CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ashley PAULL
Hearing dates:	28-31 July 2025
Date of Findings:	18 August 2025
Place of Findings:	Coroners Court of New South Wales, sitting at Coffs Harbour Courthouse
Findings of:	Magistrate David O'Neil, Deputy State Coroner of NSW
Catchwords:	CORONIAL LAW collision with truck whilst walking along highway – mental health in custody – release from police custody after detention for secondary drug test – schizophrenia – Community Treatment Order – Kempsey Mental health – mental health treatment and care-interaction between police and mental health service
File number:	2019/222760

Representation

Counsel Assisting, Mr Jake Harris, instructed by Ms Imogen Pearson and Ms Charlotte Ward of the NSW Crown Solicitor's Office

Mr David Evenden, instructed by Dawoud Ayache of Legal Aid NSW, for Sandra Hicklin

Ms Christine Melis, instructed by Mr Aurhett Barrie of the Office of the General Counsel, for the Commissioner of NSW Police Force

Mr Joe Kellaway, instructed by Mr Dominic Longhurst of Longhurst and Associates, for Sergeant Robert Holstein and former Senior Constable Michael Duxbury

Mr Patrick Rooney, instructed by Mr Nathan Guenette of Norton Rose Fullbright, for the Mid North Coast Local Health District

Findings:

The identity of the deceased

The person who died was Ashley Ronald Paull ("Ash").

Date of Death

Ash died on 15 July 2019.

Place of Death

Ash died on the Pacific Highway at Clybucca.

Cause of death

The cause of Ash's death was multiple injuries.

Manner of Death

Ash's death was through misadventure and occurred in the context of him suffering a relapse in schizophrenia and methamphetamine use. Ash was struck by a truck while walking along the Pacific Highway after being released from Police custody.

Recommendations

I make the following recommendation pursuant to s 82 of the Coroners Act 2009 (NSW)

To the NSW Commissioner of Police:

1. Consider amending the Charge Room and Custody Management SOPs, and/or the Police Handbook, to clarify the nature and extent of a review of information held on police systems that should be undertaken by arresting / escorting officers and custody managers where a person is in custody.

2. Consider providing guidance to officers in charge of coronial investigations, where a person has died following a recent period in police custody, to ensure any CCTV footage depicting the person in custody is retained for the investigation.

INTRODUCTION

1. Ashley Ronald Paull (whom the family have asked be referred to as "Ash") died on the 15th of July 2019, on the Pacific Highway at Clybucca, north of Kempsey. He was 49 years old. In the afternoon of that day, he had been stopped by police near his home at Fishermans Reach and was asked to undergo a breath and drug test. Drugs were detected and he was taken to Kempsey police station. On being released from the police station at 3.45pm, he told police he was going to walk home, a distance of about 50km. He was hit by a truck while walking northwards on the Pacific Highway at about quarter to 11 that evening.

2. An inquest was held between 28 and 31 July 2025.

THE CORONER'S ROLE

3. An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death. It is not the primary purpose of an inquest to blame or punish anyone for the death. The process of holding an inquest does not imply that anyone is guilty of wrongdoing. Despite this there may nevertheless be factual findings which necessitate an adverse comment or criticism to be made.

4. The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Coroners Act 2009 (NSW) (the Act); namely:

    - the person's identity;
    - the date and place of the person's death; and
    - the manner and cause of the person's death.

5. Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the

death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

CORONIAL INVESTIGATION

6. Prior to holding the inquest, a detailed coronial investigation was undertaken. Investigating Police compiled an initial brief of evidence, and a number of documents were obtained, including a report by a forensic pathologist as to the cause of death. The court also received statements from police, civilian and expert witnesses. The original officer in charge was Senior Constable Damien Murphy. In June 2023, Senior Constable David Richards assumed the role of officer in charge.

7. All the documents including witness statements and expert reports obtained during the coronial investigation formed part of the five-volume brief of evidence that was tendered at the commencement of the inquest. Material was also received and tendered throughout the inquest. All of that material, and the oral evidence at the inquest, have been considered in making the findings detailed below.

8. The following agencies and individuals were identified as having a sufficient interest in the proceedings and received notification:

    I. Ms Sandra Hicklin

    II. The Commissioner of NSW Police

    III. Sergeant Robert Holstein

    IV. Senior Constable Michael Duxbury

    V. Mid North Coast Local Health District

WITNESSES CALLED TO GIVE EVIDENCE AT THE INQUEST

9. The following witnesses gave oral evidence in the inquest.

I. Senior Constable David Richards

II. Dr Ian Duncan Thorburn

III. Patrick Cotterill

IV. Sergeant Robert John Holstein

V. Superintendent Kirsty Hales

VI. Superintendent Robert Toynton

VII. Dr Kerri Eagle (forensic psychiatrist)

ISSUES CONSIDERED AT INQUEST

10. A list of issues was prepared and circulated to the interested parties before the inquest commenced. These issues guided the coronial investigation and were considered at inquest. The issues examined included:

    I. What was the nature of Mr Paull's mental health condition?

    II. Did Mr Paull receive adequate and appropriate mental health treatment, in the period from 20 February 2019 to his death? What steps were taken to ensure Mr Paull complied with his medication, and were these adequate?

    III. What information was conveyed by Ms Hicklin to Mr Cotterill on 15 July 2019? Was the planned response adequate? Should attempts have been made to contact Mr Paull, or the police?

    IV. What information was known to police regarding Mr Paull's mental health?

    V. Did Mr Paull display signs and symptoms of mental illness at the time of his arrest and during his time in custody on 15 July 2019?

VI. What action could have been taken by police in respect of Mr Paull's mental health following his arrest, including the power pursuant to s. 22 of the *Mental Health Act 2007*? Was any action taken, and if not, why not?

VII. What steps were taken by police when discharging Mr Paull from custody, to assist him to make his way home? Were further steps available, or warranted?

VIII. Was there an adequate response by police to the emergency report made by Kevin Wood at about 9pm on 15 July 2019?

11. The inquest also considered whether any recommendations were necessary or desirable in relation to any matter connected with Ash's death.

BACKGROUND

12. Ash was born on 17 February 1970. He was a proud First Nations man. His mother was Aboriginal. Her family were from La Perouse, and Ash grew up in Maroubra. He was sporty. When he was young, he played in the under-16s for the Rabbitohs.

13. In 1994, Ash was involved in a serious car accident. He suffered an injury to his cervical spine which required fusion and traction. He suffered ongoing pain as a result and was prescribed medication including fentanyl patches.

14. Happily, while in Royal North Shore Hospital spinal unit, he met Sandra, his future fiancée. She was there visiting her brother. They formed a relationship for about 6 months the following year. They met again in later life.

15. Ash was good with computers and technology. He had his own business for a period, called DataTech.

16. However, Ash also had issues with his mental health, and with substance use. He later told doctors that he had started using drugs as a teenager, mainly

cannabis and methamphetamine. He attended drug rehabilitation at Odyssey House in his early 20s. He relapsed into drugs use in about 2013. His mental health deteriorated as a result.

17. In 2014, Ash's mother died. Sandra believes his mental health deteriorated at that point.

18. He was admitted to Coffs Harbour Hospital on 2 March 2014 and prescribed antipsychotic medication.

19. That was the first of several involuntary and voluntary admissions over the course of that year. He became psychotic in the context of methamphetamine use or when he stopped taking medication.

20. Ash was commenced on a depot injectable antipsychotic, paliperidone, during an admission to Port Macquarie Hospital in March 2015. He was discharged on a Community Treatment Order (CTO), which required him to receive medication and be reviewed by the community mental health team.

21. By March 2016, his treating psychiatrist considered he had developed schizophrenia. The CTO was extended, because Ash was guarded and evasive, reluctant to take medication, and did not think he had a mental illness.

22. On 23 October 2016, Ash was sentenced to 20 months' imprisonment for a series of offences. His non-parole period expired in 2017, and he was released to parole. He was required to undertake fortnightly urine drug screens.

23. In February 2018, Ash and Sandra rekindled their relationship. He moved in with her and her children at Fishermans Reach and remained living there until his death. They later became engaged.

24. Ash was subject to a further CTO during this period, and he was case managed by the Kempsey Community Mental Health Team's Intensive Treatment Service.

25. At the end of 2018, Ash was being reviewed regularly by psychiatrists Dr Crellyn Taylor and Dr Peter Ross. He was still receiving depot medication, but he complained about the side effects. In November 2018, the treating team agreed to reduce his dose of paliperidone to address the side effects.

26. On 7 January 2019, Ash attended the community mental health team in Kempsey for his depot injection. That was last time he attended at the community health team's clinic.

27. On 2 February 2019, the Mental Health Review Tribunal considered Ash's CTO. It agreed to a short extension of 3 months, because at that stage the team was awaiting a review by the Community Forensic Mental Health Service (CFMHS). That Service eventually provided a report, which supported continuation of the depot medication, due to Ash's history of violence and poor compliance.

28. On 5 March 2019, Ash was reviewed by psychiatrist Dr Ian Thorburn, the Clinical Director of the Hastings Macleay Mental Health Service, within Mid North Coast Local Health District. He noted Ash's concerns about side effects. Ash denied he had schizophrenia, or ever having any symptoms. He said he did not like engaging with mental health. However, Dr Thorburn noted that the CFMHS supported ongoing treatment. He planned to increase the dosage of Ash's medication and review him every 3 months, with more frequent review by the case manager.

29. At that stage, Ash was being managed by Patrick Cotterill, an experienced mental health nurse who was working as an agency nurse for the community team. He saw Ash on at least 5 occasions over the next few months, in order to provide the deport medication.

30. On each occasion, Ash received his depot medication late. On three occasions, Mr Cotterill involved the police to attend the home, to take Ash to hospital if he declined to accept the medication. However, on those occasions, when police attended, Ash accepted his medication willingly. The first such occasion was

on 5 April 2019. As a result, Ash was consistently receiving his medication late during 2019.

31. The longest gap in Ash's medication occurred in June 2019. On 7 June 2019, Mr Cotterill attended Ash at Fishermans Reach, intending to give him his medication. Ash welcomed him in, and they went out for a coffee. Unfortunately, an incident occurred when they returned to the house, where Ash got locked inside Mr Cotterill's vehicle. This "spooked" him, and he refused to accept the medication.

32. He then failed to attend his next review with Dr Thorburn, on 12 June 2019. Dr Thorburn reviewed the file and noted that Ash was:

> *At elevated risk of psychotic relapse of schizophrenia with consequent elevated risk of danger to others in association with recent reductions in paliperidone depot dose and now being two weeks overdue for depot*

33. Dr Thorburn planned to commence the breach process for the CTO, pursuant to s 58 of the Mental Health Act 2007. That provides a process where a breach notice is served on a patient, requiring him to comply with treatment. If the patient fails, a breach order is issued, and the patient can be taken to a mental health facility. Police may be asked to assist in conveying the patient to hospital.

34. Dr Thorburn also planned to transfer care to a colleague, Dr Vasko.

35. Mr Cotterill attended Ash's home the following day, to provide him with the breach notice. Mr Cotterill was with Senior Constable McLaren from South West Rocks police station. Ash accepted his depot medication.

36. Around the beginning of July 2019, Sandra says she noticed Ash's behaviour had begun to change: He began talking to himself and appeared different.

37. He was due his next depot on 11 July 2019. Ash did not attend the community team clinic. The team discussed his case, and planned assertive follow up the following day.

38. Accordingly, on Tuesday 12 July 2019, Mr Cotterill attended Fishermans Reach together with police, this time Senior Constable Byrne from South West Rocks police station. Ash told Mr Cotterill he had been feeling well. He said he was happy to see his new psychiatrist, Dr Vasko. He accepted his depot medication willingly.

39. That was the last depot medication Ash received before his death, a few days later.

EVENTS OF 15 JULY 2019

40. On Monday, 15 July 2019, Ash woke up early and went to the beach, as he often did. Sandra said that Ash was talking to himself. He was also seen at a local pub. At 12:38pm, a member of the public reported Ash's vehicle, a white commodore had harassed and tailgated a vehicle driving on Fisherman's Beach Road.

41. Senior Constable Duxbury responded to that report at 1:06pm. He was a highway patrol officer based at Port Macquarie and made his way to the area. Sandra saw a highway patrol vehicle pass her home and do a U-Turn just as Ash was arriving back home. When Ash returned home, he had a shower and smoked. Sandra said he was behaving unusually. He grabbed her on her behind in front of the children, something he would not normally do. He wanted her to go to the pub with him, however she declined as this was something they did not usually do. They would normally go to the pub once a fortnight as a family.

42. Ash left home again at about 1:45pm. Sandra was concerned about Ash's behaviour that morning and decided to call the Kempsey Community Mental Health Team. She made that call at 1:50pm and spoke with Mr Cotterill also

known as 'Joe'. The full detail of this conversation will be discussed later in these findings. At 1:53pm, Senior Constable Duxbury sighted Ash's vehicle and caused Ash to pull over. After Sandra finished calling Joe, she called Ash but he did not respond, he was at that point with Senior Constable Duxbury.

43. When Senior Constable Duxbury caused Ash to pull over, he conducted a roadside alcohol test which was negative. He then conducted a roadside drug test which was positive. Senior Constable Duxbury told Ash he'd have to go to Kempsey Police Station for a secondary drug test. Senior Constable Duxbury was arresting Ash albeit he did not use the words 'under arrest', but he made it clear he was not free to leave.

44. Ash and Senior Constable Duxbury arrived at Kempsey Police Station at 2:52pm. The custody manager was Sergeant Robert Holstein. Sergeant Holstein gave evidence that Ash was belligerent and uncooperative. Ash refused to answer questions telling Sergeant Holstein *I've had enough, this is fucked*, and banging on the dock door. At one point Ash attempted to put his necklace back on and reacted angrily when Sergeant Holstein told him to take it back off. In oral evidence, Sergeant Holstein said that he thought the necklace was important to Ash.

45. Sergeant Holstein did not form the opinion that Ash's behaviour warranted him being dealt with under s. 22 of the *Mental Health Act*. Section 22 provides power to Police to take a person to a declared Mental Health facility if the officer believes on reasonable grounds that among other things the person has recently committed an offence and it would be beneficial to the person's welfare to be dealt with under the *Mental Health Act* rather than in accordance with law.

46. At 3:06pm, about 15 minutes after he arrived in custody, Ash was taken by Senior Constable Duxbury to a room in order to provide a secondary sample for drug testing. This sample was positive for methamphetamine, and Ash was issued with a notice prohibiting him from driving for 24 hours.

47. Ash was then to be released from custody. Sergeant Holstein asked if Ash needed someone to pick him up, however Ash said he would walk, stating something along the lines of "*Fuck you, I'll walk home*". He continued to be belligerent, and was released from custody at 3:45pm.

48. After Ash was released, Sergeant Holstein was driving along Smith St in Kempsey when he saw Ash. He stopped at a set of traffic lights and said that Ash looked at him with 'disdain'.

49. At 4:25pm, there was a report of a man holding a push bike in the middle of Smith Street, and walking along the road. The person who made this report indicated that the man was waving his arms around, yelling and screaming, and appeared to be talking to someone who wasn't there.

50. Officers attended the location however did not find anyone of this description. Based on the description provided by that witness, which does not match Ash in terms of physical appearance, I am not satisfied that was a sighting of Ash.

51. There were no reports of Ash during that afternoon, (as distinct to the night), following his release. After his death, there were three reports to Crime Stoppers relating to a male walking along Macleay Valley Way, walking towards the Pacific Highway. They are possible sightings of Ash.

52. At about 7:30pm, Mr Kevin Wood was driving a B double truck northbound on the Pacific Highway when he heard over the UHF radio that a male was walking in a northbound lane in Clybucca area, about 20kms north of Kempsey. Between 8 and 9pm when he was about 8km south of Clybucca, Mr Wood saw a man jump into the lane of the highway about 200m in front of him. Mr Wood swerved to avoid the man, otherwise he would have hit him. Mr Wood warned other drivers on the radio, then called 000 at 9:04pm. Computer Aided Dispatch (CAD) records indicate Mr Wood had seen a male about 5km south of Clybucca wearing a black and grey tracksuit. Based on this description, the time and location, it seems likely that was Ash.

53. At 9:30pm, the General Duties Unit officers Zamora and Carter responded and patrolled the area near Clybucca. They did not see anyone on or near the highway and returned to other duties.

54. At 11:56pm, a man was seen lying on the road, and a 000 call was made. At 12:14am, a truck driver observed a body, stopped and called 000. Police, including the General Duties Unit officers Zamora and Carter, attended and located Ash, who was unresponsive. Paramedics attended and confirmed that Ash was deceased.

55. An autopsy was conducted on 22 July 2019 by Forensic Pathologist Leah Clifton. She found that the cause of Ash's death was multiple injuries, noting that the injury profile was in keeping with those involved in motor vehicle accidents. Methamphetamine and metabolites were detected in post-mortem toxicology.

56. The original officer in charge of the investigation, Senior Constable Murphy of Mid North Coast Crash Investigation Unit, attended at 1:20am and commenced a review of the physical scene. He concluded that Ash had been hit by a vehicle by a glancing blow. He then commenced an investigation to identify the vehicle involved. He identified a list of vehicles travelling northbound via point to point RMS camera. He then began contacting owners. The owner of a Pearson Transport truck was able to supply dash cam footage which depicted Ash at 9:54pm walking along the highway about 5kms south of Clybucca. This location allowed Senior Constable Murphy to identify an approximate time of collision and a shorter list of vehicles of interest.

57. Senior Constable Murphy contacted Kalite Transport and spoke with the owner who confirmed one of the trailers had sustained damage on a journey from Sydney to Brisbane. Police officers attended to examine the prime mover which was not damaged and attended an address in Sydney where the trailers were located. They observed damage to the trailer, and noted the presence of blood, although this could have been human or animal blood. Senior Constable

Murphy then attended the scene of the collision and located a piece of rubber which exactly matched the damaged section of the mudguard.

58. On 17 July 2019, Senior Constable Murphy spoke with Mr Darren Forrest, who had been the driver of the truck on 1 July 2019. Mr Forrest said that he was not aware of the collision, and had the radio turned down so he hadn't heard reports of a person walking near the Highway. When he was told about the presence of blood, he thought he had hit a dog near Yamba, NSW. He contacted Police the next day, advising he remembered hitting a bump, however he thought it was a pothole at the time. He said he was adjusting his cruise control at the time as the truck was moving a bit fast. He was interviewed on 19 July 2019, and provided a consistent account with his comments to Senior Constable Murphy.

59. Subsequent inquiries revealed the following:

    a. Analysis of the truck GPS data just south of the Clybucca Rest Area, places the time of collision between 10:47-10:48pm.

    b. The truck was travelling at 100km/hr at the time of the collision.

    c. Between 10:49 and 11:02pm, Mr Forrest called his wife three times, with the longest call being about 11 minutes.

    d. At 11:07pm, Mr Forrest stopped at a rest area about 3kms north of Clybucca. He only stopped for five minutes. He said he stopped to go to the toilet.

60. Senior Constable Murphy concluded there was no evidence of dangerous driving.

61. On the basis of the location of the damage to the rear mudguard of the trailer, and the nature of Ash's injuries, Senior Constable Murphy concluded that Ash fell accidentally or deliberately into the path of the truck. Senior Constable David

Richards, also of the Mid North Coast Crash Investigation Unit, who later assumed the role of officer in charge, held the same view.

Issue 1: What was the nature of Mr Paull's mental health condition?

Issue 2: Did Mr Paull receive adequate and appropriate mental health treatment, in the period from 20 February 2019 to his death? What steps were taken to ensure Mr Paull complied with his medication, and were these adequate?

62. As confirmed by Dr Kerri Eagle in her first written report, Ash had a diagnosis of schizophrenia, and had experienced relapses of psychosis from time to time. These relapses had occurred in the context of non-compliance with treatment and substance use, and were associated with agitation, irritability, fearfulness and risk to self and others. He was noted to display poverty of spontaneous ideation.

63. Ash had poor insight into his illness and need for treatment. A lack of insight is a common feature of schizophrenia where individuals are unaware of their illness or its symptoms. It is sometimes considered a neurological deficit rather than a denial and can be a barrier to accessing effective continuity of treatment. Ash also had a substance use disorder and he also suffered from chronic back pain.

64. Dr Eagle opined that Ash had a pervasive lack of insight into his illness and need for treatment, that did not improve during periods of recovery and possibly reflected the disorder itself as causing the lack of insight.

65. Relevantly, in Dr Eagle's opinion, the lack of insight was an additional barrier to continuity of treatment and care likely contributing to instability of Ash's illness. Persistent substance abuse including methamphetamine would have exacerbated psychotic relapses and effectiveness of treatment. It is unclear to what extent Ash relapsed into the use of methamphetamine, though it is clear he had relapsed at time of his death.

66. Dr Eagle was of the view that Ash had received reasonable and appropriate care by Kempsey Community Mental Health Services (KCMHS). She described the treatment as assertive, however she did identify areas for improvement.

67. Firstly, in relation to the clinical documentation by the care coordinators, particularly in the weeks leading up to Ash's death, there was no reference, in some of the clinical records relating to home visits, to a mental state assessment. Brief generalised comments that Ash had said he was fine, or that there were no issues, provide limited information. The mental state examination on 13 June 2019, after a two-week delay in administration of his Paliperidone depot would have been important to document.

68. The absence of documentation at mental state examination makes it difficult to consider how Ash was presenting longitudinally and whether there were softer signs of deterioration. It is trite to note the importance of clinical notes that record both details observed by treating clinicians on the day and then available for other clinicians to refer to. It is of note there was some evidence of staff turnover in the health service emphasising the need for detailed and clear clinical notetaking.

69. Secondly, Dr Eagle expressed the view that the use of police support for home visits, as what she described as "*a routine intervention*", needed to be closely considered. She noted, uncontroversially that the presence of police can jeopardise the therapeutic relationship, can be a barrier to engagement and can be distressing to patients. She opined that the resource should only be used as a last resort and only where no other less restrictive option is available.

70. I note that competing submissions were delivered by the family, the LHD and counsel assisting regarding what Dr Eagle meant in this regard.

71. In submissions on behalf of the family, Mr Evenden referred to the routine use of police in a temporal aspect, and also the informal use of police. After submissions from the Mid North Coast Local Health District (the LHD), Mr

Evenden indicated that there was only one occasion of informal use of police, which occurred on 12 July 2019, and in circumstances where breach proceedings had not been initiated. No party disputed the principle that use of police should be as set out by Dr Eagle.

72. In reply, Mr Harris emphasised Dr Eagle's reference to "*routine use*" was not in relation to repeat usage but for example, in the circumstances of two male members of the staff not being available. To be clear, there was no evidence that there was routine, in the sense of regular, use of police to support home visits, within the LHD. I accept the LHD understands and takes on board Dr Eagle's comments, which emphasise that police accompaniment be a last resort whilst accepting statutory power to use police in appropriate circumstances.

73. I accept Dr Eagle's view that overall, the care provided by the LHD was appropriate and reasonable. I note that in her attendance upon a general practitioner shortly after Ash's passing, Sandra expressed a similar view, as well as her gratitude for the manner in which Ash was dealt with by the Kempsey Community Mental Health Service.

Issue 3: What information was conveyed by Ms Hicklin, Sandra, to Mr Cotterill on 15 July 2019? Was the planned response adequate? Should attempts have been made to contact Mr Paull or the police?

74. There is some controversy as to what information Sandra relayed to Mr Cotterill when she called him on 15 July 2019. In Sandra's typed statement provided in May 2023, she indicated that she had felt a bit funny about Ash after he left home. When she spoke with Mr Cotterill, he told her Ash had some "bad stuff" on the weekend, meaning a bad dose of illegal drugs. Sandra's concern was for Community Mental Health to come out and speak to Ash and assess him because she was concerned about his well-being. She indicated the factors of it being unusual for Ash to want to go to the pub, and his otherwise unusual conduct.

75. Mr Cotterill's note of the conversation includes "she (Sandra) reported that Ash had changed. She has found him talking to himself, difficult to engage in conversation, slamming doors, and easily irritable." The difference lay in the next entry, where it is indicated that "Sandra fears for the safety of herself and her two daughters." There is then a reference to increase in medication and then a note:

> "*Discuss with RRS and team leader, then returned call to Tina [Sandra], advising her to call triple-0 for police assistance should her situation worsen. Sandra stated she had a place of safety for her two daughters to go to. She also confirmed that she is comfortable in calling for assistance. Ash is currently away from the property at Fishermans Reach. He has told Sandra he has gone to the beach. No identification of which one. Plan: await either police or Tina's contact.*"

76. In submissions by Mr Evenden, it was stressed that Ash had never been physically violent towards Sandra. If there was any concern expressed for Sandra and her daughters' safety, I am satisfied it was because of the potential for risk-tasking and irrational behaviour in the general context of Ash's behaviour showing signs of psychosis. In this regard, I note Sandra's doctor noted on 27 July 2019, during a consult with Sandra, that Sandra reported Ash started becoming unwell about two weeks prior to his death. He was talking to bikie Pete and Jarrad intermittently, and at other times, behaviour was normal. The note indicated Sandra had stated, "*Partner had not been aggressive, and Sandra called the mental health case manager, being advised to call the police if she was concerned about his behaviour.*"

77. In relation to the reference to "Ash taking bad stuff on the weekend", Mr Cotterill did not specifically recall this conversation. He accepted in evidence, however, that he may have made such a comment. In separate evidence, Mr Cotterill indicated clients, from time to time, told him of other clients using drugs. If Mr Cotterill did have that knowledge, it would have heightened his concern for Ash's well-being.

78. There were differences within the evidence from the LHD as to precisely what the plan was following Sandra's call. Mr Cotterill gave oral evidence in which he was unmoved from his expectation that the RRS (rapid response service or team) would be in contact with Ash within two to three hours of him speaking to them. He must have spoken to them at some time prior to 2:38pm, when his note was made. That note also indicates he spoke to them prior to Sandra being called back.

79. The expectation of Dr Thorburn, Hastings Macleay Mental Health Clinical Director within the Mid North Coast Local Health District, was that there would be phone contact with Ash that day (ie the same day as the call from Sandra). Dr Thorburn first met Ash in a clinical setting on 5 March 2019. He reviewed him on that occasion and on 12 June. He noted that Ash's paliperidone had been reduced from 100 milligrams, then to 75 milligrams, and then to 50 milligrams, which was the then-current dose. Dr Thorburn formulated the opinion in June, when Ash was approaching being two weeks late in taking his dosage, that Ash was at increased risk of psychotic relapse. Whilst Doctor Thorburn did not see Ash again, he was aware of him having received a further dose on 12 July 2019. On the information available to him, on 15 July 2019, as I have said, he would have expected the rapid response service to at least attempt to make phone contact with Ash. It needs to be noted that as at 15 July 2019, Kempsey Community Health Service knew Ash's relapses were, on occasions, initiated by methamphetamine use and knew he could be violent when psychotic post-drug use.

80. David Noble, district manager of the Community Mental Health Service as from February 2019, indicated an expectation that the RRS would respond within 24 hours. Mr Noble read the progress note as indicating the RRS did not need to act as the plan read, "Await call from police or Tina [Sandra]." Even allowing for the fact Mr Noble was not cross-examined, I prefer the views of Mr Cotterill and Dr Thorburn that the RRS should have at least attempted to contact Ash on 15 July 2019. There is no evidence they did so, and there is no positive evidence that other work requirements prohibited them from doing so. I accept counsel assisting's submission that Mr Cotterill's note must be taken to mean

the RRS pathway was not precluded by him recording a plan to await a call from police or Tina in circumstances where the RRS would likely advise and note any action they took, and the note in relation to Tina or Sandra specifically refers to action for Sandra to take if the situation deteriorated.

81. I am also persuaded by Dr Eagle's view that clinicians should accept the responsibility of contacting police rather than leaving the situation as being the family's or partner's responsibility if something happens. As I have said, the alternative of Sandra ringing police was for an emergency situation. Separately, someone from the mental health service should have made a welfare call to police and advised them of the identified concerns in relation to Ash's well-being. If that call had been made, police would have had more information when it turned out Ash was in their custody, and perhaps there would have been a different outcome. Whilst that cannot be known, I am confident there would have been an increased prospect of there being a reduction in the risk to Ash's well-being if police knew Ash's well-being had been discussed with Kempsey Mental Health that day and Kempsey Mental Health knew Ash was in police custody or had been in police custody.

82. Issues 4, 5, 6, 7 can be dealt with together, albeit in order.

Issue 4: What information was known to police regarding Mr Paull's mental health?

Issue 5: Did Mr Paull display signs and symptoms of mental illness at the time of his arrest and during his time in custody on 15 July 2019?

Issue 6: What action could have been taken by police in respect of Mr Paull's mental health following his arrest, including the power pursuant to s 22 of the Mental Health Act 2007? Was any action taken, and if not, why not?

Issue 7: What steps were taken by police when discharging Mr Paull from custody to assist him to make his way home? Were further steps available or warranted?

83. The evidence is clear that police holdings included recent COPS entries in relation to police accompanying health workers when administering Ash's antipsychotic medication. Those entries informed police that Ash suffered from schizophrenia. The entries contained that very wording. It was common ground that the primary responsibility to review that information was that of the arresting officer, Senior Constable Duxbury. The Senior Constable was excused on medical grounds from giving evidence in this inquest beyond the statements he provided. In the material provided, there was no evidence that Senior Constable Duxbury accessed the relevant police holdings, such as the COPS entries, to see if there was any information about Ash. If Senior Constable Duxbury had accessed the relevant information, he then should have passed it on to the custody manager. Sergeant Holstein had concerns as to Ash's mental health. He accepted in evidence that the further information in the COPS entries would have been helpful to know.

84. I am of the view that a combination of the known information that Ash had tested positive for methamphetamine, the observations Sergeant Holstein had made in relation to Ash, and the information that should have been provided to Sergeant Holstein that Ash suffered from schizophrenia, may have led to Sergeant Holstein taking a different course in relation to his decision as to whether he should use the powers under s 22 of the Mental Health Act for Ash to be taken to Kempsey Hospital.

85. Whilst the evidence was that Senior Constable Duxbury had primary responsibility to check the COPS records, Sergeant Holstein also could have followed that course. As Superintendent Toynton pointed out, there was a joint responsibility in this regard. As specified in the 2019 New South Wales Police Force Handbook:

> *"The arresting or escorting officer was to assist the assessment of detained people, check COPS for information such as warnings, and tell the custody managers if you are aware that the person has, amongst other things, a history of psychiatric illness, a history of drug or alcohol abuse."*

In relation to the custody manager: "*Conduct your own COPS check for warnings.*"

86. On the evidence, the checks should have gone beyond the warnings that come up automatically on certain parts of the COPS system. There was no automatic warning in relation to Ash's mental health, as it was understood on the evidence that there was no mental health interaction involving police wherein Ash behaved violently.

87. Regrettably, there was also no indication on the police system that Ash was Aboriginal. There is no suggestion in the evidence that that was the fault of the police, but if there was such an entry, a different pathway would have been followed. Sergeant Holstein indicated he would have immediately called the Aboriginal Legal Service.

88. The lack of that information does not take away from the Sergeant's responsibility to find out "*who was in front of him*", as was expressed in evidence, and whether it was appropriate to keep him (Ash) in custody. Mr Kellaway, on behalf of Sergeant Holstein and Senior Constable Duxbury, referred to the *timeliness* of the situation of Ash's custody. Ash was only at the police station for approximately one hour. Mr Kellaway eloquently submitted that Ash's limited time there meant the focus had to be on processing him - that is, applying all the appropriate steps in terms of entering him into custody - then conducting the secondary drug test and then releasing him. He noted that Ash's situation was different to someone who has been arrested for the purpose of charging and who would likely be in custody for a significantly longer period to facilitate the charging process. Ash was to be released after the secondary testing, and the result of that testing awaited, subject only to him being prohibited from driving for 24 hours following a positive secondary test. Superintendent Toynton also pointed to the time constraints in his evidence.

89. I accept that police officers have busy work lives. In fact, it is expected of them that they conduct their duties in what, at times, will be a busy setting. Given that neither officer knew Ash previously, given Ash's described behaviour whilst

in custody, given the primary focus as per Sergeant Holstein and Superintendent Toynton, was to determine Ash's suitability to be and remain in custody, and given Sergeant Holstein's concerns as to Ash's mental health, at least one of the officers should have looked at the most recent COPS entries. There was no positive evidence before me that either police officer did not have time to do this.

90. It is clear that Ash showed signs of mental illness when in custody on 15 July 2019. The custody management record includes, "*Appears to have a mental illness, consistently talking to himself belligerent towards police, banging dock door, yelling out, 'This is fucked.'*" In response to, "*Does the person appear irrational?*" Sergeant Holstein entered, "*Yes.*" The comment thereunder, "*Uncooperative towards police. Appears to possibly have a mental health problem.*" There is also a long list of items under the heading "*questionnaire*", all of which are marked "*refused*", indicating Ash refused to respond in relation to, for example, tablets, drugs, insulin, medication, and whether he currently had a mental illness.

91. Whilst it is clear Ash showed signs of mental illness, the next issue raises the question of the application of s 22 of the Mental Health Act. The issue, as posed, was whether action *could* have been taken by police in relation to s 22. Of course, that option was available to police. As the inquest ran, the issue became whether Sergeant Holstein *should* have exercised the power pursuant to s 22. Earlier in these findings, I referred to a portion of s 22. I will now further refer to s 22 and add a further relevant portion.

> *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 them to a declared mental health facility if the officer believes on reasonable grounds that the person is committing, or has recently committed, an offence or the person will attempt to cause serious physical harm to himself or any other person, and 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. A police officer may apprehend*

a person under this section with a warrant and may exercise any powers conferred by s 81 on a person who is authorised under that section to take a person to a mental health facility or another health facility.

92. It is important to consider what information Sergeant Holstein had available to him as at July 2019. His evidence was that he had undertaken a custody manager's course many years prior. He indicated there would have been some further education, but he could not recall when or any particular content of any education subsequent to the course which he undertook in about 2004. He had available to him, firstly, the New South Wales Police Force Handbook, containing a chapter on custody. The handbook version was the 2018 version. At p 11, the following was recorded: "*If you have concerns about the person's mental state, arrange an assessment by a mental health team.*"

93. At p 25, under the heading, Medical Matters:

> "*Seek medical attention immediately if you have concerns about a detained person's mental or physical condition. Continually assess the level of risk. Increase inspection frequency if the level of risk increases.*"

94. Interestingly, the custody management record indicates an *inspection frequency* of ten minutes. Sergeant Holstein indicated he did not know where the *ten minutes* came from. His usual approach was to inspect every 30 or 60 minutes. Mr Kellaway drew attention to the short period for which Ash was in custody. Sergeant Holstein indicated he could see Ash all that time. That evidence was incorrect to the extent that Senior Constable Duxbury took Ash into a separate room to apply the secondary test. Sergeant Holstein indicated he had been in that room, at one stage, to use either a printer or a photocopier. As the custody manager, he would have been required to look at or inspect Ash with some level of frequency. It is likely it is as he recorded, every ten minutes, suggestive of the concern otherwise detailed in the custody management record.

95. The next document available to the sergeant was the Kempsey Police Station Local Custody Management Directions (Kempsey Directions). That guidance documentation, published in August 2018, was superseded shortly after Ash's passing. The Kempsey Directions noted that if a prisoner had an injury, an assessment needed to be made about the need for treatment by an ambulance at the scene or the need to convey them to hospital. This included a mental health assessment. The Kempsey Directions made no mention of transfers to a mental health facility, pursuant to s 22 of the Mental Health Act 2007. In pointing to that evidence, Superintendent Toynton noted the reference I have already referred to in the Handbook custody chapter about arranging an assessment by a mental health team. As I have indicated, the Kempsey Directions were superseded by the 2019 Standard Operating Procedures on 31 July 2019 and ceased to have effect from that day. The Kempsey Directions did not contain information about contacting a local community mental health team or a person in custody's known treating clinician, as further set out in the evidence of Superintendent Toynton.

96. Also available at the time was the New South Wales Police Force Handbook chapter on mentally ill people, with an entry:

> "*Alternative options for mental health intervention. Where concerns are held by police about a person's mental health status that has not met the criteria for the person being detained and taken for assessment under s 22 of the Mental Health Act, the New South Wales Police Force promote the use of alternate means of intervention, which could include referral to a community health team, contacting the mental health line [the number is then provided, and an indication it is a 24/7 service], engaging a member of the person's family or a primary carer to take responsibility for the welfare of the person, where possible, making an attempt to contact the person's treating clinician or care coordinator, engaging the services of Ambulance Service of New South Wales, who may detain and take for assessment the person where the ambulance officer believes on reasonable grounds that the person is mentally ill or mentally disturbed.*"

97. There was also information in the handbook relating to s 22 of the Mental Health Act. It is noted that the evidence suggests that this particular guidance material was not directly aimed at custody managers. However, it was available online, and it was part of the New South Wales Police Force Handbook. It would not take precedence over a custody manager's reference to the custody chapter, but in my view, it should sit alongside the information provided in the custody chapter, supplement that information, and fill in any relevant gaps.

98. Sergeant Holstein appeared to have little to no knowledge of the additional options. He had a limited view of s 22 in that he seemed to think the only issue to be considered was whether Ash was a threat of physical harm to himself or anyone else. He did not consider the issue of whether he believed on reasonable grounds Ash had committed an offence. However, as Mr Kellaway correctly pointed out, as other criteria had to be met, and Sergeant was not satisfied that Ash presented a risk of harm to himself or others, or that it would be beneficial to Ash's interest to take him to a declared mental health facility it was of little moment that the Sergeant did not consider whether he believed on reasonable grounds that Ash had committed an offence.

99. Despite the content of the custody management record, I do not second-guess the Sergeant's decision in relation to s 22. It may be that an underpinning consideration for the Sergeant was the high bar for people sent to Hospital for assessment. As he expressed it, his experience was, when he did send people to Hospital pursuant to the provisions of s 22, they were mostly sent back. There were also numerous references by himself, Superintendent Toynton, and Superintendent Hales, as to the fact that many people present in custody in a manner not dissimilar to the way Ash presented. As I say, I do not second-guess that determination of Sergeant Holstein.

100. However, it was the next step that could have been taken that is most troubling. Sergeant Holstein's evidence was that the only alternative option he would consider as at 2019 was to call an ambulance. Despite the content of the custody section of the New South Wales Police Force Handbook reading, "*If you have concerns about the person's mental state, arrange an assessment by*

a mental health team", Sergeant Holstein only ever applied s 22 or, if he was unsure whether to use s 22 or not, called the ambulance service, and had the ambulance service assist him. He had no other fallback position, and explicitly, and until this day, has never contacted a mental health team. That is a regrettable situation. As I will touch upon shortly, I would hope that situation can be remedied and that it is not reflective of custody managers across the State.

101. Clearly, from the guidance material available, the Sergeant could have and should have contacted the mental health service. There was ample information in his own document - that is, the custody management record - stressing his concern as to Ash suffering a mental illness, of Ash appearing irrational, consistently talking to himself, to prompt him to have Ash assessed by a mental health team. I accept he could not have kept Ash in custody for that purpose, and if the time imperative did not allow for that to occur whilst Ash was in custody, then he should have at the very least, contacted the mental health service once Ash was released.

102. Issue 7 relates to the discharge of Ash. When being discharged, Ash, on the evidence, remained uncooperative. Police asked if Ash required someone to pick him up. He said he would walk home. They offered to call someone. He said, "*Fuck you. I will walk*," or words similar. I note that on the evidence, Sandra did not have a licence at that time. The prospect of Ash, given Sergeant Holstein's observations of him, walking or attempting to walk 50 kilometres home was a daunting prospect. Sergeant Holstein did not think Ash would try to walk that entire distance. I think that was a genuinely held thought.

103. There was some evidence that a scuffle had occurred between the Sergeant and Ash at some stage. This evidence came from Sandra in a recent statement. Inquiries have been made in relation to the issue. Sandra set out in her statement that a police officer had told her that there had been a scuffle. The officer in charge of the coronial investigation, Senior Constable Richards, investigated the issue, finding out the names of all police officers on duty at the relevant times and asking them if they had any recollection of either a scuffle

or of telling Sandra or any family member of a scuffle. Sandra had given a description of the officer who conveyed that information to her. Whilst Sandra's statement was relatively recent, her GP's note from 22 July 2019 records, "*Whilst in the police station, Ash had a conflict with the sergeant before they discharged him to find his way home*."

104. It is accepted by Mr Evenden, on behalf of the family, that, on the evidence, I could not be satisfied there was a scuffle. Sergeant Holstein denies there was physical interaction. In my view, it is quite possible there was some form of conflict, given the Sergeant's description of the way Ash conducted himself and the Sergeant's various references to Ash apparently not liking him. There was some focus during the inquest on the fact that the descriptions of how Ash behaved at the police station were different to what was revealed by the in-car video in terms of Ash's interactions with Senior Constable Duxbury. There was no detail in Senior Constable Duxbury's statements as to poor behaviour by Ash. In those circumstances, I think it is likely there was some form of interaction which could be described best as conflict, likely around the time Ash was leaving the station, but as I say, I certainly cannot determine there was any scuffle.

105. It remained open to police, as I have indicated, to call the mental health service. However, as I have set out in detail, that is not something that Sergeant Holstein was going to do. It was not an option he was aware of. He should have been aware of it. That is, the option of engaging the mental health service or team. If time stopped him the Sergeant engaging the Community Mental Health team, because Ash had to be released, then the Sergeant could have contacted the mental health service. He could have done that at any time, preferably, shortly following Ash's release, at the latest, and simply indicated he had a concern for Ash's well-being and where Ash had last been seen. If there was an informed and healthy relationship between police and the local mental health service this would have been and obvious step to take.

106. What, then, for the future in relation to some of the deficiencies I have referred to in considering these issues?

107. Firstly, there is to be two-yearly re-accreditation of custody managers. They will be examined every two years, albeit in an open-book examination. The fact of being examined and needing to be re-accredited will draw attention to being properly across the guidance material. The testing will, no doubt, be accompanied by opportunities for ongoing training. The re-accreditation proposal is to be applauded. During the currency of this inquest, it was confirmed that it was due to start on 4 August this year.

108. Secondly, in relation to roadside drug testing, the <u>secondary</u> testing can now be done on the side of the road, either at the time of the stop or at a police truck similar to an RBT truck if police are conducting an operation. This completely removes the need for drivers who have tested positive to the first test being taken back to police stations.

109. Thirdly, the mental health command, under Superintendent Hales, is in the process of developing a one-stop shop in terms of the guidance material relating to mental health. It is anticipated this will be available by the end of the year. My reference to the various and varying material available to Sergeant Holstein as at July 2019 would underscore the potential benefits in there being one document with all the guidance material relevant to mental health. Particularly relevant in relation to Ash's circumstances is that there will be more guidance around the breakdown, as expressed by Superintendent Hales, of section 22 of the *Mental Health Act*.

110. Fourthly, Superintendent Hales' evidence is that endorsed for the future will be an approach where police, when appropriate, ring the mental health line set up by New South Wales Health. Superintendent Hales' appropriately acknowledged that she is "police", not "health", and indicated that there are ongoing discussions in this area, but the preferred police endorsed approach statewide is that police be made aware of the capacity to ring the mental health line (which is run by "health") as the first step to take. Within that approach, if there are well-functioning local arrangements, pursuant to the memorandum of understanding between health and police, through well-functioning local MOU protocol committees, and a healthy relationship, in particular, between

community mental health and police, calls can be made directly to mental health services. That is, the first point of contact is either the mental health line or, in circumstances where there are appropriate local arrangements, the mental health services.

111. The second option is to call an ambulance. Sergeant Holstein's evidence was that he currently has only two options. If he has not exercised s 22 but still has concerns, as I have indicated, he will call the ambulance service. He noted that they sometimes complain. That is understandable. There is much community awareness of the strained ambulance services. Another benefit of access to the health line, or strong local arrangements with mental health services, is removing any additional burden upon ambulance services.

112. As appropriately acknowledged by all parties, an aspect of the tragedy of Ash's death is that Mental Health knew he was unwell, Sergeant Holstein knew he was unwell, and yet neither contacted the other. The police station and the hospital, on the evidence, were within a very short distance of each other. It is, with the benefit of hindsight, very difficult to contemplate the reality that there was no contact, no communication between the two agencies on that day.

113. The evidence in this inquest makes crystal clear the potential benefits of a strong local arrangement and understanding, where communication can be free flowing between mental health services in a local health district and police in a local area command. I urge the Mid North Coast Local Health District and the Mid North Coast Local Area Command to do all they can to develop strong communication lines between police and mental health services throughout their geographical areas of responsibility. On the evidence in this inquest, in particular, I urge that all be done to develop such communication between police stationed at Kempsey Police Station and the Kempsey Community Health Service. It would be a very significant outcome from the tragedy of Ash's death if a healthy relationship were built such that information was free flowing where appropriate.

Issue 8: Was there an adequate response by police to the emergency report by Kevin Wood at about 9pm on 15 July 2019?

114. On the evidence, it is uncontroversially the case that the response was appropriate in two police being dispatched to travel up and down the highway in the identified area to see if they could see anyone. General Duties Unit officers Zamora and Carter undertook this task.

MANNER OF ASH's DEATH

115. In relation to the formal findings the only issue at inquest was: *What were the circumstances of Ash's death?*

116. The only question to be considered was whether there was any basis at all to conclude that Ash came into collision with the truck because of a deliberate act of self-harm. I find there is no basis for me to conclude that was the case, and a strong basis to conclude that Ash had no intention to deliberately self-harm and did not do so.

117. Firstly, there is the evidence of both Sandra and Mr Cotterill that there was no suggestion from Ash of any thought of self-harm. Secondly, at the time, Ash was suffering from a relapse of schizophrenia and methamphetamine use. Thirdly Professor Jones, expert toxicologist, found the level of methamphetamine present in Ash's system prior to death was likely in the toxic range and contributed to his risk of developing cognitive effects, including psychotic effects and agitation, which can lead to poor judgment and increased risk of being involved in accidents and trauma. Fourthly Dr Eagle referred to the potential for dehydration in Ash undertaking such a long walking journey. Finally, on this topic, I am satisfied the area of damage to the truck wheels is suggestive of a falling into rather than a walking into in terms of the physics of the collision. Ash's death was a result of misadventure.

PROPOSED RECOMMENDATIONS

118. I now turn to the question of recommendations.

There were two recommendations from counsel assisting, each to the New South Wales Commissioner of Police.

Recommendation 1

119. Recommendation 1: consider amending the charge room and custody management SOPs and/or the police handbook to clarify the nature and extent of a review of information held on police systems that should be undertaken by arresting/escorting officers and custody managers where a person is in custody.

120. This issue was explored, in particular, with Superintendent Toynton in view of the failure of either police officer to examine the COPS records. It was accepted by Superintendent Toynton that more clarity could be provided, and there was no resistance to the recommendation.

Recommendation 2

121. Recommendation 2: consider providing guidance to officers in charge of coronial investigations, where a person has died following a recent period in police custody, to ensure any CCTV footage depicting the person in custody is retained for the investigation.

122. This recommendation arose from the circumstance of the completely understandable and dedicated focus of the first officer in charge upon the circumstances of the incident. My earlier setting out of aspects of the investigation makes clear just how thorough that investigation was in terms of the accident. Later in the investigative stage, attention turned to the circumstances of Ash's custody, given his mental health position. By that time, the CCTV footage had not been retained. The evidence was that currently positive steps need to be taken to retain CCTV footage after six months or the

footage is no longer available. It is in that circumstance that the provision of guidance material for officers in charge is recommended.

FORMAL FINDINGS – FINDINGS REQUIRED BY SECTION 81(1)

123. As a result of having considered all of the documentary and electronic evidence, and the oral evidence given at the inquest, pursuant to section 81(1) of the Act, I make the following findings in relation to the death of Ash Paull.

I. **The identity of the deceased:** The person who died was Ashley Ronald Paull ("Ash").

II. **Date of Death**: Ash died on 15 July 2019.

III. **Place of Death**: Ash died on the Pacific Highway at Clybucca.

IV. **Cause of death:** The cause of Ash's death was multiple injuries.

V. **Manner of death:** Ash's death was through misadventure and occurred in the context of him suffering a relapse in schizophrenia and methamphetamine use. Ash was struck by a truck while walking along the Pacific Highway after being released from Police custody.

RECOMMENDATIONS

124. Pursuant to section 82 of the Act, Coroners may make recommendations connected with a death. I am of the view that the evidence supports that the recommendations outlined below are appropriate and are necessary or desirable to be made in relation to Ash's death.

To the NSW Commissioner of Police:

1. Consider amending the Charge Room and Custody Management SOPs, and/or the Police Handbook, to clarify the nature and extent of a review of information held on police systems that should be undertaken by

arresting / escorting officers and custody managers where a person is in custody.

2. Consider providing guidance to officers in charge of coronial investigations, where a person has died following a recent period in police custody, to ensure any CCTV footage depicting the person in custody is retained for the investigation.

ACKNOWLEDGEMENTS AND CONCLUDING REMARKS

125. Before closing this inquest, I would like to express my sincere and respectful condolences to Ash's family and friends, and thank Ash's partner Sandra, her family members and Aunty Cheryl for their participation in the coronial process generally and specifically in the inquest.

126. The family were greatly supported by the wonderful ACISP team of Nicole Lowe and Simone Kubecka. The compassion and dedication of ACISP is an integral part of the coronial jurisdiction. They are much admired for their work and the family expressed their gratitude to them during the inquest and subsequently.

127. I would like to acknowledge Senior Constable Richards and thank him for taking over the investigation. I am most grateful for the way Senior Constable Richards attended to the issues that arose and the assistance he has provided.

128. I thank all the lawyers involved. They all participated in a most helpful and respectful manner. The benefit to the family of the way the lawyers approached their roles was touchingly illustrated in the exchange between Mr Kellaway and the family when referencing the family statement and in particular the music within that statement.

129. Finally, my thanks go to the assisting team of Mr Harris, Ms Pearson, Ms Ward and their predecessor Ms Boatman. The team were tireless in their attention to the extensive information in the original brief, dedicated to examining all relevant areas of investigation, efficient in formulating the issues that were

ultimately considered and endlessly co-operative during the inquest which enabled oral reasons underpinning these findings to be delivered on country the day after the close of the evidence.

130. I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

25 August 2025

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