STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Brett Andrew Walker
Hearing dates:	29 April 2024 – 3 May 2024
Date of findings:	13 August 2024
Place of findings:	Coroners Court of NSW at Lidcombe
Findings of:	Deputy State Coroner, Magistrate Erin Kennedy
Catchwords:	CORONIAL LAW – diagnosis of mental health condition – care and treatment provided, Community Corrections assessment prior to release on parole, service provision for parolee in the community, compliance with pre-release requirements, death in police operation, fatal shooting
File number:	2022/00203026
Representation:	**Counsel Assisting the Coroner**: Ms Maria Gerace SC, Instructed by Ms E Trovato and Ms L Carter (Crown Solicitor's Office) NSW Commissioner of Police, NSW Police Force ('NSWPF'): Mr A Mykkeltvedt of Counsel instructed by Mr C Norman (NSWPF Office of the General Counsel) NSW Commissioner of Corrective Services ('CSNSW'): Ms Alecia Wood and Ms Claire Dunn (Department of Communities and Justice Legal) Justice Health and Forensic Mental Health Network ('JHFMH'), Mr H Norris Lawrence Ave Methadone Program ('LAMP'), Ms T Berberian of Counsel instructed by McCabes Lawyers

Findings:	1. **Section 81 Findings:** a. **IDENTITY**: The identity of the deceased is Brett Andrew Walker b. **DATE AND PLACE:** The date of death was 9 July 2022 and the place was the intersection of Albert and Kinghorne Streets, Nowra, NSW c. **CAUSE**: The cause of death was multiple gunshot wounds d. **MANNER**: Mr Walker's death occurred as a result of being struck by bullets fired by a police officer who was at all times acting lawfully in the course of a police operation. a police operation.
Recommendations:	1. The following recommendation is made to The Commissioner of Corrective Services NSW: a. The Court's findings be provided to the CSNSW Quality Assurance Directorate for its consideration when undertaking its holistic review of offenders in custody and the community and specifically in relation to the examination of preparing offenders for release and managing of offenders with short or backdated sentences. b. That Correctives Services advise the Court of the outcome of the CSNSW Quality Assurance Directorate review specifically any changes to procedures or policies for preparing offenders for release and managing of offenders with short or backdated sentences.

Contents

Introduction

1. Mr Walker was 37 years old when he died as a result of injuries from a fatal police shooting on 9 July 2022. The shooting happened following a domestic violence incident where Mr Walker stabbed his then partner in the neck and another person who came to her aid while her young child was present. The police attended as he left the scene, they attempted to negotiate with him, attempted to utilize OC spray and taser, however he ultimately attacked one officer who then discharged his weapon.

2. Mr Walker had been released from prison just 23 days prior. He suffered from drug addiction and mental health issues for most of his adult life. He had been a regular recipient of Opioid Substitution Treatment (OST), usually in the form of methadone. Mr Walker had a criminal history for crimes of violence, including domestic violence, and offences related to his drug addiction. He was sentenced to multiple periods of incarceration during his adult life.

General Overview of Events Leading to Mr Walker's death

3. On 20 December 2021, while serving an Intensive Corrections Order, Mr Walker was arrested for fresh offences and refused police bail. On 8 April 2022, the Albury Local Court convicted and sentenced Mr Walker in relation to those offences which included Assault Officer in Execution of Duty (6 counts), Resist Officer in Execution of Duty and Destroy or Damage Property (2 counts) and he was sentenced to a term of imprisonment (aggregate) for 10 months (backdated to 20 December 2021) concluding on 19 October 2022 with a non parole period of 6 months commencing 20 December 2021 and concluding on 19 June 2022. Mr Walker was to be released from custody on parole on 19 June 2022.

4. The conditions of Mr Walker's sentence meant that CSNSW was aware that he would be released on 19 June 2022 immediately after he was sentenced (on 8 April 2022). As the release day became closer Mr Walker started planning for his parole, and decided that he wanted to relocate from Albury to Nowra, to move away from past bad influences and from an area where he was regularly coming into contact with the law. It appeared he was trying to make a decision to improve his situation. He tried to convince his son to join him from Albury, however his son decided that he did not want to be part of the ongoing drug use that he was concerned about.

5. Community Corrections NSW became involved, and arrangements were made at release for Mr Walker to access short term temporary accommodation, referral to agencies in Nowra, continued OST and likely referral to local drug and alcohol services.

6. Mr Walker left custody on 19 June and moved to Nowra as planned. He came very quickly to commence a new relationship with someone he met in Nowra, Ms Skye Cruickshank-Walker. He was known to frequent her residence and to stay there for periods of time. This was perhaps unsurprising given he had

no other long-term accommodation at that time.

7. Mr Walker continued his OST in the community and received his methadone dose on the morning of 9 July 2022. He also continued to use prescribed drugs including Pregabalin (prescribed for pain in this case) and illicit drugs including Ice. Mr Walker was observed to be paranoid, agitated and fidgety in the days before his death. This was most likely associated with his use of Ice, but he was also known to be agitated and erratic when drug seeking. The records also suggest this may have been his baseline manner of interacting.

8. On 9 July, Mr Walker became aggressive with his new partner Ms Cruickhank-Walker and cornered her in a shed. This happened while she was holding an infant. She was asked to put the child down. He hit her and attacked her with a knife, stabbing her in the neck. Her niece's partner, Mr Harley McKenzie went to assist and was also attacked by Mr Walker.

9. A call was made to 000 and NSW police from Nowra attended. Mr Walker left the Albert Street residence and walked up Albert Street. Attending officers called for Mr Walker to stop but he ignored their requests. Mr Walker told police to shoot him on a number of occasions. First attending officers called for further assistance and a car from Culburra LAC attended. Mr Walker moved to the corner of Albert and Kinghorn Street. Police attempted use of a taser but failed to subdue him. Mr Walker refused the further direction of police to stop, pulled out a large knife and ran towards one of the officers, Officer Saddler, who having engaged his gun, fired 7 rounds at Mr Walker. Mr Walker was dead at the scene.

The purpose of the inquest

10. The inquest for Mr Walker was a mandatory inquest, pursuant to s. 23(1)(c) and s. 27(1)(b) of the *Coroners Act 2009*. This is the case where a death occurs in the course of a police operation, as here. There are sensible reasons for this, but in particular to allow for an independent review of the surrounding circumstances of such death.

11. Section 81 of the Act requires that at the conclusion of the inquest that findings are recorded as to:

    a. The identity of the deceased;

    b. The date and place of his death; and

    c. The manner and cause of death.

12. The principal issue requiring examination for Mr Walker is the manner of his death, and that involved also considering his release on parole and reintegration into the community.

13. Recommendations may also be made as a result of the inquest process if they are necessary and desirable after hearing the evidence arising from the inquest.

14. Evidence was given at the hearing by various witnesses. Evidence was also tendered in the form of a very extensive brief generated by the officer in charge and his team, and contained within that brief were also witness statements, CCTV footage, body worn footage and taser footage, some of which was played at inquest.

Personal Background of Brett Walker

15. A reflection on the person who died is important at this point. The inquest covered mostly the incident surrounding his death and on some past dealings with the law to give context to what occurred. However, it is important to note that Mr Walker was previously a partner, a father, brother, son and grandson. He is missed by family and friends, particularly his grandmother who was a great support to him.

16. Brett Walker was born in Albury on 12 June 1985. His mother and father, worked full-time and so his maternal grandmother regularly looked after he and his brother, and continued to maintain close relationships with them into adulthood. She noted that Mr Walker's father was volatile and violent, and treated his wife and children in a terrible manner. There were episodes of domestic violence that the children witnessed. His grandmother was often listed as Mr Walker's emergency contact. He had a strong relationship with her in his life, and was always loving to her. However, she did see him behave in a violent manner to others. He would call her each week, even from prison and he told her he never wanted to take drugs again, he wanted to reduce his methadone dosage, and return to work as a boiler maker after moving to Nowra. He wanted his brother Daniel to move to Nowra with him.

17. After he was released he continued to call her, and told her about his newly formed relationship. Sadly, he called her just prior to his death, when he simply said "Nan" before the phone was placed on mute.

18. After finishing high school, Mr Walker completed an apprenticeship as a boiler maker. He worked in Albury for about four or five years. During this period, Mr Walker met his partner. They married and had a son. Mr Walker and his wife separated about five years later. Mr Walker went to live with his mother and father while his son remained with his ex-wife.

19. Mr Walker also had another relationship and had a daughter as a part of that relationship. They also separated, and his daughter remained with her mother.

20. His grandmother said that Mr Walker's brother suffered from schizophrenia, which was treated by fortnightly injection and she suspected his father who was a heavy drinker also suffered from mental health issues, undiagnosed. Mr Walker's grandmother did not suspect that her grandson had any mental health issues when he was a child. However, when he turned 18, he started using drugs and stealing his mother's prescription medication, oxycontin, and she also became aware from observation and from what she had been told that he

used valium, heroin and ice over years and also Kalma for anxiety. He was on methadone. However, at no point did Mr Walker discuss what he used with his grandmother.

Mr Walker's Drug Use and Mental Health

21. Mr Walker was known to be mistrusting in his engagement with medical and allied health professionals. A previous partner observed Brett was fearful of police and that he thought the police were trying to set him up or kill him and spoke about this regularly. Mr Walker would always ensure police had their vest cameras operating when they spoke to him." His son stated, 'My father hated the police and was fearful of them. He thought the police were trying to set him up and put him back in prison. Even when he was straight he thought the same thing".

22. Mr Walker expressed recurrent themes that people were trying to set him up or kill him. In the days before the critical events, he told his son that people were trying to set him up. He accused his new partner and friends of trying to set him up. Over the years he and others reported that it was believed this paranoia was a response to drug use however, those treating him queried whether he had an underlying mental illness or schizophrenia. Mr Walker was personally resistant to this idea and the records do not contain any formal diagnosis of schizophrenia.

23. Mr Walker's long term treating doctor, Dr Martin, received a report made by Albury Wodonga Health in 2016 which stated that Mr Walker was "excessively paranoid due to methamphetamine use to the point of destroying many objects in the family in search of bugs." They also reported that he was suffering delusions that people were out to get him.

24. Mr Walker had been diagnosed with substance use disorder, antisocial personality disorder and anxiety. He was diagnosed by Dr Bhavanishankar in 2019, who noted 'Brett has suffered from running psychosis due to methamphetamine abuse and has been hospitalised due to psychotic symptoms. He currently denies any psychotic symptoms. He reports low mood, anxiety, panic attacks he also reports lack of motivation and periods of agitation. Brett clearly presents with symptoms of a severe benzodiazepine dependence and drug seeking. Brett also has antisocial personality disorder and suffers from anxiety".

25. Over many years of engagement with medical professionals and hospitals, there were very few other documented psychiatric assessments, or any continuous psychiatric evaluation to clarify his psychiatric history and onset of psychiatric symptoms. He had been prescribed medication and offered treatment but did not successfully engage with any treatment. He had a history of self-harm in the form of self-cutting.

26. Mr Walker also had a documented history of anxiety and his GP commented that he was often difficult to engage. His regular GP in Albury had records of attendances from 1997 to April 2021.

27. He engaged with Albury Wodonga Health and Nolan House in the period 2007 to 2017 in relation to drug and alcohol issues and opioid treatment services. His engagement however was intermittent and was affected by housing and relationship issues, requirements for engagement through Probation and Parole, OST and drug seeking. Short admissions occurred from time to time as a result of drug intoxication. Treatments provided included methadone and counselling. Records going back many years identify the use of crystal methamphetamine and paranoia/paranoid and delusions/possible hallucinations/erratic behaviour allowing the conclusion to be drawn that Mr Walker was a very long term drug user.

28. The records support the following observations by DCI Walpole:

> *"From 2008 until his death, further case file notes indicate dozens of appointments being made with various health professionals including psychiatrists, drug and alcohol counsellors and opioid intervention specialist. According to the file notes obtained from these health professionals Brett WALKER rarely attended. Many of the file notes indicate the rare times he did attend was to obtain prescriptions and authorities for "takeaways" relating to the Methadone program he was on" and "During the later years (2016 until his death) file notes indicate he was banned from attending a number of clinics due to his aggressive and intimidatory behaviour. File notes indicate Brett WALKER would arrive without an appointment and become abusive to staff. He would also demand certain scripts and when denied would become aggressive in nature."*

29. Mr Walker had difficulty coping in the community generally. He had difficulty with managing interpersonal relationships, managing his emotions, managing his time and relating in a meaningful way to services.

The Doctors at Lavington

30. The local GP practice regularly prescribed Mr Walker pregabalin (Lyrica). It was prescribed for neuropathic pain, for a left shoulder injury at some point, the records do not document a date when these injuries occurred. It appears that he was misusing pregabalin. Records from Gadens Medical Group document a warning in their records: seeks drugs, *no script for Valium, abusing Lyrica, multiple visits in 2016 using brother Daniel Walker's identity for Lyrica scripts*." The Gadens Medical Group records show he last attended the Centre on 1 December 2017 seeking Lyrica, and was refused, and it was documented that he was trying to use his brother's identity.

Mr Walker's Criminal History, Imprisonment and Engagement with Police

31. There were extensive records obtained from Corrective Services NSW, NSWPF Computerised Operational Policing System or "COPS" and NSW Justice Health given Mr Walker's interaction with the law over many years, and these indicate the start of a consistent pattern of offending from age 19.

32. Between 2004 and his death, Mr Walker was arrested and charged multiple times with drug, traffic and assault offences. Many of the assault offences involved domestic violence against a partner. In many of these cases AVO's were frequently breached. Brett was charged on 42 occasions between 7 February 2004 and 20 December 2021, with convictions for drug, property, assault, weapon and traffic offences, as well as contravening Domestic Apprehended Violence Orders and stalking/intimidating with intent to cause fear of physical harm.

33. Mr Walker had several periods of incarceration as discussed, and while under supervision of Probation and Parole, he was referred to or engaged, with doctors, clinicians, drug and alcohol case workers and opioid treatment specialists over the years.

34. NSW Police Management Custody Records on 20 December 2021 state Brett was aggressive, seriously affected by drugs, with cuts to his torso and limbs due to violent wrestles, and due to aggression he needed to be escorted by multiple officers. After arrest, Brett needed to be sedated for compliance after a lengthy struggle where police needed to use several appointments in an attempt for the deceased to comply.

35. He demonstrated behavioural issues within the custodial setting. His custodial history includes multiple instances of breaches of discipline in custody including violence, involving possession of a knife and other prohibited goods in custody, assault, and failures to comply with routines and directions and in relation to failing to provide urine samples. By way of example, on 17 December 2020, and whilst in custody, the deceased was observed to assault another inmate, refused directions from officers and then assaulted another inmate. This information relating to his violent behaviour and non compliance was known to Community Corrections.

Community Corrections Preparations for Mr Walker's release

36. On 1 June 2022, a Correctives Services NSW Risk Mitigation Plan was requested in anticipation of Mr Walker's release to parole. The plan was finally completed on 16 June 2022. Select parts of the assessment and risk mitigation plan were:

    a. He was to relocate to Nowra and the proposed address was crisis supported accommodation Link2Home. There were 'nil identified' risks to any proposed co-residents.

b. Protective factors were identified as being the relocation to the Nowra area to minimise his pattern of offending behaviours by removing himself from risks known to him in the Albury area. It was also identified that he had indicated a willingness to participate with community service work and regular contact with services and treatment providers readily available in the area.

c. In relation to past violence and aggression they identified his extensive criminal history pertaining to violent and domestic related offences from 2004 with multiple convictions related to resist and assault police. His inability to appropriately regulate his emotions also presented as a pattern in his offending. They identified that he had negative insight to victim and noted 2 x AVO. The Parole Unit also recommended strategies to mitigate this risk including referral to various services and programs and to contact Police to monitor compliance with ADVO.

d. In relation to his mental health factors, it was noted that he had a reported history of mental health issues relating to depression and anxiety and attempts of self-harm. He advised officers during interview that when he was feeling anxious or depressed he would self-medicate with illicit substances that would result in drug induced psychosis. Mr Walker advised that after the passing of his mother in 2013 his mental health declined, and with the passing of his father it deteriorated further. The officers noted that he had previously been medicated for mental health concerns but that he was not regular in taking his medications, resulting in further offending behaviours when in the community. It was also recorded that Mr Walker reported that he suffered from substance use and antisocial personality disorders. The Parole Unit recommended referral to Community Mental Health for counselling, to a GP for mental health assessment/treatment/care plan, and to a psychologist for assessment, diagnosis, treatment. Recommendations were made for referral to services and for monitoring of medication.

e. In relation to illicit drug use, it was observed that his criminal offending centred around his extensive history of methamphetamine use, which commenced in early teens. Mr Walker reported that he thought the drug use contributed solely to his aggressive behaviours. At the time of the index offence, he stated he was highly affected by Ice. The Parole Unit recommended referral to Odyssey House NSW Centre for drug rehabilitation and treatment, to Pathways Shoalhaven – Salvation Army Support Group Services or Community Health AOD, random drug testing to monitor compliance, and programs. It was stated that a referral to Pathways Community Drug and Alcohol Service in Nowra should occur with the appointment made in the first week of release, and recommended random and targeted drug testing and intervention for managing cravings and achieving goals.

37. The Plan also summarised Brett's risks and strategies to mitigate the risks:

Risk factors specific to the address	Priority	Strategies
Use of illicit Substance	H	Referral to community Based Drug and alcohol program – Direction to cease all drug use if required and random drug testing.
Mental Health	H	Referral to GP to obtain MHCP to gain access to community psychology for a mental health review and treatment options.
Violence/Aggression/DV	H	Referral to Anglicare Men's Behaviour Change Program Referral to Community Corrections DFV Program
Stability of accommodation	M	Referral to John Purcell House referall to Co-existing disorders Program for support and connection to housing services

Community Assessment

38. On 15 June 2022, Community Corrections Officer Darren O'Keefe at Nowra documented on the plan his view that the plan adequately mitigated the offender's risk factors, considering that Mr Walker would be located a long distance away from his victim and past anti-social associates, and would have access to further supports and services to address his criminogenic needs that are not available while he is incarcerated.

39. On 16 June 2022, Senior Officer Kylie Eager, A/Service Manager recorded on the Plan that while placement in temporary accommodation is not ideal, Mr Walker's desire to move aware from the area he has continually offended in, to start a new life, is positive. Ms Eager stated that there are services available to address his risk factors and he will be a significant distance from the victim adding to her safety.

40. On 16 June 2022, Parole Unit Officer Amy Westblade documented that the risk mitigation plan would be used for statutory release.

Release on Parole on 19 June 2022

41. On 19 June 2022, Mr Walker was released on parole from the South Coast Correctional Centre and he was given a number of documents relevant to the terms of his parole, including copies of the Local Court's order and his Parole conditions, a copy of the Community Correction Order previously made on 11 November 2021 and a copy of Final ADVO orders. Mr Walker acknowledged the Parole reporting arrangements immediate on release which included:

    a. Mr Walker was to be provided 2 nights temporary accommodation at Salt Care the Pines at Nowra paid for by DCJ Housing.

    b. He was to contact the Southern Centre Community Housing at Nowra to discuss further options presenting ID, proof of income and bank

statement.

c. He was to present for his first Community Corrections appointment with the Intake Officer at Nowra Community Corrections Office between 10.00am and 12.00pm on 20 June 2022.

42. Mr Walker was given $463 in cash on release and was given back his paperwork, including his birth certificate and Medicare Card. A taxi was booked to take him to Salt Care, the Pines in East Nowra.

43. Mr Walker was to attend the Lawrence Avenue Methadone Clinic (LAMP) at Nowra for his ongoing OST.

44. The events leading to his death occurred just 23 days later.

The Events Occurring After Release

45. On 17 June 2022, and before his release on parole, he met with RN Annie Lewis, Registered Nurse and Connections Transition Coordinator, Justice Health and Forensic Mental Health Network. It was evident that living arrangements were important to Mr Walker, and he was actively raising his concerns before his release. RN Lewis recorded that CCO were still to arrange temporary accommodation at that point.

46. The evidence suggests that although arrangements were made intending for temporary accommodation after his parole, he did not access both of those nights accommodation, which largely remained unexplained at hearing. This fact distressed Mr Walker.

47. On 22 June, RN Annie Lewis contacted LAMP as she had not heard from Mr Walker since his release. In a phone call from Siobhan at LAMP, RN Annie Lewis was advised that Mr Walker had attended for methadone dosing the day before and that he was quite emotional as he had only had accommodation for the last night, presumably therefore on 20 June.

48. Siobhan told Annie Lewis that she had provided information about Homeless Hub and local food charities and that she would try and get his phone number for RN Annie Lewis.

49. Ms Daniels from Community Corrections noted that he reported as required on 22 June 2022. She observed that although neatly groomed, he was chaotic, with bags overflowing. He was preoccupied by finding shoes, although he had shoes. He reported being homeless. It seemed his basic needs weren't being met at that time, and as a result it is unsurprising that at that time his focus was not on rehabilitation. There was evidence of disorganization.

50. RN Lewis recorded her involvement with Mr Walker and it can be summarized as follows:

    a. She met with him pre-release on 17 June. She discussed the Connections treatment plan with him and advised him of the

arrangements at LAMP Nowra clinic for dosing for 20 June and gave him the address. Local charities were discussed to allow him to access support, material and food. He was informed of a medical appointment at Worrigee Medical Centre on 24 June at 9.00am. She emailed the medical centre with the gaol release summary, medication charts and a cover letter. Mr Walker said it would be easier to go to Grand Pacific Health and said he would call her on Monday and give her a mobile number.

b. On 22 June, she had not heard from Mr Walker since release. She emailed LAMP and Nowra Community Corrections Office seeking information and had intended to call both to see if they had a mobile number for him.

c. On 22 June, she received the call mentioned above from Siobhan. Siobhan advised that Mr Walker had not reported to Community Corrections as required. She then provided a mobile number for Mr Walker. RN Lewis then called Mr Walker on the number provided and left a voice mail asking him to contact her but he did not call back.

d. On 23 June, she attempted to call Mr Walker again, but he did not answer. She left a message to call her as the Connections Transitions Coordinator and provided her mobile number. RN Lewis also sent a text message reminding him of his GP appointment at Worrigee Family Medical Practice.

e. On 24 June, she received a call from Nick at LAMP, telling her that Mr Walker had not attended for dosing or a scheduled nursing assessment. She again called Mr Walker but he did not answer and a voice mail was left for him and text messages were also sent, however no response was received.

f. On 27 June, she sent a text to Mr Walker asking him to call and said she would contact his grandmother if she didn't hear from him. Later she received a call from him using a LAMP phone. Mr Walker told RN Lewis her that he had issues with his own phone. RN Lewis met with Mr Walker at Subway at midday and bought him lunch. They sat together for 30 minutes, and Mr Walker told her that he hadn't been able to secure housing. He asked if she would go with him to Southern Cross Housing to talk about accommodation.
She went with Mr Walker to Southern Cross Housing but he had missed his appointment at 11.00am that day and they could not see him. He had apparently missed several appointments that week with SCH. He became teary and tried to explain why he missed appointments, when told he needed an appointment and to attend when scheduled, Mr Walker became aggressive, speaking loudly and swearing. He agreed to go to Safe Shelter. They walked to Safe Shelter but Mr Walker said that he would not stay there as it was across the street from the Police Station. He said that no one was helping him and they were setting him up to fail.

They then walked to Nowra Community Corrections Office in Kinghorne Street. RN Lewis observed that Mr Walker's speech was rambling and at times it was difficult to keep up with his conversation and he moved from one topic to the next and would lose his train of thought. He presented as paranoid and thought people were deliberately trying to make his life difficult by not giving him housing, food and appointments. He accused a stranger of taking his phone but he had previously said he had 'hocked' it. RN Lewis asked if he wanted to go to a hospital for a mental health assessment, but he said no. Mr Walker said that he would have access to a phone tomorrow and would call.

g. By 1 July, Ms Lewis had not heard from Brett since 27 June. She checked and records confirmed he attended his appointment with Community Corrections on 29 June and that he had been to LAMP for dosing. No updated phone number was available to Community Corrections and she could not contact him further.

h. By 8 July, she had still had no contact from him. She checked OIMS and there was an updated address (Albert Street residence with partner Skye) and an updated phone number. She called but there was no answer and she could not leave a message.

i. RN Lewis tried to contact Mr Walker again from 11 July, not knowing at that time that he was deceased.

51. Community Corrections Officer Koklas was allocated as Mr Walker's supervising officer, and at the meeting on 29 June, Mr Walker disclosed recent ice use, the previous week. and he appeared drug affected.

52. He next reported to Community Corrections on 7 July 2022, just two days prior to the events leading to his death. He was with Ms Cruickshank-Walker and introduced her as his partner. There were discussions about difficulties with drug and alcohol use, domestic violence and participation in the EQUIPS program. There was discussion about craving management. Mr Walker disclosed that he was struggling with his mental health, and being back in the community and a referral was made to New Access for access to mental health services.

53. In relation to his financial situation, it was very limited also. He had been given $463 at the time of his release from prison. Investigators identified a NAB account which showed:

a. As at 30 June 2022, he had no funds in his NAB account.
b. On 5 July 2022, a Social Security payment of $304.96 had been deposited
c. On 5 July the he withdrew $250.
d. On 7 July a cash deposit of $175 was paid into the account.
e. On 7 July, there was a withdrawal of $150.
f. On 8 July, there was a withdrawal of $79.00 Leaving an account balance of 0.96c.

Investigations into the Critical Events on 9 July 2022

Evidence of mental state in the period preceding the critical events

54. At the time of his death, the deceased was receiving daily doses of Methadone from the Lawrence Avenue Methadone Program ("LAMP"), which forms part of the Illawarra Shoalhaven Local Health District (ISLHD). The deceased last attended the LAMP at 10:07am on 9 July 2022 and received 105mg of Methadone. LAMP staff noted the following concerns about the deceased's mental health:

    a. 27 June 2022 - Cathleen Curran (Nursing Unit Manager) noted: 'Demonstrating paranoid presentation at commencement of interview which settled somewhat with therapeutic engagement and some trust established. Brett was able to describe recent and past situations that may have contributed to his paranoia'.

    b. 30 June 2022 - Leon Richards (CASMO) - 'Does have some paranoid distortions which he has insight to, he thinks it is the hangover from ice use about 10 days ago'.

    c. 8 July 2022 - Siobhan O'Doherty (Registered Nurse) - 'Possible paranoid ideation noted by staff'.

55. Mr Walker appeared to experience increasing paranoia and erratic behaviour in the days before his death. Mr Harley McKenzie who resided at the same address as Mr Walker and Ms Cruickshank-Walker later told police that Mr Walker became really paranoid and thought Mr McKenzie and the others at the residence were setting him up and that police were going to come and get him. Mr Walker was searching peoples phones.

56. Ms McPherson (Mr Walker's ex-partner) said that at 4.30pm on 8 July 2022, Mr Walker called her phone to speak with his son, who was living with her at the time. His son spoke with Mr Walker on loudspeaker. Mr Walker appeared paranoid, was talking fast and appeared agitated. He referred to people trying to do things and was asking his son why 'they' would be going through his bags with gloves on and only taking his letter. Ms McPherson says she does not know what letters he was referring to. Mr Walker's son noted that his behaviour was indicative of when he had used drugs in the past.

57. Two residents were also living temporarily in the shed at the Albert Street residence. Ms Hubbert thought Mr Walker was concerning and she described unusual behaviour including his repeated entry into the shed at night when she was sleeping and her waking to find him standing over her. He was described as "a very paranoid person", a user of drugs and that he would inject himself. Mr Walker's behaviour worsened when he was using and he would accuse people of spying on him or recording him and "setting him up". Ms Hubbert said that in her view Mr Walker was very controlling of his new partner and that she appeared to be afraid of him. Ms Cruickshank-Walker told her that Mr Walker was acting very weird and that she had asked him to leave several times but

he hadn't. There was further evidence that was consistent with this from Ms Hubbert's partner, Mr Bell.

58. A further witness admitted to sourcing the drug ice for Mr Walker.

59. Mr Walker had a prepaid mobile account with Optus. Contacts made through this number were obtained by investigating police. The contacts included a number of people whom the investigator identified as known to police for drug use/supply, and the investigator concluded from the frequency of contact that the deceased was "likely sourcing /using drugs prior to his death based on the frequency of his contact with suspected drug suppliers".

The Critical Events

60. The critical events are summarised in the statement obtained from Detective Sergeant Lovell together with stills taken from the only BWV available. The summary was based on Detective Sergeant Lovell's review of the investigations, interviews, statements and records.

61. Senior Constable Collier was an experienced officer. She was working with Probationary Constable Godfrey in a marked car. They arrived and engaged with Mr Walker. Senior Constable Collier drew but did not use her OC spray during the incident. She activated her body worn footage which captured the events.

62. She also called for backup, she was obviously a very respected officer, because the comment was made that if she called for assistance, they responded knowing the situation was very serious if it was one that she couldn't resolve.

63. Constable Richards and Constable Saddler were also uniformed officers and arrived to assist. Constable Richards drew her Taser and discharged one cartridge at Mr Walker. One of the taser probes struck Mr Walker, but the second probe did not. The taser had its own footage.

64. Mr Walker was armed with a knife in his right hand and was also holding two mobile phones in his left hand. He approached Constable Saddler with the knife raised in front of him. Constable Saddler drew his firearm and moved backwards away from Mr Walker, however Mr Walker continued to move towards Constable Saddler, who then discharged his firearm and stumbled backwards. He fired 7 times. Mr Walker ended up on top of Constable Saddler.

65. Constable Saddler noted in his interview "he didn't look scared of that I had a firearm aimed at him. He didn't look like he wanted to run away. He um, just looked dead at me then started um, charging at me with the knife."

66. He told him to drop the knife and believed that he would be stabbed. He believed that Mr Walker was trying to kill him, or at least, cause him serious injury. Mr Walker's expression didn't change as he approached Constable

Saddler, even when shots were fired Constable Saddler saw no expression or sign that he had registered the shot.

67. I accept the following summary of the timing of the events:

    a. At 12:22pm the first call to 000 was made.

    b. At 12.25pm Senior Constable Collier and Probationary Constable Godfrey arrive at the scene.

    c. At 12.26pm Constable Richards and Constable Saddler arrived at the location.

    d. At 12.26, Mr Walker said to PC Godfrey (2-3m away) “Shoot me you cunt”. SC Collier said to Mr Walker “Get on the ground”. Mr Walker did not comply.

    e. 12:26:24, Mr Walker said, “Shoot me mother fucker” and removed a knife from his pants. Constable Richards and Constable Saddler exited their vehicle. PC Godfrey yelled that Mr Walker had a knife.

    f. 12.26.26, SC Collier says “He’s got a knife”.

    g. 12.26:27, Constable Richards draws her Taser and yelled “Taser, taser, taser”.

    h. 12:26:26, Constable Saddler had his firearm drawn and said, “Get the fuck down”.

    i. 12:26:29, Mr Walker turned and ran towards Constable Saddler. Someone else yelled “get on the ground”.

    j. 12:26:29, Constable Richards discharged her taser. Mr Walker is moving. The taser does not immobilise Mr Walker.

    k. 12:26:31, Constable Saddler discharged his firearm (not captured on BWV as it occurs out of view).

    l. 12:26:32, Constable Saddler reappeared on BWV and was moving away from Mr Walker, who was following him. Mr Walker had his knife out and raised and was moving towards Constable Saddler.

    m. 12:26:33, Constable Saddler tripped backwards over the northern gutter of Albert Street and fell onto the kerb. Mr Walker fell towards and somewhat on top of Constable Saddler, who discharges his firearm as Mr Walker fell.

    n. 12:26:36, Constable Saddler moves away from Mr Walker and stands up with his firearm covering Mr Walker, who collapses face down on the Northern kerb. Mr Walker was unresponsive.

o. At 12.27pm, paramedics arrive. Mr Walker was in cardiac arrest with penetrating gunshot wounds. Resuscitation efforts started. At 12.32pm, Mr Walker was unconscious and pulseless, and his injuries were deemed incompatible with life.

p. The likely time between Senior Constable Collier and Probationary Constable Godfrey arriving on scene and Mr Walker being shot/non-responsive was 1 minute and 38 seconds.

q. The likely time between Constable Saddler and Constable Richards arriving on scene and the deceased being shot/non-responsive was 14 seconds.

r. Time between Constable Saddler and Constable Richards arriving on scene and the first shot being fired was 7 seconds.

68. A number of witness accounts corroborated the above timeline and added observations of what appeared to them to be happening.

a. Ms Skye Cruickshank-Walker was attacked by Mr Walker and stabbed with a knife. She told police that as of 9 July, she had been in a relationship with Mr Walker for a couple of weeks. She was aware he was on the Methadone program and up until the 9 of July had not been subject to any domestic violence incidents with the deceased. On 9 July Mr Walker had gone into Nowra to get his dose at the Methadone clinic and on returning to her unit in Albert Street, "He like, he's already left, to go get his methadone, and when he come back, he was just, I don't know, acting weird. And kind of freaked me out, wouldn't let me out of the house." Family members were trying to break into the house to get to her, but Mr Walker would not let them in. She managed to run into the outside shed with her baby, but Mr Walker followed her in and locked the door and barred her from leaving. She states "And then he pulled the dryer over towards the door and was telling me, he's like, put the baby down, put the baby down. Like screaming at me with the knife and as soon I put her down, and like, went to sit her in the pram, that's when he come over top of me. And that's all I remember " and "When I went to sat her in the pram, he come over top of me and then, but that was it like, that's what I remember. And then I got up and then got hit in the head." Ms Cruickshank-Walker acted quickly to care and protect her child and seek help.

b. Mr Richard Futcher recalled that Ms Cruickshank-Walker went to his unit saying that she had been stabbed. She was bleeding from the neck and had a young child with her. He made a call to 000. Later he saw the police walking away from a male, he was carrying something but didn't know what that was at the time. The male was walking at the police, he noted that he "was really coming for them, I don't know who the man is that had something", the police had him surrounded, they walked all the way from the corner of Bundeena to the corner of Kinghorne, but he

couldn't hear what was happening. He saw one of the police officers walking away from the man with the weapon, as he was moving the police officer looked like he tripped over on the gutter, the officer was down on one elbow, the male was leaning towards the officer and he saw the officer shoot the man.

c. Mr Raymond Cattermole saw Mr Walker walking up Albert St. Two police officers followed him and he heard the police say, “put it down” or “get down”. Mr Walker started running. He stopped just past him and mumbled something but he “couldn’t understand it”. He noticed that Mr Walker had blood on himself, including his head and down back of his neck. He saw Mr Walker interact with the police, and then saw him move towards the police and heard the shots fired. At points his recollection differed from the footage, which is understandable given the very stressful and fast event that he watched unfolding in front of him.

d. Mr Harley McKenzie was a resident at the Albert Street residence and was in a relationship with Ms Casey Walker. He went to help her Aunt, Ms Cruickshank-Walker. He found that Mr Walker had barricaded her in the shed. He booted the door in about 20-odd times, however Mr Walker kept pushing it shut. Then Mr Walker moved the dryer over and tried barricading the door with it. Mr McKenzie managed to kick through the door and got into the shed to see Mr Walker standing over Ms Cruickshank-Walker. There was blood coming out of her neck and she had her baby in her arms. He punched Mr Walker numerous times in the back of the head, trying to knock him out and believed that he split him really bad across the back of the skull and shoved him out the door. Mr McKenzie suffered puncture wounds to his mandible and an injury to his hand during the struggle. He later heard gunshots. Mr McKenzie also showed great bravery in going immediately to the aid of Ms Cruickshank-Walker and trying to assist her and her child from Mr Walker.

e. Mr Raymond Dolman and Ms Cheryl Dolman gave accounts consistent with the police accounts from the time of arrival of police when they first came across the incident. Cheryl Dolman says she saw a male police officer get out of the passenger side of the police car. He walked to the back of the police car and kept walking towards the intersection of Kinghorne Street and turned to face South. She saw the male pull out a knife from behind his back with his right hand and it was a large knife and reminded her of a butcher's knife. His face looked very aggressive and angry. He held the knife in his right hand with the handle in his hand and the blade sticking up.

   Ms Dolman saw the male then run at the male police officer who started backing away. She also saw a thin white line going through the air towards the male as he ran at the male police officer which she thought was pepper spray. The male didn't stop when he started to bend over and grab his face but kept running at the first male police officer. She heard three "pops". The male kept running towards the first male police

officer who tripped over at this point and fell on his back. The male continued toward the first male police officer and fell on top of him. The first male police officer quickly got out from under the male. The male was lying face down with his head over the drain and his body on the road.

f. Ms Mary Bloxsome was a witness to only part of the events. She saw the police and was concerned about 2 children in the vicinity. Ms Bloxsome was very concerned about the children and kept her eyes on them. She saw Mr Walker jumping up and down and it seemed to her that he was about to run at police. She then heard gunshots.

g. Two children also gave an account. One said that he heard Mr Walker talking to an old man and asking for help and then threatening him if he didn't help. "We were about 30 metres away when the other cops pulled up. There were two more cops who showed up, so four cops in total. The first two cops chased the man to the corner. The man stopped and I saw he had a massive weapon, like a machete, it was a massive knife thing. It was bigger than a school ruler (30cm). He had it in his left hand, holding it near his side. He ran at one of the police officers, a male. The police tasered him at first, he didn't fall, he kept running, running straight at the male cop. Then it got more serious, he raised the knife first in his left hand then into his right hand and he tried to stab the male cop and that's when they all shot at him. I heard about 12-gun shots. The man fell, the police officer fell backwards onto the ground and the man fell on top of the police officer."

   The second child said: "When the cops went after this man, this man walked up to an old man and started talking to the old man, but I couldn't hear what they were talking about. After this man was talking to the old man the man went further up the street towards the corner. There was Police in front of this man and behind him. When this man was walking towards the corner the Police were yelling at him, "Stop come here" and telling him to calm down. This man got angry and pulled out a big knife. I thought it was a machete. It was longer than a 30cm school ruler. This man started running with the knife up to the corner and the knife was beside him. I saw the Police officer trying to grab at the man and the man tackled one the male Police officers and this was near the corner and the male Police officer got the man off him and the man started to run towards where me and my brother was. I started to panic so I ran down the street away from the man and (my brother) was jogging behind me trying to watch it, but I wasn't watching it. I then heard some gun shots. It sounded like 10 or 11 shots. I looked back to see if (my brother) was okay and I then saw the man lying on the grass near the corner."

Critical Incident Investigation

69. Southern Region Commander Assistant Commissioner Cotter declared the death a critical incident.

70. A Level 1 Critical Incident Investigation was called and a Critical Incident Investigation Team (CIIT) formed. Detective Chief Inspector (DCI) Walpole assumed the role of Senior Critical Incident Investigator (SCII) and Detective Sergeant (DS) Lovell was part of the CIIT. Detective Acting Inspector Robinson from Professional Standards Command was appointed as the Reviewing Officer and Dr Gabrielle White and Lily Wozniak from the Law Enforcement Conduct Commission (LECC) acted as monitors of the CII.

71. The CIIT correctly and quickly identified the following Directly Involved Officers:

    a. SC Hayley Collier

    b. Probationary Constable Max Godfrey

    c. Constable Tyrone Saddler

    d. Constable Jessica Richards

72. Senior Constable Collier had activated her BWV during the incident and this was reviewed.

73. Witnesses to the events were identified, and interviewed, but no relevant CCTV was identified on canvass of the area surrounding the incident.

74. A further 6 officers were identified by the CIIT, and who each provided a statement to the CII:

    a. SC Fuller

    b. SC Harrison

    c. SC Heydon

    d. LSC Walsely

    e. SC Latimer

    f. SC Nethery.

75. An extensive investigation was undertaken gathering criminal history medical and hospital records, Corrective Services records, OST records.

76. It appears the CIIT attempted to investigate fully the events surrounding the Critical Incident and matters relevant to Brett's drug use, mental health, criminal history and events preceding the incident.

77. In DCI Walpole's opinion:

    a. The initial police response to this incident was appropriate and timely. It is his belief that no other viable actions were available to police at the time. It is also his view that the actions of police that day probably saved lives.

    b. During the investigation and in particular the interviews with some of the Directly Involved Officers, several minor training issues were identified. These issues involved mental health and taser training whilst the officers were trainees at the NSW Police Academy. The officers have received further training since leaving the academy. This issue was also brought to the attention of the South Coast Police District and any necessary remedial training that is deemed appropriate is being managed by that command's Education and Training Unit.

78. The opinions expressed by DCI Walpole are supported by the evidence.

Autopsy Results and Observations

79. Post mortem analysis of Mr Walker's blood was:

    a. Positive for the presence of crystal methamphetamine (Ice), and its metabolite, amphetamine.

    b. Methadone level of 0.96mg/L.

    c. Alcohol at a low level of 0.005g/100ml.

    d. Pregabalin at 5.4mg/L.

80. Dr Cala, Pathologist, undertook the autopsy reporting the cause of death as "multiple gunshot wounds" noting:

    a. Chest wounds (x 2) which injured the heart, liver, diaphragm, right lung and two right sided ribs. There was a right haemothorax with 800ml of blood in the right pleural cavity as a result of the gunshot wounds to the heart and right lung.

    b. A bullet wound to the abdomen which passed through the transverse colon, small intestine and left PSOAS major muscle.

    c. A bullet wound to the right forearm, right upper arm, and the dorsum of the left hand.

81. Medically, the most important wounds were the chest wounds which would have proved fatal even if no other shots were fired. Both chest wounds passed through the right side of the body and caused wounding to the heart, diaphragm, right lung, liver and 7th and 9th ribs.

82. Four (4) bullets were recovered at autopsy and provided to police for further ballistics examination. A possible taser mark was identified to the right upper thigh however no other signs such as the presence of a barb or wiring on or around the body.

83. There were foreign objects identified in the deceased's rectum being a flat sheet of plastic which contained a sheet of paper with documentation relating to methadone and its use and 11 white tablets later identified as Pregabalin.

84. Non firearm related injuries found at autopsy included a laceration to the back of the head and a tram track patterned bruise to the left side of the back. Dr Cala reported that both injuries could have been caused by a similar blunt object and were likely inflicted ante- mortem. Other blunt force injuries to the nose, forehead and left knee, likely occurred when he collapsed after being shot.

85. As to the finding of methamphetamine, Dr Cala reported the psychiatric effects vary from euphoria to overt paranoia and psychosis, which is characterized by paranoid delusions, hallucinations and bizarre, aggressive or violent behavior and its presence at any level could be potentially toxic.

86. As to the finding of methadone, Dr Cala concluded that the deceased's blood methadone level of 0.96mg/L is within the reported toxic and fatal range for methadone toxicity however it would appear it played no role in his death other than behaviorally, given just prior to his death he appeared physically active and alert.

87. The finding of alcohol in the low range, may have been due to post-mortem decomposition. Dr Cala also noted that Pregabalin (found in the deceased's blood, and 11 pills were secreted in his rectum) is used to treat chronic pain and can be addictive.

Discussion of the release of Mr Walker into the Community

88. From the totality of the evidence, it appeared clear that Mr Walker was going to have difficulty reintegrating into the community. He had a long history of mental health and illicit drug use. He was moving to an area that was relatively unknown to him, where he had no supports in place.

89. There is no criticism of individual officers, however it seems that Community Corrections have limited powers to ensure for the quick progression of those inmates released who require assistance by referral to community services to ensure that their rehabilitation continues, and that the community is kept safe.

90. Mr Walker himself made the comment that he felt that he was set up to fail. He had no long-term accommodation, limited short term options, he was a person that struggled when interacting with others, was disorganized and drug seeking.

91. In this case Community Corrections did not meet their own prerelease service

standards in preparation for Mr Walker's release, in that there was not contact with him every four weeks. There is no way identified in the current practice of how this could realistically have been achieved in Mr Walker's case.

92. Ms Westblade was a new officer and had only a singular contact with him. She made attempts for further contact with him. Ms Westblade did her best in the circumstances as a new officer during difficult COVID-19 times and in accordance with the policy.

93. No supervising officer was allocated to him when the risk management plan was complete, and he was released without a supervising officer being allocated, and as an obvious result he was not aware of who his officer would be.

94. There appeared to be some breakdown in the arrangement of housing for him, which again could not be properly determined at inquest. I accept that for some reason he ended up with no initial housing, which he found very distressing. It appears that he was either not advised of accommodation, or that he did not understand or comprehend the information provided to him at discharge. Given his distress that he did not have housing, I can accept that at minimum he did not understand the housing arrangement.

95. RN Lewis was able to give evidence that he was at times sleeping in a cemetery with people he did not know, which she considered this was placing him in risky situations.

96. During her evidence, RN Lewis confirmed her recollection of the documentation. She explained that Mr Walker seemed distressed, and at times unwell. She was worried for him. RN Lewis was very caring and understanding. It was apparent from the evidence that she did what she could for him, indeed it seemed she went out of her way to try and help him. She spent time with Mr Walker, listened to him, went to attempt to fix the situation with him, and followed him up. She was a genuinely caring service provider and said at no time did he become aggressive nor angry at her. From the evidence it was clear that she did all that she could to assist him get some assistance in the community. Her role however was limited, and she had limited ability to assist him or direct him any further. However, she was kind and considerate to him, listening to him and trying to help him function in the community.

97. The Community Corrections policy for drug testing seems to be one that needs review also, in that Mr Walker presented self-admitting ice use. He also entered into a new relationship extremely quickly with a person with young children. It was known that he had used drugs, and this should have been a warning sign for Community Corrections in allowing him to make those arrangements to reside with a relatively new partner, who may not have known of his offending behavior in the past.

98. Ms Loundar is the Director Operations Southern District Community Corrections. She provided two statements for the assistance of the inquest.

She agreed in her evidence that the prerelease standards for attending on Mr Walker to prepare for his release were not complied with. He was to be seen once every four weeks prior to his release, which did not occur.

99. It was acknowledged that Ms Westblade was new to her role and she was allocated the responsibility for Mr. Walker's pre-release planning. COVID-19 restrictions were in place at the time, and as such she could not provide the contact required. Ms Loundar noted that he was allocated to the Junee parole unit about 10 weeks prior to being released, however he was then moved to Parklea and then to South Coast. As a result of policy, he was kept with Junee Community Corrections.

100. She agreed that part of the rationale for the meeting every four weeks is to ensure there is time for discussion around the plan for release.

101. She noted that at the time there was a policy of provision of temporary housing of up to two days, and now that has changed to seven days housing. She noted that Mr Walker was identified as having a high criminogenic risk in the community. She noted that he was just below the highest rating for risk to the community, being T2 with T3 being the highest risk. She agreed that the risk factors included his drug use and mental health.

102. It is the case that before an inmate will have accommodation confirmed in the community it will need to be assessed and approved, and that includes telling any third party the criminal history of the parole. A home visit would be conducted. This is contrasted where a person leaves without fixed accommodation. Once in the community the same process does not necessarily occur. An attempt was made to attend and visit the house that he intended to reside in with Ms Cruickshank-Walker, however the officer did not feel he had consent to discuss the criminal history of Mr Walker with Ms Cruickshank-Walker.

103. Ms Loundar gave evidence in relation to domestic violence training with the staff. In this case Ms Loundar properly recognized that the Community Corrections Officer is often faced with difficult decisions, such as the risks in this case of him being homeless as opposed to him being in a relationship where he felt like there was a positive response. Ms Loundar also identified the need for increased opportunity for accommodation for parolees, which may have meant that Mr Walker would not have moved into his partner's home so quickly if he had his own stable accommodation.

104. Evidence that related to long term history of drug use was also explored. Ms Loundar pointed out that drug tests and moving to breach a parolee was a serious step, and obviously many of the parolees would resort to some drug use. This evidence was somewhat confusing. On one hand it is a parole condition that there is no drug use, and Mr Walker was known to be potentially violent, particularly when drug-affected, yet to drug test was thought to be extreme in these circumstances. There was evidence that the type of drug testing would not be suitable to use as evidence of a breach of parole. However there didn't appear to be a role for identification of the drug use as an

important tool in its own right.

105. She noted that that the policy indicates that it is not appropriate to do a drug test when an offender appears to be under the influence and the test results would not change the CCO's response. Further is it not appropriate to drug test where the offender admits to drug use and the test results would not change the CCO's response.

106. In relation to compliance with their own standards, Ms Loundar indicted that in many cases the 4 pre-release visits cannot be met given the shorter period of time nominated for custody.

Discussion of evidence

107. The inquest heard evidence from several employees of Community Corrections including Ms Westblade, Ms Daniel, Ms Buxton, Mr Koklas and Ms Loundar. He also sought the assistance of a Connections Transition coordinator from Justice Health and Mental Health Network, RN Lewis. Community Corrections did not meet their prerelease service stands in preparation for his release, and the standards could never have been satisfied. Community Corrections maintained the responsibility for planning for Mr Walker to be released into the community, including his accommodation arrangements.

108. Mr Walker had a known history of being aggressive, threatening and paranoid. The evidence from the medical records supported that drug use significantly increased to psychotic episode, paranoid delusions and increased anxiety, and the criminal offending. He was known to have a distrust with medical and allied professionals and police. It is clear that he had entered a significantly paranoid state by the time of the offending.

109. This inquest highlighted the need for offenders at risk of mental health issues and drug use coupled with the risk they present to the community to receive as much attention as possible. The concept of rehabilitation goes hand in hand with protection of the community, and in this case, particularly those who may form a domestic relationship with Mr Walker.

110. The risk mitigation plan that was prepared appropriately identified his criminogenic risks. It was approved three days prior to his release. The plan identified a number of ways to address the risk once he was in the community. He was identified appropriately as being at high risk in the community for reoffending.

111. To his credit Mr Koklas was very attentive and attempted to make a home visit but was unsuccessful because no one was home. Mr Koklas and Ms Loundar confirmed that the verbal authority previously obtained by Mr Walker to disclose his criminal history to the temporary housing providers did not extend to Ms Cruickshank-Walker. Mr Walker had disclosed his concern about his own mental state, and Ms Cruickshank-Walker also indicated that Mr Walker was struggling with mental health and was paranoid.

112. In the days leading up to the incident, Ms Cruickshank-Walker had disclosed to her nephew that she did not want Mr Walker there, and that she felt uncomfortable. This information did not make its way to Community Corrections.

113. There cannot be any major criticism of individual CCO officers. The policy itself does not appear fit for purpose for the release of prisons who are kept on shorter sentences This would be helpful to be reviewed to create a more realistic timetable to assist those higher need inmates to re integrate into society.

114. Ms Loundar was very helpful in the inquest and attended and listened to the evidence. This was important given she is in a position to promote improvement and change.

Consideration of proposed Recommendation

115. Oral and written submissions were helpfully made by CSNSW addressing the fact that the individual officers did individually comply with relevant policies for drug testing, which give them a discretion. They also highlighted the evidence that drug tests can be inaccurate. They also note that the pre-release policy must be adhered to whenever reasonable and practicable, and that the standards provide only a guide.

116. Counsel Assisting proposed on the last day of hearing a recommendation relating to a Community Corrections policy. Submissions were received from CSNSW on this issue and can be best summarised by re-producing Senior Counsel's submissions in reply as follows:

> "Having considered the matters set out in paragraphs [30] to [34] of the supplementary closing submissions, some reformulation of the proposed recommendation is warranted.
>
> Community Corrections advises that:
>
> i. the CSNSW Quality Assurance Directorate is currently undertaking a holistic review of offenders in custody and the community and that such review will include examination of preparing offenders for release and managing offenders with short or backdated sentences, notably when the offender has previously spent time on remand. Submissions are made that the review is scheduled to be completed in the third quarter of 2024 and may result in changes to policy and procedures, if indicated.
>
> ii. In addition, the CSNSW Quality Assurance Directorate is continually enhancing the Workload Management tool to better support Community Corrections Officers.

The submission at [33] that "*These initiatives are underway and provide an opportunity for a more comprehensive review and process for improvement than isolated corrections to parts of Community Corrections policies*" is a sound submission.

In the circumstances, the following recommendation is proposed:

a. The Court's findings be provided to the CSNSW Quality Assurance Directorate for its consideration when undertaking its holistic review of offenders in custody and the community and specifically in relation to the examination of preparing offenders for release and managing of offenders with short or backdated sentences.

b. That Correctives Services advise the Court of the outcome of the CSNSW Quality Assurance Directorate review specifically any changes to procedures or policies for preparing offenders for release and managing of offenders with short or backdated sentences."

117. The assistance of the parties has generated a useful submission in this regard. It appears that the evidence in this inquest supports the position that a substantial revision of the practice of release of prisoners on statutory parole is required. This material also supports good evidence, in the interests of protection of the community that higher risk offenders may require more attention than others immediately upon release in the community.

118. It would also be of benefit if Community Corrections had some priority access to services in these cases, where there is no parole hearing, to better protect community particularly in the area of domestic violence.

119. In saying that, I recognize the tension between the need to protect victims of domestic and provide to them much needed housing and services, and the need to make provisions to those on parole to provide added protection to existing and potential victims.

120. However, the benefit would flow to not only the community, but the staff of Community Corrections who are performing a very difficult task, however are in a unique position if they in turn are provided with support by services to assist them.

121. The recommendation is reasonable and necessary in my view, where there is at this stage an intended review that might result in change. This case highlights the need for change.

122. I particularly thank CSNSW for engaging so openly and helpfully to work towards consideration of improvements.

Review of the evidence of NSWPF Use of Force by the involved officers

123. As part of the CII, a report was obtained from Sgt Henley, Senior Operational Safety Instructor with the Operational Safety, Training and Governance (OSTG) in NSWPF. Sgt Henley reviewed the use of force by police on 9 July

2022 and expressed the following opinions:

a. The use of taser on 9 July was in accordance with training and policy. The taser failed to achieve its aims, because of the conditions together with obstruction by a tree. The fact it did not land was unsurprising. He discussed various models of the taser.

b. The discharging of a firearm and the number of shots fired was, in all the circumstances, in accordance with training and policy.

c. Containment and negotiation were not a viable option in this situation.

124. It should be noted that this was an internal police review. However, we had the benefit of hearing from the Sergeant in evidence. He was careful and considered. He did not embellish and was moderate and non-emotive in his review and observations. He provided very reliable and honest evidence which was accepted and very helpful to the inquest.

125. The actions of the police on that day were nothing short of a demonstration of police work at its finest. The police acted in accordance with all policies. The police remained calm and in control in the face of a very hostile and dangerous situation. They were assessing a fast moving, fluid and dangerous event as it unfolded. They proceeded to use the least force that they were able. Things escalated as a result of Mr Walker's actions. There were a number of members of the public who were present and at risk, including children.

126. The activation of the body worn footage enabled the inquest to proceed without the need for calling of the officers involved. It was all captured clearly on the footage, and they each gave detailed statements, and no request was made for anyone to question them further.

127. They were in attendance, willing to give evidence, and were offered the opportunity to give evidence if they so wished.

128. The objective evidence sat with most of the eyewitness accounts neatly, and obviously where they differed, the objective evidence was preferred. Any differences were not as a result of any dishonesty, but rather each witness was in a different location, further away, watching an horrific event unfold unexpectedly.

129. The officers tried to talk Mr Walker into stopping and cooperating with them. They then moved to try and spray him to subdue him, then taser him prior to the shooting.

130. Mr Walker presented a grave risk to the community. He had already stabbed two persons, he was armed, he was unhinged and he was very dangerous. He could not have been left to continue on into the community.

131. However, that choice was not left to the officers. He determined to suddenly

run at one of them. It is only by virtue of the fact that the officer fired his gun that he too was not a victim of stabbing. At that point there was no other option available to that officer.

132. It should be said that each of the officers were acting in proper execution of their duty. Each acted heroically to put themselves in harms way, to deflect him from members of the public and to attempt to safely restrain Mr Walker.

133. Each of the police officers Senior Constable Collier, Probationary Constable Godfrey, Constable Richards and Constable Saddler selflessly put themselves at risk to protect the community. They worked together as a team. Senior Constable Collier tried to calm the situation, pulled her OC spray as she realized the situation was escalating and called for assistance. Probationary Constable Godfrey even in his early time in the force put himself in between Mr Cattermole and Mr Walker to encourage him to move on. They did not know whether or not he was armed at this point. He remained very close to Mr Walker at that time. Constable Richards and Constable Saddler arrived and had seconds to comprehend the situation. Constable Richards attempted to protect her partner by releasing the taser, and Constable Saddler faced Mr Walker as he ran at him, firing only when it was absolutely necessary to do so.

134. The four officers were deeply affected by the death of Mr Walker. This was an event that happened on a regular shift, on a regular day at work. They attended the inquest each day, willing to assist in any way they could. It is clear from the statements and their presence in Court that this event has impacted each of their lives significantly, and for that reason it is important to reinforce the gratitude we extend to them that they deserve for their willingness to protect the community at what is a great personal cost to themselves.

135. The example of policing they each demonstrated was better than textbook, and that should be recognized. It was a tragic outcome, but an outcome that was created by the final actions of Mr Walker. He asked them to shoot him, and when that didn't occur he ran at one of the officers, leaving him no choice but to discharge his firearm.

136. The effect on each of them is another reason to look carefully at the importance of the role of rehabilitation and reintegration into the community, and to support those that are involved where possible, in that process.

Acknowledgements

137. To each of the sufficient interest parties for engaging together to assist the process of the inquest.

138. The CIIT police officers, but in particular for an excellent investigation and active involvement in the inquest process by Detective Inspector Walpole and Detective Sergeant Lovell. The brief was so comprehensive and extensive that it minimised the need for much additional evidence to be called.

139. Finally, to the team assisting, Ms Gerace SC, Ms Trovato and Ms Carter who presented a concise case, minimised distress to many witnesses and worked very impressively with interested parties. I thank them too for their written work in the opening and closing and observations, which assisted in setting out the factual matrix in these findings.

Recommendations

140. In the circumstances, the following recommendation is made to The Commissioner of Corrective Services New South Wales:

    a. The Court's findings be provided to the CSNSW Quality Assurance Directorate for its consideration when undertaking its holistic review of offenders in custody and the community and specifically in relation to the examination of preparing offenders for release and managing of offenders with short or backdated sentences.

    b. That Correctives Services advise the Court of the outcome of the CSNSW Quality Assurance Directorate review specifically any changes to procedures or policies for preparing offenders for release and managing of offenders with short or backdated sentences.

Section 81 Findings

a. **IDENTITY**: The identity of the deceased is Brett Andrew Walker

b. **DATE AND PLACE:** The date of death was 9 July 2022 and the place was the intersection of Albert and Kinghorne Streets, Nowra, NSW

c. **CAUSE**: The cause of death was multiple gunshot wounds

d. **MANNER**: Mr Walker's death occurred as a result of being struck by bullets fired by a police officer who was at all times acting lawfully in the course of a police operation. a police operation.

I extend my condolences to Mr Walker's family, particularly to his Nan and his children.

I close this inquest.

Deputy State Coroner Kennedy