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**STATE CORONER'S COURT
OF NEW SOUTH WALES**

Inquest: Inquest into the death of [REDACTED] ('EJJ')

Hearing dates: 16-17 March 2026

Date of findings: 1 April 2026

Place of findings: NSW State Coroner's Court, Lidcombe

Findings of: Judge Harriet Grahame, Deputy State Coroner

Catchwords: CORONIAL LAW – Concern for welfare check – intentionally self-inflicted death – adequacy of response- NSW Police Force - NSW Health - mental health – co-responder models for first responders – Right Care, Right Person

File numbers: 2023/57069

Representation: Ms Peita Ava Jones, Counsel Assisting the Coroner, instructed by Ms Anna O'Rourke (NSW Crown Solicitor's Office)

Ms Danielle Captain-Webb, Advocate for the Senior Next of Kin, instructed by Ms Michaela Madrill (Legal Aid NSW)

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Non-publication orders Non-publication orders were made on 1 April 2026. A copy of the orders can be obtained from the Coroner's Court registry.

Findings:

I make the following findings pursuant to section 81(1) of the *Coroners Act 2009* (NSW).

Identity: EJJ

Date of death: 16 February 2023

Place of death: 15 Cutler Avenue, St Marys, NSW

Cause of death: Hanging

Manner of death: Intentionally self-inflicted

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Introduction

1. [REDACTED] ('EJJ') was found deceased at his home in St Marys on 17 February 2023. He was 39 years old.
2. EJJ's family and friends had become concerned for his welfare the day before after learning of a message he had posted to Facebook at 2:30pm saying 'goodbye everyone. Wish you all the best. Take care. Luv you all'. EJJ's mother, [REDACTED] ('JR') spoke to police at about 8:30pm on 16 February 2023 and requested a welfare check. She wanted someone to visit EJJ's home.
3. Various inquiries were made on the evening of 16 February 2023. There were initial difficulties obtaining EJJ's address. The following morning NSW Police officers attended his home and spoke to a neighbour, but they were unable to raise EJJ. EJJ was later discovered by friends and although police and ambulance arrived shortly afterwards, EJJ was already deceased.
4. EJJ's mother, brother and cousin attended the inquest. JR spoke tenderly of her first-born son. She was only 18 years of age when she gave birth to him, and she described him as a bright, gentle and thoughtful child. He grew into a quiet and sensitive man who worked hard and loved trains and the natural world. He had visited the Grand Canyon and swum with dolphins and turtles in Hawaii. However, JR said his greatest love was his young son. EJJ was a committed father and tried his best to be present for his son.
5. Over the years, EJJ had struggled with mental health issues and had previously attempted self-harm. His sad death has affected all those who loved him. I offer his family my sincere condolences.

The role of the coroner and the scope of the inquest

6. EJJ's death was reported to the Coroner pursuant to the combined effect of ss 21(1)(a) and 6(1)(a) of the *Coroners Act NSW 2009* (NSW) ('*Coroners Act*'). Using the language of s 6, EJJ's death was 'a violent or unnatural death' - which covers a broad range of incidents where death has not been caused by old age or disease.
7. Although police were contacted by family about concerns for EJJ's welfare, I have decided that the circumstances do not enliven s 23(1)(c) of the *Coroners Act* because it does not appear that his death was 'as a result of police operations'. Nevertheless, there was a police operation in close proximity to EJJ's death and for this reason the investigation initially commenced pursuant to protocols used in s 23 matters. As a result, I am satisfied that police actions have been carefully and independently scrutinised.

8. EJJ's mother requested an inquest, and these proceedings took place at my discretion. Understandably JR was concerned to know when EJJ died and whether police acted appropriately in response to her request to check on her son.
9. The primary function of an inquest is to identify the circumstances of death. I am required by law to record in writing the fact that a person has died and also to record findings as to:
 - a. the person's identity;
 - b. the date and place of the person's death; and
 - c. the manner and cause of death.
10. 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. This is sometimes referred to as the Coroner's "death prevention function."

The evidence

11. The inquest was held at the NSW Coroners Court at Lidcombe on 16 and 17 March 2026.
12. A three-volume brief of evidence was tendered, including witness statements, police reports, and photographs. It contains the records of the investigative work and searching which took place. I will only refer to these detailed records briefly within the scope of these written reasons, however I have had the opportunity to review all the documents provided.
13. The Court had the benefit of two expert statements from Dr Johan Duflou. He is an extremely experienced consultant forensic pathologist who has conducted hundreds of autopsies over the years. He commenced practice in the specialty of forensic pathology in 1983 and has been registered as a full-time specialist forensic pathologist since 1988.
14. The Court heard oral evidence from the NSW Police Force (NSWPF) officer in charge ('OIC') of the coronial investigation, Detective Sergeant Burns and from Senior Constable Luke Hansen, one of the officers tasked to check on EJJ's welfare. The Court also heard from Superintendent Kirsty Hales, who is the Commander of the NSWPF Mental Health Command, Capability Performance and Youth Command. Superintendent Hales has a Bachelor of Nursing specialising in acute psychiatric nursing, a Master of Forensic Psychology, a Master of Clinical Psychology, and an Advanced Diploma in Police Negotiation. Superintendent Hales has 20 years experience as a police negotiator at both team member and team leader levels involved in suicide intervention and siege incidents.
15. Prior to inquest proceedings commencing, a list of issues was circulated to the parties. After setting out a brief chronology of events, I deal with each of these issues in turn.

Background

16. EJJ was born on 16 March 1983.
17. At the time of his death, he was seeking alternative employment but had been working as a warehouse foreman.
18. EJJ shared his son, born in March 2019, with his ex-partner [REDACTED] ('MF'). MF describes EJJ in her statement in the brief as 'a great dad' and someone she got along with really well.
19. EJJ had previously struggled with his mental health and had one known previous suicide attempt on 19 April 2018. On that occasion, police scheduled EJJ under s 22 of the *Mental Health Act 2007* (NSW), and he had a brief admission to Nepean Hospital for treatment.

Events of 16 February 2023

20. At 2:30pm on Thursday 16 February 2023, EJJ posted a message on Facebook that said:

'GOodbye everyone

Wish you allthe best

Take care

Luv y all'

21. EJJ's ex-partner MF, saw EJJ's post on Facebook and tried calling him at 2:48pm from her workplace. He did not answer. MF says she contacted their mutual friend, [REDACTED] ('AK'), and asked her to go check on EJJ.
22. AK says she saw EJJ's Facebook post saying 'goodbye' and had a bad feeling about it. Earlier that day, she had agreed to collect EJJ's son from daycare for him because EJJ had contacted her stating that he was unwell and 'feeling horrible' and that MF would be at work until 8:00pm. AK told her partner that she was concerned about EJJ and she went to his home sometime after 3:00pm to try and find him.
23. At EJJ's house, AK observed the black Subaru that EJJ used parked in the driveway. She knocked on the door and called out EJJ's name, but nobody answered. AK had her daughter with her and left because she was getting upset.
24. AK recalls that she went to MF's work to share her concerns about EJJ. She says she was advised by MF to contact the police and request a welfare check. AK's evidence is that she 'continually' tried to call St Marys Police Station, but her calls would ring with no answer.

25. AK made another attempt to raise EJJ at his home before she drove to St Marys Police Station. She says she stood around for about 15 minutes, but nobody came out. She kept trying to call St Marys Police Station while she waited but her calls went unanswered.
26. As promised, AK collected EJJ and MF's son from daycare and he ended up staying the night at her home.
27. MF finished work at 8:00pm. She says she walked straight to EJJ's place to try and speak with him and make sure he was ok. She says: 'I knocked on the door. I tried to call him and yelled out.' There was no answer so she went home.
28. EJJ's mother was alerted to EJJ's Facebook post by her son Tyrone. She stated that she:
'rang around like a crazy person, trying to get in contact with EJJ. I tried calling him on Facebook messenger and he wasn't answering. I tried just normal phone call. When I was calling his mobile, it was ringing but he wouldn't pick up. I sent messages through Facebook, and he didn't answer any of them.'
29. JR says she first attempted to call St Marys Police Station at around 7:30pm but that call and her subsequent calls were not answered. At 8:04pm and 8:05pm, JR posted on EJJ's Facebook page that she was worried about him and asked whether his friends had heard from him.
30. The evidence suggests that at 8:40pm, JR's phone call to St Marys Police Station was answered by Constable Flynn Cole from Nepean Police Area Command (PAC) and that same officer created a record of JR's report in the police Computer Aided Dispatch (CAD) system stating:
'POL [police] TO CONDUCT A WELFARE CHECK ON EJJ DOB: 16/03/1983. JONES STATED ON FACEBOOK "I HAVE ENOUGH, I AM DONE, I AM OUT OF HERE" – POSTED AT 3PM 16/02/23. JONES WAS LAST SPOKEN TO BY PHONE ABOUT 3PM 16/2. PLEASE CONTACT INF [informant] OF OUTCOME.'
31. JR's evidence is that during her call to police she informed them about EJJ's Facebook post and a previous suicide attempt where police broke into EJJ's house. She says she 'stressed' to police that they would probably need to go inside his house to locate EJJ based on his previous suicide attempt. I note that the version of the Facebook post recorded in the CAD message does not exactly match the post. There is now no way of knowing whether it was recorded inaccurately by Police or whether JR, in her distress, gave Police the gist of the post, rather than the exact words.
32. I note that the COPS Event Summary for that earlier incident is contained within the brief of evidence and would have been available to police on a search of the COPS system. The date of that incident is 19 April 2018 and the COPS Event records that:

'...Police walked around the side of the house and continued to bang on windows. Police observed the P/N [EJJ's] side bedroom window to be open with a fan on inside. Police removed the flyscreen and looked through the window. On looking through the window police observed a pair of legs on the carpet. Police immediately yelled out with nil response. Police jumped inside the room and continued to yell out to P/N [EJJ]. The P/N [EJJ] was non responsive and appeared to be in a semi-conscious state. Police grabbed the P/N [EJJ] by the arm while applying a soft sternum rub. This appeared to wake the P/N [EJJ] from his semi-conscious state.'

33. On that occasion, police relied upon s 22 of the *Mental Health Act 2007* (NSW) to take EJJ to Nepean Hospital. He was discharged from that hospital four days later.
34. On 16 February 2023 when JR spoke to NSW Police, she was not able to give them EJJ's address. JR states that she did not know EJJ's current address because he had recently moved so she gave police MF's address and suggested they go there to obtain EJJ's current address. Unfortunately, this did not occur.
35. Instead, police did a search for EJJ in their COPS system and found a recorded address for him of 15 Canberra Street, Oxley Park.
36. This is the address that Senior Constables Daniel Ellul and Joshua Payne from Nepean PAC attended at 10:47pm in response to the CAD broadcast. These officers spoke with the residents of 15 Canberra Street who informed police that EJJ did not live there and that they did not know him.
37. The officers say that they returned to their police vehicle and attempted to contact JR for an alternative address but could not make contact. JR's account is that she 'never received a phone call back from Police that night. I sat up all night waiting'. It is not possible to resolve this conflicting evidence. However, it is clear that Officers Payne and Ellul promptly conducted another check on the COPS system for EJJ that revealed an address for him of 15 Cutler Avenue, St Marys, registered with Roads and Maritime Services (RMS). At 10:54pm Senior Constable Ellul informed police radio of the St Marys address and confirmed they would be attending.
38. They arrived on scene four minutes later at 10:58pm. The residence was observed to be in complete darkness as were the neighbouring properties. Officers Payne and Ellul approached the front door and knocked but nobody answered. Senior Constable Ellul kept knocking whilst Senior Constable Payne attempted to look into the house through the windows, but it was too dark for him to see.

39. The Officers conducted checks on the cars parked in the driveway and in front of 15 Cutler Avenue. Those checks revealed that none of the cars were registered to EJJ. This would have included the black Subaru EJJ used, but which was in fact registered to MF.
40. Senior Constable Payne conducted another check of the COPS system but could find nothing to link EJJ to the St Marys address. The officers were not sure that EJJ resided there given nobody had answered the door and there were no vehicles registered to him. Senior Constable Payne states that: 'I did not deem it justifiable to force entry or trespass on a potentially unrelated persons property'. This is an issue to which I will return.
41. The officers left the St Marys address at 11:06pm and made a radio broadcast stating: 'UNABLE TO RAISE ANYONE PLEASE LIL (LEAVE IN LIST)'.

Events of 17 February 2023

42. Officers Payne and Ellul both state that they intended to return to the premises later in their shift but were unable to do so due to the constant demand of other jobs. At 5:18am on 17 February 2023, Senior Constable Ellul broadcast to police radio for the concern for welfare job to be rescheduled for 7:00am. His message noted that police had attended but could not raise anyone and that the vehicles in the driveway were not registered to EJJ. Senior Constable Payne explains that this broadcast was to prompt day shift to attend 'to make enquiries with the residents and neighbours to ascertain if [EJJ] resided there at a more reasonable time of day.'
43. Senior Constables Ashliegh Wiggett and Luke Hansen were working general duties together within the Nepean PAC on 17 February 2023 commencing at 6:00am. These officers are Senior Constables now but at the time they both held the rank of Constable. They acknowledged EJJ's concern for welfare job on the CAD system at 7:19am and arrived at the St Marys address at 7:56am.
44. Senior Constable Wiggett tells the Court that she and Officer Hansen sat in their car for a few minutes to familiarise themselves with the job and to conduct checks on EJJ, which 'revealed nothing untoward'.
45. They observed that the front yard of the property was surrounded by a low wire fence. Access to the backyard was blocked by Colourbond fencing. Behind that fencing, Senior Constable Wiggett observed a car parked in the driveway and a detached garage with maroon-coloured barn style doors which were closed.
46. Senior Constable Hansen approached the front door and knocked but there was no response. He attempted to look through the front windows, but the blinds were closed. The Officers saw

a vehicle parked in the driveway and conducted a check on the vehicle but it was not registered to EJJ. This vehicle was likely the black Subaru that belonged to MF.

47. Officer Hansen thought that the outside of the residence appeared to be in a 'normal state' and he did not locate any items of concern. He requested a phone number for EJJ at 8:06am through police radio. He called the number supplied but there was no answer.
48. The Officers then went to speak with [REDACTED] ('LS') who lived next door at number 13. LS confirmed that EJJ lived at number 15. The most contemporaneous account of what LS told police is found in the COPS Event Narrative submitted by Senior Constable Hansen at 4:09pm on the day EJJ's body was located. It says:

'...LS informed police that he had spoken to the deceased two days prior to the death...where the deceased asked to borrow his lawn mower. During that conversation, the deceased made mention that he 'felt depressed' however when LS attempted to comfort the deceased inviting him over to chat the deceased responded with "nah it's all good it's not like that". The deceased appeared to be in normal spirits.

LS held no immediate concern for the deceased and believed the deceased was currently dropping his child off at a nearby childcare centre.'
49. This latter statement is expanded upon in Senior Constable Hansen's second statement, where he reports that LS: 'stated EJJ' is normally dropping his son off at a nearby childcare centre at this time'.
50. Senior Constable Hansen goes on to explain that consistent with Officer Wiggett's evidence: 'after speaking with LS, I was of the belief it was likely that EJJ was not at the location and was dropping his son off at childcare. With the information available, I did not hold any immediate and serious concerns for the welfare of EJJ.' In the circumstances, he did not consider that he was empowered by s 9 of the *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) ('LEPRA') to enter EJJ's house or garage.
51. The Officers made a decision to re-attend the St Marys property later that morning in the hope that they could catch up with EJJ after daycare drop off, talk to him about his Facebook post, assess the situation and conduct a mental health assessment. Their radio broadcast at 8:12am states: 'LIL [Leave in List] WILL REATTD [reattend]'.
52. Officers Hansen and Wiggett arrived at their next job in the suburb of St Clair at 8:24am. Upon arrival, they ascertained that this job was an allegation of sexual intercourse without consent which went on to occupy them for the next two hours.

53. EJJ's family and friends were still concerned that they could not make contact with EJJ. At about 10:00am, MF caught an Uber to EJJ's house from her workplace because she thought it was strange that she hadn't heard from him and she wanted to find him. Once there, she tried knocking on the front door but there was no answer, so she 'jumped' the side fence and entered EJJ's house through an open sliding door. She could not locate EJJ in the house.
54. At some point, AK joined MF at the house and she kicked down EJJ's bedroom door because it wouldn't open. EJJ was not in the bedroom.
55. AK then entered EJJ's backyard and approached the detached garage. This is where she located EJJ. She told MF that she had found EJJ hanging and MF immediately called 000. The records from NSW Ambulance confirm that MF's call was received at 10:31am.
56. Paramedics arrived on scene at 10:36am but, tragically, they determined that EJJ was deceased.
57. Senior Constables Hansen and Wiggett were at the job in St Clair when MF's report to 000 about EJJ was broadcast over police radio at 10:31am. They acknowledged or 'copied' the job at 10:36am and proceeded urgently to St Marys. They arrived on scene at 10:44am and observed there to be numerous police officers already at the location.

Autopsy

58. An autopsy was conducted by Dr Rebecca Irvine on 21 February 2023. In her post-mortem report, Dr Irvine gives EJJ's cause of death as 'hanging'. This evidence was undisputed and was confirmed by Dr Duflou's independent review.
59. Toxicology analysis detected alcohol in EJJ's post-mortem blood sample at 0.204g/100mL and a non-toxic range concentration of diazepam (an anti-anxiety medication).

Issues

The date, place and medical cause of EJJ's death

60. EJJ's mother first contacted Police in the early evening of 16 February 2023, after learning of his Facebook message which had been posted around 2.30pm. EJJ was not found until 10.30am the following day. The Court was keen to understand if an earlier attendance by NSW Police might have saved his life. Unfortunately, the available evidence indicates that EJJ's death could not have been prevented even if NSW Police had attended as soon as JR called.
61. All the available evidence points to a conclusion that EJJ died on 16 February 2023 shortly after his last message on Facebook at 2:33pm. In coming to that conclusion, I have taken into account the following matters:

- EJJ did not answer a phone call from MF – the mother of his child to whom he remained close - which was placed at 2:48pm on 16 February.
- Friends went to EJJ's home commencing around 3:00pm on 16 February and could not raise him.
- Dr Duflou reviewed police statements and crime scene photographs (taken around midday on 17 February 2023) and concluded in his second report that, based on the observed post-mortem changes, EJJ's death likely occurred closer to the mid-afternoon of 16 February 2023.
- Dr Duflou's evidence that death due to hanging is generally rapid and probably occurs within a few minutes in most cases.

62. The evidence about the identity of the deceased, the location of the death and the medical cause of EJJ's death was uncontroversial – EJJ died at 15 Cutler Avenue, St Marys, from hanging.

Was EJJ's death intentionally self-inflicted?

63. A finding that a death is intentionally self-inflicted should not be made lightly. The evidence should be clear and cogent and established to the *Briginshaw standard*.¹ There was significant evidence before me that EJJ's death was intentionally self-inflicted.

64. I have taken into account the following matters:

- evidence of EJJ's final 2 Facebook posts;
- the searches he did that day on his phone including 'ready to die' at 2:14pm;
- the note found with his body; *and*
- the mechanism of death.

65. These matters establish that EJJ's death was deliberately self-inflicted, to the requisite standard.

66. I find EJJ's death was intentionally self-inflicted.

¹ *Briginshaw v Briginshaw* (1938) 60 CLR 336

What was the response of NSW Police Force officers to JR's concern for welfare call regarding EJJ made on 16 February 2023 and was that response reasonable and appropriate?

67. I have already set out the actions taken by NSW Police officers on 16 and 17 February 2023 in response to JR's concern for welfare call. In assessing the adequacy of the response, a number of issues arose.

Phone calls

68. The Court was concerned and somewhat disturbed by the evidence of phone calls going unanswered over a long period of time on 16 February 2023 at St Marys Police Station. Quite obviously this would have been frustrating and stressful for EJJ's family and friends. None of the police at the Inquest appeared surprised by the evidence and Detective Sergeant Burns suggested that these issues were likely a consequence of the high workload confronted by officers stationed at St Marys.

69. That evidence was supported by statistics presented to the Court which revealed that in 2023 Nepean PAC, within which St Marys Police Station sits, dealt with the highest number of concern for welfare jobs in the state: 6948 that year, equating to 19 per day.² Senior Constable Hansen also gave evidence that the workload at Nepean is 'unique' when compared to his time at Surry Hills. By way of example, he told the Court that at Surry Hills he never saw the job list hold more than 6 jobs, whereas Nepean will be allocated 60 jobs that are categorised 'priority 3'.

70. As a consequence, priority 3 jobs – including concern for welfare jobs – may not be attended to in a timely fashion. Whilst officers are 'encouraged to prioritise domestic violence and concern for welfare jobs', these can sit in the list for upwards of seven hours, even 24 hours. Senior Constable Hansen lamented that the significant workload and resourcing limitations at Nepean PAC meant that he couldn't always respond to jobs in what he would consider a reasonable timeframe.

71. The Court was informed that two or so officers are assigned to the front desk, and their role is to answer phones and attend to people who present to the Station. They also do court preparation and maybe some of their NSWPF training. It is not a surprise that these responsibilities in a high workload environment mean that calls to the Station are missed.

²https://www.police.nsw.gov.au/__data/assets/pdf_file/0005/902849/0745665_Statistics_relating_to_welfare_checks_conducted_by_police.pdf

72. The Court was informed that since the time of EJJ's death, an answering service has been implemented so that phone calls do not simply 'ring out' as they did for JR and AK. While this is clearly an improvement, it remains concerning that calls cannot be answered immediately.
73. Superintendent Hales gave evidence that the answer phone message is complemented by information on the NSWPF homepage. That page provides, among others, the numbers to call in an emergency (000) and non-emergency (131 444).³
74. These mechanisms may go some way to address the situation EJJ's family and friends faced, that is where a family member wants to request a 'concern for welfare' check but the local police station cannot answer their call. However, as identified by JR's representative, there may still be occasions where a family member is confused as to whether a 'concern for welfare' constitutes an emergency warranting a call to 000.
75. Superintendent Hales' evidence was that: 'in the first instance, for members of the public...000 is most appropriate if you are unsure if it is an emergency.' That message does not appear on the NSWPF homepage or on the station answering service.
76. The Court considered whether there is still work to be done in creating a system which more effectively answers and triages community calls of this nature. In my view the creation of a more robust statewide co-responder triage system has the capacity to improve the service offered to those experiencing mental distress and their families and I will return to this issue.

The Welfare Checks

77. The question of whether the welfare checks by the 11:00pm and 8:00am crew were reasonable and appropriate was addressed the OIC and Superintendent Hales.
78. With respect to the 11:00pm car crew, the consistent evidence of these experienced police officers was that:
- Firstly, the **checks and enquiries** conducted were sufficient and reasonable given the information available to them.
 - Secondly, the shared **state of mind** of these officers, based on their enquiries, of uncertainty as to whether EJJ resided at the St Marys address was reasonable.
79. Thirdly, the **decision** to leave the job in their list and return later was reasonable in the circumstances.

³ [Home - NSW Police Public Site](#)

80. With respect to the 8:00am car crew, the consistent evidence of Detective Sergeant Burns and Superintendent Hales was that:
- Firstly, the **checks and enquiries** conducted were sufficient and reasonable.
 - Secondly, the shared **belief** of these officers, based on their enquiries, that EJJ was likely dropping his son at daycare, was reasonable.
81. Thirdly, the **decision** to leave the job in their list and return later that morning was reasonable in the circumstances.
82. One option available to the 8:00am car crew during that attendance was to call the informant, EJJ's mother, to gather more information. On reflection, Senior Constable Hansen said that he doesn't remember why he didn't call JR but he now feels that he should have done so. I agree with his hindsight assessment of his conduct. JR should have been called back. Senior Constable Hansen frankly acknowledged that information from JR could have increased or decreased the level of urgency and, in turn, guided the response.
83. Counsel Assisting submitted that Senior Constable Hansen's thoughtful reflection and insight is a foundation upon which he can continue to build his skills as a police officer. She noted at the time of this incident, Senior Constable Hansen was still *Constable* Hansen in his fourth year on the job. Perhaps even more importantly he was only in his third shift at Nepean PAC, dealing with very different jobs to those he was used to and still acclimatising to an increased workload intensity. I accept that Senior Constable Hansen has thoughtfully reflected on his actions and is willing to learn and improve.
84. Although JR was not contacted and in hindsight Senior Constable Hansen agreed she should have been, I note that neither Superintendent Hales or Detective Sergeant Burns were critical of the Officer. Certainly, there was no policy requirement mandating a call to JR. Superintendent Hales suggested that, in the circumstances, a phone call to the informant would have been appropriate the next time Senior Constables Hansen and Wiggett attended and EJJ still could not be raised, allowing time for daycare drop off to have occurred.
85. Counsel Assisting submitted that the Court could accept the evidence of Superintendent Hales and Detective Sergeant Burns and find that the welfare checks conducted by both car crews in response to JR's concern for welfare call were reasonable and appropriate, including that no policy or procedure breaches were identified.
86. JR's representative submitted that there were deficiencies with the conduct of the welfare check. Primarily, that the Officers did not call to provide an update to JR as requested. It was submitted that it would have been appropriate to call JR, as she may have been able to provide further valuable information to the officers, which could have assisted with their response.

87. I accept that while there was no policy mandating a call back to the informant requesting the check, good policing would have necessitated calling JR back. It would have given officers an opportunity to discuss with her what their investigations had uncovered to date and a chance to see if she had any further information to share. I commend Senior Constable Hansen for his honest reflection on this issue.

Section 9 Law Enforcement (Powers and Responsibilities) Act 2002 NSW

88. The Court examined the question of whether police would have been empowered to enter EJJ's home without permission in the context of a welfare check, having as they did limited information.

89. The power to force entry or trespass is found in s 9 of the *LEPRA*. Relevantly to EJJ's matter, s 9(1)(b) empowers police to:

‘enter premises if the police officer believes on reasonable grounds that...a person has suffered significant physical injury or there is imminent danger of significant physical injury to a person and it is necessary to enter the premises immediately to prevent further significant physical injury or significant physical injury to a person’.

90. Counsel Assisting noted that s 9 cannot be displaced by a permission to enter those premises by a non-occupier. Counsel Assisting also drew the Court's attention to a number of other relevant matters, including:

- Firstly, the shared uncertainty felt by the 11:00pm car crew that EJJ lived at the St Marys address was a reasonable state of mind in the circumstances and one that was incompatible with the belief required by s 9 of the *LEPRA*. Put another way – being uncertain he lived there meant it would not be reasonable for them to have held a belief at the same time that it was necessary to enter.
- Secondly, the shared belief held by the 8:00am car crew that EJJ was likely dropping his son at daycare was a reasonable belief in the circumstances and one that was incompatible with the belief required by s 9 of the *LEPRA*. Put another way – their belief he was running an errand meant it would not be reasonable for them to have held a belief at the same time that EJJ was in imminent danger.

91. The two senior officers who gave evidence before me were unanimous in their view that s 9 was not enlivened in the circumstances of this case. Both Superintendent Hales and Detective Sergeant Burns were of the view that the attending police did not have sufficient evidence on which to legally enter the premises without explicit permission. Regarding the 11:00pm attendance, Detective Sergeant Burns said the COPs record was ‘not gospel’ in relation to

where EJJ lived and if the police didn't 'have a suspicion that he lived there, they could not have had a suspicion they should enter'.

92. Overall, Counsel Assisting submitted that NSW Police Officers not invoking s 9 of the *LEPRA* to enter EJJ's premises on 16 and 17 February 2023 was reasonable and appropriate because they did not hold the requisite belief to do so. Counsel for the Commissioner concurred.
93. The family's representative also accepted the evidence of Superintendent Hales and Detective Sergeant Burns, that s 9 of the *LEPRA* was not enlivened in the circumstances. However, it was submitted that the discrepancy between the information recorded in the CAD, and the actual contents of EJJ's Facebook post should be noted, as in the family's view, situations may arise where if information is not recorded properly, it could vary or change the appropriate response of police. The family's representative further submitted that although Senior Constable Hansen stated he does not believe he would have invoked s 9 had he had an accurate recording of the Facebook post, it is important for police to have accurate information when attending jobs, as it can inform the level of response required.
94. It is certainly important for NSW Police to accurately record information which is relevant to assess the level of risk involved in a concern for welfare job. This in turn may have some impact on decisions made pursuant to *LEPRA*. Unfortunately, as I have already stated, it is difficult to now know how NSW Police came to record an inaccurate version of the Facebook Post. There were also other difficulties at play in the circumstances of this case, including the delay in being able to confirm the correct address. In my view both of these issues may have been solved by better contact with JR after her initial report.

What is the role of NSW Health (including NSW Ambulance) in responding to concern for welfare jobs in which the concern relates to a mental health crisis and should its role be enhanced?

95. The inquest heard that there is growing interest worldwide in finding better ways to support first responders in situations that involve mental health concerns. There is broad recognition that police currently attend jobs that may be more appropriately handled by a health professional. In parts of the United Kingdom, this issue is now addressed by a co-responder model – Right Care, Right Person ('RCRP') – which has a triage process at the initial 000 stage. In other places mental health professionals may be embedded in police stations or form part of mobile teams. These kinds of approaches are currently being closely examined in NSW.
96. There is already a recognition in the Memorandum of Understanding between NSW Police and NSW Health from 2018, that: 'For the most part, attendance by police at non-urgent mental health related incidents is associated with poor outcomes for mental health consumers and

should be a last resort'.⁴ Beyond this MOU there have been wide ranging discussions between all stakeholders about how to deliver a better service to those experiencing mental health issues, particularly where there is limited risk to other members of the community.

97. One of the current approaches examined at the inquest was the PACER (Police, Ambulance, Clinical, Early Response) program - which commenced as a pilot program in about 2017. It is a service which involves experienced mental health clinicians attending and providing advice to police. I accept that PACER has been a positive development in NSW.
98. Senior Constable Hansen said he has used the PACER services about 15 – 20 times and had found it useful. Superintendent Hales' evidence was that PACER is generally well received by police. Of course, a PACER would not have been activated when EJJ's address and whereabouts was still in question.
99. The PACER program is only available in metropolitan NSW (although there are other co-responder models in some regional areas) and not at all PACs. Despite its many benefits to police and vulnerable members of our community, evidence as to whether PACER will be expanded was not available to this inquest. However, Superintendent Hales was able to confirm that both the NSWPF and NSW Health have been involved in a separate process aimed at improving services for citizens who would currently come in contact with police because they are experiencing mental distress. Different co-responder models have been investigated. The talks and proposals are well advanced but as they are subject to "Cabinet in Confidence" confidentiality restrictions, Superintendent Hales was unable to disclose the likely result.
100. She advised that the Court could be satisfied that stakeholders from the NSWPF, NSW Health and NSW Ambulance are working together to find solutions that will bring 'better outcomes for the future'. There was evidence to similar effect during the recent Inquest into the deaths at Westfield Bondi Junction ('the Bondi Junction inquest').⁵
101. One alternative model to PACER that finds support from NSW Police is the RCRP model from the United Kingdom. Superintendent Hales gave some evidence about that, stating that the model sees all calls go through '999' (the equivalent of 000) and that police stations do not receive calls for triage. Superintendent Hales noted that if RCRP was adopted in NSW, there would need to be training for police to divert calls to 000 for triage, as unlike in the United Kingdom, police stations in NSW can receive direct calls. Superintendent Hales further stated that the NSWPF are supportive of the principles of the model.

⁴ <https://www.health.nsw.gov.au/mentalhealth/resources/Publications/mou-health-police-2018.pdf>

⁵ Bondi Junction Inquest Day 20 Transcript: T63.36-44.

102. There is also evidence from the Bondi Junction inquest about a service available in Queensland called the Police Communications Centre Mental Health Liaison Service ('PCC MHLS'). The PCC MHLS is:

'a mental health service that supports police in the first response to people in mental health crisis. It facilitates the provision of mental health information, advice, and assistance to QPS [Queensland Police Service] officers at a statewide level.

The PCC MHLS is a partnership between QPS and Queensland Health, which aims to provide real-time information sharing and support for QPS officers in responding to situations involving people experiencing mental health issues. Clinicians can provide advice on a person's mental health records to assist with the QPS response'.

103. As the name suggests, these clinicians are embedded in QPS Communication Centres (000).⁶

104. A recommendation was proposed by Counsel Assisting in the Bondi Junction inquest that the NSWPF and NSW Health establish a similar 'real time 24/7 mental health information sharing and advice service that is not geographically bound' including that consideration be given to setting up mental health clinicians in NSWPF Communication Centres (000).

105. Counsel for the Commissioner, NSWPF, at that inquest did not object to the recommendation, but noted the limitations to the effectiveness of such a model in NSW. In relation to those limitations, Superintendent Hales gave evidence to the Bondi Junction inquest that the lack of any central database to, relevantly, access mental health records within NSW Health is likely to significantly limit the ability of any clinicians embedded in the NSWPF Communication Centres.

106. Ultimately, having regard to matters including the live Cabinet process considering co-responder models, one recommendation was made by the State Coroner in the Bondi Junction inquest that has relevance to the issues explored in EJJ's matter. That was:

Recommendation 11: To the NSW Government

That the NSW Government consider options to support the roll-out of appropriate co-responder models so that they are more widely available throughout NSW.

107. The State Coroner's recommendation is certainly appropriate in the circumstances of EJJ's death. Had JR's first call gone to a central triage point where there would be access to records held by Police, RMS and Health Services, it is possible that the information she had, including

⁶ [Police Communications Centre Mental Health Liaison Service, Enhancing outcomes for people in mental health crisis, Australasian Psychiatry.](#)

her suggestion that EJJ's ex-partner be contacted, may have been managed more effectively and a response delivered more quickly.

108. In my view rolling out better co-responder models is one of the most important issues facing NSW Government currently. I will return to the issue shortly.

Mental Health Standard Operating Procedures

109. As part of a number of developments driven by Superintendent Hales, the Court heard evidence about the more recent development of NSWPF Mental Health Standard Operating Procedures ('SOPs'). I accept that this a positive development by the NSWPF who are increasingly being called to jobs involving mental health issues.

110. One aspect of the SOPs that Superintendent Hales revealed is that they will include information to police about gathering information regarding the person in crisis, perhaps through a family member or other trusted person.

111. Superintendent Hales anticipates that these SOPs will 'go live' by the middle of this year.

Is it necessary or desirable to make any recommendations pursuant to s 82 of the Coroners Act 2009?

112. The Court considered whether it was necessary or desirable to make any recommendations pursuant to s 82 in this inquest.

113. On balance, Counsel Assisting submitted that it was not necessary or desirable to make any recommendations to the Commissioner of Police ('Commissioner') arising from the evidence in this inquest.

114. Counsel Assisting submitted that I can be satisfied that the intersection between mental health and policing issues is a topic undergoing serious review by the NSW Government at present and that the Commissioner is actively supportive of this approach. I was informed that further consideration of co-responder models is ongoing. It seems fair to say that whatever model or models are adopted, there is broad support for the role of NSW Health being enhanced in jobs involving first response to a person experiencing a mental health crisis.

The family's draft recommendations

115. Counsel for JR and EJJ's family put forward three draft recommendations to the Commissioner at the conclusion of proceedings. I will deal with each in turn.

Endorse recommendation 11 of the Bondi Junction Inquest in relation to the roll out of co-responder models.

116. The family's representative submitted that it is appropriate to make a recommendation endorsing recommendation 11 of the Bondi Junction Inquest. I share their concern about this issue and endorse the State Coroner's recommendation without reservation.
117. The Commissioner, with reference to the ministerial statement released on 5 February 2026, submitted that the evidence received in this inquest, and others, demonstrates that consideration of reform in this area is well advanced, and that there is nothing to be served by the Court enunciating proposed recommendation 1.⁷
118. I accept that there is likely to be little utility in making a formal recommendation to the NSW Commissioner of Police on this issue. However, I intend to send a copy of these findings to the Premier of NSW to assist in his understanding of the importance and urgency of rolling out enhanced co-responder models in NSW.

That the NSW Police Force provide clear, direct and publicly accessible guidance stating that welfare check requests involving a mental health crisis, including suicidal ideation or threatened self-harm, should be treated as an emergency and directed to Triple Zero.

119. The family's representative submitted that there is ongoing ambiguity for members of the community as to how welfare concerns should be raised, and that a person seeking a welfare check may reasonably conclude that calling 000 is inappropriate where it is unclear whether the situation constitutes an emergency. The family's representative further submitted that in these circumstances, callers may be routed through the NSWPF interactive voice response system to local stations which may result in call cycling and significant delays at a stage when timely intervention may be critical. It was submitted that this reflects a broader gap in public education, guidance and accessible resources for family members, friends and the community regarding how to seek welfare checks in the context of a mental health crisis. The family's representative submitted that this could be addressed by inserting within the NSWPF website a reference to NSW Health's Mental Health Line which outlines the response that should be taken in relation to a mental health crisis.⁸
120. The Commissioner submitted that dialling "000" is a well-known avenue to accessing an emergency response in NSW (and in Australia generally). The Commissioner submitted that when accessing the NSWPF website, there is a prominent homepage banner, which displays

⁷[https://www.nsw.gov.au/ministerial-releases/nsw-government-to-consider-recommendations-from-bondi-
junction-inquest](https://www.nsw.gov.au/ministerial-releases/nsw-government-to-consider-recommendations-from-bondi-junction-inquest)

⁸ <https://www.health.nsw.gov.au/mentalhealth/Pages/mental-health-line.aspx>

as the first option 'ALL EMERGENCIES: Triple Zero (000)' for 'Police, Fire, Ambulance in an emergency' The Commissioner further submitted that there is also information provided for the non-emergency 131 444 number, which is stated to be for 'for non-urgent police assistance and general enquiries' and that when dialled it plays a recorded message which gives the caller three options. The first option is to contact 000 for an emergency, the second option is to report non-urgent crime online through the community portal, and the third option is to stay on the line to speak to a customer service representative.

121. The Commissioner further submitted that the guidance is clear, and if a member of the community perceives that a person is having 'a mental health crisis, including suicidal ideation or threatened self-harm' then they are clearly directed, either at first instance or along the reporting pathway, to use 000 to obtain emergency assistance. On that basis, the Commissioner submitted that the proposed recommendation would serve no useful purpose and any attempt to implement it would tend to detract from the current clear guidance given to, and understood by, the general community and undermine guidance given elsewhere.
122. I largely accept the Commissioner's submissions on this issue. However, an even more robust approach to this issue will flow if a co-responder model is introduced in NSW which has a Right Care, Right Person style triage system in place.
123. I decline to make the recommendation.

That the NSW Police Force be invited to undertake a review of the resourcing allocated to the Nepean Local Area Command, particularly having regard to the increasing demand for welfare checks call-outs within that command.

124. The family's representative drew the Court's attention to the resourcing issues at Nepean PAC which were disclosed during the evidence at this inquest. I too was concerned that phones were routinely unanswered and that Police faced an unrelenting list of jobs which resulted in delay.
125. The Commissioner submitted that resource allocation within the NSWPF is already the subject of intense consideration and regular review across and within a wide range of commands, capabilities and geographic areas, and that bearing in mind the specificity of this recommendation within a Local Area Command, the recommendation should not be made.
126. I have given the matter considerable thought and while I accept that resourcing in the Nepean PAC appears to remain an issue, it is a problem that is no doubt intermingled with other resourcing issues about which I have no knowledge. For this reason, taking into account the Commissioner's submissions, I decline to make the draft recommendation. Nevertheless, I intend to send a copy of these findings to the Minister of Police for her information.

Findings

127. For the reasons set out above, I make the following findings pursuant to section 81(1) of the *Coroners Act*:

Identity

EJJ is dead.

Date of death

EJJ died on 16 February 2023, shortly after his last Facebook message at 2.33pm.

Place of death

EJJ died at 15 Cutler Avenue, St Marys.

Cause of death

EJJ died from hanging.

Manner of death

EJJ's death was intentionally self-inflicted.

Conclusion

128. The inquest shone a light on a variety of extremely important issues. It was clear that NSWPF officers who were tasked to investigate JR's concern for welfare call were under-resourced. It is also clear that more needs to be done to prioritise and action calls such as that made by JR on the evening of 16 February 2026. In my view the existence of a more robust co-responder system, which is better able to triage calls, might have made it possible for an earlier response to have been made. Sadly, the evidence disclosed during the inquest makes it highly likely that EJJ was already deceased by the time JR became aware of the Facebook post and that even a quicker Police response could not have saved his life.

129. I endorse recommendation made by the State Coroner in the Bondi Junction Inquest and urge the NSW Government to consider options to support the roll-out of appropriate co-responder models so that they are more widely available throughout NSW.

130. I thank Counsel Assisting Peita Ava Jones and her instructing solicitor Anna O'Rourke for their hard work preparing this inquest.

131. Finally, I once again offer my sincere condolences to JR and her family for their profound loss. I thank them for attending and participating in this inquest.

132. I close this inquest.

Judge Harriet Grahame
Deputy State Coroner
1 April 2025
Coroners Court of NSW, Lidcombe