



**CORONERS COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of JF
Hearing dates:	3 November 2025
Date of findings:	3 November 2025
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Magistrate Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death as a result of a police operation – mental health – appropriateness of police response – suicide prevention measures at Redhead Headland
File number:	2024/00057088
Representation:	Ms K Heath, Counsel Assisting the Coroner, instructed by A Jeffares, Crown Solicitor's Office Mr C Norman, solicitor, representing the Commissioner of Police
Non publication order:	A non-publication order has been made pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) in relation to parts of the brief of evidence. Further non-publication and pseudonym orders have been made pursuant to s75(2)(b) and s75(4) of the <i>Coroners Act 2009</i> (NSW). Copies of these orders are on the Registry file.

<p>Findings:</p>	<p>The identity of the deceased</p> <p>The person who died was JF</p> <p>Date of death</p> <p>JF died on 12 February 2024</p> <p>Place of death</p> <p>JF died at Redhead Beach, Redhead NSW 2290</p> <p>Cause of death</p> <p>JF died of multiple injuries</p> <p>Manner of death</p> <p>JF died after she propelled herself from the edge of a cliff onto the rocks below with the intention of ending her life while in the presence of police officers who attended in order to intervene.</p>
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1 Introduction

- 1.1 This is an inquest into the death of JF. JF was 60 years old when she died at approximately 10:00pm on 12 February 2024. JF died after propelling herself off the edge of a cliff at Redhead Headland.
- 1.2 In the years leading up to her death, JF experienced a decline in her mental health. She was admitted to hospital on three occasions following expressions of suicidal intention and was diagnosed with a major depressive disorder for which she was prescribed antidepressants.
- 1.3 At the time of JF's death, officers from the NSW Police Force (**NSWPF**) were present and were attempting to engage with JF. However, without warning, JF stepped towards the edge of the cliff and jumped head first from the cliff, resulting in fatal injuries.
- 1.4 In making these findings, I acknowledge the profound impact that JF's death has had, and will continue to have, on both her immediate and extended family and I extend my sympathies for their loss.

2 Why was an inquest held?

- 2.1 Under the *Coroners Act 2009* ("the Act") a coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a coroner can answer questions that are required to be answered pursuant to section 81 of the Act, namely, the identity of the person who died, when and where they died, and the cause and the manner of that person's death. A secondary function of a coroner is to make recommendations, arising from the evidence, in relation to any matter connected with the death.
- 2.2 The combined effect of sections 23 and 27 of the Act is that it is mandatory for a senior coroner to hold an inquest in circumstances where, as in this case, a person has died as a result of a police operation. This is because where an individual dies during a police operation, it is important to examine whether the significant power that the state places in the hands of police officers, is used in a way that is both lawful and appropriate.
- 2.3 The material gathered during the coronial investigation was tendered at the commencement of the inquest in the form of a five-volume brief of evidence. There was no factual controversy in relation to the circumstances leading to JF taking her own life and many of the issues that the coronial investigation explored had been satisfactorily

answered by the time of the inquest. For this reason, none of the witnesses who provided statements were required to give evidence.

- 2.4 Counsel assisting provided a detailed summary of the evidence in this matter in her very comprehensive submissions. In preparing these findings I have relied heavily on her account which, in my view, accurately reflects the evidence before me.

3 JF's life

- 3.1 While any inquest inevitably focuses on the circumstances of the death of a person, it is important to recognise and acknowledge the life of the person the subject of the inquest in a brief and hopefully meaningful way, in order to appreciate what their life, and their loss, meant to those who knew and loved them.
- 3.2 JF was born on 17 December 1963. She was one of five children born to her parents' relationship. Her father was a police officer, and during JF's childhood the family moved from place to place in NSW due to his work. Aside from these moves, JF's sisters believed JF's childhood to have been a happy one.
- 3.3 JF moved out of home when she was about 17 and went to work in Sydney after completing secretarial studies at TAFE. After living with one of her sisters in Sydney for a few years, in 2009 she moved to Newcastle where she was employed as an 'executive assistant'. She was good at her job, and her skills were sought after.
- 3.4 In 2010 JF met BD. They were married on 28 September 2013. JF and BD loved each other and got along well. However, JF would have issues with anxiety 'from time to time' and had trouble sleeping.
- 3.5 JF commenced working at the University of Newcastle not long after she and BD married. She formed a good group of work friends and for the most part enjoyed her work. However, in around 2020, JF started a new position at the University of Newcastle. She reportedly experienced significant difficulties with her supervisor, who she felt did not appreciate her or value her skills. This weighed heavily on JF and caused her significant anxiety. JF stated that she hated her job and was having trouble sleeping. At around this time, JF was in a 'catatonic state from anxiety and depression.'
- 3.6 Those who were close to JF noticed that in the years preceding her death JF was having trouble sleeping and was struggling increasingly with her mental health. JF's husband and

her family did everything they could during this time to support JF and to be vigilant for signs of that she was considering taking her own life.

- 3.7 It was clear from evidence in the brief of evidence and from information provided by BD in the course of the inquest, that JF was very much loved and continues to be very much missed.

4 Events leading up to JF's death

First mental health incident

- 4.1 On 5 July 2021, JF went missing and was found in the cliff area at Bar Beach or Mereweather and was having suicidal thoughts. BD convinced JF to come home.
- 4.2 JF was voluntarily admitted to the Mater Hospital before being released into BD's care. While at hospital, she told staff she had been driving to different locations and was contemplating jumping. This included Redhead Headland.
- 4.3 Following this incident, JF was prescribed medication by her general practitioner to assist with sleeping. However, this did not assist and JF told TP that she was 'in a fog' due to the medication and lack of sleep.
- 4.4 At around this time, JF's family were concerned for her welfare. She was very depressed, anxious and had a flat mood. TP attributed this to JF's difficulties with sleeping.

Second mental health incident

- 4.5 On 12 July 2021, JF went missing again. She was found by BD lying on the side of the rocks at Caves Beach, on the edge of a cliff. BD pleaded with her and hugged her for around 10 to 15 minutes. JF then got up and walked out of the bush with BD.
- 4.6 JF was taken by ambulance to the Mater Hospital and was admitted as an involuntary patient. She told hospital staff that she had intended to jump but there were too many people on the beach, and so she laid down instead. She said her sleep had been poor for weeks prior to the incident.
- 4.7 BD described the Mater Hospital as a 'horrible place to be' and arranged for JF to be transferred to Warners Bay Private Hospital. JF was admitted to Warners Bay Private Hospital on 22 July 2021. On admission, she was diagnosed with adjustment disorder with depressed mood. Her recent change of job and relationship issues due to COVID were

reported to have led to poor sleep, poor concentration, poor appetite and overwhelming thoughts leading to suicidal behaviour. She had been started on Escitalopram following her previous admission to Mater Hospital and was also taking Seroquel. The Seroquel was tapered and stopped during this admission.

- 4.8 JF was discharged from Warners Bay Private Hospital on 12 August 2021. Her discharge plan included follow-up arrangements with her psychologist and her general practitioner.
- 4.9 According to BD, JF seemed 'ok' and was progressing well after her discharge from Warners Bay Private Hospital. She worked a cleaning job and then started work in a different department at the University of Newcastle. According to BD, JF 'loved her job.' BD believed that JF was taking her prescribed medication.

Third mental health incident

- 4.10 On 7 March 2023, BD and JF were at home alone. BD came out of his office and saw blood and blood-stained knives in the bathroom. He went into the backyard and saw JF standing on the roof of the garage 'with blood pouring out of her neck' and 'in a zombie like state.'
- 4.11 BD climbed onto the roof of the garage and coached JF down. He called triple zero. Paramedics attended and conveyed JF to Mater Hospital.
- 4.12 On 9 March 2023, JF was admitted to Warners Bay Private Hospital. On admission, her diagnosis was recurrent major depressive disorder. She was commenced on Mirtazapine 7.5mg, which was gradually increased to 30mg. She engaged well with individual psychotherapy and inpatient dialectical behaviour therapy (DBT). She started to sleep well and could 'feel the fog lifting.'
- 4.13 JF was discharged from Warners Bay Private Hospital on 13 April 2023 with a plan to follow-up with her general practitioner. It was suggested that she continue her current medication for 12 months. The need for ongoing psychological support in the community was noted, as well as 'possibly' a review by a psychiatrist in 6 to 12 months. Her medications on discharge were Mirtazapine and Escitalopram.
- 4.14 On 6 June 2023, JF had an appointment with her general practitioner in relation to her recent admission. Her general practitioner recorded that she was 'overall doing well' and had 'booked at newpsych for ongoing DBT through EAP'. They discussed a 'MHCP [mental health care plan] if uses all EAP sessions up.' While JF remained engaged with her general practitioners, who continued to prescribe her with Mirtazapine and Escitalopram, it does

not appear that she sought any psychological or psychiatric appointments following her discharge.

- 4.15 JF's last appointment with her general practitioner was on 29 January 2024. JF's medical records from her general practitioner do not reveal any acute mental health concerns following her discharge from Warners Bay Private Hospital.

Events leading up to 12 February 2024

- 4.16 After JF's discharge, things were going well again. However, there were several stressors in her life, including the illness of family members and friends and a minor car accident. Despite this, JF seemed to be fine, had a good circle of friends and made plans for the future.
- 4.17 In December 2023, JF celebrated her 60th birthday at a bowling club. According to BD, she seemed happy. However, in the weeks prior to her death, JF's mood declined. According to TP, JF told her that she was worried about financial commitments. TP asked if she had been to see her psychologist. JF said that it did not really help.
- 4.18 According to BD, everything seemed fine until around a fortnight prior to JF's death. She told him she was feeling flat, anxious and useless. She appeared to stress over the smallest things. According to JF's sister, PO, JF's problems 'tended to fester in her mind and bear heavily on her and her mental state.'
- 4.19 On 7 February 2024, JF resigned from her job at the University of Newcastle because she was 'not enjoying [it] at all'. Her last day was scheduled for 21 March 2024. She viewed this as her retirement.
- 4.20 On 11 February 2024, JF went for a walk with her sisters, TP and PO. She appeared fine but spoke about some negative aspects of her life including the illnesses of a friend and BD's brother. That evening, JF attended a birthday dinner for TP. She was in a fairly good mood.

5 Events of 12 February 2024

- 5.1 On the morning of 12 February 2024, BD woke up and gave JF 'a cuddle and a kiss' before he left for Sydney.
- 5.2 At 8:57am on 12 February 2024, JF was captured on CCTV at the University of Newcastle carpark. She parked her car and walked in the direction of her workplace.

- 5.3 At 1:37pm, JF was captured on CCTV walking back towards her car. She drove in the direction of University Avenue, Callaghan, at around 1:40pm.
- 5.4 JF's movements between 1:40pm and 3:08pm are unknown.
- 5.5 CCTV footage from Iluka Street in Redhead shows JF's vehicle on three occasions on the afternoon of 12 February 2024. At 3:08pm, her vehicle travelled East along Illuka Street. At 3:10pm, her vehicle was again captured travelling East. At 3:11pm, her vehicle travelled West along Iluka Street before coming to a stop and parking on Iluka Street. The residents of the premises near where JF had parked saw JF get out of her car and walk towards the Redhead Headland.
- 5.6 At 3:34pm, JF sent a text message to BD stating, 'I love you.' BD texted back, 'I love you too. Is everything going OK.' JF replied, 'Yes, I'm fine.' This was the last time BD heard from JF.
- 5.7 At around 3:40pm, JF sent a text message to her sisters, PO and TP, asking if they could collect her dog from her house as she thought it might be hot. PO collected the dog and took it to TP's house. She tried calling JF and sent her a text message at 6:00pm but did not receive a response. PO and TP went to JF's house, but she was not there. They were concerned for her welfare, and so at around 6:50 pm, they reported her missing at Waratah Police Station. Police attended JF's address but were unable to raise anyone. They obtained the door access code from BD and entered the residence and confirmed that no one was home.
- 5.8 BD attempted to call JF multiple times but did not receive a response. At around 8:00pm, he left Sydney to return to Newcastle.
- 5.9 The residents of the premises near where JF had parked were concerned that JF had not returned to her vehicle as the area was known to them for people self-harming. As a result, they called triple zero at around 8:00pm.
- 5.10 Police identified JF's car registration as being associated with the missing person report made by her sisters. At around 9:00pm, Senior Constable Geoffrey Searant and Constable Samara Smith attended Redhead Headland. They walked along the track at Redhead Headlands towards the cliff face. They came across a memorial site and saw a pair of crosses just outside it. Inside the memorial site, they saw a mobile phone, a set of keys and a pair of reading glasses. While police were inspecting these items, the phone rang and showed the name of BD. Police realised that these items belonged to JF.

- 5.11 Senior Constable Searant and Constable Smith then started scanning the cliff face for JF. At around 9:05pm, Senior Constable Searant saw JF 'tucked down' on a crevice. He called out her name. She looked at him, stood up and then walked to the edge of the cliff face and then looked at him again. She began to squat down and stand up several times while looking over the cliff edge. Senior Constable Searant activated his body worn video camera.
- 5.12 Constable Smith informed police radio that JF was on the cliff edge. She observed that JF appeared 'frantic and agitated' and kept looking at police. She did 'half-squat' movements and went backwards and forwards to the cliff edge, as though she was going to jump but 'just couldn't bring herself to do it.'
- 5.13 At 9:07pm, police requested assistance from negotiators as JF was not talking to them and was moving towards the edge of the cliff.
- 5.14 At around 9:12pm, Sergeant Nicholas Carroll arrived and saw JF on the edge of the cliff with Senior Constable Searant around 30 metres back. JF appeared to be moving backward and forward to the cliff edge and was bending at the knees at times. It appeared to him 'like she was pumping herself up to jump.'
- 5.15 Constable Smith returned to the entry to the track on Iluka Street to guide responding Police Rescue and Fire and Rescue NSW (**FRNSW**) officers to JF's location.
- 5.16 Sergeant Carroll and Senior Constable Searant decided that they would not approach JF and would have negotiators attend the scene.
- 5.17 Acting Inspector Magann arrived and established a command post on Iluka Street. Acting Inspector Magann spoke to Sergeant Carroll and formulated a plan to try to negotiate with JF until specialist negotiators arrived to assist.
- 5.18 At some point, JF's sisters, TP and PO, arrived. They asked to speak to JF. However, this request was refused by police. They asked police to mention JF's dog to her.
- 5.19 Sergeant Carroll then spoke to a specialist police negotiator, referred to by the pseudonym Negotiator 3, who advised police to:
- nominate just one police officer to speak with the subject to model a calm, clear, reassuring communication;
 - reassure the subject that police are not going to approach, and that they were there to help her;

- keep talking to the subject without upsetting her;
- have other police obtain collateral information about the subject by contacting next of kin contacts and the local hospital; and
- not introduce any family to the conversation unless she brings it up or a background assessment is completed.

5.20 The negotiator also advised police that they should not get too close to JF or physically intervene, and to use their body worn video cameras.

5.21 From around 9:06pm, Senior Constable Searant continuously attempted to engage with JF. Throughout the encounter, he adopted an empathetic and reassuring manner and invited her to come and talk to him and another officer. He encouraged her to move away from the cliff edge and offered to get her assistance. He attempted to speak to her about her dog and offered to collect her dog for her. He offered her coffee and reassured her that she was not in trouble.

5.22 JF occasionally responded to police, although it is difficult to make out her responses on the body worn video. The officers at the scene had difficulty hearing her, although Sergeant Carroll heard her say that she wanted to die. She also yelled out, 'no' when Senior Constable Searant asked if he could get closer.

5.23 According to Senior Constable Searant, during this period, JF remained on the edge of the cliff while he tried to engage with her. He was approximately 35-40m away from her. She would occasionally move back from the edge of the cliff.

5.24 Between around 9:35pm and 9:40pm, Police Rescue officers, Senior Constable Hair and Senior Constable Richardson arrived. Senior Constable Richardson and Sergeant Carroll agreed on an Emergency Action Plan. This plan was not documented in writing because planning needed to be done quickly and on-the-go. They prepared a 'suicide intervention kit' which consisted of specialised equipment such as a quick release coupling system used to control falls, 50m of rope, an ASAP (a two-person system that regulates the rate at which something falls), and a harness that can be used to harness the suicidal person or negotiator.

5.25 Police Rescue officers walked through the bush and scrub towards the cliff edge. They set up a harness and anchor point, and Senior Constable Hair began to descend towards JF. The purpose of this was to manoeuvre police into a position to assist JF to return to safety if she

chose to or to help negotiators get to a safe position where they could negotiate with JF. Specialist officers from FRNSW were also present to assist police. The presence of FRNSW officers is evidence of the forward planning by Police Rescue to have extra personnel available if necessary.

- 5.26 Senior Constable Hair began to slide across the terrain leading down to the cliff edge, to be directly in line with JF. He observed her to walk over to the cliff edge a number of times and crouch down and bend her knees as if preparing to jump.
- 5.27 Towards the end of the body worn video recording, Senior Constable Searant can be heard to call out 'No, [JF], No.' According to Senior Constable Searant, JF was about four steps from the cliff edge at this point. She took three or four steps from the cliff edge, put her arms out in front of her, and 'swan d[ove]' off the edge of the cliff. According to Seargent Carroll, JF jumped 'head first.' Senior Constable Hair saw her dive off the cliff with her arms raised 'as if diving into water.'
- 5.28 JF jumped off the edge of the cliff at 9:59pm.
- 5.29 Police located JF's body at the bottom of the cliff at 10:22pm and confirmed that she was deceased.
- 5.30 Police calculated that the height of the cliff was approximately 42.3m above sea level.

6 What issues were considered at the inquest?

- 6.1 The following issues were considered at the inquest:
1. Whether JF jumped from the cliff edge deliberately and with the intention of ending her life.
 2. The police response, including:
 - a. The availability and resourcing of police negotiators, particularly in regional areas;
 - b. Whether an action plan should have been put in place to try and restrain JF;
 - c. Whether police officers received appropriate training in responding to mental health crises and suicide interventions.
 3. Whether suicide deterrence measures are required at Redhead Headland.

7 The cause and manner of JF's death

Cause of death

7.1 On 15 February 2024, forensic pathologist, Dr Donovan Loots conducted an external postmortem on JF. Toxicological analysis of JF's blood detected the presence of non-toxic levels of Citalopram and Mirtazapine. The toxicology results were non-contributory to the cause of JF's death. In his report of 28 May 2024, Dr Loots recommends that the cause of JF's death be recorded as 'multiple injuries.'

7.2 I accept the opinion of Dr Loots as to the cause of JF's death.

Manner of death

7.3 A finding of death by suicide is to be made on the balance of probabilities and in accordance with the principles set out by Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 336. It is necessary that it be proven by clear, cogent and exact evidence.

7.4 Having regard to the following, I am satisfied that JF died as a result of actions taken by her with the intention of ending her life:

- the manner in which JF jumped from the cliff, specifically by taking deliberate steps towards the edge of the cliff and diving off;
- the length of time that she stood on the cliff edge making motions consistent with preparing to jump;
- the comments she made while standing on the cliff edge, which included her saying that she 'wanted to die;' and
- her history of mental health issues and prior suicide attempts in relatively similar circumstances.

8 The adequacy of the police response

8.1 The police at the scene tried for nearly an hour to prevent JF from jumping from the cliff at the Redhead Headland.

8.2 The brief of evidence contained a number of applicable NSW Police Force policy documents. Counsel assisting submitted, and I accept, that no issues emerged during the inquest as to adherence with applicable policies and procedures during the course of the police operation. Further, I accept that while various decisions were not documented in writing,

this was due to the need to take timely action and in the circumstances I am not critical of this.

The availability and resourcing of police negotiators, particularly in regional areas

- 8.3 Police negotiators had been called and were en route to the scene when JF died. The coronial investigation considered whether negotiators were dispatched and made available in a timely manner. Evidence on this issue was received from the Manager of the Negotiation Unit in the Tactical Operation Group, given the pseudonym Negotiator 4, who has overall responsibility for the NSWPF negotiation capability throughout NSW.
- 8.4 Negotiator 4 explained that accredited NSWPF negotiators are available 24 hours a day throughout NSW. In regional NSW, Police negotiators perform negotiation duties on a part-time basis and in addition to their usual policing duties. Specifically, in the Newcastle and Central Coast area, there is a team of four part-time negotiators always rostered on-call. If they are requested, they are 'activated' by the North Region Resource Coordinator. They then need to leave their home, place of duty or other location, travel to a police station to collect a police vehicle, and their arms, appointments and equipment, then travel to the scene of the incident.
- 8.5 About 10 minutes passed between police first locating JF at about 9:06pm, and the North Region Resource Coordinator being briefed and negotiators being requested. Negotiator 4 opined that it was 'entirely appropriate' for first responders to make enquiries with the person as to their intentions, to engage with them, to ask them to surrender or move to a safer position and offer them the opportunity to seek medical assistance. This allows a proper assessment of the situation and consideration of the necessary resources.
- 8.6 The request for negotiators was activated in a timely manner, and a team of four negotiators being activated by 9:22pm.
- 8.7 Within three minutes of being activated, one of the negotiators (Negotiator 3) telephoned Sergeant Carroll and provided advice and guidance about engaging with JF. Negotiator 4 explained that the provision of advice and guidance is 'usually very effective' and can often result in the person surrendering before the arrival of specialist police. It also can de-escalate or reduce the threat level and assist in the management of on scene resources and information gathering.

8.8 Given the time of night, police negotiators likely needed to be recalled to duty from their homes. They would then have needed to travel to the Waratah Police Station to collect the Negotiator Equipment vehicle before driving to the scene. The response would be 'urgent duties' with lights and sirens being activated. By 9:54pm, approximately 32 minutes after being activated, the first car of negotiators broadcast that they were en route to the scene from Waratah Police Station.

8.9 Negotiator 4 expressed the following opinion:

At 21:59 LM 14 broadcast on the police radio [JF] has jumped off the cliff. This being some 43 minutes after negotiators were initially requested by the Supervisor at 21:16. Given it would have taken at least 5-10 minutes for the Region Resource Coordinator to obtain deployment and then telephone four Negotiators to brief and deploy them, I do not consider 35 minutes, (for them to stop whatever else they were doing, get changed, drive to the nearest police station, collect a vehicle and/or equipment then drive to the incident scene) to be an unreasonable amount of time especially in a regional area.

8.10 Counsel assisting submitted that this evaluation of the response should be adopted. She submitted that there does not appear to be any unreasonable or unexplained delay in the time between negotiators being requested and them being en route to the scene. Four negotiators were on-call and able to be efficiently activated, but there was some inevitable lapse of time due to the practical realities of deploying specialist police resources in regional areas. In the meantime, appropriate support by way of telephone advice was provided in a timely manner and followed by police at the scene. The Commissioner of Police adopted counsel assisting's submissions on this issue.

8.11 Having regard to all the evidence, I am satisfied that there were no unreasonable or unexplained delays in specialist negotiators responding to the incident involving JF. I accept the unchallenged evidence of Negotiator 4 in this respect.

Whether an action plan should have been put in place to try and restrain JF

8.12 The *Police Rescue Self Harm/Suicide Intervention Standard Operation Procedures* state that there needs to be an 'agreed action plan' prior to any deliberate action being taken to apprehend persons in a self-harm situation. This prompted questions as to whether there ought to have been an action plan put in place to try and apprehend JF.

8.13 The evidence of Negotiator 4 on this question was as follows:

It is not the role of a Police Negotiator to 'apprehend', presumably meaning to physically restrain or grab a person, in order to prevent their suicide. A Negotiator ought not to do so, especially at a dangerous height, as this poses an unacceptable safety risk to both the Negotiator and to the subject. This is reinforced in negotiation training. In practice, the physical restraint of an unwilling person at heights, is stringently discouraged even in the most urgent of circumstances.

8.14 Counsel assisting submitted that the safety concerns associated with attempting to restrain a person threatening suicide from a dangerous height are readily apparent. The photographs contained in the brief of evidence reveal the difficult and dangerous topography where the police operation took place. Consistent with the evidence of Negotiator 4, Sergeant Carroll described that the decision was made not to approach JF 'due to the risks involved,' and that the 'plan centred around negotiating [JF's] safety rather than take any physical action to try and remove her from the cliff top.' It is also relevant that JF had verbally indicated for police to stay away from her and so approaching her risked escalating the situation.

8.15 Further, counsel assisting submitting that Police Rescue were appropriately deployed not to restrain JF, but rather to provide support if JF wished to be extracted, or to allow police negotiators to safely approach her.

8.16 I accept the submissions made by counsel assisting that it was appropriate for police to remain at a distance from JF and not attempt to restrain her.

Whether police officers received appropriate training in responding to mental health crises and suicide interventions

8.17 The coronial investigation examined the training provided to general duties police officers, who will often be the first responders to a mental health crisis before negotiators arrive, in engaging and assisting people experiencing a mental health crisis and expressing suicidal intention. The inquest was assisted by a statement provided by Superintendent Kirsty Hales, who has held the role of Commander of the Mental Health Command since June 2024. The role of that Command is to provide strategic oversight and training regarding the NSWPF's response to mental health in the community.

- 8.18 Superintendent Hales sets out the relevant training in mental health that is provided to all police officers, from the time they commence as a student at the Academy and continuing throughout their career. Relevantly, since 2023, sworn police officers are required to undertake annual mandatory mental health training as part of their Mandatory Continuing Police Education. Prior to that time, mental health training was not an annual requirement, although a mandatory online training package titled *Mental health – STOPAR* was delivered in the 2020/2021 training year.
- 8.19 In the 2023/2024 training year, officers were required to complete an online mental health training titled *Mental Health – Signs, Symptoms and De-Escalation*. In the 2024/2025 training year, officers were required to undertake mandatory face-to-face mental health training titled *Mental Health – Communicate to Connect*. An outline of the content of both programs is annexed to Superintendent Hales' statement. The focus of each presentation is on de-escalation of a mental health crisis through communication. Training is delivered in relation to assessing a person for a risk of suicide. The 2023/2024 training focuses on a 'listen – pause – respond' model, teaching skills relating to controlling the environment, engaging in active listening, demonstrating empathy and building rapport, all as steps to try and influence a person's behaviour. The 2024/2025 training builds on these communication skills and also includes footage of survivors of suicide to explain a suicidal crisis from their perspective.
- 8.20 The NSWPF operation largely centred around engagement of JF by Senior Constable Searant, an experienced officer. Counsel assisting submitted that there is nothing in the evidence to suggest that he had received inadequate mental health training or that he lacked strategies for de-escalation. Senior Constable Searant's communication with JF was consistent with the training provided in that he persisted in trying to build rapport with her and responded empathetically to the situation, while noting the circumstances that made hearing and talking to JF difficult. Counsel assisting submitted that there is no basis to criticise the adequacy or appropriateness of the mental health training received by first-responding officers to allow them to adequately and appropriately engage with JF. I accept counsel assisting's submissions. Having regard to the material provided by Superintendent Hales, I am satisfied that police officers receive appropriate training in responding to mental health crises and suicide interventions.

Whether police officers should have permitted TP and PO to speak to JF

- 8.21 An issue that emerged in the course of the inquest was whether police should have permitted JF's sisters, TP and PO, to speak to JF after they arrived at the Redhead Headland.
- 8.22 In accordance with the *Police Rescue Self Harm/Suicide Intervention Standard Operation Procedures*, Negotiator 3 advised officers on the scene with JF that police should not introduce any family into the conversation unless the subject brought it up or a background assessment is completed. I accept that it was reasonable for police to refuse to allow TP and PO to speak to JF while she was at the edge of the cliff. At the time, police had not completed a background assessment and could not have known how JF might have reacted to the presence of TP and PO. In those circumstances, there was a risk that any interaction with JF might have escalated the situation. Further, JF's location meant that it would be necessary for TP and PO to approach the edge of the cliff for them to speak to her and be heard above the sound of the surf. This would have created a risk to safety of TP and PO given the difficult and dangerous topography where the police operation took place.
- 8.23 However, TP and PO told police to speak to JF about her dog. Senior Constable Searant did so on a number of occasions in attempt to build rapport with JF.

9 Whether suicide deterrence measures are required at Redhead Headland

- 9.1 Police were called to Redhead Headland with concerns for JF's welfare when residents of Illuka Street observed that her car had been parked at the entrance to the headland for several hours. The residents explained that their concerns stemmed from the fact that they knew of other people who had attended the headland in the past to attempt suicide. The inquest considered whether there were appropriate safety measures in place at Redhead Headland.
- 9.2 A review of police records of incidents at Redhead Headland indicated that, since 2020, there had been between three to five police interventions each year for attempted self-harm or suicide attempts, and three deaths by suicide (including JF). Lifeline, a national charity providing suicide prevention services, identified Redhead Headland as an area with increased suicidal activity.
- 9.3 Redhead Headland is managed by Lake Macquarie City Council (**the Council**). During the coronial investigation, information was sought from the Council about whether there were

any suicide deterrence measures in place at, or planned for, Redhead Headland. The response provided by Ms Helen Plummer, Director of Service Delivery, indicates that, since JF's death, steps had been taken by the Council to implement suicide deterrence measures, including as part of a Mental Health Partnership Signage Project conducted in collaboration with Lifeline Australia.

9.4 Specifically, after Lifeline identified to the Council that Redhead Headland was an area with increased suicidal activity, the Council installed two temporary signs in July 2021, and four permanent signs in June 2024. The signs offer clear guidance for individuals in distress and provide the details of Lifeline's phone service. The Council also erected fencing at key locations.

9.5 The location of the signs and fencing is marked on the map below, with a dot and line respectively. As indicated by the red arrow, there is now both signage and fencing at the approximate location of JF's death.



9.6 The Council is also engaged in an ongoing partnership with Lifeline and has stated its commitment to continuing to explore and support efforts to reduce suicides in public spaces by encouraging help-seeking behaviours.

9.7 I accept counsel assisting's submissions that these initiatives are to be commended. In the circumstances, I do not consider that any recommendations are necessary or desirable in relation to suicide deterrence measures at Redhead Headland. While the above map shows that only a relatively small area of the headland has been fenced, the evidence indicates

that the fencing was erected at key locations. I accept that it would be impractical to install fences around the entirety of the headland.

10 Conclusion

- 10.1 An inquest into JF's death was mandatory because she died as a result of a police operation. Having regard to all the evidence, I am satisfied that the police at the scene made significant efforts to engage with JF in an effort to dissuade her from self-harm. Police were faced with a very difficult situation, particularly given JF's location, which made hearing and talking to her difficult.
- 10.2 I commend all the officers involved, particularly Senior Constable Searant, for their efforts to assist JF and for the difficult work performed as first-responders to a person experiencing a mental health crisis.
- 10.3 Nothing in the evidence in this matter lends itself to the making of any recommendations pursuant to s 82 of the Act, particularly given the efforts the Council has already made to address the occurrence of self-harm incidents at Redhead Headland.

11 Findings required by s 81(1)

- 11.1 As a result of considering the evidence I am able to make the following findings in relation to the matters listed in s 81(1) of the Act:

The identity of the deceased

The person who died was JF

Date of death

JF died on 12 February 2024

Place of death

JF died at Redhead Beach, Redhead NSW 2290

Cause of death

JF died of multiple injuries

Manner of death

JF died after she propelled herself from the edge of a cliff onto the rocks below with the intention of ending her life while in the presence of police officers who attended in order to intervene.

12 Close of Inquest

12.1 I thank counsel assisting, Kathleen Heath, and her instructing solicitor, Amelia Jeffares from the Crown Solicitor's Office, for all the assistance they have provided in preparing and conducting this inquest. I also thank Detective Sergeant Stephen Sutherland for all the hard work he has done in investigating the circumstances of JF's death.

12.2 Once again on behalf of the Coroners Court, I offer my sincere and respectful condolences to JF's family and friends.

12.3 I close this inquest.



Magistrate Kasey Pearce

Deputy State Coroner

Coroner's Court of New South Wales

Date 3 November 2025