B W was alone and under the influence of alcohol when he [redacted] hang himself.

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Introduction

1. This inquest concerns the death of B W.

2. B W was born in Sydney on 31 May 1988, and died on 17 April 2020 at Westmead Hospital, aged 31 years. His death by hanging occurred shortly after NSW Police officers effected an emergency removal of his daughter pursuant to *Children and Young Persons (Care and Protection) Act* 1998 (NSW) ("the Care Act").

3. B W was the youngest of three children. He had a close relationship with his mother L C. She remembers him with enormous love. She told the court that as a boy he was mischievous and cheeky, and that they were "*the best of friends for most of his life*". She attended each day of the inquest and her grief was palpable.

4. As a child B W was diagnosed with ADHD. Growing up he was exposed to family violence and alcohol abuse, and he was bullied at school. He left school at age 16 and worked in retail and then hospitality.

5. At age 23 B W became a father to his first daughter, A W. Within weeks of A W's birth, B W became her sole carer. At age 28, B W became a father again, to another daughter, P W, who he remained in contact with until his death.

6. Becoming A W's sole carer was an enormous responsibility, which B W took on wholeheartedly. He loved her dearly but found life difficult as a single and financially disadvantaged parent. B W had his own demons and struggled with the effects of his own past trauma.

7. L C told the court that A W was B W's "*everything in life*". Their close connection is disclosed in records provided by her school, police, medical services, and counsellors. The evidence of those interactions illustrates B W's enduring commitment to meeting his parenting responsibilities, even when he was really struggling to do so. His love for A W is also self-evident in his grief and despair on the night of his death, at the prospect of her not being returned to his care.

The role of the coroner and the scope of the inquest

8. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address

issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

9. B W's death followed very soon after police had attended his home and made a decision to remove A W from his care, in the exercise of police powers under section 43 of the Care Act. After officers left B W alone at the house, he telephoned his mother, who in turn rang the local Police Station and then Triple 0 to voice her concerns and ask for assistance in relation to his threats to self-harm. B W hanged himself shortly before officers had returned to his home to check on his welfare.

10. On the basis that his death is understood to have occurred "*as a result of police operations*", within the broad meaning of that statutory language, an inquest into B W's death is mandated by sections 23 and 27 of the *Coroners Act 2009.*

11. The date, place and medical cause of B W's death were not in dispute and the inquest focused on the manner or circumstances leading up to his death.

The evidence

12. The court took evidence over four hearing days. The court also received extensive documentary material in five volumes. This material included witness statements, child protection records, and policies and procedures of various governmental agencies. The court also heard oral evidence from Department of Communities and Justice ("DCJ") child protection workers who had been involved with the family and from NSW Police officers who attended on the evening of B W's death.

13. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

14. A list of issues was prepared before the proceedings commenced[3]. These issues guided the investigation and focused on the factors which may have impacted B W's state of mind on the evening of his death. An inquest tends to crystalize the major issues and I intend to deal with them broadly after recording a brief chronology.

[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).
[3] Issues list disseminated to parties to the proceedings dated 11 July 2023.

Fact finding and chronology

15. As will be clear, I have relied heavily on Counsel Assisting's opening to set out the chronology of events, most of which is not contested. I have also used submissions provided by Counsel Assisting to set out the background of some of the policy considerations arising from the evidence. Submissions provided by other parties have also been considered carefully and taken into account wherever appropriate.

16. A helpful chronology of material was prepared by the assisting team. There were no objections to that document and I have annexed it to these reasons.

The context of B W's death

17. It is necessary to place B W's death in context prior to examining the particular facts of his death.

18. Firstly, it should be recorded that B W's death occurred in the context of police removing his daughter pursuant to the Care Act. Removals of this kind are rare events and ones that most police have little or no personal experience of. The court was informed that between July 2019 and June 2020 NSW Police removed children on 54 occasions, representing 3% of the total number of removals of children across NSW that year. Comparatively, between July 2020 and June 2021, there were 73 police removals and between July 2021 and June 2022 there were 56 police removals (making up 4% of removals conducted across NSW in each of these years). The vast majority of these occurred outside the Sydney metropolitan region.[4]

19. At times NSW Police also attend removals of children in support of DCJ. In these cases, their presence is often required to de-escalate any breaches of the peace which may arise.[5]

20. Secondly, B W's death occurred very soon after the commencement of the first COVID-19 lockdown. The impact of the fear, confusion and loneliness of this period cannot be understated. The impact of changes wrought by the pandemic on the operation of DCJ is also a significant issue and one to which I will return.

[4] Exhibit 1: Tab 36, Statement of Lisa Charet at [107]-[108].
[5] T191.18-20, T196.48-50 (19 July 2023).

The Family's contact with Department of Communities and Justice

21. Both NSW Police and DCJ had some limited involvement in A W's life during her first few years, as B W understandably struggled to adjust to his sole parenting situation. However, the available records of that time indicate his commitment to his parenting responsibilities, and his positive engagement with the Brighter Futures family support service. Ultimately, no removal action was taken by DCJ, and no risk of significant harm ("ROSH") reports were received between December 2015 and December 2019.

22. It appears that B W's mother L C was a source of mental and practical support to him, and to A W, throughout this period.

23. From about 2018, B W somewhat reduced his contact with L C, however they remained in touch and she provided him with mental support and assistance with A W in times of need. L C explained that in the two or so years prior to his death, alongside an increase in A W's behavioural difficulties, she observed in B W an escalation of his drinking and a deterioration of his coping abilities.

24. It is clear from L C's account, as well as B W's neighbour J P, that he was open with those around him about his difficulties. L C reported that B W made comments about not coping and threats to end his life frequently. She supported him by talking with him, and encouraging him to seek psychological assistance. She observed these conversations had a positive effect on him, and at no time did she believe he would follow through with his thoughts of ending his life.

25. In November 2018 B W's General Practitioner (GP) identified signs of depression and anxiety. B W was receptive to help and was referred to a psychologist pursuant to a mental health care plan for a diagnosis of major depression of "*severe*" severity. He attended upon that psychologist on fourteen occasions between November 2018 and June 2019.

26. There appears to have been a real escalation of B W's difficulties from the end of 2019.

27. In August 2019 B W's GP identified signs of parenting stress and referred both B W and A W to a psychologist for family counselling.

28. From October, A W's behaviours at school were increasing in intensity. On 11 December 2019 she displayed violent behaviours. B W attended the school and

called an ambulance for assistance. A W was assessed at hospital. A ROSH report to DCJ followed. While concerns were raised in the course of the hospital assessment about B W's mental health and alcohol use, it appears only his drinking was reported to DCJ. The report recorded B W admitting to drinking and stating "*nothing helps anymore, only a bottle of wine helps*".

29. Noting the timing coming into school holidays, the school counsellor marked the family for follow up in the new year. At this time, B W completed the referral form to the family counselling service which had been provided in August, and together with A W they commenced sessions with a psychologist. In December 2019 B W's GP also issued a further referral to the psychologist he had been seeing earlier in the year, however he did not attend upon her further.

30. A 72-hour response time was allocated to the ROSH report, and the Auburn Community Services Centre ("CSC") received it. Acting Manager Client Services Ms Shalu Ahuja considered the report and decided a least intrusive approach was preferable, given B W was seeking help, A W's school had not reported any risk of significant harm or neglect or mental health information, and there had been no other reports since late 2015.

31. It appears B W was contacted by telephone, and agreed to accept a referral to a functional family therapist (or "FFT"). He told DCJ that he was "*wanting to get help*". No face-to-face assessment was undertaken either with A W or B W. No visit to the home took place.

32. On 30 December 2019, Auburn CSC closed the case in relation to this first ROSH report. The closure record noted both "*no capacity to allocate*", with supporting commentary "*referral made to FFT*". The date of closure was the date of B W and A W's first appointment with the FFT.

33. In the meantime however, on 26 December 2019, police attended B W's home in circumstances similar to those of 17 April 2020. A W had run away, and B W called the police for assistance. On arrival, police identified concerns as B W being intoxicated, and additionally neglectful, by reason of the condition of the home and a lack of food. On that occasion, L C attended and took A W with her temporarily. It appears that a ROSH report about the incident was not then made to DCJ until 8 January 2020.

34. On 8 January 2020, the police ROSH report was marked for a less than ten-day response and initially allocated to Parramatta CSC, who determined to undertake a field assessment, which involves a home visit. By reason of the home address, it was then transferred to Auburn CSC, who did not determine to do a field assessment.

35. On 17 January 2020, the FFT undertook a home visit. B W reported to her further behaviours by A W, including lighting fires while he was lying down, which she suspected meant asleep intoxicated. The FFT observed and discussed with B W possible mental health issues, namely signs of depression and anxiety. He told her he was not seeing anyone in respect of this.

36. The FFT made a ROSH report that day, raising concerns about B W consuming alcohol as a way to cope with the struggles brought about by being a single parent. The report was screened in for inadequate supervision and self-harming/risk-taking behaviour, though not for alcohol abuse, on the basis that it was only a "*possible*" reason for him lying down at the time of the reported behaviours.

37. The FFT ROSH report was assigned a response time of less than ten days and received at Auburn CSC on about 22 January 2020, together with the police ROSH report from 8 January 2020.

38. On 23 January 2020, the Acting Manager Client Services Ms Ahuja and the Acting Manager Case Work Ms Ashwini Thakur undertook a joint review of both police and FFT ROSH reports from 8 and 17 January 2020. They determined an update from the FFT should be sought.

39. DCJ records of that contact note the FFT indicated three visits had taken place and progress was still in the "*engagement and motivation*" phase. It was recorded that A W was exhibiting complex behaviours, and was newly engaged with a counsellor; apparently for the purpose of diagnosis/delay, though only one session had occurred. The FFT reported "*there are no supports in place for B W".*

40. The FFT's record of that contact indicates she communicated a "hope" that the case would be assigned to a DCJ worker, for case management and other supports that DCJ could provide which she could not.

41. The information Ms Thakur says was relayed to her was that B W was engaging with the FFT.

42. At this time, A W's behaviours at school deteriorated further. On 5 February 2020, a Learning Support Team Referral form was completed for A W. Unsafe behaviour including attempts to harm others and herself were cited.

43. Between 6-10 February 2020, Ms Ahuja and Ms Thakur determined to close the case. The closure record again noted "*no capacity to allocate*", alongside commentary that "*FFT is currently involved with the family and conducts home visits every week. Father is engaging*". It appears no contact with the school or with police had been made by DCJ.

44. In February 2020, A W was suspended from school for throwing chairs and jumping out of windows. On 25 February 2020, the school counsellor made contact with Auburn CSC and was told the case was closed. It was recommended to her that she contact the FFT. She did so, and then also contacted the psychologist at the family counselling service who had been engaging with A W.

45. In early March 2020, A W was again suspended, this time for putting pins inside her mouth, twisting a student's arm, hiding in the garden and throwing books and chairs. Further reports were submitted by the Department of Education's ("DoE") Child Wellbeing Unit, presumably about these events, to ChildStory, a database which is shared with DCJ. However, because there was no active case, and the events were not reported via the DCJ Child Protection Helpline as ROSH reports, these reports were not received by Auburn CSC at the time they were made.

46. It appears that the DoE Child Wellbeing Unit was, however, under the belief that there was a "*current allocation*" for the matter with Auburn CSC. The Unit communicated this to the school, with directions to liaise with DCJ regarding a case plan and other supports the school required, and to link the school counsellor with the FFT and family counselling psychologist. As noted above, the latter had already occurred, however there is no evidence that the school took any further steps to contact DCJ directly.

47. On 5 March 2020, the FFT had what was to be, in light of the COVID-19 pandemic developments that followed, her final face-to-face appointment with B W and A W.

48. On 11 and 18 March 2020, in sessions with the family counsellor, B W was reluctant about suggestions of involvement with more intensive family support services. At the time he was attending with A W upon the family counselling psychologist, and the FFT for counselling services, as well as engaging with the school for in-school

support. 18 March 2020 was the last time B W and A W attended upon the family counsellor.

49. Also on 18 March 2020, the FFT provided an update to Auburn CSC that B W remained engaged but was reporting a lack of trust in her service. This was not a ROSH report, but plainly information the FFT considered significant to provide to DCJ.

50. The following evening on 19 March 2020, B W again called for police assistance as A W had run away. A further ROSH report to DCJ was made on 21 March 2020, citing significant concerns for A W's welfare due to her age and living conditions. The ROSH report noted "*it appears father is struggling to provide a clean environment and adequate living conditions. A W's behavioural issues are escalating"*. The separate police event report additionally recorded concerns for B W's mental health and alcohol consumption, though these do not appear to have been part of the ROSH report to DCJ.

51. This third police ROSH report was screened in by DCJ on 22 March 2020 with a 72-hour response time on the basis of inadequate basic care and hazardous living conditions. On 23 March 2020, it was received at Auburn CSC. Ms Thakur, who supervised a case worker in triage responses to ROSH reports, recalls giving a direction that the FFT be contacted about the report, however it is unclear when she gave such direction. The FFT was ultimately not contacted until 30 March 2020, after a further ROSH report was received. Police do not appear to have been contacted by DCJ in relation to the report.

52. Clearly by this time, B W was not coping. He was unable to manage A W's increasingly complex behaviours and was struggling to maintain positive engagement with the supports that were in place to help him. The supports which were in place were, by now, obviously insufficient.

53. It is incredibly unfortunate then, that this deterioration coincided with the commencement of the first COVID-19 pandemic lockdown in Sydney, on 23 March 2020. That circumstance appears to have had a material adverse impact on A W's behaviours, and on B W's ability to cope and on his recourse to alcohol. The circumstance also impacted the ability of those who were engaged with him and A W to maintain not only engagement, but even simply visibility of the situation.

54. B W, understandably, decided to keep A W home from school for the school term. The FFT appointments became by telephone only.

55. On 27 March 2020, the FFT made a further ROSH report to DCJ reporting a primary concern about neglect and an additional concern about B W's mental health, lack of support and use of alcohol to cope. That report was screened in with a response time of less than 72-hours.

56. On 30 March 2020, at the direction of Ms Thakur, a caseworker from Auburn CSC called the FFT. The record of the contact noted that face-to-face visits had stopped, that work was predominantly taking place on gaining trust and working with B W to form a relationship with A W's school. It was noted that the FFT was attempting to create safety plans in light of A W's repeated running away, but was finding this difficult because of a lack of engagement by B W.

57. The FFT's own record of the call additionally noted that she had identified to the caseworker the possibility of B W having mental health issues and the difficulties this posed for safety, as well as concerns about socially isolating and not attending school resulting in B W struggling to deal with A W's behaviours without a break and with no other safe adults available. The FTT further recorded that she encouraged that the case be allocated to a DCJ caseworker in order to have more services involved.

58. On 3 April 2020, Ms Thakur formed the view that the open ROSH reports from police and the FFT on 23 and 27 March 2020 should be closed. She recommended as much in an email to Ms Ahuja. In her statement in the inquest Ms Thakur stated "*I do not recall the rationale behind my recommendation…however it was likely to be based on other competing reports and because FFT had been trying to engage with B W*".[6] She also gave oral evidence on this issue and it is one to which I will return.

59. What followed appears to be appropriate adherence to a DCJ review procedure, which ensures oversight and peer review of case closure decisions, and which led to the matter ultimately being allocated for a field assessment and caseworker.

60. On 7 April 2020, Ms Ahuja reviewed Ms Thakur's closure recommendation. She disagreed that the case should be closed and recommended adding it to the case list at the next Weekly Allocation Meeting ("WAM"). In her statement in the inquest,

[6] Exhibit 1: Tab 38, Statement of Ashwini Thakur at [28].

Ms Ahuja stated "*I considered that the risks for A W were increasing and that the family needed to be allocated to a child protection caseworker for further assessment and intervention*".[7]

61. Ms Ahuja's recommendation was then reviewed by Ms Thakur the following day. By the time that had occurred, the WAM for that week had already taken place earlier that day. Accordingly, the matter was listed for the next WAM, a week later on 15 April 2020. A decision was also made that a Triage Assessment form outlining all DCJ records and reports would be prepared.

62. On 6 April 2020, the FFT had what appears to be a final conversation by telephone with B W. Any contact thereafter was by text message only, and the FFT was in any event on leave from 9-13 and 15 April 2020. School holidays commenced on 10 April 2020 with the Easter long weekend falling on 10-13 April 2020.

63. On the evening of 12 April 2020, B W called an ambulance after A W complained of neck pain and breathing difficulties. They attended hospital, and it was assessed that A W had been attempting to leave isolation rather than suffering any physical problems. Another ROSH report to DCJ at approximately 12.45am on the morning of 13 April 2020 followed the hospital attendance.

64. At about 1am DCJ called the hospital for further information. It was reported that while nothing "*overly concerning*" about B W had been observed that evening, B W did appear to be struggling with A W's behaviours and was "*quite open*" about feeling like he needed more support. The DCJ record additionally noted that paramedics had raised unparticularised concerns about B W's mental health, and there were "*previous*" concerns with alcohol use.

65. At about 10.30am that morning, this final ROSH report was screened in for risk of neglect, with an additional parental risk factor of mental health, and allocated a response time of less than 10-days. When received by Auburn DCJ, it was referred for review at the forthcoming WAM on 15 April 2020, with the same rationale recorded as for the FFT's ROSH report on 27 March 2020.

66. Prior to the WAM at which the case was discussed, no contact appears to have been made with either A W's school or the police.

[7] Exhibit 1: Tab 37, Statement of Shalu Ahuja at [44].

67. At the WAM on Wednesday 15 April 2020, the case was allocated to the Child Protection Team and a field assessment directed. DCJ records suggest that assessment was to be executed by a certain staff member with a due time of 12am on 16 April 2020. It was explained in subsequent evidence that this time and date was automatically generated by the computer system, and bore no relationship to any policy requirement about timeframes for such assessments.

68. No field assessment had taken place, or been arranged, by the time of B W's death on 17 April 2020. In an email on Thursday 16 April 2020, Ms Thakur said to the FFT that the allocated caseworker would be in touch with her, and that the FFT should email the caseworker the following week if she wished to liaise with her, as she was "*not in*" that week.

69. On 16 April 2020, a phone appointment was scheduled between B W and the FFT. They exchanged some text messages in the morning, in which B W wrote "*doing okay, going stir crazy like most of Australia, hope you and your family are doing well*". He did not answer the FFT's call at the 1pm scheduled appointment time, and she sent a text message suggesting a phone session the following day.

70. The evidence establishes that B W died after DCJ had determined to become directly involved with the family, but prior to any contact having been initiated with B W or A W.

Events on the evening of B W's death

71. In the early hours of 17 April 2020, at approximately 1.45am, B W phoned L C reporting that A W had run away again. L C thought that he sounded very intoxicated on the phone. She encouraged him to contact the police, which he did about ten minutes later, despite his concerns about his state of intoxication. L C also contacted Granville Police Station to directly report that A W had run away.

72. A large contingent of police attended B W's home at approximately 2am. A search dog and police helicopter were involved, and an ambulance attended. B W himself assisted in trying to find A W, and he also enlisted the assistance of his neighbour J P.

73. Detective Inspector Andrew Mackay led the search. After some time, A W was found hiding in the chassis rails of a large truck parked approximately 250m south of the home. A W disclosed to Detective Inspector Mackay that B W was a drunk and had

yelled at her, and that she was afraid. He observed her to be "*malnourished*" and unclean.

74. With the agreement of B W, Detective Inspector Mackay together with Sergeant David Sommerville conducted a walk-through of the home. They observed the home to be in a very poor state; with cockroaches, dirty clothes, mould, and no real food in the fridge or pantry. Body worn footage of the walk-through was available to the court and it corroborated the views expressed by police.

75. A W was reviewed by paramedics, with no physical issues identified. Together, and after a brief discussion, Detective Inspector Mackay and Sergeant Sommerville formed the view that A W was at immediate risk of harm pursuant to the Care Act.

76. It was decided to exercise the police power of emergency removal. I accept the submissions of the Commissioner of Police that in making that decision police clearly understood the relevant consideration that the paramount principle was the safety, welfare and wellbeing of the child. I accept that it was a decision open to them in all the circumstances that evening.

77. The decision was nevertheless plainly one that caused B W very significant distress. Despite his intoxication, he advocated strongly for police not to remove A W and to have a family member take her into their care until DCJ responded.

78. Police were present at and around the property for approximately one hour. The court heard from Detective Inspector Mackay, Sergeant Sommerville, Constable Halls and Probationary Constable ("PC") Nedelkovska about their interactions with B W, and their observations of him during this period.

79. Each observed B W to be intoxicated and emotional, however his presentation did not cause any of them to consider that any action under the *Mental Health Act 2007* (NSW) ("MHA") was warranted. This is an issue to which I will return.

80. Sergeant Sommerville in particular spent a lengthy period speaking with B W about the situation prior to police departing the area shortly after 3am. The court had the benefit of body worn footage which depicts some of that interaction.

81. Various views were expressed about the tone of that interaction. Counsel for Sergeant Sommerville described his approach as compassionate and encouraging and one that would not warrant criticism. Counsel for Sergeant Sommerville submitted that the officer allowed B W to convey his point of view, talking with him

for 17 minutes. He conceded that the officer was firm, noting that he needed B W to know "*we weren't going to move on our position*."[8]

82. Counsel Assisting submitted that the footage of the conversation displays a brief expression of Sergeant Sommerville's "*own version of compassion and encouragement at the end of the interaction"*, while accepting it was nevertheless inadequate for the situation. On the other hand, the family submissions characterised the interaction as condescending, dismissive and likely to inflame a distressed parent. The court's attention was drawn to Sergeant Sommerville telling B W "*Your suggestion means squat. It means nothing. Zero"* and telling him to "*clean up his act*," and suggesting that "*FACS might decide [A W] might be best served by taking her to a location you don't know about*."[9]

83. I accept the family's submission that any empathy or encouragement was minimal. The approach was generally clumsy and ill advised. It was not the time to lecture or demean B W who was clearly extremely distressed and facing his worst nightmare. Having said that I have no doubt that Sergeant Sommerville had no *intention* to demean B W, he merely lacked sufficient insight into the effect his words would have on a parent whose child was being removed from their care.

84. On the matter of whether police should have done more to contact B W's family, I note the evidence of Detective Inspector Mackay who stated that he spoke with L C while at B W's home that morning.[10] His recollection was that she did not want to assist at that time. While L C does not remember the call, there is evidence that B W called her around the time police were leaving the scene and it is L C's evidence that she contacted another family member around this time who did not want to "*get involved*".[11]

85. By approximately 3.07 am, Sergeant Sommerville, Constable Halls and PC Nedelkovska were all still in the general vicinity of the front of the home but were preparing to leave the area. On a video recorded by B W's neighbour J P at this time, B W can be heard clearly stating "*I'd rather fucking die than let my daughter go*".[12] On the body worn footage recorded by Sergeant Sommerville at the same

[8] T216.45-50 (19 July 2023).
[9] Exhibit 1: Tab 32-2, Body Worn Footage.
[10] Exhibit 1: Tab 7, Response to Directive Memorandum of Detective Inspector Mackay at [5], Tab 21, Cumberland PAC Duty Officer Hand Over, p.1.
[11] Exhibit 1: Tab 23, Statement of L C at [32].
[12] Exhibit 1: Tab 35, Video filmed by J P.

time, the comment is audible, though less clearly.[13] There is however no doubt the words were spoken.

86. B W said the words in a calm and quiet, but serious manner. He had become increasingly distressed in the course of the lengthy and repetitive conversation with Sergeant Sommerville about the removal of A W.

87. The issue was explored during the hearing and was given some prominence in the proceedings because it would be extremely serious if it were established that Sergeant Sommerville heard and ignored the words.

88. While Sergeant Sommerville was plainly within earshot to *be able* to hear B W speaking, in my view the evidence is insufficient to establish that he *in fact* heard B W make the specific statement and ignored it, or that he heard something said and ignored it. Certainly Sergeant Sommerville denied hearing B W say anything at all, explaining he didn't have "*situational awareness"* at the time because "*I was turning my mind to where my backup was at that point, because we were leaving the location*" and was turning and looking for where they were.[14]

89. I accept that Sergeant Sommerville was the closest to B W, however he was still at least 2-3m away[15], and possibly further it appears from the body worn footage.[16] The footage shows that at the time B W made the statement, Sergeant Sommerville had already turned away from facing him front on and was walking towards the road.[17] The footage does not suggest Sergeant Sommerville physically responded in any way to B W speaking, supporting his account that he did not hear B W say anything. In oral evidence Sergeant Sommerville expressed a view that prolonging police presence in stressful circumstances can exacerbate the situation.

90. PC Nedelkovska recalled that she was approximately 3 metres behind Sergeant Sommerville.[18] She could not at the time of her statement in September 2022 or in oral evidence recall exactly what she had heard. However she did recall initially being clear that B W had said words to the effect of "*wanting to kill himself if the child was going to be removed".*[19]

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[13] Exhibit 1: Tab 32-2, Body Worn Footage.
[14] T193.42- 194.4 (19 July 2023).
[15] T137.5-33 (19 July 2023).
[16] Exhibit 1: Tab 32-2, Body Worn Footage.
[17] Ibid.
[18] T230.3-20 (21 July 2023).
[19] Exhibit 1: Tab 11, Response to Directive Memorandum of Constable Katerina Nedelkovska p.4; T230.3-43 (21 July 2023).

91. PC Nedelkovska said she raised it with Constable Halls, as a "*concerning comment"* given the situation that had unfolded.[20] She said she asked Constable Halls whether B W had just said he was going to kill himself, to which Constable Halls responded to the effect "*that's not what I heard*".[21] She said she then doubted "*a little*" what she had heard,[22] but did not push the issue any further, or ask Constable Halls what she had heard, thinking "*maybe I've misheard something, being so junior*".[23] She did not think to ask Sergeant Sommerville given he had been closest, because "*he told everyone to leave so no, I was following*".[24]

92. Constable Halls was behind PC Nedelkovska, on the opposite side of their police vehicle which was parked adjacent to the property driveway. She observed that Sergeant Sommerville was about 2-3m away from B W, with the vehicle another 10-15m away from the two men.[25]

93. In her statement made in September 2022 Constable Halls stated she recalled hearing B W say "*something to the Sergeant regarding him dying*", which she interpreted not as any indicator of a mental health issue but rather as an attempt to prevent police from removing his daughter. She said she assumed Sergeant Sommerville had heard the comment and agreed with her interpretation, as he had directed police to leave.[26]

94. In oral evidence Constable Halls said she didn't clearly hear what B W said,[27] but did not seek any clarification because she "*just assumed that Sergeant Sommerville, because he was standing so close to him and he was speaking with him, had heard it, and then he turned around and told us to leave*", and further that "*I just didn't think anything else on that, because the Sergeant had then told us to leave."*[28]

95. Constable Halls did not recall PC Nedelkovska raising the issue with her,[29] suggesting that if she had she would have "*thought more of it and, obviously, done something about it, probably",*[30] namely made further enquiries by "*I probably would*

[20] T232.15-25 (21 July 2023).
[21] Exhibit 1: Tab 11, Response to Directive Memorandum of Constable Katerina Nedelkovska p.4; T230.5-6 (21 July 2023).
[22] T233.1-2 (21 July 2023).
[23] T232.49-50 (21 July 2023).
[24] T231.8-16, T232.31-50 (21 July 2023).
[25] T137.5-33 (19 July 2023).
[26] Exhibit 1: Tab 12, Response to Directive Memorandum of Constable Alexandra Halls at [17]-[18].
[27] T138.48 (19 July 2023).
[28] T139.5-20; T148.33-44 (19 July 2023).
[29] T139.28-45, T140.5, T146.15-17 (19 July 2023).
[30] T139.49-50 (19 July 2023).

have stopped and gone and asked the sergeant".[31] However, she accepted the possibility that the conversation took place,[32] and it was not suggested to PC Nedelkovska that the conversation did not occur. Constable Halls' evidence does not provide a clear basis to contradict PC Nedelkovska account.

96. Without a finding that Sergeant Sommerville heard B W say anything, no specific criticism of him in respect of this issue is warranted. In respect of PC Nedelkovska, having regard to her very junior status (being three and a half months into the job[33]) and general role ("observe, learn"[34]), that she did not press the issue further with Constable Halls or raise it with Sergeant Sommerville does not in my view warrant personal criticism.

97. As to Constable Halls, the evidence does not support a finding that she heard exactly what was said, although she told the court she heard something about "*dying*". I accept that she took into account Sergeant Sommerville's closer proximity to B W and the fact that she assumed Sergeant Sommerville had heard and assessed what was said. She was also of relatively junior status (one year as a confirmed Constable and two years overall.[35]) While it remains difficult to reconcile Constable Hall's evidence with PC Nedelkovska's evidence of the later conversation between them, I do not record personal criticisms of her either.

98. However, the deference that both PC Nedelkovska and Constable Halls paid to the hierarchy within which they were supervised (by not making further inquiries of B W himself or raising the issue with Sergeant Sommerville, despite hearing B W - who they observed to be distressed in a situation they recognised as distressing situation[36] - make some kind of reference to dying or wanting to kill himself), suggests some deficit in the confidence of junior officers to raise matters of objective concern[37] with their supervisors. That PC Nedelkovska was more junior than anyone else present had no bearing on her ability to properly hear something. It is a

[31] T140.10-24 (19 July 2023).
[32] T140.7-8, T146.19-21 (19 July 2023).
[33] Exhibit 1: Tab 11, Response to Directive Memorandum of Constable Katerina Nedelkovska p.2.
[34] T233.48-49 (21 July 2023).
[35] Exhibit 1: Tab 12, Response to Directive Memorandum of Constable Alexandra Halls at [5].
[36] T143.19, T138.50-T139.4, T143.30-36 (19 July 2023).
[37] Both Detective Inspector Mackay and Sergeant Sommerville confirmed that had they heard B W's statement, or been informed of it, they would have made more inquiries of him to ascertain his intention and mental state, with a view to having him scheduled under the MHA or requesting review by an ambulance: T224.4-31 (19 July 2023); T244.8-20 (21 July 2023).

concerning matter which in my view is properly dealt with by way of recommendation.

99. It is also important to record that Detective Inspector Mackay stated that if he had heard the words, he would have ensured that the ambulance officers present at the scene spoke to B W and assessed him. In the absence of ambulance officers, he would have engaged B W in conversation to see if it was just a "*fleeting comment*" or something that warranted further attention.[38] Other officers also reflected that they would now be quick to consider an ambulance assessment or ask if assistance was needed to arrange the support of a neighbour, friend or family member. I was heartened by their reflections on the issue.

100. At the time police left, B W had been told that A W was being removed because of immediate concerns about her welfare, based on the events of the evening and what police had observed inside the home. He was told DCJ would be contacted and it would be for DCJ to determine what happened with A W from there. Based on B W's statements to others after police left, it appears he did not understand where exactly she was being taken and the timeframe in which DCJ would respond.

101. No contact was made by police to DCJ until after the decision to remove A W had been made, and she had been taken to the Granville Police Station. Neither police nor B W had any reason to know A W's and B W's case had been allocated to a DCJ case worker.

102. Immediately after police departed his home with A W, B W became hysterical. He phoned L C, who tried to calm him down. His neighbour J P heard him say "*I don't know where they've taken her*" and "*I'm going to kill myself, I just want my baby back".* In his desperation, he sent a text message to the FFT stating "*the police took A W from me please help me*". One can't help but wish he had been able to contact DCJ but of course he had not yet been allocated a case worker.

103. L C phoned Granville Police Station at approximately 3.24am and spoke with Constable Jorja Rostek. L C told Constable Rostek that police had just been at B W's address and he had then called her saying "*If I don't get my daughter back I'm going to kill myself*". Constable Rostek told L C she would put on a job for police to reattend and advised her to call 000 if the matter escalated.

[38] T244.10-25 (21 July 2023)

104. There is a contemporaneous record of L C's call which Constable Rostek recorded on the Computer Aided Dispatch ("CAD") system. It reads,

"INF STATED POL WERE JUST AT AA WITH POI B W, THE POI CALLED THE INF AND STATED "IF I DON'T GET MY DAUGHTER BACK IM GOING TO KILL MYSELF" POI KEPT REPEATING THIS OVER THE PHONE TO THE INF BEFORE HANGING UP".[39]

105. Constable Rostek gave unchallenged evidence of having a clear memory of the phone call consistent with the content of the CAD narrative, and of having repeated back to B W's mother what had been said.[40] As to any suggestion that reference additionally to hanging was reported by L C, that was not her evidence[41] and it was at any rate not information that she had at that time.[42] Having reviewed all the evidence on this issue I accept that the CAD record accurately records what was reported at that time.

106. As to the response to that information, the evidence is as follows. Constable Rostek spoke with the internal Sergeant Irwin (who had not attended B W's home) and Sergeant Sommerville and relayed the reported information to them.[43] She was aware that Sergeant Sommerville had attended B W's home, but was not aware of any conversations had with police there. She did not recall asking Sergeant Sommerville for any information, or receiving any information, about what had happened at the property.[44]

107. Constable Rostek said she was directed by Sergeants Sommerville and Irwin to "*put on a CAD job*" so police could attend. It was a fairly quick conversation. She did not recall being given any direction on what priority to grade the job (Priority 2 or 3).[45] Sergeant Sommerville recalled that Constable Rostek had relayed the content of the conversation with L C, and his understanding was that "*all the available information [his mother] had had already been provided*".[46] When asked if B W should have been telephoned at this point, he explained that calling B W at this time

[39] Exhibit 1: Tab 20, CAD Incidents Annexure B: CAD Job record 309838-17042020.
[40] T154.37-T155.25, T160.25-38 (19 July 2023).
[41] Exhibit 1: Tab 23, Statement of L C at [25], T41.19-39 (17 July 2023).
[42] Ibid at [34]; Tab 30, Text messages exchange and Exhibit 3: Agreed Chronology pp.15-17 entries on 17 April 2020 between 3.08am and 4.03am.
[43] T156.24-26 (19 July 2023).
[44] T156.28-39, T156.41-42, 48-50 (19 July 2023).
[45] T154.10-15, T155.30-42, T157.5-6 (19 July 2023).
[46] T221.12-27 (19 July 2023).

might trigger an escalation or cause him to "*become mobile*" which might mean police could not locate him when they were ready to go to the job.[47]

108. Constable Rostek did not ask L C whether B W had a weapon or implement he could use to take his own life,[48] or whether he had a history of self-harm or suicide threats. She did not recall being directed to make any such inquiries.[49] She gave evidence that, with the additional experience she now has, she would ask further questions of the informant in the same situation.[50] However, there is no evidence that such questions or inquiries would at that stage have yielded information that would necessarily have changed the priority of the job, given the requirement for immediacy, which is discussed below.[51] Constable Rostek appropriately told L C to call Triple 0 if the situation escalated.[52]

109. After speaking with Sergeants Sommerville and Irwin, Constable Rostek created the CAD job and assigned it a priority 3 by following the automated populating options in the CAD system for a "*concern 4 welfare"* job label.[53] She said did not label the job "*self-harm*" or make the job a priority 2 because the information did not disclose that he was, at the time, currently harming himself or had identified a means of how he would harm himself.[54]

110. Sergeant Sommerville gave evidence of some discussion of the priority grading of the job, and agreed with a priority 3 grading on the basis that:[55]

"it wasn't an immediate threat. He wasn't trying to commit suicide at that time. He hadn't indicated that he was making preparations to, so the justification for priority 2 is an urgent response job, resulting in a urgent duty police, potentially several urgent duty police vehicles to attend that location, with the dangers to the community that come with police responding at high speed…".

111. As to the job label Sergeant Sommerville also gave evidence that it is "*very rare*" that a "*suicide/self harm*" label is used for "*that type of job*", explaining that that label is usually used on Triple 0 calls from ambulance communications.[56]

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[47] T202.30-48 (19 July 2023).
[48] T161.47-50 (19 July 2023).
[49] T156.44-45 (19 July 2023).
[50] T162.27-50 (19 July 2023).
[51] T221.29-36 (19 July 2023).
[52] Exhibit 1: Tab 10, Response to Directive Memorandum of Constable Jorja Rostek p.2.
[53] T151.40-T152.11 (19 July 2023).
[54] T158.3-26 (19 July 2023).
[55] T202.2-8 (19 July 2023).
[56] T203.32-46 (19 July 2023).

112. There was evidence that car crews are required to self-initiate responses to broadcast jobs in the first instance, with the mobile shift supervisor performing a resource monitoring/oversight function and giving particular directions at times.[57] No officers responded to the job when it was first broadcast, or after two further repeat broadcasts at 3.41am and 3.49am. It appears that all available cars were attending other jobs.

113. Sergeant Sommerville then made his own broadcast at 3.50am, directing the next available crew to make it a priority and let him know, stating he would also "*head over".*[58] At 3.51am a response message was recorded, however no officers physically attended the address before the Priority 2 job was broadcast at 4.10am after L C phoned Triple 0.[59]

114. I accept Counsel Assisting's submission that the evidence does not support a finding that the response to L C's call to Granville Police Station breached any policies in place at the time. However, the evidence supports a finding that Sergeant Sommerville's own view of the evolving situation was somewhat rigid, and perhaps distorted by his focus on the potential for violence and a breach of the peace arising from the removal, rather than a real appreciation of the risk B W would carry out his threat.

115. Sergeant Sommerville accepted that L C's call indicated an "*escalation*" in B W's presentation compared with when he had left the home.[60] However, his reasons for why he "*did want [at the time of the conversation with Constable Rostek] a car crew that was available as soon as possible to get to that job"* appear more directed to addressing "*potential escalation*" of the removal situation,[61] rather than an increase in his level of concern for B W's own welfare. He described "*I had no increased fears in relation to the job. My view was that I just did not want that sitting around too long. I didn't want it to get lost in the chatter. And I wanted it to be seen to before FACS were involved because I didn't want a trigger situation to happen while we – before we got back there*".[62]

[57] T183.30-T183.11 (19 July 2023).
[58] Exhibit 1: Tab 20, CAD Incidents Annexure B: CAD record 309838-17042020 pp.1-2.
[59] Ibid Annexure A: CAD record 309881-17042020 p.1.
[60] T202.25-28 (19 July 2023).
[61] T202.15-28 (19 July 2023).
[62] T206.1-27 (19 July 2023).

116. Even accepting that he had not heard B W's first statement that he would rather die than let A W go, Sergeant Sommerville does not appear to have squarely considered that this new information, on the background of the emergency removal which had just taken place, may create a significant risk of suicide or self-harm that required urgent attention.

117. The evidence as a whole highlights deficiencies in the policy at the time in the creation of CAD jobs, for the description of reports involving threats of self-harm or suicide that are not actually in progress at the time of the report. It is an issue to which I will return.

118. Between 3.38 and 4.03am L C received a series of text messages from B W expressing his distress and suicidal ideation. She continued to support him, responding to his messages with encouragement to see a way out, and giving him the number for Lifeline asking him to call them.[63]

119. At 4.03am L C received a final text message from B W stating "*I have nothing to live for"*, with a photo of himself with [redacted] around his neck. It appears that although L C had heard B W threaten self-harm before, to her this event was a serious and very concerning escalation of the situation. At 4.05am L C called Triple 0 and relayed this information.

120. At 4.08am a new priority 2 CAD job was created by the Triple 0 call responder. The process took some time as the street address was checked, and a range of COVID-19 screening questions were asked.

121. The first police crew, including Sergeant Sommerville, arrived at B W's home at 4.16am. Officers found B W inside, at the bottom of the stairwell, unconscious and not breathing with [redacted] around his neck. They cut [redacted] and commenced CPR. Officers continued CPR for more than 10 minutes until paramedics arrived and took over by 4.30am.

122. At 4.50am B W was loaded into the ambulance. At 4.56am he reverted into a potentially perfusing rhythm, and a weak carotid pulse was recorded, before he re-arrested. At 4.59am the ambulance arrived at Westmead hospital. Tragically, at 5.17am B W was pronounced deceased.

[63] Exhibit 1: Tab 30, Text messages exchange between B W and L C.

Cause of Death

123. An autopsy was conducted by Dr Istvan Szentmariay at Forensic Medicine in Sydney on 23 April 2020. He confirmed that the death should be recorded as in keeping with hanging, noting that while there was no typical ligature mark around the neck, there were contusions consistent with the kind of ligature used. Routine toxicology showed a moderately high blood alcohol level (0.22g/100ML) but no commonly used medications or illicit drugs.

124. I accept that the cause of death should be recorded as hanging.

Manner of death

125. A finding that a death is self-inflicted should not be made lightly. The evidence must be cogent and persuasive. I am satisfied that in this case the manner of death should be recorded as intentionally self-inflicted. There is extensive evidence to support this finding. In particular I rely on B W's recent statements to police and to his mother which clearly indicate his state of mind just prior to taking deliberate action.

126. The evidence establishes that B W had been struggling with mental health issues for some time. Nevertheless, the clear and spoken trigger for taking action that night was the emergency removal of his daughter.

Discussion of Issues

127. There can be no doubt that there are lessons to be learnt from the circumstances of B W's death. I turn now turn to the major issues arising from the evidence.

The adequacy and appropriateness of the NSW DCJ response to reports between 23 March and 15 April 2020

128. The court was keen to understand the decision-making processes within DCJ in the period before B W's death.

129. I accept that the COVID-19 pandemic adversely affected the operations of DCJ in a number of ways. Ms Charet, Ms Thakur and Ms Ahuja each spoke of the difficulties they suddenly faced in conducting their duties within the novel pandemic landscape. There were staff shortages and problems with conducting home visits. Staff who usually worked together were separated and some suddenly worked in more isolated home settings. The available non-DCJ services ceased face-to-face contact

and were no longer taking referrals. At the same time, staff were concerned that necessary public health restrictions would impact the proper assessment of children at risk. The restrictions removed many children from the visibility of mandatory reporters in the community. There was concern that domestic and family violence might rise once restrictions were in place.

130. The DCJ witnesses each spoke of "*fear*", "*anxiety*", "*stress*" and "*confusion*" among DCJ workers. In particular Ms Thakur explained how the experience affected her. She told the court "*I remember that time so vividly. It was, like, what – how is this going to – how are we going to do our work?".* She spoke of an influx of reports and the feeling of being "*overwhelmed*".[64] I accept her evidence and consider it relevant background to the decisions she made at the time COVID restrictions commenced. She explained that she struggled with making the particular closure decision under consideration, but at the time DCJ was receiving more "*high threshold*" reports.[65] She explained that the matter was closed because of the other "*competing reports*", explaining that there were families "*with higher worries*".[66]

131. While I accept that the COVID-19 pandemic exacerbated the situation facing a relatively junior decision-maker at the time like Ms Thakur, I pause to note that the closing of files because of "*competing priorities*" is a dangerous practice that dates back for many years before the pandemic. I have had cause to draw attention to this issue over the years on a number of occasions.[67]

132. I repeat now that it is entirely unsatisfactory that the only agency in NSW tasked with a statutory responsibility for protecting children and young people from the risk of significant harm can operate in this manner. That unique statutory responsibility cannot be shifted by accepting a culture where overwhelmed staff feel any sort of pressure to close reports that should be further investigated because on review there appears to be "*other families with higher worries*".[68] The Minister and Departmental Secretary must be made to grapple with these issues and find solutions to the resourcing issues identified.

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[64] T99.9-19 (18 July 2023).
[65] T104.7-30 (18 July 2023).
[66] T104.24 (18 July 2023).
[67] See *Inquest into the death of BLGN and DG* (8 June 2018), *Inquest into the death of Z* (10 March 2021) among others.
[68] T104.24 (18 July 2023).

133. The point is well-illustrated by evidence given by Ms Ahuja relating to management of this family in the period *prior to* the COVID-19 pandemic restrictions. Ms Ahuja was an extremely experienced child protection caseworker, well used to working in high volume settings. She explained to the court that she was the person who was responsible for closure and the referral to FFT back in December 2019. She explained that this was not because "*they could not see risk*".[69] In fact she said that she would have preferred to keep the matter, "*if she had the resources*."[70]

134. Ms Ahuja's evidence suggests that there may also be a particular issue in allocating cases of neglect where a crisis point has not been reached. In my view, her evidence highlights ongoing issues for review at the highest level. Non-Government agencies have a role to play, but they are no substitute when a statutory response is required. Clearly resourcing pressure existed well before the particular difficulties of the COVID-19 pandemic.

135. Returning to Ms Thakur's decision. She gave evidence before me and presented as a thoughtful witness who approached the court proceedings with honesty and insight. I was impressed by her ability to reflect on what had occurred and her openness to learn from her participation in events.

136. Ms Thakur told the court that when her recommendation to close was reviewed by her more senior manager Ms Ahuja and subsequently reversed, she was immediately "*on board with the decision*" and felt "*relieved*."[71] I accept her evidence and have no doubt that she has genuinely reflected on the issues raised in this court. I also accept Ms Ahuja's evidence that Ms Thakur did not have a pattern of making unsound assessments. The evidence indicates that staff are asked to work in impossible conditions, and that even senior staff sometimes close files they would prefer to keep open.

137. While I understand the pressures on Ms Thakur, and I accept Counsel for DCJ's submission that there is a degree of artificiality in isolating a single decision with the benefit of hindsight, I have no real hesitation in describing the decision Ms Thakur made as wrong. Given the reports made on 23 and 27 March 2020 and the information received from the FFT on 30 March 2020, the matter should have been listed at a WAM so that it could be allocated for field assessment. The peer review

[69] T74.45 (18 July 2023).
[70] T75.5-9 (18 July 2023).
[71] T104.2-17 (18 July 2023).

process worked correctly in this case. While the peer review process resulted in a delay in the matter being listed at a WAM, it is not possible under the circumstances to make a firm finding that earlier allocation would have ensured direct contact was made with B W prior to 17 April 2020.

138. I accept Counsel Assisting's submission that given the way the initial recommendation was peer reviewed, there was no breach of policy or procedure involved. However when one views the decision in the complete context, including Ms Ahuja's evidence that she would have preferred to have allocated the matter the previous year, it is apparent to me that while there may not have been a specific breach of policy, there is a recurring systems failure caused by inadequate resourcing.

NSWPF response and assessment of B W at the time of the child removal

139. As I have stated above, emergency removals of children led by NSW Police are rare. This is as it should be. Removal is a delicate and potentially damaging act of last resort that, where possible, is best left to those trained in understanding trauma.

140. It was not surprising that even the experienced officers involved in A W's removal in the early hours of 17 April 2020 had limited experience in this area. Detective Inspector Mackay told the court that he had been involved in at most three removals previously[72] and Sergeant Sommerville on one prior occasion in around 2007-2008 where no parent had been present[73]. They had received no formal training or guidance in respect of decision-making or the conduct of removals.

141. Sergeant Sommerville had also attended three or four instances where police had assisted with removals by DCJ, where his focus was on "*prevention of breach of the peace by parents or other family*" and where "*usually what we were confronted with was overwhelming to blinding anger which was the reason DCJ had contacted us in the first place."*[74]

142. I think it likely and understandable that these experiences influenced the way he approached his task in the early hours of 17 April 2020. At various times he explained his thinking reflected the likelihood that a breach of the peace could occur at any point.

[72] T235.20-33 (21 July 2023).
[73] T179.38-180.25 (19 July 2023).
[74] T181.45-182.5 (19 July 2023).

143. Of the officers present, only Sergeant Sommerville appeared to have had formal mental health training. The course he described was a one-day course, more than ten years ago which apparently focused on "*persons in states of psychosis and dealing with violent confrontation in those circumstances."*[75]

144. Sergeant Sommerville described his ability to assess people's behaviours as deriving from "*field experience*" and he explained that "*most of the mental health matters I've dealt with over the years have been de-escalating confrontation."*[76] I think it is clear that he assessed the situation through this prism, focusing primarily on whether there would be a violent escalation of B W's behaviour, even when B W had not exhibited violence or made threats.

145. Each of the attending officers observed that B W was distressed. Sergeant Sommerville and Detective Inspector Mackay also observed that he was intoxicated. However they did not turn their minds to his welfare generally, in terms of the impact upon him of the potential and then actual removal of A W.[77] Detective Inspector Mackay explained that his focus was on the safety of A W and that he did not turn his mind "*any further than when we leave he would possibly be asleep on the lounge afterwards."*[78] Similarly Sergeant Sommerville explained that while he had turned his mind to B W's level of intoxication and whether he could be left alone for that reason, he did not turn his mind to the question more generally "*is he going to be okay when I leave*?".[79] To my mind this was an extraordinary and troubling admission from a senior officer apparently trained in mental health issues.

146. It was objectively apparent that B W was distressed, intoxicated and that his home was in a state which indicated that he was not coping. Unfortunately, no officer considered taking any action in relation to his mental health. It appears that if they considered the issue at all it was through the limited prism of their potential powers under section 22 of the MHA which would empower them, in certain limited circumstances, to detain B W and take him for an assessment.[80]

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[75] T174.37-175.34 (19 July 2023).
[76] T175.35-44- (19 July 2023).
[77] T197 8-15,33-45 (19 July 2023); T241.39-50 (21 July 2023).
[78] T 241.49 (21 July 2023).
[79] T197.35 (19 July 2023).
[80] Section 22 Detention after apprehension by police
(1) A police officer who, in any place, finds a person who appears to be mentally ill or mentally disturbed may apprehend the person and take the person to a declared mental health facility if the officer believes on reasonable grounds that—

147. It appears that the issue was approached in an either/or manner, that is if his conduct and behaviour does not reach the threshold test under section 22, then we should just get on with our primary purpose which is to remove the child and get her back to the station so that we can call DCJ.

148. Counsel Assisting drew the court's attention to the NSWPF Handbook ("Handbook") section on "Mentally Ill People"[81] which acknowledges that "*mental illness can take many forms such as depression, anxiety, schizophrenia and personality disorders*". It guides officers to take alternative options short of detention and assessment under section 22 MHA (such as ambulance officer assessment, or contact with family) only "*where concerns are held by police about a person's mental health status that has not met the criteria" of section 22 MHA*.

149. There is no detailed guidance on how depression and anxiety might present, independently or coupled with or masked by alcohol intoxication, in a manner that should give rise to such "*concerns*". Nevertheless, it is clear that all NSW Police officers should be aware that there are options which can be considered aside from detention. Various officers gave evidence about how – in hindsight - ambulance services could have been used in this circumstance.

150. It is concerning that officers did not turn their mind to the possibility that the emergency removal of a child would be extremely distressing to the parent of the child. I accept that police officers are not social workers, however they are regularly called on to conduct welfare checks and refer people to more specialised support services. It is not unreasonable to expect that when exercising police powers to remove a child from a parent's care that some regard is had to the welfare of that parent.

(a) the person is committing or has recently committed an offence or that the person has recently attempted to kill himself or herself or that it is probable that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person, and

(b) it would be beneficial to the person's welfare to be dealt with in accordance with this Act, rather than otherwise in accordance with law.

(2) A police officer may apprehend a person under this section without a warrant and may exercise any powers conferred by section 81 on a person who is authorised under that section to take a person to a mental health facility or another health facility.

[81] Exhibit 1: Tab 42, NSWPF Handbook Chapter: Mentally ill People.

Policy issues relating to emergency removals by NSWPF

151. The court was keen to understand the formal guidance given to officers in relation to child removal. It is clear from the evidence of the officers involved (who were of varying experience levels), as set out above, that none were aware of any policies that applied, nor had they received any particular guidance or training in relation to the exercise of the police power of emergency removal of children. That is entirely consistent with the limited scope of policy, guidance and training material produced by NSW Police to this inquest on the issue of the conduct of such removals.

152. The Handbook[82] and the NSWPF Operations Manual[83] ("Manual") include content identifying and guiding the *decision* to exercise the police power of emergency removal in section 43 of the Care Act. The Handbook and Manual direct police to consider, as part of consideration of the power in section 43:

- The child's "immediate and ongoing safety, wellbeing and welfare, including whether they need care and protection."
- "The least intrusive and most effective method of intervention".
- "The rights of any non-offending parents or caregivers".

153. The Handbook and the Manual do not include any content mandating or guiding the *conduct* of emergency removals by police, whether in terms of provision for the *welfare* of the child, or the parent, as a *result* of the removal. The Handbook and the Manual also do not include any content mandating or guiding contact with DCJ in relation to the decision to conduct an emergency removal of a child.

154. The court was provided with copies of two documents described as "Six Minute Intensive Training" ("SMIT") records published in January 2018, dealing with "Removal of Child from Public Place" and "Removal of Child from Private Premises".[84] SMITS are described as "*generally used by [Education and Development Officers] or other officers at PACs/PDs to reinforce and/or upskill NSWPF officers and staff with small periods of learning…The EDO leading the trainings may or may not refer to these during their workshops/courses".*[85] There is no evidence as to the time and extent of the documents' distribution. The two

[82] Exhibit 1: Tab 41, NSWPF Handbook Chapter: Sexual Violence and Child Abuse, pp.11-12.
[83] Exhibit 1: Tab 51, NSWPF Operations Manual Chapter: 4 p.8.
[84] Exhibit 1: Tabs 45, SMIT: Removal of a child from private premises and 46, SMIT: Removal of a child from public places.
[85] Exhibit 1: Tab 51, NSWPF Operations Manual Chapter: 4 p.2.

documents contain no content directed to the welfare of parents at the time of removal.

155. The court was also supplied with two flyer type documents, described as "Pocket Guides" created by the NSWPF Child Wellbeing Unit, and circulated state-wide in early 2021 to Education and Development Officers at each PAC/PD.[86] The Pocket Guide "Reporting a Child at Risk of Significant Harm" includes the statement "*If you consider the child/young person to be at imminent risk of significant harm, remove the children/young person and phone DCJ Child Protection Helpline immediately on*…".[87] The Pocket Guides contain no content guiding the conduct of removals.

156. By contrast, the DCJ material includes a policy which mandates particular regard be had to support for parents and children in the course of removals undertaken by DCJ staff, and readily available practice guidance on the impacts of separation and loss on parents relevant to the removal of children.

157. The "Removal or Assumption of a Child" mandate[88] is a policy document that directs DCJ case workers on *how* to carry out removals, whether pursuant to Court orders, warrants, or in emergency situations. In particular the mandate:

a. under the heading (p.4) "Providing support during the removal process", directs caseworkers to "Give casework support to the child and all family members, including parents, throughout the removal process", specifically identifying this as to be "Completed by CW".
b. within a box under that heading, includes "Practice Advice" (p.4) which:
   i. recognises that removal of a child is "traumatic" for the child and their family; that parents can understandably often become "upset", "scared", "angry" and "overwhelmed by these emotions";
   ii. suggests steps be taken including: spending time with parents to support them to say goodbye, consider having one worker stay with the parents to provide support while the other supports and make arrangements for the children to "demonstrate to the parent that they are important and cared about", contact the parents the next day to check in on them and let them know how their children are".

[86] Ibid.
[87] Exhibit 1: Tab 43, NSWPF Child Wellbeing Unit Pocket Guides.
[88] Exhibit 1: Tab 36, Statement of Lisa Charet at [90]-[91], Annexure LC-12; T119.19-25 (18 July 2023).

c. in respect of removals done without an opportunity for planning, directs caseworkers to "talk to the parents and the child about the reasons the child is being brought into care and what is likely to happen after next" (p 9).
d. in respect of removals done with an opportunity for planning, advises caseworkers to "wherever possible, explore options for a planned removal and support the parents and family to understand what is going to happen and give them choices about how it occurs" (p.4).
e. refers to and provides hyperlinks to Information Sheets that "may be helpful to leave with the parent and child after having further conversations about what is happening", including the "Information for parents and carers – When your child is removed from your care" document (p.5).[89]

158. The mandate also repeatedly cross-refers (and includes hyperlinks) to the Separation and Loss practice advice document,[90] which is a guidance resource, accessible to DCJ staff on the DCJ intranet.[91] That document contains extensive information about:
a. the grief and loss emotional responses parents of removed children will experience following removal;[92]
b. the behaviours parents may engage in following removal, including use of drugs and alcohol or "other destructive behaviours to dull the emotional pain", including attempts at self-harm or suicide;[93]
c. the continuing connection between removed children and parents, and the need to maintain this connection;[94]
d. the need and rationale for supporting parents through removal processes.[95]

159. Lisa Charet, DCJ Executive District Director of the Western Sydney Nepean Blue Mountains Districts, reflected on the Separation and Loss document as follows:[96]
"…*any time we remove a child, we remove all their normal, and we have a big impact on their parent, and I think for caseworkers, the importance of understanding that, understanding the impact, understanding what it will mean for a parent and a child, and how we can support them through it. This is guidance on, you know,*

[89] Exhibit 1: Tab 36A, 'When Your Child is Removed From Your Care' Information Sheet.
[90] Exhibit 1: Tab 36, Statement of Lisa Charet Annexure LC-13.
[91] T118.41-50 (18 July 2023).
[92] Exhibit 1: Tab 36, Statement of Lisa Charet Annexure LC-13, p.2-3.
[93] Exhibit 1: Tab 36, Statement of Lisa Charet Annexure LC-13, pp.2, 4- 5.
[94] Exhibit 1: Tab 36, Statement of Lisa Charet Annexure LC-13, pp.2-3.
[95] Exhibit 1: Tab 36, Statement of Lisa Charet Annexure LC-13, pp.2-3.
[96] T118.25-35 (18 July 2023).

every step of the, you know, the process. And certainly we try, wherever possible, the day after we have removed a child, or the day we remove a child, we're talking about restoration. Wherever there's hope to restore a child to a parent - you know, often parents and children will be completely lost. So it's what can we do in our work to support them and to make the best possible outcome for them, and I think this is kind of detailed, but really clear."

160. Ms Charet explained the following aspects of DCJ conduct of removals in practice in her Districts. For planned removals, a "care pathways panel" is convened to "*discuss the family, the risks, the pathway forward and we would plan for the parent as part of that*", including for example, sending a caseworker to go and stay with a parent after the child has been removed to "*try and support them, to try and get family around them, to try and not leave them alone without some support*".[97] She said that in emergency removal situations, there would still be some thought and planning in relation to the parent, and connection with the child after the event.[98]

161. The evidence does not suggest any inadequacy in the DCJ policies, guidance and training on carrying out removals of children, whether planned or in an emergency. However I accept Counsel Assisting's submissions that the whole of the evidence demonstrates that NSW Police officers require greater knowledge for carrying out emergency removals of children needs if the welfare of parents is to be adequately provided for. This could be achieved by drawing on DCJ policies and practices, and also by better access to and support from DCJ services.[99]

162. Ms Charet agreed that parents whose children are removed by NSW Police have no lesser entitlement to care and support, but considered that officers are not currently "*well-versed enough*" to provide that kind of support that DCJ caseworkers do on a daily basis.[100] She indicated that the people who take calls to the Child Protection Helpline are trained case workers with the capacity to offer some such care and support, and information about the process, over the phone to parents in B W's position.[101] Currently however, there is no Memorandum of Understanding

[97] T119.39-49 (18 July2023).
[98] T120.15-23 (18 July 2023).
[99] Noting the unchallenged evidence from Sergeant Sommerville as to wait times for police accessing the DCJ After Hours Team via the Child Protection Helpline: T190.34-40 (19 July 2023).
[100] T122.39-123.3 (18 July 2023).
[101] T122.1-25 (18 July 2023).

between DCJ and NSW Police about the emergency removal of children by NSW Police.[102]

163. I accept Counsel Assisting's submission that the catastrophic potential ramifications of emergency removals done without due regard to the welfare of parents, as occurred when B W took his own life after A W was removed from his care, underscore the need for collaboration between the two agencies to make improvements.

164. In my view NSWPF policies, training and guidance on carrying out emergency removals pursuant to section 43 of the Care Act are inadequate in preparing police to carry out such removals with due regard for the welfare of parents. It follows that the officers involved in the removal were inadequately equipped to carry out the removal on the morning of 17 April 2020. It was foreseeable that B W would be seriously impacted by their decision and no police officer present turned their mind to the possible consequences.

The need for recommendations

165. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

166. Counsel Assisting and Counsel for the family put forward a number of draft recommendations, all of which have been considered in the light of submissions made by all parties.

<u>To the Secretary, Department of Communities and Justice</u>

The Department facilitate priority access to the After-Hours Response Team by NSW Police Force officers who have conducted, or have determined to conduct, removal of a child pursuant to s 43 *Children and Young Persons*

[102] Exhibit 1: Tab 36, Statement of Lisa Charet at [110].

***(Care and Protection) Act 1988*, for example by way of a direct telephone line or extension from the Child Protection Helpline.**

167. The court was keen for NSW Police to be able to obtain as much support as possible when conducting or considering an emergency removal. The court was informed that NSW Police did not consider contacting DCJ until A W had been taken back to the Police Station. One cannot help but wonder whether contact with a skilled DCJ worker at an earlier time might not have alerted NSW Police to the possibility that it was necessary to check if the parent needed support. In this context I was concerned by evidence given by Sergeant Sommerville in relation to his previous dealings with DCJ where he reported to having been left on the DCJ Helpline for long periods of time. It seemed possible that this played into the decision not to make the initial call from the scene.

168. The court received further information from DCJ on this issue in submissions including a document entitled Child Protection Helpline Priority Queue Guidelines, which has now been tendered[103]. This document confirms that since September 2020 the new priority queue guidelines have been in place. These provide a priority queue system that seeks to ensure certain circumstances and categories of callers receive the timeliest service and that their calls are transferred to the first available caseworker. Incoming calls are monitored and will be escalated if they are not promptly answered. NSW Police requesting urgent assistance from DCJ are triaged to the priority queue.

169. I accept that given the priority queue system currently in place, it is neither necessary nor desirable to make the recommendation.

The Department implement a requirement that upon notification to the After-Hours Response Team of a removal of a child by police pursuant to s 43 *Children and Young Persons (Care and Protection) Act* 1988, a caseworker attempt to contact the parent or parents as soon as reasonably practicable for the purpose of offering casework support consistent with that offered to parents in the conduct of removals of children by DCJ.

[103] Exhibit 7: Child Protection Helpline Priority Queue Guidelines.

170. DCJ submitted that the recommendation was not necessary as the recommendation already encapsulates the existing position upon DCJ being notified of a removal of a child by NSW Police. Further, it was submitted that in the tragic circumstances of this case there was effectively no time for DCJ to contact B W. However in "*normal circumstances*" arrangements would be made as soon as possible to speak with a parent and to offer casework support.

171. While I have some hesitation, knowing the way resource stress can affect deadlines at DCJ, I accept that the recommendation is not necessary in all the circumstances.

The Office of the Senior Practitioner give consideration to what further policy guidance, training support, and practical assistance the Department can provide to the NSW Police Force in respect of the conduct of removals of children pursuant to s 43 *Children and Young Persons (Care and Protection) Act* 1988.

172. The court was impressed by the guidance available to DCJ workers in relation to the issues that may arise in removals. While NSWPF officers are rarely involved, they nevertheless need some, albeit limited, guidance in relation to the issues that may be involved from a specialist perspective.

173. DCJ expressed a commitment to engaging with NSWPF to discuss the issue of police removals but drew the court's attention to the limited resources already available to the Office of Senior Practitioner and its need to direct its resources to training DCJ staff.

174. I accept those submissions and make an amended recommendation removing "training support".

<u>To the Commissioner of the NSW Police Force:</u>

The Commissioner implement a requirement that NSW Police immediately notify the Department of Communities and Justice After-Hours Response Team of any determination to exercise police power to pursuant to s 43 *Children and Young Persons (Care and Protection Act) 1998* to remove a child.

175. The evidence in this matter indicated while NSWPF may at times be called upon to remove a child, the sooner DCJ are involved to offer their expertise the better. The

Commissioner opposed the recommendation in its draft form. She submitted that the word "immediately" could create practical problems. She submitted that there will be occasions where the better course is to remove the child from the area and to make contact with DCJ at the station or in a space removed from the parent or carer's location. I accept this is the case, especially where issues of child and officer safety are in play. I intend to make the recommendation in an amended form requiring notification as soon as reasonably practicable and as a priority.

The NSW Police Force Handbook (Sexual violence and child abuse) and Operations Manual (Sexual assault and child abuse) be reviewed with a view to enhancing police knowledge, skills and practices in carrying out decisions to remove children pursuant to s 43 *Children and Young Persons (Care and Protection Act) 1998*, by including content in line with following sections of the Department of Communities and Justice (DCJ) Removal or Assumption of a Child Mandate:

a. **"Separation and loss".**
b. **"Providing support during the removal process".**
c. **"Helping children make sense of the removal".**
d. **"Assuming care of the child".**

176. While the Commissioner did not provide specific instructions to oppose this draft recommendation, Counsel for the Commissioner of Police cautioned the court in making any recommendations which might confer on officers a role akin to that of trained caseworkers employed by DCJ. She reminded the court that police are not social workers, that police removal is rare and that when it occurs, it is supervised by a senior officer. She drew the court's attention to the evidence of Ms Charet which identifies some of the joint projects and collaborative practices that already exist between DCJ and NSWPF, including the operation of the Western Sydney Service Delivery Reform Group.

177. I was not persuaded that a review of these police resources, taking into account the material prepared by experts within DCJ, is akin to expecting individual officers to have the expertise one might expect from a social worker. One would not expect the content to be simply reproduced in all its detail, rather it could be used as a reliable source to provide further guidance, in summary form to officers who may be faced with the issue.

178. I intend to make the recommendation as drafted.

The Child Wellbeing Unit review its publications and training resources on the topic of emergency removals of children pursuant to s 43 *Children and Young Persons (Care and Protection) Act 1998*, having regard to the content of the following Department of Communities and Justice material:

a. **Removal or Assumption of a Child Mandate**
b. **Separation and Loss Practice Advice Topic.**

179. This recommendation arose from evidence indicating officers would benefit from more information and training to support their involvement in the emergency removal of children.

180. While the Commissioner of Police did not provide specific instructions to oppose this draft recommendation, Counsel advised the court that the recommendation if made should not be directed to the Child Wellbeing Unit, which has no expertise in relation to education and training in relation to section 43 of the *Care Act.* I accept that advice and intend to make the recommendation directly to the Commissioner.

Consideration be given to the delivery of training sessions by the Child Wellbeing Unit, to an appropriate class of officers, including by online means, on the carrying out of decisions to remove children pursuant to s 43 C*hildren and Young Persons (Care and Protection) Act 1998.*

181. This recommendation arose out of evidence indicating some officers may benefit from enhanced training in the area of child removals.

182. While the Commissioner of Police did not provide specific instructions to oppose this draft recommendation, Counsel advised the court that the recommendation if made should not be directed to the Child Wellbeing Unit, which has no expertise in relation to education and training in relation to section 43 of the *Care Act.* I accept that advice and intend to make the recommendation directly to the Commissioner.

The Radio Operations Group Standard Operating Procedure and Prioritising Police Responses to Incidents policy be amended to incorporate:

a. **a requirement that all incidents involving threats of self-harm and/or suicide are clearly identified in the broadcast PoliceCAD incident label or narrative as "self-harm/suicide".**
b. **a requirement that the description of Priority 3 incidents refers specifically to incidents of self-harm or suicide threats that are not Priority 2 because they are not "in progress".**

183. This recommendation arose out of evidence relating to the priority which was given or which should have been given to the initial report to Constable Rostek at the Granville Police Station that B W had made a threat to kill himself. The recommendation was supported by Counsel for the family who added that there should also be a requirement for any person taking the call to ask further questions about mental health and situational risk so that the matter could be properly allocated.

184. Following the closure of the oral evidence, the court was informed that in May 2023 the NSW Police Radio Operations Group ("ROG") had amended their Standard Operating Procedures ("SOPS"), and those amended SOPS were tendered. The amendments as they relate to reports of self-harm were as follows:

(1) "*When a self-harm call is received, the ROG telephonist must "Commence a PRIORITY 2 POLICECAD "Self Harm*".[104]

(2) The definition of self-harm in Incident Types for CAD now defines "self-harm" as "*Self Harm: A person is suspected of deliberately causing or threatening self-harm to themselves*."[105]

185. In submissions, Counsel for the Commissioner explained that the SOPS now require that *all* reports of incidents of self-harm must be treated as Priority 2 job on the CAD system.

186. It is understood that the changes mean it is no longer necessary for a threat of self-harm to be a threat to life which is "*occurring now*" in order to be treated as a Priority 2 job, which was the evidence of the officers involved in the response to the call taken by Constable Rostek.

[104] Exhibit 5: SOPS Self Harm Suicide Threat Attempts in Progress Telephony p.1.
[105] Exhibit 6: SOPS incident Types p.9.

187. In these circumstances, Counsel submitted the draft recommendation was "*opposed on the basis that it is not necessary in light of the changes to the NSW Police CAD and the ROG SOP*".

188. The amendments to the SOPS are positive insofar as all calls involving threats of self-harm received by the ROG should now receive Priority 2 attention from police and/or ambulance services. However it is apparent from the oral evidence of the officers involved that there remains a concerning gap, or inconsistency, between the requirements of the amended SOPS and the understanding of station-based officers of those requirements. Those officers also receive calls reporting threats of self-harm and are also responsible for the creation of CAD jobs, but are not bound or directed by the ROG SOPS.

189. The officers involved in this particular case gave evidence indicating that the need for a threat to life to be "*occurring now*" remained their understanding of the priority framework that applied to calls involving threats of self-harm as of July 2023. Further, the Prioritising Police Response to Incidents policy document produced by the Commissioner, which reflects the understanding of the officers involved and was the subject of suggested amendment in the draft recommendation, does not appear to have been updated since the ROG SOPS were introduced.

190. I accept that the recommendation as drafted is no longer necessary given the amendments to the ROG SOPS. However consequent upon those amendments, in view of the important role of station-based officers in responding to calls for assistance in relation to self-harm threats, I make a related recommendation. Given the issues have been fully canvassed before me, I see no particular unfairness in asking the Commissioner to review this related issue, without delaying proceedings to ask for a specific response. I intend to make the following recommendation.

The Commissioner review the Prioritising Police Response to Incidents policy, and any other relevant policy and guidance material applicable to station-based officers, to ensure consistency in the implementation of the amended Radio Operations Group Standard Operating Procedure that all incidents involving a threat of self-harm be assigned a Priority 2 response upon creation of a CAD job.

The contents of the education and training delivered at the NSW Police Academy prior to attestation as a Probationary Constable be reviewed for the purpose of ensuring inclusion of adequate instruction on the importance of junior officers raising directly with their supervisors relevant information they obtain in the course of their duties.

191. This recommendation arose out of the evidence of the junior officers involved in this matter. While the court accepts that NSWPF has a rank-based structure, there may be a need to encourage junior officers to share the useful information they have.

192. I note the Commissioner did not oppose the recommendation and I intend to make it.

The Commissioner implement a requirement that NSW Police, where possible, ascertain if the Department of Communities and Justice have an open case for a family from which a child is proposed to be removed pursuant to s43 *Children and Young Persons (Care and Protection) Act* and, where possible, conduct any removal procedures in accordance with case specific information provided by the Department of Communities and Justice.

193. This recommendation was proposed by Counsel for the family. It arose out of evidence which indicated that NSW Police officers would have been assisted by information already held by DCJ about A W. The concern is a legitimate one.

194. The recommendation was opposed by Counsel for the Commissioner of Police, citing the possibility of it increasing undue delay and thereby potentially increasing the harm to the child. I accept this view, and consider the objective is better achieved by requiring notification and hence involvement by DCJ as soon as practicable and by ensuring NSW Police have priority access to the Helpline. In view of the other recommendations I intend to make, I decline to make the recommendation sought.

Consideration be given to the delivery of training sessions to NSW Police on identifying mental health issues and when and how to implement alternative means of intervention (other than detention under s 22 *Mental Health Act 2007*).

195. This recommendation was proposed by Counsel for the family and was generally opposed by Counsel for the Commissioner of Police.

196. In my view the evidence clearly indicates that the involved officers would benefit in additional mental health training, particularly training which incorporated practical skills for interacting with people who may be depressed or overwhelmed and intoxicated. The evidence before me indicated that the involved officers were alive to their powers under the Mental Health Act and were particularly focused on the possibility of a violent breach of the peace. They were blind to the risks involved in leaving B W alone, distressed and intoxicated.

197. I am loathe to make a recommendation, without having full knowledge of the mental health training currently available before me. From information available in recent inquests it appears that some aspects of mental health training in the NSWPF may currently be the subject of review. If changes are being made, I have no doubt that it would be useful to provide officers with information which might help them in identifying people who may be in need of mental health assistance but who do not cross the threshold of needing involuntary care.

198. Without making a formal recommendation, I intend to provide a copy of these Findings to the NSW Police Force Mental Health Intervention Team for their consideration and review.

To the Commissioner of the NSW Police Force and the Secretary, Department of Communities and Justice

Joint consideration be given to the creation of a fact sheet, required to be given to a parent or parents present at the time of any emergency removal of a child by police pursuant to s 43 *Children and Young Persons (Care and Protection) Act 1998*, including content addressing the following matters, in line with the DCJ *"When your child is removed from your care"* fact sheet:

a. **In general terms why police have removed the child.**
b. **What happens next.**
c. **Contact details for the DCJ Child Protection Helpline.**
d. **Space for the name and contact details of a relevant police officer and relevant police station who the parent can contact for more information.**

e. **Other useful contact details including for Legal Aid NSW and any appropriate complaint arising from the conduct of police.**
f. **Contact details for 24/7 mental health support services (Lifeline, Beyond Blue, NSW Mental Health Line).**

199. Counsel for DCJ supported this recommendation. Counsel for the Commissioner of Police did not oppose the recommendation but submitted that the Commissioner should not be the owner nor responsible for updating the fact sheet, and noted that fact sheets may not be accessible to many people due to low literacy or where it has not been translated into languages other than English. It was also noted that a simple business card may be a better option.

200. These are matters that can be jointly considered and determined by the Commissioner and Secretary. I intend to make the recommendation as drafted.

The Interagency Guidelines on Reporting and Responding to Child Wellbeing and Safety Concerns be jointly reviewed, with a view to including reference to the police exercise of power under s. 43 *Children and Young Persons (Care and Protection) Act* 1988, with hyper-links to relevant NSWPF policies and guidance materials.

201. Counsel for DCJ expressed a willingness to liaise with the relevant personnel from NSWPF as to the relevant policy material to be included in these guidelines, while noting that it is doubtful that such a document would be consulted by police officers executing an emergency removal.

202. The Commissioner of Police did not provide instructions in relation to this matter. Nevertheless, Counsel for the Commissioner re-iterated concerns that police officers are not social workers and suggested that it is unlikely that the document would be accessed by officers. Having considered all the evidence before me, I remain of the view that the recommendation has some utility. I intend to make the recommendation as drafted.

Findings

203. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was B W.

Date of death

B W died on 17 April 2020.

Place of death

B W died at Westmead Hospital, Westmead, NSW.

Cause of death

B W died from hanging.

Manner of death

B W's death was intentionally self-inflicted. It occurred shortly after NSW Police officers conducted an emergency removal pursuant to *Children and Young Persons (Care and Protection) Act*, of his daughter A W. B W was alone and under the influence of alcohol when he [redacted] hang himself.

Recommendations pursuant to section 82 *Coroners Act 2009*

204. For the reasons stated above, I recommend:

<u>To the Secretary, Department of Communities and Justice:</u>

(1) The Office of the Senior Practitioner give consideration to what further policy guidance and practical assistance the Department can provide to the NSW Police Force in respect of the conduct of removals of children pursuant to s 43 *Children and Young Persons (Care and Protection) Act 1988*.

<u>To the Commissioner of the NSW Police Force:</u>

(2) The Commissioner implement a requirement that NSW Police notify the Department of Communities and Justice as soon as reasonably practicable of

any determination to exercise police power to pursuant to s 43 *Children and Young Persons (Care and Protection Act) 1998* to remove a child, noting such contact should be done as a priority and priority access to the DCJ Child Protection Helpline is available for this purpose.

(3) The NSW Police Force Handbook (Sexual violence and child abuse) and Operations Manual (Sexual assault and child abuse) be reviewed with a view to enhancing police knowledge, skills and practices in carrying out decisions to remove children pursuant to s 43 *Children and Young Persons (Care and Protection Act) 1998*, by including content in line with following sections of the Department of Communities and Justice (DCJ) Removal or Assumption of a Child Mandate:

a. "Separation and loss".

b. "Providing support during the removal process".

c. "Helping children make sense of the removal".

d. "Assuming care of the child".

(4) The Commissioner review publications and training resources on the topic of emergency removals of children pursuant to s 43 *Children and Young Persons (Care and Protection) Act 1998*, having regard to the content of the following Department of Communities and Justice material:

a. Removal or Assumption of a Child Mandate

b. Separation and Loss Practice Advice Topic.

(5) Consideration be given to the delivery of training sessions, to an appropriate class of officers, including by online means, on the carrying out of decisions to remove children pursuant to s 43 *Children and Young Persons (Care and Protection) Act 1998.*

(6) The Commissioner review the Prioritising Police Response to Incidents policy, and any other relevant policy and guidance material applicable to station-based officers, to ensure consistency in the implementation of the amended Radio Operations Group Standard Operating Procedure that all incidents involving a threat of self-harm be assigned a Priority 2 response upon creation of a CAD job.

(7) The contents of the education and training delivered at the NSW Police Academy prior to attestation as a Probationary Constable be reviewed for the purpose of ensuring inclusion of adequate instruction on the importance of junior officers raising directly with their supervisors relevant information they obtain in the course of their duties.

To the Commissioner of the NSW Police Force and the Secretary, Department of Communities and Justice

(8) Joint consideration be given to the creation of a fact sheet, required to be given to a parent or parents present at the time of any emergency removal of a child by police pursuant to s 43 *Children and Young Persons (Care and Protection) Act 1998*, including content addressing the following matters, in line with the DCJ *"When your child is removed from your care"* fact sheet:

a. In general terms why police have removed the child.

b. What happens next.

c. Contact details for the DCJ Child Protection Helpline.

d. Space for the name and contact details of a relevant police officer and relevant police station who the parent can contact for more information.

e. Other useful contact details including for Legal Aid NSW and any appropriate complaint arising from the conduct of police.

f. Contact details for 24/7 mental health support services (Lifeline, Beyond Blue, NSW Mental Health Line).

(9) The Interagency Guidelines on Reporting and Responding to Child Wellbeing and Safety Concerns be jointly reviewed, with a view to including reference to the police exercise of power under s. 43 *Children and Young Persons (Care and Protection) Act 1988*, with hyper-links to relevant NSWPF policies and guidance materials.

Conclusion

205. I offer my sincere thanks to Counsel Assisting, Ms Sian McGee and her instructing solicitor Ms Rosanna Muniz for their hard work and enormous commitment in the preparation of this matter and in drafting these findings.

206. Finally, once again I offer my sincere condolences to B W's family, especially his mother, L C. I thank her for her participation in this inquest.

207. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
NSW State Coroner's Court, Lidcombe
8 September 2023

Inquest into the death of B W
CSO Ref: 202102701 | Court Ref: 2020/116336
Chronology of material events as at 16 July 2023

Date	Event	Brief reference
31 May 1988	[redacted] born (aged 31 years old at death). He was the youngest of three children. He was exposed to parental violence and alcohol abuse as a child. He was diagnosed with ADHD at approximately age 7. He had a close relationship with his mother throughout his life. He worked sporadically. He commenced excessive alcohol use in early adulthood.	Vol 1, Tabs 23, 24, 27, 28, Vol 5, Tab 92
21 January 2012	[redacted] born. [redacted] became a single parent with full-time care of [redacted] within weeks after [redacted] birth. Initially some DCJ involvement, then Family Court litigation resulting in him receiving sole parental responsibility in 2013.	Vol 1, Tab 23 Vol 4, Tabs 75, 80
9 September 2013	Self-harm concern for welfare response by police to call made by [redacted] friend, after police attended home earlier on report of loud arguing. [redacted] appeared to be intoxicated. [redacted] made statements to his friend indicating he should "end it all". Police attended, and [redacted] reported that his statement was in reference to his current living conditions and fear he would not be able to provide for his daughter and was concerned police would remove her. He did not wish to see a doctor, admitted to past depression but said had never self-harmed and did not make any self-harm or suicide threats.	Vol 1, Tab 19: E 51951009
September-December 2013	Reports made by police to DCJ based on concerns about [redacted] alcohol use and difficulties managing single parenting.	Vol 1, Tab 19 Vol 4, Tabs 75, 80
2013-2014	[redacted] engaged with Brighter Futures family support service and no removal action taken by DCJ.	Vol 4, Tabs 75, 80

Date	Event	Brief reference
August 2014	Last Safety Assessment undertaken by DCJ.	Vol 5, Tab 95 p. 4
December 2015	Last risk of significant harm report to DCJ until December 2019.	Vol 5, Tab 95 p. 4
February 2017	[redacted] became a father to a second daughter. He maintained contact with her until his death.	Vol 1, Tab 29
2018	[redacted] started at new school: [redacted]	Vol 1, Tab 23
2018-2020	Difficulties with [redacted] behaviour at school became apparent. From 2018 [redacted] did not contact and seek support from his mother as regularly as previously, however was open about his difficulties with his mother and his neighbour [redacted] His mother observed a deterioration in his drinking and issues with anger during this time. In conversations with his mother while drinking, he threatened suicide on average once per fortnight.	Vol 1, Tab 23
November-December 2018	[redacted] attended his GP regarding pain from a fall and raised complaints of depression/anxiety. A further appointment took place to prepare a Mental Health Care plan and referral to psychologist. He was subsequently diagnosed with Depression and Panic Disorder and was referred to psychologist, [redacted] with the GP noting "major depression" as the principal diagnosis, with "Severe" severity.	Vol 5, Tab 92
February 2019	[redacted] classroom teacher completed a Learning Support Referral form, recommending counselling.	Vol 5, Tab 91
November 2018 - June 2019	[redacted] attended sessions with [redacted] psychologist, on fourteen occasions.	Vol 5, Tab 94
25 August 2019	[redacted] attended his GP in relation to eye/temple plain. Stress was observed, and the GP referred both [redacted] and [redacted] to Merrylands Counsellors.	Vol 5, Tab 92

Date	Event	Brief reference
October 2019	Attention and responses to [redacted] behaviours at school increased.	Vol 5, Tab 90
December 2019	[redacted] GP completed a referral form to Merrylands Counsellors for [redacted] noting he "*needs help to cope/raise daughter*". An intake form was completed shortly after. [redacted] responded to the question "*what do you need support with as a parent?* "*Not sure, maybe everything*!". Sessions for [redacted] and [redacted] with psychologist [redacted] at Merrylands Counselling began. GP also issued a further referral to psychologist [redacted] for [redacted], but he did not attend any further sessions.	Vol 5, Tabs 92, 96
11 December 2019	[redacted] displayed violent behaviours at school leading to ambulance attendance and hospital review. Ambulance was called by [redacted] and he asked for hospital assessment. Concerns raised about [redacted] mental health and alcohol use, and reports by [redacted] of excessive discipline by him when under the influence of alcohol. A risk of significant harm report is made to DCJ by police, reporting excessive discipline and drinking. Reported "father admitted to drinking and said nothing helps anymore, only a bottle of wine helps". Screened in as <24h response but in consultation was agreed downgraded to 72h because [redacted] had been assessed at Westmead. The report was transferred to Auburn CSC transferred to Auburn CSC for further assessment with a recommended response time of <72 hours.	Vol 4, Tabs 58-59 Vol 1, Tab 19: E 72738512 p 48
12-13 December 2019	School counsellor noted 11/12/19 incident and marked matter for follow up in 2020. DCJ case worker called The Children's Hospital Westmead and was advised that "notes say father advised of escalating violence and bullying at school" and that Merrylands Counselling involved.	Vol 5, Tab 90, p. 80 Vol 4, Tab 62

Date	Event	Brief reference
	DCJ Acting Manager case work ("A/MCW") Shalu Ahuja decided that "least intrusive approach" was preferable given no risk of significant harm or neglect or mental health information from school, and no other reports since late 2015. Ms Ahuja recommended referral to FFT ("Functional Family Therapy") being Mackillop Family Services at the time. DCJ worker called [redacted] about referral to FFT, which he agrees to, indicating he was "wanting to get help", is "more than happy to work with some [sic] to support himself and [redacted]" and "is keen to find some social support and activities for [redacted] as he has limited finances and limited social network of children the same age as [redacted]". DCJ referral form to FFT noted: "This referral is from Triage with no face-to-face assessment completed with dad [redacted] or [redacted]". In the "Issues family may require assistance to address" section of the FTT referral form, "Alcohol or substance misuse/abuse" and "Child has complex or high needs which impact on coping skills and personal resources of the family or parent" are selected as issues. In the "Support needs" section of FFT referral form, mental health issues not flagged, and Merrylands Counselling not noted as other kind of support service currently received. In FFT risk assessment form, in response to "are there any mental health concerns", notes "not listed in detail but [redacted] and [redacted] are seeing psych at Merrylands". School was informed of referral to FFT by DCJ.	Vol 2, Tab 37 Vol 5, Tab 95, p. 4-6
26 December 2019	Police attended at [redacted] request as [redacted] had run away. Intoxication/excessive alcohol use and neglect concerns (condition of the home and lack of food) were noted and reported to DCJ. [redacted] attends and ultimately [redacted] is taken to her home temporarily. Attending police create "Child at Risk" report as part of Event record on 27.12.19 and incident is reported to DCJ as ROSH on 8.1.20.	Vol 1, Tab 19: E 73243907 Vol 4, Tabs 63-65

Date	Event	Brief reference
30 December 2019	[redacted] and [redacted] first appointment with FFT. DCJ triage assessment report closed the case on the basis that "no capacity to allocate", with supporting commentary "Referral made to FFT". A/MCW and Acting Manager Casework Services ("A/MCS") at Auburn CSC decided (on weekly peer review per Triage Assessment Mandate) to close the case since referral had been accepted by FFT. Closure decision made without knowledge of 26.12.19 incident, because this incident was only reported to DCJ via the Helpline by police on 8 January 2020 as outlined below.	Vol 5, Tab 95 Vol 4, Tab 62
8 January 2020	ROSH report reported by police regarding attendance on 26.12.20 (<10 days response). ("**First ROSH report**"). ROSH report included that [redacted] told police "he was embarrassed of the way his home was, that he was struggling with depression and dealing with a defiant 7 year old. He expressed he thought he would have more support from his mother and other family but no one is around to help". Report also includes [redacted] told police he drinks once a fortnight or once a week, however police were under belief this occurs on more regular occasion. Screened in under serious self-harming/risk taking behaviour. Not screened in for inadequate basic care, nor alcohol use because "although he consumed wine, he was able to chase [redacted] and phone for police, which suggests his alcohol abuse does not impact his ability to provide care". Transferred to Parramatta CSC for further consideration with a recommended response timeframe of <10 days. Paramatta CSC decided to conduct a Field Assessment, however when [redacted] was contacted by Parramatta CSC to set this up, it became apparent that his incorrectly recorded address meant Auburn CSC was most appropriate and the report was referred to Auburn CSC on 21.1.20 (see below), who did not conduct a follow-up considering FFT had accepted DCJ's referral.	Vol 4, Tabs 63-65 Vol 2, Tabs 36-38 Vol 1, Tab 19, p 33ff (Event 73243907) Vol 2, Tab 36, at [146]
17 January 2020	FFT home visit. [redacted] reported further behaviours by [redacted] – lighting fires while he was lying down [suspected intoxicated]. Discussion between FFT and	Vol 5, Tab 95, pp. 113

Date	Event	Brief reference
	[redacted] about "possible mental health", as [redacted] did not see someone about this, and "described signs of depression and anxiety".	Vol 4, Tabs 66-68
21 January 2020	ROSH made by FFT to DCJ ("**Second ROSH report**"). Report included "concern about parent": "concerns regarding the father consuming alcohol as a way to cope with being a single parent". Screened in for inadequate supervision and self-harming/risk-taking behaviour but again not substance (Alcohol) abuse because only a "possible" reason for him lying down and feeling unwell is a pattern of behaviour consuming alcohol. Decided not enough evidence to determine that he was under the influence at the time of the incident. Assigned response time of <10 days. Received at Auburn CSC 21 or 22.1.20	Vol 4, Tabs 66-68
21 January 2020	Parramatta CSC transferred case to Auburn CSC; First ROSH report dated 8.1.20 was transferred to Auburn CSC.	Vol 2, Tabs 36-38
23 January 2020	On a joint review by A/MCS and A/MCW Auburn CSC of ROSH reports received 8.1.20 and 21.1.20, DCJ decided to request progress update from FFT. Contact attempts made by DCJ caseworker on 28 January 2020, 3 February 2020 and 4 February 2020 (email and voicemail).	Vol 2, Tabs 37-38, Vol 4, Tab 70 (pp 8-9)
4 or 5 February 2020	Contact established between DCJ caseworker and FFT. DCJ record of contact: FFT reports only three visits, currently in "Engagement and Motivation Phase with the family". FFT reports complex behaviours by [redacted], states "there are no supports in place for [redacted]". Reports [redacted] is newly engaged with a counsellor in Merrylands for the purpose of testing for diagnosis/delay, though only one session has occurred. FFT record of contact: Received phone call from Auburn DCJ advising of reports and request for more information. Confirmed [redacted] drinking and [redacted] behaviours were planned to be worked on with the family "however that as work is still early on that we	Vol 4, Tab 70 Vol 5, Tab 95, pp. 103-105 Vol 2, Tabs 37-38 Tab 70, pp 9-10 Vol 2, Tab 38, [21]

Date	Event	Brief reference
	have not been able to target these issues as of yet". FFT indicated "hope" that case would be assigned to a worker for case management and other supports that DCJ could provide that FFT service could not. Information provided to A/MCW was that [redacted] was engaging with FFT and that the therapist was working on building trust; the therapist did not advise that the risk was too high for FFT to be involved.	
5 February 2020	School Learning Support Team referral completed for [redacted] sought "partial attendance, counsellor referral, access request". Noted unsafe behaviours including attempts to harm others and herself. Meeting with teachers, Assistant Principal and school counsellor occurs, concerns expressed about [redacted] safety by her behaviours.	Vol 5, Tab 90, pp. 72, 78
6-10 February 2020	Based on joint A/MCW and A/MCS review, DCJ close case on the basis/rationale that "FFT is currently involved with the family and conducts home visits every week. Father is engaging." Also recorded closure reason: "no capacity to allocate". On 6 February, DCJ contacts the FFT therapist and advises outcome that the decision made not to allocate the case and for it to remain closed based on the family having supports in place. The CW encourages FTT therapist to report when needed. FFT and School Counsellor commence coordination/communication.	Vol 4, Tab 70, p 1 Vol 5, Tab 90 p 98 Vol 5, Tab 95, p 102
February-March 2020	[redacted] behaviours at school increased, including suspensions for throwing chairs and jumping out of windows (February) and putting pins in her mouth, twisting a student's arm, hiding in the garden and throwing books and chairs (March). Actions on school learning support plan occurred, meetings, consent and assessments. [redacted] expressed frustrations about service engagement but remains engaged with Merrylands psychologist, FFT and the school including school counsellor. He attended Merrylands counselling with [redacted] but does not wish to discuss own issues.	Vol 5, Tab 90, pp. 29-30, 41-42, 51, 56-64 Vol 5, Tab 95, pp. 67-99 Vol 5, Tab 96, p. 27

Date	Event	Brief reference
18 February 2020	Report of [redacted] threatening [redacted] with a bread knife. Information was at some point submitted on ChildStory by the Department of Education ("DOE") Child Wellbeing Unit ("CWU"). This report was not considered by Auburn CSC as there was no open case for [redacted]; the incident was not reported to the Child Protection Helpline by the DOE CWU.	Vol 5, Tab 90, pp. 56-57 Vol 2, Tab 36, [137]-[138]
24 February 2020	[redacted] suspended from school for 2 days.	Vol 5, Tab 90, p 51, 55
25 February 2020	School counsellor makes contact with Auburn DCJ and is informed case is closed and contact with FFT is recommended. Counsellor contacts FFT and Merrylands Counselling psychologist.	Vol 5, Tab 90, pp. 52- 54
2 March 2020	[redacted] suspended from school for 1 day. [redacted] receives a written warning from school principal under *Enclosed Lands Act* following his response (described as an "aggressive outburst") to being informed of [redacted] suspension while on-site at the school.	Vol 5, Tab 90, p 41-43
3 and 4 March 2020	"Carer Concern – Mental Health" reports submitted by school to DOE CWU. These reports are then submitted via ChildStory, but not read by Auburn CSC DCJ because no open case at the time. These incidents were not reported to the Child Protection Helpline by the DOE CWU.	Vol 5, Tab 90, pp. 34, 47-48 Vol 2, Tab 36, [137]-[138]
5 March 2020	Date of last FFT home visit. No issues were raised by FFT with DCJ following this visit.	Vol 5, Tab 95, p. 132 Vol 2, Tab 37 at [37]
9 March 2020	DOE CWU advised school: There is "current allocation" for [redacted] with Auburn CSC School directed to liaise with DCJ re case plan and other supports school requires, and to link school counsellor with FFT and Merrylands.	Vol 5, Tab 90, p. 32
11 and 18 March 2020	In sessions with Merrylands Counselling psychologist, [redacted] was reluctant towards suggestions of involvement with more intensive family support services.	Vol 5, Tab 96, pp. 32-33

Date	Event	Brief reference
12 March 2020	[redacted] is suspended from school for 2 days.	Vol 5, Tab 90, p 29-30
18 March 2020	FFT provided update to Auburn CSC DCJ regarding the family's progress; this was recorded by DCJ as follows: • "Family is currently engaged • Dad has informed service that he has lack of trust. Continue to build the relationship with the family."	Vol 4, Tab 74, p 4
19 March 2020	Police attended at [redacted] request at 10pm following [redacted] running away again. Police Event report additionally recorded concerns about the state of the premises food supplies, and "concerns for father's mental health and alcohol consumption" (although he did not appear to be affected by alcohol at the time). Event report also notes that the child's physical and emotional state appeared to be fine.	Vol 4, Tabs 72-74 Vol 1, Tab 19: E 74657329 At Tab 19, pp.19-20
21 March 2020	Police report events of 19 March 2020 internally to CWU who then escalate to DCJ Helpline for ROSH based on professional judgment, following cumulative risk appraisal and ROSH outcome. "Significant concerns for safety, welfare and wellbeing of [redacted] due to her vulnerable age and inadequate living conditions. It appears father is struggling to provide a clean environment and adequate living conditions. [Her] behavioural issues are escalating." (**Third ROSH report**).	Vol 4, Tabs 72-74 Vol 1, Tab 19: E 74657329
23 March 2020	COVID-19 lockdown commenced. Third ROSH report of police attendance on 19.3.20 screened in for "inadequate basic care: hazardous living conditions" with <72-hour response time and transferred to Auburn CSC. [redacted] decided to keep [redacted] home from school. Contact with FFT became by telephone only.	Vol 4, Tabs 72-75 Vol 1, Tab 23

Date	Event	Brief reference
	During lockdown, [redacted] observed increase in [redacted] alcohol consumption.	
24 March 2020	School counsellor emailed FFT indicating [redacted] decision to keep [redacted] home for the term and suggested "they may both benefit from continual support by an external agency during these uncertain times".	Vol 5, Tab 90
27 March 2020	FFT made a ROSH report on basis of main concern neglect, and also [redacted] mental health, lack of support and alcohol abuse to cope. The report was transferred to Auburn CSC with a <72-hour response time. (**Fourth ROSH report**). Report detail included "There are concerns around [redacted] mental health. He displays depressive symptoms…refuses to talk about his mental health concerns with a doctor to receive specialist treatment. [redacted] distrusts services, and he distrusts the Functional Family Therapist he is linked to. [redacted] mental health appears to be a barrier to engaging with services. [redacted] lack of mental health treatment, and the impact [his mental health] has on his daily functioning, places [redacted] at risk of significant neglect." [redacted] alcohol use as a coping mechanism, and difficulties controlling [redacted] significant challenging behaviours displayed also at school, were also reported. It is noted: "The caller has concerns that with [redacted] and [redacted] isolating, the risks to the family may increase, particularly as [redacted] will not be visible to the school or caller".	Vol 4, Tabs 76-77
30 March 2020	Auburn CSC case worker contact the FFT therapist working with [redacted] from Mackillop Family Services at request of A/MCW. DCJ advised that in-persons visits had stopped due to COVID-19 pandemic and that FFT had been trying to build trust with [redacted] but it was difficult due to his lack of engagement. FFT account of call: Discussion about recent events and new ROSH reports. FFT reports last in person appointment on 5 March 2020. FFT identifies possibility of mental health issues and difficulties this poses for safety parenting; also concerns about socially isolating and not attending school meaning [redacted] struggling to deal with behaviours day to day with no breaks.	Tab 95, pp. 41-43 Vol 2, Tab 38 Vol 4, Tab 80

Date	Event	Brief reference
	Identification of no safe adults other than [redacted] for [redacted] FT reported [redacted] not attending any service for himself, and unsure if [redacted] still attending Merrylands Counselling because of social isolation. Also advised ongoing behavioural and intellectual assessment by school counsellor, and repeated school suspensions. FFT encouraged allocation of the case within DCJ in order to have more services involved. DCJ account of call: FFT reported face to face visits stopped and counselling by phone for two weeks. Predominantly working on gaining trust, by working with [redacted] to form a relationship with the school. FFT is using phone sessions to check in and provide support for [redacted] mental health. FFT reported attempting to create safety plans in light of repeated running away. Advised difficulty in this because of lack of engagement by [redacted] Advised that [redacted] is currently home from school until next term.	Tab 95, pp 43 and 131. Vol 4, Tab 81, pp 9-10.
1 April 2020	Department of Education confirmed [redacted] meets criteria of "Mental Health Problems" for purpose of disability consultation.	Vol 5, Tab 90, pp. 12-15
3 April 2020	DCJ Auburn A/MCW recommended in email to A/MCS closing the third and fourth ROSH reports. States "I do not recall the rationale behind my recommendation to close the reports, however it was likely to be based on other competing reports and because FFT had been trying to engage with [redacted] that I was recommending closure".	Vol 2, Tab 38 at [28]
6 April 2020	FFT last phone conversation with [redacted] to check how he was going. Amongst other matters, the FFT therapist checked on how [redacted] was going at home – [redacted] said "that they are doing okay", and that they had borrowed a computer from school so that [redacted] could complete work "however she will mostly go on YouTube instead of doing her work". The FTT therapist's file note records: "I asked [redacted] how he was doing with everything at the moment and he expressed he is okay and had been having lay downs and naps to have some me time and have some space. I sequenced when [that] is happening while he is upstairs by asking questions such as what does [redacted] normally do, does she sometimes get up to	Vol 5, Tab 95, p. 32, 130

Date	Event	Brief reference
	mischief since your upstairs to see if we could discuss a behaviour pattern however [redacted] me that [redacted] has been doing well and will just come see him if she needs something".	
7 April 2020	DCJ Auburn A/MCS peer reviews the A/MCW recommendation that the ROSH reports made on both 21 March and 27 March 2020 be closed as part of DCJ's Triage Assessment Mandate; disagrees and recommends to add to case list at next Weekly Allocation Meeting ("WAM"). Stated "I…considered that the risks for [redacted] were increasing and that the family needed to be allocated to a child protection caseworker for further assessment and intervention. I held concerns that [redacted] was no longer engaging with FFT and [redacted] behaviour seemed to be escalating." This rationale is recorded in DCJ records on this date as: "There's a lot of worries been expressed over several months and while FFT were seemingly engaged with the father, it was ok for us to close. I am worried about the recent statements the father has made about FFT and the limited work FFT have been able to do. There's a further vulnerabilities for [redacted] in terms of her behaviours".	Vol 2, Tab 37 Vol 4, Tab 81, p 10
8 April 2020	Further review by DCJ Auburn A/MCW with agreement to list at WAM (in 7 days) and for triage to complete a Triage Assessment Form for the family outlining all DCJ records and reports. Text message exchange between FFT and [redacted] checking nothing required before long weekend. Both ROSH reports are referred to the next WAM at Auburn CSC on 15 April 2020.	Vol 5, Tab 95, p. 130 Vol 4, Tab 81, p 10
9-13, 15 April 2020	FFT therapist on leave.	Vol 5, Tab 95, p. 130
10-26 April 2020	School holidays.	
12 April 2020	[redacted] called ambulance after concerns about [redacted] neck pain and breathing; appears to be an attempt to leave house isolation; taken to hospital.	Vol 4, Tabs 78-80

Date	Event	Brief reference
	ROSH report follows: screened in for risk of significant neglect with parental risk factor of mental health with a suggested < 10 days response. (**Fifth ROSH report**). Amongst other matters, this report noted that [redacted] came into ED with "unconcerning presentation and … has been medically cleared and is fine to go home". It also noted that [redacted] declined the opportunity to speak on her own (although father agreed to leave the room); [redacted] had wanted her father to stay. The report noted the father presented as "fine", was interacting appropriately with [redacted] and did not appear be inebriated (although file notes indicate the father has problems with alcohol) or substance affected. DCJ call to hospital at 1am on 13/4/20 for further information: reported "…nothing overly concerning about [redacted] tonight, but did say that he could see [redacted] appeared to be struggling with her behaviours and was quite open about feeling like he needed more support. Caller said that to him the situation with [redacted] seemed to be more about her feeling a little stir crazy at home due to the lockdown situation and wanting a change of scenery as opposed to putting on symptoms as a cry for help". DCJ record noted in respect of mental health that "paramedics raised concerns for father's mental health but did not particularise", and in respect of substance abuse that "previous concerns with alcohol use noted". Reported forwarded to Auburn CSC. Auburn CSC decision: to be reviewed at WAM. Analysis/rational verbatim as for 27.3.20 Fourth ROSH report.	
15 April 2020	DCJ Auburn CSC WAM meeting. Case allocated to Child Protection Team and allocated for a Field Assessment.	Vol 4, Tab 81 Vol 2, Tabs 37-38
16 April 2020	Text messages exchanged between FFT and [redacted] including his response "*doing okay, going stir crazy like most of Australia, hope you and your family are doing well*". FFT phone session scheduled for 1pm. [redacted] didn't answer, FFT sends text message at 2pm suggesting phone session on 17/4/2020. Email from A/CWM Auburn CSC to FFT advising matter allocated within Child	Vol 5, Tab 95 pp. 30-31, 130

Date	Event	Brief reference
	Protection Team for assessment. Stated: "The allocated worker [redacted] will be in touch with you. If you want to liaise with her, I would recommend to email her next week as she is not in this week."	
Friday, 17 April 2020		
Approximately 1.45am	[redacted] called his mother [redacted] stating [redacted] has run away and taken the house keys. She tells him to look under the trucks and asked if he had called the police. He says he hasn't because he was drunk. She observes he sounded very intoxicated on the phone.	Vol 1, Tab 23
Approximately 1.50am	[redacted] knocked on neighbour [redacted] door stating he had woken up to find [redacted] wasn't home and asks for her help. She agreed and they exchange phone numbers so they could contact each other if they found her, then separated and started looking in different directions.	Vol 1, Tab 25
1.52am	[redacted] called Granville Police Station stating [redacted] has run away.	Vol 1, Tab 23
1.54am	[redacted] contacted police reporting he has woken up to find [redacted] missing.	Vol 1, Tab 19: E 74045423
Approximately 2.00-2.50am	NSW Police attended [redacted] address. Officers include Sergeant Sommerville, Detective Inspector Mackay, Constable Nedelkovska and Constable Halls. General purpose search capacity dog and police helicopter also involved, and NSW Ambulance attend. Detective Inspector Mackay lead local coordinated search with dog handler. [redacted] is found hiding in the chassis rails of a large truck parked approximately 250m south of the home. He spends several minutes speaking with [redacted] who reported [redacted] was drunk and had yelled at her, reported she was afraid. Detective Inspector Mackay observed her to be malnourished and unclean. Detective Inspector Mackay and Sergeant Sommerville, with agreement/permission of [redacted] walked through the premises and observe cockroaches, dirty clothes, no real food. [redacted] reviewed by paramedics with no issues identified.	Vol 1, Tabs 7, 8, 11, 12 Vol 1, Tabs 32-1 and 32-4: Body Worn Video and Images

Date	Event	Brief reference
	Officers form the view that [redacted] was at immediate risk of harm and determine to exercise emergency removal power pursuant to s. 43 *Children and Young Persons (Care and Protection) Act 1998.* Rationale was the state of the premises, [redacted] intoxicated state, the absence of any other fit person to provide care, and [redacted] responses when she was found.	
Approximately 2.50-3.07am	Interaction between [redacted] and Sergeant Sommerville captured on body-worn video. Includes the following exchange: SS: "Okay. What I have explained to you already is that your daughter is being taken up to the police station because we have immediate concerns for her safety and welfare. Based on what we've seen in the house, based on the actions tonight and based on her reactions when we spoke to her. Department of Community Services will be contacted, and they will make an adjudication on where she goes from there. " BW: "I understand that, but with that said, a family member can act on my behalf to take my daughter way from my immediate care until FACS comes into play". SS: "No, she will go up to the police station and FACS will make the adjudication from there. If they believe that the person is nominated is suitable then that is fine, but until we get that call made that's not happening".	Vol 1, Tab 32-2
Approximately 3.08am	Police departed [redacted] address, with [redacted]. At the time of police departure, [redacted] stated "I'd rather fucking die than let my daughter go". Immediately following their departure, [redacted] called [redacted] stating police had taken [redacted] perceived him as "hysterically upset" and told him to remain calm and they would sort it out. Neighbour [redacted] hears [redacted] on the phone to his mother yelling and crying. In her statement, [redacted] stated "I could hear [redacted] asking his mother to go get [redacted]. He said "I don't know where they've taken her". I heard [redacted] say straight away "I'm going to kill myself, I just want my baby back"." She then heard "banging" coming from [redacted] home until just before 4am.	Vol 1, Tabs 32-2, 35 Vol 1, Tabs 23, 25-26

Date	Event	Brief reference
3.09am	[redacted] contacted [redacted] sister and asks her to attend to check on [redacted] sister is unable to attend.	Vol 1, Tab 23
3.10am	[redacted] sent text message to FFT stating "the police took [redacted] from me please help me".	Vol 5, Tab 95, p. 29
3.13am	[redacted] called Granville Police Station to find out what was happening with [redacted] informed [redacted] was on her way to police station.	Vol 1, Tab 23
3.14am	[redacted] called [redacted] still upset. Stated things like "I've failed. They have taken her" and "I'm going to kill myself". [redacted] could not calm [redacted] down. Approximately 3 minutes phone call duration.	Vol 1, Tab 23
3.24am	Following that phone call, [redacted] contacted Granville Police Station. Conversation between [redacted] and Constable Rostek. Constable Rostek then spoke with Sergeant Irwin and Sergeant Sommerville and determined to create Priority 3 'Concern 4 Welfare' CAD job.	Vol 1, Tab 23 Vol 1, Tab 10
3.30am	Constable Rostek created CAD 309838-17042020 as follows: "*Priority 3. Concern 4 Welfare (017) MERGE)"* CAD radio message: *"Inf stated pol were just at AA with PO [redacted] the PO called INF and stated "If I don't get my daughter back I'm going to kill myself" PO kept repeating this over the phone to the inf before hanging up."*	Vol 1, Tab 20
3.36am	[redacted] received a text message from [redacted] stating "Tell [redacted] I hate him and I will see him in hell". She replied "that's not the answer".	Vol 1, Tab 30
3.37am	[redacted] sent a text message to [redacted] stating "What's that about".	Vol 1, Tab 30
3.38am	[redacted] received a text message from [redacted] which said "I'm going to kill myself". She replied "that's not the answer".	Vol 1, Tab 30
3.40am	[redacted] received text message from [redacted] which said "[redacted]	Vol 1, Tab 30

Date	Event	Brief reference
	can't do anything" and then "By".	
3.41am	[redacted] sent a text message to [redacted] stating "What can't he and please don't".	Vol 1, Tab 30
3.43am	[redacted] received text message from [redacted] stating "Listen to bad child. Look after [redacted]. She replied "You're not a bad child we can worth this out. Call these people to talk to [redacted]131114 please." (Lifeline number).	Vol 1, Tab 30
3.50am	[redacted] received text message from [redacted] stating "Let her know I love her". She replied "Call them [redacted] talk to them".	Vol 1, Tab 30
3.50am	CAD radio message 309838-17042020: Sergeant Sommerville communicated on-air: "CMB13/next avail crew to make priority and let me know when theyre otw and ill head over".	Vol 1, Tab 20
3.53am	First report made by police to DCJ Child Protection Hotline (DCJ Record notes: Current location of child: at the police station). [This is a reference to Granville Police Station].	Vol 1, Tab 37 Vol 1, Tab 19, p 12 Vol 4, Tab 82, p 1
4.03am	[redacted] received text message from [redacted] with a photo of himself with a piece of hose tied around his neck and the words "I have nothing to live for". She replied "stop it".	Vol 1, Tab 30
4.05am	After receiving the photograph message from [redacted] called 000.	Vol 1, Tab 23
4.08am	Call Job details (CAD 309838 closed and merged into CAD 309881-17042020) *"Concern 4 Welfare (017)"* *"Dispatch code 25B03W. You are responding to a patient who has abnormal or suicidal behaviour. The patient is a 31-year-old male, whose consciousness and breathing is unknown."*	Vol 1, Tab 20
4.09am	CAD 309881-17042020 incident grade changed from 3 to 2.	Vol 1, Tab 20
4.10am	DCJ consultation with Triage Manager concerning screening; it was agreed to screen	Vol 2, Tab 36, LC-18, p 307

Date	Event	Brief reference
	in report of 3.53am for "symptoms of psychological harm, neglect, non-parent/carer available/willing to provide care, inadequate supervision and threat to kill/injure. Response priority recommended as "<24 hours referral to AHRT" being the After-Hours Response Team ("AHRT").	Vol 4, Tab 85, p 2
Approximately 4.15am	NSWPF officers arrived at [redacted] home and find [redacted] inside the unit at the bottom of the stairwell, unconscious and not breathing. NSWPF officers commenced CPR and continue until Ambulance officers arrived.	Vol 1, Tabs 13-16
4.45am	Call from DCJ to police to obtain further information on earlier report of 3.53am. Caller noted that since police had left with the child, the father had attempted to commit suicide. CPR in progress and it was not known if he would survive.	Vol 2, Tab 36, LC-18, p 307 Vol 4, Tab 85, p 2
4.27am	NSW Ambulance paramedics arrived and continue CPR.	Vol 1, Tab 1; Vol 3, Tab 54
4.50am	[redacted] loaded into ambulance.	Vol 1, Tab 1 Vol 3, Tab 54
4.56am	[redacted] reverted into potentially perfusing rhythm (cardiac arrythmia), weak carotid pulse recorded.	Vol 1, Tab 1 Vol 3, Tab 54
4.59am	Ambulance arrived at Westmead Hospital.	Vol 1, Tab 1 Vol 3, Tab 54
5.08am	Earlier report of 3.53am transferred by DCJ Helpline to AHRT. Matter allocated to a CW at 5.15am. CWs from AHRT onsite at Granville Police Station by approx. 6:15am.	Vol 2, Tab 36, LC-18, p 300 Vol 4, Tab 85, p 16.
5.17am	[redacted] pronounced deceased at Westmead Hospital.	Vol 1, Tab 1 Vol 3, Tab 54