CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Tammy Michelle Shipley
Hearing dates:	10-17 September 2024 and 24-27 February 2026
Date of Findings:	19 November 2026
Place of Findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	State Coroner, Judge Teresa O'Sullivan
Catchwords:	CORONIAL LAW – polydipsia – hyponatraemia – schizoaffective disorder – psychosis – community mental health – PACER – custody management – custodial mental health management – Risk Intervention Team – Mum Shirl Unit – bail report – JusticeLink – sentence administration – legal representation of vulnerable persons
File number:	2022/384929
Representation:	Counsel Assisting: Dr Peggy Dwyer SC instructed by Yvette Edgell and Clara Potocki of the NSW Crown Solicitor's Office Vicki Shipley: Ms Sarah Talbert and Steven Rees instructed by Jacklyn Dougan-Jones of the Aboriginal Legal Service Commissioner of Corrective Services NSW: Mr Paul Bolster instructed by Phillip Nixon of the Department of Communities and Justice, Legal Correctional Officers Asif Iqbal, Lee Yeah Soh, Jessica Turner and Jacob Wilson: Mr Stephen Russell instructed by Nathan Keats of McNally Jones Staff Lawyers Justice Health and Forensic Health Mental Health Network, South Western Sydney Local Health District and Registered Nurses Disha Makadia and Michelle Murphy: Mr Jake Harris instructed by Kate Hinchcliffe of Makinson d'Apice Lawyers

Dr Lloyd Buan: Mr Matthew Hutchings instructed by Judith Alderson of Avant Law

Commissioner of Police, NSW Police Force: Mr David Jordan instructed by Craig Norman of the Office of the General Counsel, NSW Police Force

Legal Aid NSW: Mr William de Mars instructed by Tiana Jovanovic of Legal Aid NSW

Protective Orders: Non-publication orders apply to this matter. A copy of the orders can be found on the Registry file.

Findings:

Identity
The person who died was Tammy Michelle Shipley

Date of death
Tammy died on 20 December 2022

Place of death
Tammy died in the Mum Shirl Unit at Silverwater Women's Correctional Centre, Silverwater NSW 2128

Manner of death
Tammy died in custody. The medical conditions that caused her death were not recognised, monitored or treated early enough to prevent her death.

Cause of death
The cause of Tammy's death was hyponatraemia with antecedent causes of polydipsia and complications of schizoaffective disorder.

Recommendations:

To the Commissioner of Police, NSW Police Force

I. Give consideration to amending the relevant Standard Operating Procedures (SOPS) and the Police Handbook to clarify that arresting police are responsible for checking the COPS to identify any mental health issues of the person to be detained/arrested, given the possible relevance to risk assessment.

II. Give consideration to amending the relevant Charge Room and Custody Management SOPS, and/or the Police Handbook to clarify that the Custody Manager making a bail determination must check the COPS to identify any mental health history of the arrestee that may be relevant to bail in accordance with the requirement to give consideration to any of the factors under s. 18(1) of the *Bail Act 2013*.

III. Give consideration to amending the relevant Charge Room and Custody Management SOPS, and/or the Police Handbook to clarify that where any mental health history of an arrestee may be relevant to bail, such factors should be mentioned in the Facts Sheet prepared for Court.

IV. Give consideration to amending the relevant Charge Room and Custody Management SOPS, and/or the Police Handbook to clarify that the Custody Manager responsible for completing the "Custody Management Record" must check the COPS to identify any mental health history of the arrestee that may be relevant to welfare and custody management; and record any "significant mental health incident."

V. Consider an upgrade to the COPS so that there is a drop-down menu to easily record and look up any "significant mental health incident" for a member of the public who police are called out to attend on.

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

VI. That a review be conducted to determine the cause of discrepancies in Court outcomes recorded in the JusticeLink system being reflected in the COPS system, and on criminal history reports, and that DCJ and the NSWPF work together to rectify any deficiencies.

To the Commissioner Corrective Services NSW and the Minister for Corrective Services NSW

VII. That a review be conducted of the environment of the Mum Shirl Unit at Silverwater Women Correctional Centre to determine what more can be done to improve therapeutic care of women in that Unit, including by providing training to Correctional Officers in the Unit in relation to trauma informed care of prisoners suffering mental illness.

VIII. That Corrective Services NSW require Officer Jacob Wilson to complete the “Awareness of Managing at Risk Offenders” course, within 6 months of returning to operational duties.

IX. That Corrective Services NSW reviews its policies and procedures for monitoring inmates on a RIT to ensure that observation requirements are properly validated through routine audits of monitoring records and regular reviews of CCTV footage.

To the Justice Health and Forensic Health Network

X. That the Justice Health and Forensic Mental Health Network ensure that where a prisoner is identified as requiring an urgent psychiatric review, that prisoner is flagged for follow up by a psychiatric nurse in the event that the timeframe for review by a psychiatrist cannot be met.

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The *Coroners Act 2009* (NSW) in section 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of the inquest into the death of Tammy Shipley.

INTRODUCTION

1. Tammy Michelle Shipley (whom I will refer to from now on as Tammy) died on 20 December 2022 in the Mum Shirl Unit (MSU) at Silverwater Women's Correctional Centre (SWCC) of hyponatraemia with antecedent causes of polydipsia and complications of schizoaffective disorder.

JURISDICTION

2. Jurisdiction arose for me to hold an inquest into Tammy's death because she died while she was an inmate in a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999* (NSW), pursuant to s. 23(1)(d)(ii) of the *Coroners Act 2009* (the Act).

3. An inquest was required to be held into Tammy's death, pursuant to s. 27(1)(b) of the Act, because jurisdiction to hold the inquest arose under s. 23.

THE ROLE OF THE CORONER

4. The primary role and function of a coroner is to identify the circumstances of a person's death.

5. At the conclusion of an inquest the Coroner is required by s. 81(1) of the Act to record findings with regard to the following:

    a. the deceased person's identity;

    b. the date and place of the person's death;

    c. the manner and cause of the person's death.

6. The Act does not define the phrase "manner and cause of death". It is generally accepted that it is a composite phrase involving inter-related, but distinct, concepts. The manner of death relates to the circumstances in which a death took place whereas the cause of death is the direct and proximate physiological cause of the death.

PROCEDURAL BACKGROUND / THE PROCEEDINGS

7. These coronial proceedings were held over 11 days in two tranches from 16 to 27 September 2024 and 23 to 26 February 2026.

8. The adjournment in proceedings occurred due to adjudication of interlocutory proceedings brought by the Commissioner of Police, NSW Police Force (Commissioner NSWPF) in both this Court and the Supreme Court of NSW, in relation to the scope of

the issues to be explored at the inquest. The decision in this Court was handed down on 16 January 2025[1] and the Supreme Court decision was handed down on 26 September 2025.[2] Both decisions are annexed to these findings.

9. The Court received extensive audio visual material into evidence as well as 18 volumes of documentary material and additional exhibits which included; statements from family members, community medical practitioners, NSW Police Force (NSWPF) officers, Corrective Services NSW (CSNSW) officers and Justice Health and Forensic Mental Health Network (JHFMHN) employees; video and audio footage from both before and during Tammy's final period in custody at SWCC; extensive medical records; policy material; and expert opinions.

10. The Court also heard oral evidence from numerous witnesses including; the NSWPF officer in charge of the coronial investigation; experts in the fields of forensic psychiatry and intensive care medicine; institutional witnesses from CSNSW, JHFMHN, the NSWPF; and a panel of representatives from those organisations along with Legal Aid NSW and the Aboriginal Legal Service.

11. Several interested parties were jointly represented at the inquest. These include:

    a. South Western Sydney Local Health District (SWSLHD), JHFMHN and Registered Nurses Disha Makadia and Michelle Murphy who are collectively referred to in these findings, when necessary, as the "NSW Health parties"; and

    b. Correctional Officers Asif Iqbal, Lee Yeah Soh, Jessica Turner and Jacob Wilson, who are collectively referred to, when necessary, as the "the MSU COs".

12. Where submissions have been made on behalf of jointly represented parties, but appear relevant to specific interested organisations or individuals, those submissions have been attributed to the appropriate respective party.

FACTUAL BACKGROUND

13. Tammy Michelle Shipley was born on 29 January 1975 to her mother, Vicki Shipley, and her father, John Shipley, who has since passed away. Throughout her adult life, Tammy suffered periods of very poor mental health and drug addiction.

14. Tammy's mother Vicki outlined in her statement to the Court some of the major traumas Tammy had experienced in her life, including; sexual assault, domestic violence, post-partum haemorrhage and resultant heart issues, and recurrent lymphoma. The severity and trauma of these incidents makes it unsurprising that Tammy subsequently struggled with mental health and drug use.

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[1] *Inquest into the death of Tammy Michelle Shipley (2022/384929)* [2025] NSWCorC 3 (16 January 2025) (Annexure A).
[2] *Commissioner of Police, New South Wales Police Force v Attorney General of New South Wales* [2025] NSWSC 1119 (Annexure B).

15. Prior to 2022, Tammy's only lengthy period in custody was in 2016, when she served a four-month sentence for an offence of stalk/intimidate. During that time, JHFMHN recorded her diagnosis as schizoaffective disorder, and noted her history of illicit drug use, including methamphetamine (Ice) and heroin.

16. Despite her struggles, Tammy was greatly loved and supported by her family including Vicki and her children who were her strongest advocates and referred to Tammy as a both a caring mother and a survivor.

Mental health and repeated hospital admissions

17. From 2012, Tammy's life was marked by repeated admissions to hospital in relation to her mental health. She was voluntarily admitted at Bankstown Hospital, was twice scheduled to a specialised mental health ward at Concord Hospital, and spent periods being managed by the Campbelltown Community Mental Health Emergency Team (CoMHET).

18. On 11 December 2021, Tammy self-presented to Liverpool Hospital Emergency Department (ED), explaining that there were family concerns for her mental state due to non-adherence to prescribed medication since October 2021. She left the ED before a management plan was discussed and was subsequently referred to the CoMHET for follow up.

19. On 12 December 2021, Tammy was dispensed Zuclopenthixol decanoate (also known as Clopxiol depot), an anti-psychotic, by general practitioner (GP) Dr Abdul Matin at My Doctors Medical Centre at Glenquarie Town Centre (My Doctors).

20. On 13 December 2021, the NSWPF and a Police, Ambulance, Clinical, Emergency Response (PACER) team were involved in transporting Tammy to hospital. NSW Police Force officers reported Tammy was "…rambling, with pressured speech and paranoid delusions…" She was "distressed and agitated" and increasingly using verbal aggression towards the PACER team. Tammy was consequently scheduled under s. 19 of the *Mental Health Act 2007* (NSW) and admitted with relapse of mania, secondary to non-compliance and polysubstance use.

21. On 15 December 2021, Tammy was admitted to Banks House and subsequently discharged to the community on 20 December 2021 with CoMHET follow up.

Interaction with NSW Police Force for mental health related episodes

22. The NSWPF recorded multiple dealings with Tammy that were focused on mental health episodes.

23. As noted above at [20], on 13 December 2021, almost one year before she died, the NSWPF responded and a PACER team was called and Tammy was scheduled. She was conveyed to Campbelltown Hospital and admitted to the Adult Community Mental

Health Team (CMHT) at MacArthur Aged and Mental Health Care after suffering a "relapse of other illness", secondary to non-compliance with her medication and polysubstance use.

24. On 13 January 2022, Tammy was scheduled under s. 22 of the *Mental Health Act 2007*, following hallucinations that she was seeing people outside her window. She was threatening to harm her neighbours and damage their property.

25. On 22 October 2022, police attended on Tammy after an altercation with her neighbours. Tammy was assessed by a PACER team and referred to the Campbelltown CoMHET.

26. On 26 November 2022, about one month before she died, Tammy came to the attention of the NSWPF for the fourth and last occasion solely in relation to a mental health episode when she attended Macquarie Fields Police Station to report that her neighbour was "*talking in her head"* and wouldn't stop "*talking to her in her mind"*. She was voluntarily conveyed by ambulance to Campbelltown Hospital.

Tammy's interaction with NSWPF and NSW Health in 2022

27. As noted above at [24], on 13 January 2022, a NSWPF officer detained Tammy under s. 22 of the *Mental Health Act 2007* after she physically threatened others. The Officer made a request for a mental health assessment however PACER was not contacted on that occasion because they were not rostered. An ambulance was not available and Tammy was transported to Campbelltown Hospital by NSWPF officers. Tammy was examined at the Campbelltown Hospital ED and found to satisfy the definition of "a mentally ill person". She was admitted to the Adult Mental Health Unit at Campbelltown Hospital, with the reason for admission recorded as "MH – hallucinations".

28. On 14 January 2022, Tammy was transferred to the Birunji Youth Unit at Campbelltown Hospital. She was noted by a psychiatrist to have evidence of "paranoid and grandiosity delusions" and disordered "thought form".

29. On 25 January 2022, a Community Treatment Order (CTO) was sought and on 28 January 2022, Tammy was discharged to the community on that order, which required her to follow a treatment plan. On discharge, her diagnosis was "Bipolar affective disorder, current episode manic with psychotic symptoms". The medication regime involved Abilify (an antipsychotic) via depot injection and Suboxone (used to treat drug dependency). It was noted that a Clopixol depot had been ceased.

30. In the first six months after discharge Tammy received her mental health treatment and appeared to have a significant improvement. Tammy's Abilify (aripiprazole) medication was administered by her GP in the community on 7 March, 28 March, 6 May, 7 June, 29 July, 13 September, 22 October and 3 December 2022.

31. On 28 June 2022, Tammy was reviewed via telehealth by Dr Robert Annen, a psychiatrist with the CMHT. Dr Annen recorded a plan to review Tammy in late August/early September noting the CTO would not be renewed. The CTO expired on 26 July 2022.

32. On 30 August 2022, Dr Annen again reviewed Tammy via telehealth. He recorded that she had "no signs of psychosis, suicidal ideation, or perceptual disturbance" and that she had "remained well on depot Abilify which she gets from her GP". The plan was to discharge Tammy from Community Mental Health.

Arrest and incarceration

33. On 4 October 2022, Tammy was seen by a loss prevention officer entering a Target store in Glenquarie Town Centre and taking several pieces of clothing without paying. She was stopped, police were called, and she was issued with an indefinite banning notice from all Target stores. The NSWPF officer in charge did not arrest Tammy that day.

34. On 5 October 2022, police laid a charge of shoplifting and served a Future Court Attendance Notice for Tammy to attend Campbelltown Local Court on 21 October 2022. The court attendance notice was served on Tammy on 9 October 2022. The matter was dealt with in court on 21 November 2022 and Tammy received a $650.00 fine.

35. On 13 October 2022, Tammy was dispensed Abilify (which was not administered until 22 October 2022). On the same day, there was a mental health review by Dr Annen and the Community Mental Health Team. It was noted that Tammy wanted to be discharged as she was receiving her depot injection from her GP and had NDIS supports in place. She was aware she needed medication. Tammy reported cannabis use but denied using other substances. The plan was to discharge Tammy and that her GP could refer her to telepsychiatry for a six month review.

36. On 22 October 2022, Tammy's neighbours broke her window after she was screaming at them and seemed to be suffering hallucinations. She had received her Abilify medication that morning, nine days late. Tammy had also recently used Ice and cannabis. She was seen by a PACER team and it was determined that she could not be detained under Mental Health legislation. Six days later, on 28 October 2022, the PACER team referred her to the CoMHET.

37. On 4 November 2022, Tammy's CMHT case manager Registered Nurse (RN) Purcell spoke to her by telephone regarding the events of the previous weekend. Tammy did not recall the events until reminded. There was a discussion about a letter that had been prepared for Victims Compensation and that Tammy would be discharged to her GP, as she had requested, as soon as possible.

38. On 15 November 2022 Tammy was dispensed Abilify, prescribed by Dr Matin.

39. On Saturday, 26 November 2022, Tammy presented to Macquarie Fields Police Station to report that her neighbours were watching and talking about her. That was recognised by police as a mental health issue. A PACER team did not attend as there was none available. Tammy was voluntarily transported to Campbelltown Hospital via ambulance. It was recorded that her medication was three days late that week and was being arranged at her chemist. At triage at Campbelltown Hospital, it was recorded that Tammy had suffered visual and auditory hallucinations, worsening over six months. A nurse performed a mental health assessment, finding her alert and orientated, with good insight, calm and compliant. She was to have a mental health review but appears to have left the ED prior to this occurring.

40. On 2 December 2022, RN Purcell called Tammy for the final time. The plan was to discharge her from the CMHT, as per her request.

41. On 3 December 2022, Tammy saw Dr Naim Samann at My Doctors for an injection of Abilify. Dr Samann noted “pt was a bit teary, complained of headache, tiredness; She is 2 week[s] late for the injection”. Tammy attended My Doctors two days later, on 5 December 2022, and was again crying and upset, but declined to provide much more information.

42. On 6 December 2022, Tammy was discharged from the CMHT. The discharge summary, included:

    - “When unwell [Tammy] can present with acute psychotic symptoms including thought disorder, auditory hallucinations, and delusions. She recovers quickly with medication and abstinence from illicit substances”.
    - “Discharge Medication; Abilify depot 400mg q 4/52 IMI; Suboxone 8mg Daily (Dr. Hawkins is prescriber)…”
    - “Identification of Risks: Suicide… Self Harm… Violence… Vulnerability / harm from others… ‘Low’”.

43. On 9 December 2022 sometime in the morning, Tammy attended Macquarie Fields Police Station and asked to be arrested by Police.

44. At around 11:00am, Tammy was seen to go to a Target store she had been banned from and she was stopped by staff who believed her to be shoplifting. Police attended and Tammy was arrested. She was charged (H76115633) and was released with a bail condition “not to enter the Glenquarie Shopping Centre”.

45. The NSWPF Facts Sheet created states “Police are not aware of any drug or mental health issues of the accused”.

46. Later that afternoon, Tammy re-attended Glenquarie Shopping Centre[3] and shoplifted a small quantity of goods from Woolworths. Different NSWPF officers attended. Tammy was arrested and charged with enter inclosed lands, larceny and breach of bail on the offences from earlier in the morning (H91715522).

47. At 7:00pm, Tammy was admitted into custody at Campbelltown Police Station by Leading Senior Constable Tracey Evry. The Custody Management Record indicates an answer of "No" to the questions of whether Tammy had a mental illness or was on medication or had medical issues. It is not clear how that happened, given that her lengthy history of mental illness was known to the NSWPF. Senior Constable Evry recorded that Tammy was Aboriginal or Torres Strait Islander and noted that she refused to speak with the Aboriginal Legal Service.

48. Tammy was refused bail by Police and taken to Amber Laurel Correctional Centre (ALCC) in Emu Plains to appear before Parramatta Local Court the next day.

49. The Court received into evidence body worn video from NSWPF officers who attended on and interacted with Tammy after her offending at Woolworths.

50. One of the attending officers, Sergeant Byran Villacres stated:

> "Due to her behaviour, I thought to enquire about her wellbeing, asking why she wanted to get arrested and if she wanted to go to gaol to which she replied, "*That would be nice*". I asked what was happening at her home and she replied she was having difficulty going through a detox. I tried to explain the seriousness of the offence and being in possession of a knife which she held at one point. I didn't get a response, and she appeared sad".

51. Senior Constable Benjamin Albrecht also made observations about Tammy's presentation that day. He stated:

> "Throughout my interaction with [Tammy], I observed her to remain emotionless and [she] was virtually straight faced the entire time. She mentioned on multiple occasions that she was committing the stealing offences so she could go back to gaol. She also mentioned that she was detoxing but made no mention of what she was detoxing from, substance abuse or any mental health related issues".

52. On 10 December 2022, Tammy appeared before Parramatta Local Court via audio visual link (AVL) in relation to the charges from the evening of 9 December 2022 (H91715522) and a detention application (H76346271) arising from the breach of bail for the charges from the morning of 9 December 2022. Tammy did not seek bail and was refused bail by the Court on both sets of offences. On 11 December 2022, she was taken to SWCC.

[3] Glenquarie Town Centre.

53. The H91715522 matters were adjourned to Campbelltown Local Court on 12 December 2022. The H76115633 matters remained listed for first mention on 12 January 2023 before Campbelltown Local Court.

Experience at Silverwater Women's Correctional Centre

54. On 11 December 2022, at 8:30am, Tammy arrived at SWCC. The events that followed are relevant to understanding how mentally unwell Tammy was and they underscore the need for her to have access to urgent and ongoing mental health treatment.

55. At about 1:00pm, she attempted to harm herself by strangulation in reception and was placed on an Immediate Support Plan (ISP). That afternoon, she was transferred to D Wing, where she was observed to place shorts around her neck. Tammy was then transferred to the Mum Shirl Unit (MSU), where she was seen by a Risk Intervention Team (RIT).

56. On 12 December 2022, Tammy was again assessed by a RIT. She appeared unwell, was naked, disengaged, maintained poor eye contact and declined to participate in the assessment. It was decided that Tammy would remain in a CCTV cell and could only have access to a modesty gown, safety blanket and no sharps. The RIT plan required 30 minute physical observations and constant electronic observations, as well as encouraging Tammy to have human interaction with access to services and calls.

57. That afternoon, a JHFMHN nurse performed a welfare check. Tammy was alert and orientated, was engaging well, reported that she had a shower, was eating and drinking well and said she felt better. Tammy was due to be taken to a cell to appear in court by video link in relation to the H91715522 matters only. However, she was deemed too mentally unwell to attend and a JHFMHN nurse completed a medical certificate so that she could be excused.

58. On 13 December 2022, a RIT review could not proceed due to a CSNSW strike. A JHFMHN nurse attended Tammy's cell with the then Governor of SWCC. Tammy denied any immediate issues. However, she was observed to be naked throughout the afternoon and lying on her bed under the mattress. A remand warrant was issued for Tammy to attend Campbelltown Local Court via AVL for mention of the H91715522 matters on 14 December 2022.

59. On 14 December 2022, Tammy was seen by a RIT who noted she presented as "dishevelled and odorous". According to RN Makadia, Tammy reported she felt "*much better*" since the day before and felt "*fine*" that day. She disclosed that she was on a monthly depot injection and had been using Ice and that she had previous psychosis. She said that when she came into custody she "believed she had a hit on her*"* which is why she had self-harmed. Tammy did not disclose current thoughts of self-harm and was allowed normal prison greens and linen and to have access to sharps. Her plan required

continued physical observations every 30 minutes and constantly conducted electronic observations. She was to have a TV in her cell, books to read and human interaction.

Tammy appears unrepresented at the Local Court and is sentenced

60. On the same day, Tammy appeared before a magistrate at Campbelltown Local Court via AVL. She declined any legal representation and represented herself.

61. Tammy entered pleas of guilty to enter inclosed lands (sequence 1) and shoplifting (sequence 2) of charge H91715522, which related to offending on the afternoon of 9 December 2022. She told the Court that she had mental health problems and was off her medication.

62. It is apparent from the voice recording of the court appearance, that the Magistrate told Tammy that he could deal with the matter to finality that day in a way that meant she could be discharged from custody. He imposed a $100.00 fine for the enter inclosed lands offence and a Community Release Order (CRO) for the shoplifting. The total value of the goods stolen was $23.10.

63. That left one outstanding matter; offences of shoplifting (sequence 1) and enter inclosed lands (sequence 2) of charge H76115633 which had been listed before Campbelltown Local Court on 12 January 2023. These offences of shoplifting and enter inclosed lands were the ones that had allegedly been committed by Tammy earlier in the day on 9 December 2022. The total value of the goods stolen in this offending was $574. A breach of bail on these matters (H76346271), had been established on 10 December 2022 as a result of the further offending. Unbeknown to the Magistrate on 14 December 2022, Tammy was also bail refused on those offences.

64. After sentencing Tammy, the Magistrate made a comment that "*as far as [he was] concerned, [Tammy was] free to leave*". His Honour told Tammy to remember to attend Court in January and to go and see her doctor.

65. After her court appearance, Tammy reported to Correctional Officer (CO) Kenneth Corvini that she *"got bail"* and would be going home. However, when CO Corvini contacted CSNSW Sentence Administration, he was advised there were other charges pending to be heard in January 2023. Tammy appeared to accept the decision and went to sleep. Tammy's case notes completed by CO Corvini that day state:

> "C Watch. Inmate was under the impression that she got bail and would be going home. I contacted Sentence Admin and they advised that there were other charges pending and they would be heard in January 2023. Inmate accepted decision, settled an[d] went [to] sleep."

66. Tammy was unrepresented and her comments to CO Corvini suggest that she did not understand her own position with respect to the outstanding matter. With no advocate

appearing for her, there was no-one who had the responsibility of making sure she understood the implications of the sentence, or of contacting her family to let them know.

Tammy begins to drink excessive quantity of water

67. Between 15 and 17 December 2022, Tammy was noted to be polite to SWCC staff, with no issues to report.

68. On 18 December 2022, there was a RIT review. Tammy stated she felt better and denied current suicidal ideation. She was not sure if she needed to continue taking Buvidal (to treat opioid dependence). With prompting, she mentioned her history of schizophrenia and said she was on Abilify depot. She was to remain on RIT conditions, with 30 minute physical observations and constant electronic observations. Information was to be obtained from the CMHT.

69. 18 December 2022 is also the first time that Tammy can be observed on CCTV to be drinking excessive quantities of water. CCTV footage shows Tammy in her cell consistently consuming water throughout the entire day, beginning from 2:01am. It does not appear that this issue is picked up by SWCC staff or by members of the RIT who saw her on that day.

70. On 19 December 2022, Tammy continued to drink water from the tap in her cell, using a red cup or milk carton.

20 December 2022 - Tammy's death

71. On 20 December 2022, from 12:33am to 11:51am, Tammy consumed water from the tap in her cell using a cup and milk carton. It is estimated that on that day alone, Tammy consumed at least 20 litres of water.

72. At around 8:40am, Tammy was seen again by a RIT and was said to be "calm, cooperative, [have] good eye-contact, clear speech, [be] compliant with RIT questions, alert and orientated to time place and person, [and] appropriately dressed in prison greens." However, "Tammy advised that she [could not] guarantee her own safety but [had] no thoughts of hurting herself." She was noted to be "quite withdrawn and hesitant." Tammy was to remain on RIT conditions with 30 minute physical observations and 30 minute electronic observations. The plan was to review her on 22 December 2022.

73. At around 10:04am, Tammy commenced vomiting which then continued through the morning. She defecated on the floor of her cell approximately 30 minutes later. At 11:55am, Tammy can be seen on CCTV to collapse on her bed. She begins to experience a seizure and eventually collapses face down on the floor.

74. At 1:38pm, staff finally became aware of the severity of Tammy's condition and CPR was attempted. Paramedics were unable to revive Tammy, and she was pronounced life extinct at 2:25pm.

75. The post-mortem report recorded the direct cause of death as hyponatraemia with an antecedent cause of primary polydipsia and complications of schizoaffective disorder and its treatment.

76. I have come to a slightly different conclusion as to the cause of Tammy's death as I can't be certain it was primary polydipsia or that it was due to the treatment of Tammy's schizoaffective disorder. I find that the cause of Tammy's death was hyponatraemia with antecedent causes of polydipsia and complications of schizoaffective disorder. I base this on the comments in the post-mortem report about the difficulty, in the post-mortem setting, to determine if the deceased had primary polydipsia, a condition secondary to schizoaffective disorder, or syndrome of inappropriate antidiuretic hormone (SIADH) due to the treatment of schizoaffective disorder. This is addressed further below in the consideration of "Issue 3".

77. After Tammy died, she was convicted and sentenced in her absence for the remaining offences heard on 12 January 2023. She was fined $800.00 for the shoplifting offence and $200.00 for the enter inclosed lands offence. Given Tammy had passed away, those matters should have been withdrawn and dismissed, but it appears that no-one in Court that day identified that Tammy was deceased.

ISSUES FOR CONSIDERATION

78. The below addresses the evidence and submissions broadly in line with issues identified prior to the commencement of the inquest hearing noting the primary systemic issues for consideration in this matter evolved and crystallised during the proceedings.

Issue 1: Tammy's arrest, imprisonment and mental health condition at the time

79. Tammy's interaction with police and the community justice system was contributed to significantly by her mental health conditions. In 2012, after Tammy was charged with several offences, she was dealt with under what was then s. 32 of the *Mental Health Act (Forensic Provisions) Act 1990* (NSW).[4] That provision enabled a magistrate to divert a person away from the criminal justice system into a treatment regime to break the cycle of reoffending. This was around the time Tammy was first admitted into hospital for treatment of a mental health condition.

80. In July 2016, Tammy's criminal record shows that she was sentenced to a period of about six months in custody for offences of stalk/intimate. During that period in custody, Tammy's diagnosis of schizoaffective disorder was recorded on a Reception Screening Assessment (RSA) by JHFMHN staff and notified to CSNSW via a Health Problem Notification Form (HPNF). Counsel Assisting submits that this is the only reason CSNSW

[4] The provision has been repealed and replaced with s. 14 of the *Mental Health and Cognitive Impairment (Forensic Provisions) Act 2020* (NSW).

had a record of her mental health history when she returned to custody in 2022, despite several interactions with the NSWPF and Tammy in the intervening period.

81. In the 18 months prior to her final arrest in 2022, there were three significant interactions between the NSWPF and Tammy that were recognised by NSWPF officers to be mental health crises, such that they appropriately diverted Tammy away from the criminal justice system and into mental health care.

    a. The first was on 13 December 2021, when Tammy was scheduled under s. 19 of the *Mental Health Act 2007*. She was conveyed by police to Campbelltown Hospital where she was admitted for mental health care.

    b. The second was on 13 February 2022, almost one year later, when police attended Tammy's residence and found that she was exhibiting reportedly abusive behaviour, including threats to harm her neighbours and damage their property. It was recognised by Police that Tammy should be diverted into the mental health system, and she was again scheduled (this time under what was s. 22 of the *Mental Health Act 2007*).

    c. The third was on 26 November 2022, when Tammy attended Macquarie Fields Police Station to report that her neighbour was “talking to her in her head”. An ambulance was called and she was conveyed as a voluntary patient to Campbelltown Hospital.

82. Counsel Assisting submitted the above represent three occasions where NSWPF officers recognised Tammy to be experiencing a mental health crisis, and they diverted her into the mental health system, noting these are obvious incidences of NSWPF officers exhibiting compassion and care towards Tammy.

83. On several of these occasions, Police attempted to engage the PACER service, however a PACER team was not available. The evidence of Sergeant Rendell was that the PACER team has since been made available for an increased number of hours.

84. On each of these occasions, Police made a record of the incidents on the NSWPF Computerised Operational Policing System (COPS), meaning there was a record on the COPS of Tammy suffering from mental health issues, including that she had experienced hallucinations on at least two of those occasions, most recently on 26 November 2022.

(a) Final entry into custody

85. Subsequently, on 9 December 2022, at about 11:00am, Tammy was observed shoplifting at Glenquarie Town Centre and police were called. On attendance, NSWPF officers charged Tammy with shoplifting and enter inclosed lands offences (H76115633) and released her on bail with a condition not to enter Glenquarie Shopping Centre. Later that afternoon however, at about 6:00pm, Tammy did re-enter the Glenquarie Shopping

Centre and was again detained, this time by different NSWPF officers, for shoplifting, enter inclosed lands (H91715522) and breach of bail (H76346271). The items allegedly stolen include a rolling pin, a kitchen knife, and a bottle of olive oil; as noted above at [62], the value of which totalled $23.10. There was no suggestion that Tammy intended to use or was threatening anyone with the knife.

86. The NSWPF officers who detained Tammy that evening showed concern for her welfare. As detailed above at [50], Sergeant Villacres stated:

> "Due to her behaviour, I thought to inquire about her wellbeing, asking why she wanted to get arrested and if she wanted to go to gaol... I asked what was happening at her home... I tried to explain the seriousness of the offence and being in possession of a knife which she held at one point. I didn't get a response and she appeared sad."

87. Tammy was taken to Campbelltown Police Station and was refused bail by a Custody Manager, ostensibly because her alleged offending had resulted in her breaching the bail she had been granted by police earlier in the day. The breach of that bail was a "show cause offence" and according to the record of the bail determination, Tammy was unable to show cause why her detention was not justified.

88. Counsel Assisting submitted that whilst we cannot and should not expect police to diagnose mental health issues, police should ensure that they check the COPS history of a person and identify if there is a history of mental health issues apparent in a person's dealings with police. Expert psychiatrists, Professors Matthew Large and Olav Nielssen, in their evidence observed the significance of checking that history in order to understand Tammy's flat, emotionless, sad affect at that time. Professor Large opined that affect was reflective of her illness and mental health diagnoses.

89. Tammy's mother Vicki and her family (Tammy's Family) submitted that before taking Tammy into custody on 9 December 2022, the NSWPF knew she had been previously arrested that day and that she had told police she wanted to go to gaol. They also had significant knowledge of Tammy. They had recorded interactions with Tammy for more than a decade prior, including incidents where they had made decisions involving her mental health and diversions from the criminal justice system.

90. On behalf of the Commissioner NSWPF, it was submitted that Counsel Assisting's submissions were inconsistent in their approach in this regard. On the one hand, Police were not expected to diagnose mental health issues or to have expertise in that area, noting it was conceded Tammy wasn't obviously exhibiting psychosis when she entered custody on 9 December 2022, but on the other hand that the NSWPF knew Tammy had a significant mental health issue.

91. The Commissioner NSWPF submitted any knowledge, as it was referred to by Tammy's family, or information held by the NSWPF relevant to Tammy's mental illness was not held by any one person in the NSWPF and that any history of mental illness which had been documented in the holdings of the NSWPF did not create a presumption that a person currently had a mental health illness. The Commissioner NSWPF noted the oral evidence of Superintendent Kirsty Hales of the NSWPF Mental Health Command:

> *"… the difficulty for police might be where that information has come from and the veracity of that information, and whether that's corroborated and also what the person is saying at the time in front of you as to their mood, their presentation, and then I guess that's also impacted then by people's experience, certainly custody managers, of how people present in custody generally"*

92. Counsel Assisting noted that in her statement, Inspector Jacqui Cameron, Strategic Coordinator, Custody and Corrections Portfolio, NSWPF, clarified the records that police are to check when a person enters custody. Inspector Cameron stated:

> "There is a joint responsibility for the arresting police, and the Custody manager to make enquiries with the Computerised Operating System, (COPS), to reveal if the [person in custody] has a previous entry (within COPS) regarding a possible mental illness. The arresting or escorting police are required to make enquiries within the Computerised Operating System (COPS) relevant to the person in custody (PIC), and to inform the custody manager if the person in custody has, amongst other things; *A history of psychiatric mental illness,* as specified in the Police Handbook - Chapter C Custody, under Background information".

93. The evidence of Inspector Cameron, in line with the NSWPF Handbook, was that while a custody manager conducts their own check for "warnings" on the COPS, they are not obliged to conduct their own checks into mental health history. That responsibility rests with arresting and/or escorting Police.[5]

94. Tammy's Family submitted that the systems and processes currently in place would yield no different outcome if she was arrested today. They submitted that relying on "warnings" on police systems is arbitrary as it relies on an officer from a prior interaction entering such information, and while arresting and transporting officers may check the COPS if they suspect mental health issues, noting they are not mental health professionals, this may or may not be passed on to the custody manager.

95. The NSWPF handbook indicates a person's previously recorded mental illness may be relevant to understanding the circumstances of their alleged offending. Counsel Assisting submitted it may be relevant to the questions you might ask a person, and it is of vital significance in terms of passing that on to the Custody Manager.

[5] Tab 198 – Statement of Inspector Jacqui Cameron at pp 3-6.

96. Despite this, there is no evidence that Police enquired of Tammy's clearly recorded mental health history on the COPS at any stage on 9 December 2022. If Police did make enquiries on the COPS, that information was either not passed on to the Custody Manager or otherwise it was simply not entered on the Custody Management Record that would travel with Tammy as she progressed from the custody of the NSWPF to CSNSW.

97. Counsel Assisting submitted that one explanation for this oversight might be that Police are not taking the time to look at that record because of the substantial increase in the number of callouts for mental health concerns. The Court received evidence that the NSPWF attended, or recorded, a mental health incident every nine minutes on average. In 2022, the NSWPF recorded 61,164 incidents in the COPS in relation to people experiencing a mental health emergency or incident where there was *not* an associated criminal offence.

98. The Court heard from Superintendent Hales that the NSW Government is looking closely at ways in which police can be further assisted in that regard and that at the time of the inquest hearing, there was a working group including senior officials from NSW Health, NSW Ambulance and the NSWPF looking at a health led responder model. Superintendent Hales also noted that under a "right care right person" model, in circumstances where there is a perceived risk to community or health responders at a mental health callout, police would still attend if necessary but as secondary rather than primary responders.[6]

99. Counsel Assisting ultimately submitted that while Tammy was not obviously exhibiting symptoms of psychosis on 9 December 2022, and there was no expectation that she should be transported or scheduled under mental health legislation, had police enquired of the COPS that day, they would have seen that just 13 days earlier Tammy had been hallucinating and it may have caused real questions to be asked of her about where she was in that mental health journey. The opportunity might then have been available to involve PACER to divert Tammy away from the justice system, particularly in a case where the alleged offending was shoplifting for an amount just over $23.00.

100. It was further submitted that this would not have prevented Tammy being charged for the offending or issued a Court Attendance Notice for a future date, but it may have been an opportunity to lift the burden from the NSWPF and for it to be shared with mental health professionals to assist Tammy to get the help she needed.

101. Tammy's Family submitted that on 9 December 2022, Tammy was very unwell and should have ended up in a hospital bed, not a prison cell. They drew attention to the oral evidence of Prof Large which was to the effect that if Tammy had been taken to hospital

[6] Transcript 23/02/26, pp 25-26.

by police on that day, she may have received the help she needed. In response to a question regarding what the hospital treatment regime would have been if there had been any intervention prior to 20 December 2022 that resulted in Tammy being sent to a hospital, Prof Large stated:

> *"I think the mental health professional who saw her would recognise that she had a very flat affect, and probably would [have] asked some questions that would have revealed that she was in [a] depressive phase of schizoaffective disorder, and more would've been learned about her social - what was going on at home, which was either delusional or difficult for her. So I don't think it's - I think she actually might well have been admitted if presented to a hospital."*

102. The Commissioner NSWPF submitted that an arrested person appearing to be sad and withdrawn, as Tammy was described, is a common observation, and not indicative of a mental illness, further citing the evidence of Superintendent Hales:

> *"…I think that also poses a difficulty of being a layperson assessment, that that behaviour is then not consistent with the presentation on that day, and in terms of a diagnosis of schizophrenia, that's not presenting to police like the psychosis and the hearing voices and the mania side. So, whilst it's relevant information, I think that they would look at that and think well, maybe it's about social deterrence and she finds herself in an unhappy position or there's things going on in her life and maybe it doesn't flag to them that that is potentially a symptom of schizophrenia."*

103. And:

> *"… the police come into contact with many people in circumstances not dissimilar who maybe in the last 13 days have a lot going on, and I think that the difficulties for us is that we have to deal with what's in front of us and whether or not we think we have the lawful position to be able to take someone for assessment or whether or not the Court may mandate that once they are before the Court."*

104. To be clear, the first comment of Superintendent Hales above was in response to a question about looking at Tammy's history on the COPS, not only the observation by Police on 9 December 2022 that she appeared "sad" and "withdrawn".[7]

105. On 10 December 2022, when Tammy appeared via AVL before Parramatta Bail Court, she indicated to the magistrate she did not want bail. She was unrepresented, having declined to speak to a legal representative. The Court heard from expert forensic psychiatrist Associate Professor Danny Sullivan, and Prof Large, that Tammy was likely suffering a depressive psychosis at this time and in an acute phase of her schizoaffective disorder.[8]

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[7] See Transcript 230226, p 34.
[8] Transcript 25/09/24, pp 562-563.

106. In those circumstances, Tammy was not well equipped to advocate for herself, or even to recognise whether she needed representation.

107. I am satisfied that Police did have the corporate knowledge about Tammy's mental health background. I am not critical of Police for charging Tammy with the shoplifting, but where an Accused is known by Police to have a mental health history and declines representation, it is preferable (and in the interests of the Accused and the public) for the information known to police to be passed on to the Court, to assist in a bail determination.

108. Section 18(1)(k) of the *Bail Act 2013* (NSW) lists a number of matters that the judicial officer should consider as part of a bail assessment. That includes "any special vulnerability or needs the accused person has including because of youth, being an Aboriginal or Torres Strait Islander, or having a cognitive or mental health impairment". In Tammy's case, because she declined to be legally represented (possibly because she was mentally unwell), it was Police who were in a position to advise the Magistrate about the mental health history, which may have been considered to be an impairment relevant to the determination of bail.

(b) Custody Management Record

109. All people brought into a police station in custody must have a Custody Management Record.[9]

110. Counsel Assisting submitted that while the Custody Management Record is relevant to the treatment that somebody receives at a police station, it also travels with the person to the custody of CSNSW and it may be evidence that is relevant to inform a defence lawyer, and possibly a magistrate.[10]

111. Further, because the document is structured as questions for the person who is detained, it may not provide accurate or helpful information. The evidence of Prof Large and Prof Nielssen was that persons with a mental illness are not reliable in providing information about their mental illness, whether that be out of shame or stigma or simply because they may not recognise they are unwell or are suffering psychosis.[11]

112. Tammy's Family echoed Counsel Assisting's concerns that the assessment by a custody manager relies on a detained person's self-reporting of mental illness and the "real risk" the information may be incorrect. They also highlighted the evidence of Louise Lynch, Director of Aboriginal Strategy at CSNSW, who explained several reasons why Aboriginal inmates may not report issues in relation to both their Aboriginality and mental health, including trauma, stigma and their distrust of government systems. They

[9] Tab 198 – Statement of Inspector Jacqui Cameron at pp 47-48.
[10] Transcript 24/02/26 pp 80-81.
[11] Transcript 24/02/26 p 128.

submitted this clearly demonstrated limitations in the assessment process undertaken by the custody manager.

113. The evidence shows Tammy was not able to give a reliable outline of her mental health history and, as noted above at [47], her Custody Management Record from 9 December 2022 indicates an answer of "No" in relation to whether she had any mental health issues. The comments section indicated Tammy "Appear[ed] fine and well".

114. Tammy's Family submitted that interactions between police and members of the public currently require subjective assessments or intentional acts of inquiry by officers in relation to the person they are interacting with. They submitted there is a legitimate expectation that if the NSWPF holds information useful in determining how officers deal with members of the public with known mental illnesses, those officers should be apprised of that information. They should not have to go searching for it. Further, the quality of any assessment should not be reliant on the relative experience of the officer or custody manager.

115. It was submitted that the failure of police to record Tammy's mental health history not only on the Custody Management Record, but also within the Facts Sheets for any of the alleged offending, meant that neither the Magistrate nor the NSWPF Police Prosecutor had this information before them when Tammy appeared before the Parramatta Bail Court by AVL on 10 December 2022. Counsel Assisting submitted this is an important issue when a person with a relevant mental health history is incapable of advocating for themselves.

116. Counsel Assisting submitted that knowing that Tammy had a significant mental health issue, and that 13 days earlier she had been transported to hospital after suffering a psychosis, it seemed unfair and inappropriate to place the burden on her to show cause as to why she shouldn't be detained.

117. Tammy was transferred from NSWPF custody to ALCC. There are limited records of Tammy's time at ALCC, which appeared to be only a transit point to SWCC. According to CSNSW records Tammy arrived at ALCC at 1:00am on 10 December 2022,[12] she transferred out to SWCC on 11 December 2022.[13]

118. On arrival at SWCC Tammy undertook a RSA with a JHFMHN nurse who identified Tammy was depressed and tearful and could not guarantee her own safety. The nurse completed a notification to CSNSW which activated RIT management. The nurse subsequently identified Tammy's mental health history from her previous period in the

[12] Tab 76 – New Inmate Lodgement & Special Instruction Sheet, p 1.
[13] Tab 73 – Inmate Profile Document, p 2.

custody of CSNSW,[14] despite the indication on her Custody Management Record that she did not have any mental health issues.

119. The failure to record Tammy's mental health history on the Custody Management Record remains important from a systemic view because if Tammy had not been previously incarcerated, there would have been no documented record of her mental health history available to CSNSW at that time.

120. To alleviate any future issues in relation to identifying a person's known mental health history as recorded by the NSWPF and correctly recording it on the Custody Management Record, Counsel Assisting proposed Recommendation I at [279] below.

121. The Commissioner NSWPF submitted that the suggestion of Counsel Assisting that the Custody Management Record should be provided to prosecutors and judicial officers was not of assistance in the short term, and likely to end up in failure in the long term, as provision of a suitably modified Custody Management Record required not only an update in NSWPF systems, but also for the relevant points of data entry to be correctly done and that this would require further training. That submission is unhelpful, particularly since a significant objective in any inquest is to improve the system to avoid unnecessary deaths.

122. The information about Tammy's mental health history in the COPS should have been entered into the Custody Management Record at Campbelltown Police Station on 9 December 2022. Inclusion of the mental health history on the Custody Management Record is important from a systemic view because if Tammy had not been previously incarcerated, there would have been no documented record of her mental health history available to CSNSW when she entered their custody on 10 December 2022. In Tammy's case the lack of information about Tammy's recent mental health issues in the Custody Management Record also meant that neither the prosecutor nor the Magistrate was on notice about Tammy's mental history. To prevent any future issues in relation to identifying a person's known mental health history as recorded by the NSWPF and correctly recording it on the Custody Management Record, I consider that a recommendation is necessary. I will return to this recommendation at [279].

(c) Court appearance on 14 December 2022

123. On 12 December 2022, Tammy was due to attend Campbelltown Local Court via AVL in relation to the H91715522 offences. On that day Tammy was noted to be unwell and naked in her cell. She had poor eye contact and refused to engage with a RIT. As noted above at [57] a JHFMHN nurse prepared a "Medical Certificate Non-Attendance at Court"

[14] Transcript 17/09/24 pp 126-131.

certifying that Tammy had a medical condition such that she was unable to attend Court. The Medical Certificate stated:

- "security issue / Risk as per CSNSW; mentally unwell"
- "Not discussed with patient – Not engaging. CSNSW advised"
- Tammy "should be "fit to attend court after 19/12/22".[15]

124. At 4:57pm, JHFMHN emailed a copy of the Medical Certificate to the Court.[16]

125. On 13 December 2022, it appears the matter was mentioned at Campbelltown Local Court. At 12:51pm, a remand warrant was issued by the Court with the matter listed to be heard by AVL on 14 December 2022. The remand warrant does not record the reason why the matter was adjourned. It is possible that the Court became aware of the Medical Certificate which had been emailed to the Court the day before.

126. On 14 December 2022, Tammy appeared before Campbelltown Local Court via AVL. The Court heard evidence that on that day, Tammy was offered legal representation by Legal Aid NSW, which she declined. While there was a record available on Tammy's court file indicating that she had been dealt with in 2011 under mental health legislation, the Magistrate does not appear to have had any other evidence of Tammy's recent mental health history before him, nor did the NSWPF Police Prosecutor.

127. It is unclear whether the Magistrate that day was aware of the Medical Certificate, there is no reference to it in the transcript of the appearance. JHFMHN submitted that had the Magistrate been aware, a question may have been asked regarding Tammy's fitness for the court appearance, given the Medical Certificate said she would not be fit to attend court until 19 December 2022.

128. Tammy herself stated to the Court that she "*hadn't had any Bupe for a week and … went into like a small psychosis, … [she] thought someone was after [her] and [she] wanted to just be safe so [she] went to Woolworths to get charged."* She stated she was *"alright with [her] head now*."[17] Tammy was not alright.

129. As noted above at [59], earlier that day Tammy had a RIT review at SWCC where it was noted that she presented as "dishevelled and odorous". Tammy disclosed at that time that she was on monthly depot injections but had been using Ice. She disclosed that she had suffered a psychosis, and that when she came into custody she believed she had a "*hit on her*". She did not disclose thoughts of self-harm but *could not guarantee her own safety*.

[15] Tab 219 - Shipley - Campbelltown LC 141222, p 31.
[16] Tab 219 - Shipley - Campbelltown LC 141222, p 30.
[17] Tab 217 - Campbelltown Local Court - 14 December 2022 - Unofficial Transcript, p 2.

130. This information was not available to the Magistrate who, as Tammy was unrepresented, had to rely on Tammy's own assessment of her mental health. Professor Large told the Court he was "*sure [Tammy] didn't have capacity*" to represent herself that day.

131. Tammy pleaded guilty to the H91715522 offences. Counsel Assisting submitted that the Magistrate recognised Tammy should not be in custody and structured a sentence so that she could be released. However, it appears that because of a systems failure whereby Tammy's criminal history did not accurately reflect her bail status on the H76115633 charges, the Magistrate was left with the wrong impression about her having bail in relation to those offences.

132. While it is unclear whether Tammy's criminal history printed on 9 December 2022, which appeared on the Court file, or a later copy printed on 13 December 2022 which appeared on Tammy's Legal Aid file, was before the Magistrate that day, what is clear is that both versions suggested Tammy had bail on the H76115633 offences that were to be heard in January 2023. This appears to be due to a failure of the system.

133. Evidence suggested that on 10 December 2022, when Tammy appeared before the Bail Court, JusticeLink was updated to reflect that her bail had been revoked, however the Police criminal history suggested she had bail. Superintendent Duane Carey explained the process; the magistrate makes the orders, writes the orders on the bench sheet, the bench sheet goes to the registry, the orders are updated in JusticeLink and JusticeLink then is supposed to disseminate the information to the COPS to update the Court outcome.[18]

134. The Department of Communities and Justice (DCJ) has since confirmed this process and that the 10 December 2022 court outcome was recorded in JusticeLink 20 minutes after the orders were made. The outcome should have updated to the COPS system, via a "scheduler", within sixty seconds. It remains unclear why this did not occur.

135. I accept the submission of Counsel Assisting that had the Magistrate been aware of Tammy's mental health history and the fact her bail had been revoked on the H76115633 offences, they may have considered alternative options including; dealing with the offences under s. 14 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (previously s. 32 of the *Mental Health Act (Forensic Provisions) Act 1990)*; asking Legal Aid to provide further assistance; or bringing forward the H76115633 offences to be dealt with that day, rather than in January 2023.

136. The NSWPF Police Prosecutor who appeared that day gave evidence that had he known about Tammy's bail conditions being other than what the Magistrate thought they were, he would have alerted the Court to the true position.

[18] Transcript 24/02/26, pp 98-99.

137. The Commissioner NSWPF contested the proposition that the Magistrate was not informed of Tammy's mental health status, drawing attention to the evidence that the Magistrate was informed by Tammy herself that she had recently experienced an episode of poor mental health. The Commissioner NSWPF submitted the Magistrate was clearly aware that Tammy had further matters outstanding and due before the court in January 2023 and that JusticeLink should clearly have shown that Tammy was bail revoked in respect of that alleged offending.

138. Further, there was nothing additional that the NSWPF Police Prosecutor could have done to alert the Magistrate as to Tammy's mental health status, even if he had been in possession of any of the detail of her past mental health issues, and that the most obvious causes of Tammy remaining in custody after her sentencing were that:

    a. She was unrepresented, whereby it is assumed that if she had retained a defence legal representative that person would have identified that she was not entitled to be released and taken steps to rectify that in one way or another; and/or

    b. JusticeLink was apparently not consulted by anyone in the courtroom.

139. There are several possible explanations for why the Magistrate was not given assistance that day in relation to understanding Tammy's mental health history or bail conditions, particularly given how busy Local Courts can get. I am aware, from my position as a judicial officer, that judicial officers do not have any access to JusticeLink in Court or at all. This is to ensure impartiality and protect the judicial process.

140. The outcome underscores the necessity for Police to accurately document a person's significant mental health history or known diagnosis, particularly over the course of the 12 months preceding any current charges. Counsel Assisting submitted any such history should be documented on the Custody Management Record that travels with an accused and that, or the Facts Sheet for the relevant offences, could be handed up to the magistrate. That way defence lawyers, police prosecutors and magistrates would all be alerted to potential mental health issues of an accused.[19]

141. Counsel Assisting also submitted that the JusticeLink system should be reviewed with the cooperation of the NSWPF to determine the cause of any syncing delays to the COPS with a view to resolving any issues.

142. I note the relevance of these submissions in relation to the 1991 *Royal Commission into Aboriginal Deaths in Custody* and its emphasis on the role coroners should play in identifying opportunities to prevent further deaths in custody.

143. Tammy's Family submitted that the evidence highlighted shortcomings and gaps in the Police system and that change is necessary to ensure the same errors are not made in

[19] Transcript 26/02/26, p 153.

the future. They submitted that the Magistrate, the Police Prosecutor and Tammy thought she was going to be released that day and, while no one can know the impact on Tammy when a CO told her she wasn't going home, it can't have helped her mental state.

144. The Commissioner NSWPF submitted that a review of JusticeLink to resolve any "syncing" issues was not necessary as:

    a. JusticeLink already provides, and specifically provided in this case, the information sought;

    b. delving into where and why JusticeLink did not update the COPS might not be quick, easy or effective; and

    c. any review of JusticeLink would have to be completed by DCJ, who did not appear at this inquest.

145. Those assisting me wrote to DCJ in relation to JusticeLink and their response is addressed above at [134] and in Recommendation VI at [279] below.

146. I accept that there was a clear systems failure when Tammy appeared in court by AVL on 14 December 2022. Had the Magistrate been aware of Tammy's mental health history and the fact her bail had been revoked on the H76115633 offences, there is a significant chance they may have considered alternative options, as suggested above at paragraph [135]. That is obvious from the fact that the Magistrate intended for Tammy to be released on 14 December 2022, and given the similarity of the shoplifting charges Tammy had pending, with the charges she was being sentenced for on 14 December 2022.

147. As noted above at [136], the NSWPF Police Prosecutor that day, gave evidence that had he known about Tammy's bail conditions being other than what the Magistrate thought they were, he would have alerted the Court. Thus, he demonstrated a clear understanding of his duties and I have no doubt that he intended to assist the Court, and would have corrected the record, had he understood Tammy's bail status. It is clear on the evidence that the Magistrate recognised Tammy should not be in custody and structured a sentence so that she could be released. Sadly, because of the inaccuracy on the record as to the bail status of the matter listed in January 2023, that was not the outcome.

Issue 2: Tammy's mental health treatment in the community

148. The Court received extensive expert evidence in relation to Tammy's mental health from A/Prof Sullivan, Prof Large and Prof Nielssen. Since at least 2012, Tammy was variously diagnosed as suffering from bipolar disorder, polysubstance abuse, schizophrenia and/or schizoaffective disorder; chronic conditions prone to relapse.

149. Tammy was largely managed in the community, sometimes on a CTO and sometimes under the care of her GP. Professor Nielssen opined that it would have been preferable

to keep Tammy on a CTO. Professor Large said that in his view there was no requirement that she be kept on a CTO and it was not necessarily the case that she would be more adherent to her medication while she was on a CTO.

150. It was submitted that while reasonable minds may differ, continuity of care within the mental health system is very important in terms of maintaining somebody's connection to treatment, maintaining it in a way that it is affordable to the patient and allowing them to build a therapeutic relationship with a treating team.

151. In the weeks and months before 9 December 2022, Tammy's mental health was declining. Her compliance with medication necessary to treat her mental illness fluctuated and she was required to fill her own scripts for antipsychotic medication. The GP charged with her care sent follow-up and reminder messages about her medication and appointments however Tammy's family submitted she needed greater support than could be provided by her GP.

152. They acknowledged that the evidence of Prof Large, A/Prof Sullivan and Prof Nielssen spoke to the limitations of the efficacy of CTOs and community based prescription of antipsychotic medication generally. However, they submitted Prof Large and Prof Nielssen agreed that developing and continuing relationships with community based mental health professionals were protective factors that increased the adherence to medication regimes and a continuity of care model addressed the issue of cost, which would be borne by NSW Health instead of the patient.

153. On behalf of the SWSLHD it was submitted that the experts were not agreed as to whether a CTO improves compliance with medication. In summary:

    a. Professor Large's view was that CTOs did not prevent readmission and the academic world of psychiatry was turning away from them, towards other methods of support. However, he noted CTOs were of benefit to patients who were implacably opposed to medication, and who presented a danger to themselves or others. Professor Large explained that a CTO cannot ensure that a person gets their medication on time, all the time. This is principally because the breach process takes time, including the requirement of a written warning and offering the patient a chance to comply.

    b. Associate Prof Sullivan agreed with Prof Large and opined that although he considered the decision to discharge Tammy from her most recent CTO "*a little precipitant*", a decision to continue it would have overridden Tammy's expressed wishes, and that it was very unlikely the Mental Health Review Tribunal (MHRT) would approve the continuation of the CTO if Tammy was able to demonstrate insight. Even with a CTO Tammy required prompting and while she showed fluctuating insight, there may have been other reasons for her non-compliance,

including being disorganised, intoxicated, or suffering the cognitive effects of serious mental illness.

c. Professor Nielssen's view was that, if Tammy were on a CTO, her missed dose would have been noticed and probably acted on, possibly preventing relapse.

154. The SWSLHD submitted that in those circumstances, there should be no criticism of the decision to not seek continuation of Tammy's existing CTO, or a further CTO, after it expired in July 2022. They note the MHRT is bound by the principle of least restrictive care, and it cannot be concluded that a further CTO would have been imposed. In any event, there was continued contact between Tammy and the CMHT, after the end of her CTO. Dr Annen reviewed Tammy on 30 August 2022, and she had further contact with the CMHT on several occasions prior to ultimately being discharged from the service on 6 December 2022.

155. It is not clear whether Tammy's GP, Dr Matin, ever received the CMHT discharge summary. It was not contained in the records produced to the Court by My Doctors. The SWSLHD conceded that in October and November 2022, although Tammy had contact with the CMHT, there is no evidence of any communication between the CMHT and Dr Matin. During that period Tammy deteriorated. It was acknowledged that this represented a missed opportunity.

156. The Court received evidence that the SWSLHD has since engaged in initiatives to promote interaction between GPs and the LHD, notably the Health Pathways initiative, which supports GPs, patients and carers to access mental health services and resources via an online clinical and referral information portal.[20]

157. The SWSLHD noted that Recommendations 5 and 6 from the Inquest into the deaths at Westfield Bondi Junction were directed to further improving the coordination of care between Local Health Districts and GPs and, in those circumstances, no further recommendation was required.

158. As noted above at [98], the Court also heard from Superintendent Hales that there are significant reforms planned that have the full backing of the NSWPF with respect to getting the right care for the right persons, and that the NSWPF have been working NSW Health and NSW Ambulance to develop a health led responder model and that stakeholder consultation will inform a business case to Cabinet.[21]

159. I accept the evidence of Prof Large, A/Prof Sullivan and Prof Nielssen regarding the limitations of the efficacy of CTOs and community based prescription of antipsychotic medication generally. It is clear from the evidence that continuity of care within the mental health system is very important in terms of maintaining somebody's connection to

[20] Tab 182B – Statement of Patrick Parker, p 5.
[21] Transcript 23/02/26, p 25.

treatment, maintaining it in a way that it is affordable to the patient and allowing them to build a therapeutic relationship with a treating team. In the circumstances, I make no criticism of the decision to not seek continuation of Tammy's existing CTO, or a further CTO, after it expired in July 2022. I acknowledge evidence that since Tammy's passing, the SWSLHD has engaged in positive initiatives to promote interaction between GPs and the LHD, notably the Health Pathways initiative, which supports GPs, patients and carers, to access mental health services and resources via an online clinical and referral information portal.

Issue 3: The adequacy of the response by CSNSW to Tammy in December 2022

160. On arrival at SWCC, Tammy undertook an Intake Screening Questionnaire with a CSNSW Services and Programs Officer (SAPO) who noted she "appear[ed] to be mentally unwell and withdrawing from ice".[22] The same day Tammy was seen by a JHFMHN nurse who conducted her RSA and identified she required a mental health referral noting the following about Tammy; "depressed, tearful, lack of eye contact, states she cannot guarantee own safety and to others."[23]

161. On the same day, on two separate occasions, Tammy wrapped items of clothing around her neck to form a noose and told CSNSW staff how unwell she was. In her incident report, Senior CO Soh noted the following about Tammy: "appeared low mood, behaving strangely, has no support from outside, poor eye contact. [Tammy] stated that since she came to custody she has thoughts of self harm by using her clothes to hang herself."[24] When another CO asked her why she had put the clothing around her neck, Tammy stated: "*Because I know I'm already dead*".[25]

(a) Whether the terms of the RIT plans for Tammy were appropriate in the all the circumstances?

162. The terms of Tammy's initial RIT plan required constant observations, access only to a modesty gown and a safety blanket, and no access to sharps.[26]

163. As noted above at [56], on 12 December 2020, the RIT plan was that the periodic 30 minute physical observations and constant electronic observations were to continue to be made and that staff were to encourage human interaction for Tammy with access to services and phone calls.[27] As there was no capacity to accommodate Tammy in the SWCC Mental Health Unit, she was instead placed in the MSU to facilitate her constant observation via CCTV.[28]

[22] Tab 80 – Case Management File, p 36.
[23] Tab 165 - JHFMHN Records – Volume 2, p 122.
[24] Tab 80 – Case Management File, p 16.
[25] Tab 80 – Case Management File, p 21.
[26] Tab 117 – RIT Folder documents, p 11.
[27] Tab 117 - RIT Folder documents, p 8.
[28] Tab 117 - RIT Folder documents, p 10.

164. On 14 December 2022, Tammy was allowed normal greens and linen and access to sharps. Her observation regime remained the same until 20 December 2022 when her electronic observations were reduced from constant, to 30 minutes.[29]

165. Former Senior Constable Salim Trad, the NSWPF officer in charge (OIC) of the investigation into Tammy's death, thoroughly reviewed the CCTV footage that documented Tammy's time at SWCC. Despite the observation requirements of Tammy's RIT plans, over the period of 18-20 December 2022, the OIC documented that Tammy drank excessive quantities of water. He stated:

> "The most notable observation made, is the amount of water [T]ammy consumed in the lead up to her death. On the 18th of December 2022, Tammy is observed in her cell to consistently consume water throughout the entire day, beginning from 2.01am. Her water consumption on the 19th of December becomes elevated, and she continued to drink water from the tap in her cell, red cup or milk carton."[30]

166. From 12.33am to 11.51am on 20 December 2022, Tammy refilled and drank water from the red cup on at least 67 occasions that he counted. In between that time, Tammy also consumed water from the tap and the milk carton. The OIC measured the cup used to consume the water and confirmed it had capacity for 300 ml of liquid. This means it is likely Tammy consumed about 20 litres of water on 20 December 2022 alone.

167. The Court heard and saw details of the conditions in which Tammy was held at SWCC, both before and after she was placed in the MSU. The Court received evidence that the MSU was:

> "A purpose-built 19-bed specialist therapeutic unit within SWCC, designed for female inmates who have a diverse range of risks and needs including self-harm and/or suicidal behaviour, severe and complex personality disorder, aggression, intellectual disability, acquired brain injury and vulnerabilities associated with other mental health conditions."[31]

168. The oral evidence of the Governor of SWCC, Krista Konemann, was:

> *"… the intention always of the MSU, is my understanding, is that the therapeutic environment is what really is the driving force behind creating change and supporting inmates in that area. So by delivering a therapeutic programme focusing on elements such as emotional regulation, self-management techniques, mindfulness and other kinds of cognitive behavioural therapies, the psychologists in that area, the mental health unit, plus the custodial staffing, with supports from specialists such as the personality behaviour disorder area can provide that therapeutic environment for inmates where they're engaged in activities that are either for their cognitive and behavioural wellbeing, or just general engagement activities to keep them occupied.*

[29] Tab 117 - RIT Folder documents, pp1-5.
[30] Tab 8 – Statement of Senior Constable Salim Trad, pp 29-30.
[31] Tab 191 – Statement of Krista Konemann, p 1.

> *The idea being that when they are moved from that area, they're much better equipped to manage themselves in - in the community, and they receive the medication and other care that they require, because of their mental health and other challenges."*[32]

169. Ms Konemann however agreed with Counsel Assisting that the MSU was not, in fact, a very therapeutic place for Tammy to be and that there was very little stimulus for her in the MSU and no evidence of any therapeutic engagement. Ms Konemann also agreed that additional resources would assist in improving the environment for inmates.[33]

170. The OIC stated:

> "Throughout her time in the cell, I noted that Tammy appeared upset and disconnected. Tammy spent the majority of time in the cell unless she was taken out for an interview/ RIT assessment. At times she is captured to wipe her tears with the towel or toilet paper."

171. Tammy's Family submitted that the MSU cell Tammy was detained in whilst on a RIT plan was inhumane and detrimental to the mental health of inmates placed there.

172. The Court received evidence from Prof Nielssen that Tammy may have developed an acute onset of polydipsia because of the confined environment of the observation cell and in the MSU. While Prof Nielssen has had patients who have suffered from polydipsia chronically, there is no evidence that prior to entering the MSU Tammy had ever experienced polydipsia.[34]

173. Counsel Assisting supported Prof Nielssen's view and submitted that the fact a RIT who reviewed Tammy on the morning of her death did not notice that she was drinking excessive quantities of water points to the complexity of the condition. It was submitted that common sense would dictate that Tammy was not drinking during that review because she had people with her and was distracted from doing so. She submitted it was the isolation of the cell environment that was so terrible for Tammy's mental health, and that was exactly why the RIT recommendation was that she have regular human contact.

174. The Commissioner of CSNSW (Commissioner CSNSW) did not agree with Counsel Assisting and submitted that the onset of Tammy's polydipsia was not caused by the circumstances of her placement in the MSU. They drew attention to the conclusion of the autopsy report which indicated hyponatraemia as Tammy's direct cause of death with antecedent causes of primary polydipsia and complications of schizoaffective disorder and its treatment:

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[32] Transcript 29/09/24, p 607.
[33] Transcript 26/09/24, pp 607-609.
[34] Tab 193 – Expert Report of Dr Olav Neilssen, p 10.

> "In conclusion, based on the reported circumstances, the post-mortem, toxicology and biochemical findings, the cause of death will be recommended to be recorded as hyponatraemia due to primary polydipsia due to complications of schizoaffective disorder and its treatment.
>
> Water and sodium balance are closely monitored by the kidneys with input from the release of hormones (anti-diuretic hormone) and thirst mechanisms. When anti-diuretic hormone (ADH) is released it causes retention of water. This occurs in response to high sodium and low volume (fluid) level.
>
> There may be failure of these mechanisms. In some cases, ADH may be inappropriately released despite high volume. This condition is called the syndrome of inappropriate antidiuretic hormone (SIADH) and causes retention of water. Risk factors for the development of this condition include medications, such as anti-psychotics, infections, malignancy and neurosurgery. The deceased's main risk factor was taking anti-psychotic medication. Aripiprazole (a second-generation antipsychotic) has been associated with the release of inappropriate anti-diuretic hormone.
>
> However, a poorly understood phenomenon is that of primary polydipsia. Individuals with psychiatric disorders are at risk of developing primary polydipsia – an increase in thirst that is not appropriately regulated by and does not abate with increased water intake.
>
> In the post-mortem setting it is difficult to determine if the deceased had primary polydipsia (a condition secondary to schizoaffective disorder) or SIADH (due to the treatment of schizoaffective disorder)."

175. The Commissioner CSNSW also submitted that the evidence of A/Prof Sullivan provided valuable context. In his report A/Prof Sullivan opined that "[t]he onset of psychogenic polydipsia can occur at any stage in a person's mental illness" and that it:

> "… generally commences, or is first diagnosed during acute illness, often in the first week after commencing psychiatric medication, but not generally in the early stages of a patient's mental health disorder. In fact, it may first occur many years after the first diagnosis of mental disorder."

176. The Commissioner CSNSW also highlighted A/Prof Sullivan views that:

    a. Tammy's medical records and blood test results did not provide evidence of "any other putative underlying cause, or previous evidence of related or predisposing metabolic disturbance, despite significant past health conditions."

    b. The condition can have a "rapid onset over hours without a prior history of this condition" and that in the case of Tammy there was no indication that this was a "pre-existing behaviour" or that there was a delusional motivation for her behaviour.

c. “Rapid onset likely reflects insidious development, and clinical symptoms manifesting at a late stage after disordered water intake of hours to a couple of days.”

d. A person with clinical or mental health training may identify behaviours or mental health symptoms driving increased fluid intake, however in some circumstances, the patient may be circumspect about these behaviours, and they may not easily be detected.

e. It was less likely that a person without clinical mental health training would recognise features of polydipsia, even if they observe increased fluid intake. They may only determine a person is unwell when the person shows overt manifestations of hyponatraemia such as gait disturbance, confusion or seizures.

f. In relation to the adequacy of the treatment of Tammy’s mental health from 11 December 2022 until her death, that it was appropriate that she was placed on a RIT plan and remained on RIT plan as “her mental state remained disordered, although appeared to be improving.”

g. It was “*very difficult to tell*” if polydipsia was more common in custodial settings than in the community and, acknowledging his selection bias as he encounters it more in coronial settings than in routine practice, he “*[couldn’t] say that it's necessarily more frequent in prison, but … this is probably the third or fourth case of polydipsia that [he’d] seen in the last few years in a coronial setting in a couple of States”.*

h. There was “*no statistical analysis*” in relation to excessive fluid consumption from lack of stimulation in associated with being in a prison cell and that even if asked, “*a person who has polydipsia … won't necessarily give you an accurate understanding of what causes the behaviour*.”

177. With regards to the evidence of Prof Large, the Commissioner CSNSW noted his oral evidence that:

> *“… with respect to institutions, I’ve recently had occasion to read - there are about 38 papers that describe the causes of mortality in psychiatric hospitals. There are only 38 papers that I know of, and there's not a single case of death by psychogenic polydipsia in a psychiatric hospital that is documented in the peer reviewed literature. So I don't think there's an intrinsic link between psychogenic polydipsia and institutions or death by psychogenic polydipsia.”*

178. And that, in a hospital context, Prof Large said:

> “*… we measure everybody's sodiums [sic] quite regularly and we watch what they do and stop them from drinking. It's a bit of a [palaver] but we are quite good at it.*”

179. The Commissioner CSNSW also noted that Tammy had attempted self-harm on more than one occasion prior to her placement in the MSU.

180. The Commissioner CSNSW ultimately submitted that there was little in the way of clinical evidence to suggest that the circumstances of Tammy's custody in the MSU caused the onset of her polydipsia.

181. Senior CO (SCO) Soh, CO Turner, First Class CO (1CO) Wilson and Probationary CO (PCO) Iqbal (collectively the MSU COs) submitted that psychogenic polydipsia could not have been diagnosed prior to Tammy's death. They referred to A/Prof Sullivan's opinion, expressed in his expert report, that:

> "… onset appeared initially subtle (described in retrospect as manifest in increased water intake on 18 and 19 December 2022) and then acute from morning of 20 December 2022, preceding Tammy's death by mere hours.
>
> Even if [Tammy's] behaviour had been observed and identified as potentially related to psychogenic polydipsia, confirmation would have relied upon, at the minimum, a blood test. This would likely take some hours or one to two days from the time of taking bloods to the pathology results returning..." [35]

182. And that he considered "there were no grounds prior to her death to consider [Tammy] at risk of water intoxication." [36]

183. Aside from the physical environment and the impact that may have had on Tammy, contrary to the requirements of the RIT plan, there was also very little human engagement with Tammy whilst she was housed in the MSU.

184. Tammy appears to have spent most of her time within her cell in the MSU, leaving only as necessary for medical and RIT assessments. She also appears to have had little interaction with CSNSW officers from within her cell, indeed the CSNSW Senior Investigator found that only two dedicated physical checks were conducted on Tammy on the day of her death, despite the requirement for 30 minute physical observations.[37]

185. Tammy's mental health condition between 10 and 14 December 2022, the four days she was in CSNSW's care before she went before Campbelltown Local Court, clearly demonstrated that she was severely unwell.

186. On the morning of her death, Tammy was assessed by a RIT team. As noted above at [72], they recorded that:

> "[Tammy] presented very tidy… When asked about her self-harm attempt Tammy stated, *"[she] thought someone was going to kill [her]*"… she did not know who was going to kill her, it was just a random person… her thoughts were much better today.

[35] Tab 17A – Expert Report of Dr Danny Sullivan, p 19.
[36] Tab 17A – Expert Report of Dr Danny Sullivan, p 22.
[37] Tab 72 – Serious Incident Report – Death in Custody at [51].

> Tammy … [did] not want to be on BUPE injections, … BUPE "*puts a shield on things*"… but [she] would like to go to rehab… she [could not] guarantee her own safety but [had] no thoughts of hurting herself. Tammy appeared to be quite withdrawn..."

187. The only change after the RIT assessment was that her constant electronic observations were to be made every 30 minutes. Approximately six hours after Tammy was assessed by the RIT, she passed away.

188. I had the opportunity to view the MSU with the legal representatives for the interested parties. I also viewed the CCTV footage of Tammy in her cell in her last hours. I agree with Counsel Assisting's view that there did not appear to be anything therapeutic about the MSU for Tammy when she was there in the days leading up to her death. The lack of human interaction and the lack of mandated physical checks on her is likely to have had a detrimental impact on her condition.

189. Professor Nielssen's view was that Tammy may have developed an acute onset of polydipsia because of the confined environment of the observation cell and in the MSU. I am unable to make such a finding with certainty, but I am able to find that the environment of the MSU was austere and depressing. It is self-evident that Tammy was isolated and likely bored, worried and depressed. On the last morning of her life, she is seen to be pacing her cell, and repeatedly filling her cup, in circumstances that should have been concerning, but were not noticed by Correctional staff.

190. I am gravely concerned about the environment of the MSU, which was established to be a specialised therapeutic unit. Mum Shirl was a Wiradjuri leader, who was a social worker and humanitarian activist committed to improving the wellbeing of First Nations peoples. She was a founding member of, amongst other organisations, the Aboriginal Medical Service. A unit bearing her name should contain cells that are designed to facilitate healing and human connection. The cell Tammy was housed in was nothing like this. Whether or not the environment contributed to Tammy developing polydipsia, it certainly did not facilitate staff conducting the necessary welfare checks or providing the human connection that had been recommended for Tammy when she came into custody.

(b) Whether the terms of the RIT plan and CSNSW policies and procedures were adhered to in terms of monitoring Tammy once she was placed in the MSU?

191. As identified at paragraphs [54]-[59] above, the terms of Tammy's RIT plans variously included access to safety clothing and linen, reduced access to sharps and, most notably 30 minute physical observations and, until at least 20 December 2022, constant electronic observations. Human interaction was encouraged.

192. The MSU COs submitted that each of the COs had limited experience working in the MSU and/or looking after inmates on RIT plans prior to Tammy's arrival at SWCC. They submitted the evidence was:

    a. Senior CO Soh had only worked four shifts in the MSU and had not received any training to do so. She had not been responsible for looking after an inmate on a RIT on any more than 20 occasions prior to 20 December 2022.

    b. Correctional Officer Turner had done more than ten shifts in the MSU but couldn't say whether it was as many as 20 shifts. She did not do any special training to work in the MSU.

    c. First Class CO Wilson had only completed six or seven weeks in the MSU.

    d. Probationary CO Iqbal commenced as a probationary CO in May 2022. He had done not more than 10 shifts in the MSU.

193. Senior CO Soh gave evidence that:

    a. No one officer was responsible for the physical observations of Tammy.[38]

    b. The Morse Watchman tool was not working on 20 December 2022. [39]

    c. Between 10:41am and 1:14pm on 20 December 2022, no CO checked on Tammy.[40]

194. Correctional Officer Wilson gave evidence that:

    a. He was told prior to 20 December 2022 that Tammy had a history of defecating in her cell.

    b. He did not recall being told that Tammy was drinking a lot of water at the 6:00am handover and was unaware that drinking constantly could be a danger to inmates.

    c. The MSU was busy and there were inmates that were very inclined to self-harm on the day, and an inmate or two who would fight each other.

    d. He did not see faeces on the floor of Tammy's cell that day.[41]

    e. He did not recall "the sweeper" (an inmate) raising any issue with Tammy's cell.

    f. When he and Dr Buan attended Tammy's cell, she said something. He did not smell faeces at that time.[42]

    g. It was not unusual for inmates to lay on the floor in a similar position to Tammy.[43]

[38] Transcript 24/09/26, p 371.
[39] Transcript 24/09/26, p 355.
[40] Transcript 24/09/26, p 371.
[41] Transcript 24/09/24, p 447.
[42] Transcript 24/09/24, p 453.
[43] Transcript 24/09/24, p 453-454.

h. He did not recall any conversation with another inmate about Tammy and that other inmates could not have seen the screens in the MSU Office due to their size.[44]

195. The reference to the conversation with another inmate was in relation to that inmate stating that she had seen Tammy on the screens in the MSU Office laying face down on the floor of Cell 5 and that when she asked CSNSW officers what was wrong with her, they said that Tammy was "*just sleeping*" and not to worry.[45]

196. Correctional Officer Turner said that when she worked on the MSU she was never allocated particular roles in relation to observations.[46]

197. Senior CO Soh accepted that one problem that led to no CO performing observations of Tammy was that no one officer was responsible for recording the physical observations. She accepted that she should have checked on the other officers to see who was doing the checks. She was not aware that she was required to appoint an officer for each watch to carry out the observations as part of their duties. She knew that the CSNSW Custodial Operations Policies and Procedures (COPP) required "that all observations conducted are to be recorded on an ISP RIT management plan observation record."

198. None of the MSU COs had seen an observation chart in the MSU.

199. The Commissioner CSNSW indicated that "timers" have now been introduced in the MSU to aid officers when undertaking observations.[47]

200. It was submitted on behalf of Correctional Officer Turner that the CCTV screens in the MSU Office were so small on 20 December 2022 that she did not see Tammy drinking water in her cell. It was only when CO Turner enlarged the screen because she noticed Tammy lying on the floor that she became aware of the faeces and vomit in Tammy's cell.[48]

201. The CSNSW Senior Investigator stated in their Serious Incident Report:

> "It is recommended that local management at SWCC consider an upgrade of the viewing monitors in the two MSU officer stations (East and West) to those with a larger screen size to give officers clearer views of the on-screen images of inmates under electronic observation particularly when there are multiple cells under observation."

202. It is understood that since Tammy's death, improved monitors have been installed in the MSU.

203. There were other concerns in relation to the cell Tammy was held in whilst in the MSU. While her various RIT plans required 30 minute physical observations, this was impeded

[44] Transcript 25/09/24, p 505.
[45] Tab 31 – BWV.
[46] Transcript 24/09/24, p 439-441.
[47] Tab 191 – Statement of Krista Konemann..
[48] Transcript 24/09/24, p 422.

as the blinds installed in the window in the door of Tammy's cell were not operational and were constantly closed. This prevented proper physical observations being made without CSNSW staff opening the door to either observe Tammy themselves or to provide access to JHFMHN staff. Often observations were made by both CSNSW and JHFHMN staff simply by looking through the cell door hatch, at about waist height.

204. Dr Buan also noted the relevance of the inoperable cell door blinds and that the cell door hatch, which was the only means by which he could see into the cell when he saw Tammy on the day of her death, was plainly an inadequate aperture for observation.

205. The MSU COs submitted that it had been known that the internal window blind of Tammy's cell could not be opened since at least 27 November 2022,[49] which impeded visual observations. The records produced by CSNSW indicate that the service request for the blinds was logged at 11:10am on 1 December 2022 and completed at 11:20am on the same day on the basis that the request had been cancelled. Malcolm Brown, General Manager Statewide Operations, Security and Custody, CSNSW, suggested in his evidence that the work order was cancelled so the contractor could say that it resolved issues within certain timeframes.[50] Ms Konemann, Mr Brown and Mr Skimmings all gave evidence that it was wholly inappropriate that Tammy was placed in a cell where the internal window blind was broken.[51]

206. A maintenance request had been made to repair the blinds on 1 December 2022. It had not been attended to by 23 January 2023. It appears the blinds were eventually removed in February 2023.[52] In any event, the Commissioner CSNSW concedes the blinds in Tammy's cell door were broken at all material times.

207. Tammy's Family submitted that the monitoring of Tammy by CSNSW Officers whilst she was on the RIT plan was highly unsatisfactory and not in accordance with the obligations under the RIT plans. Tammy was increasingly unwell and vulnerable, visual observations were not conducted as required and the blinds to her cell were damaged. Observation charts were not completed, and the MSU COs were unaware of the existence of those charts. It did not appear any officer was properly delegated the duty of electronic monitoring. The Morse Watchman tool, when working, appeared to have been used in a perfunctory way, not as a record of actual visual observation. Had the COs responsible for care and observation completed monitoring as directed, they would have noticed she needed help when she couldn't help herself.

[49] Exhibit 3.
[50] Transcript 26/09/24, 652-653.
[51] Transcript 26/09/24, 613.
[52] Tab 216 – Statement of Blake Conwell, pp 43, 81-87.

208. The Commissioner CSNSW accepted that the use of the Morse Watchman tool was not an adequate substitute for actual visual engagement with the inmate as required by the terms of a RIT.

209. Tammy's Family noted that the CCTV footage of the MSU Office while Tammy was detained was not retained and that it would have provided objective evidence about the conduct of COs during that time. The absence of that evidence limits the quality of the findings the Court may make about the conduct of the MSU COs compliance with policies and procedures in their monitoring of Tammy, however they submitted that Tammy relied on CSNSW to keep her safe; it was their duty and they failed in that duty.

210. The Commissioner CSNSW, relying on the evidence of A/Prof Sullivan, submitted that it should be accepted that Tammy's RIT plans were appropriate and changed over time to reflect her presentation. However, it should also be accepted that the RIT plans were not followed.

211. The MSU COs submitted that, according to Mr Brown, there was no specific policy or procedure as to whether a cell door should be opened when completing physical observations. Further, an email was sent to all staff at SWCC on 12 June 2018 directing that "the practice of recording and documenting physical observations when working within 24 hour posts in this specific Centre is to cease."[53] They submitted this may explain the absence of logs recording the physical observations that were performed.

212. The Commissioner CSNSW accepted that the email was inconsistent with the terms of the COPP and that this may have caused confusion on the part of officers whose task it was to carry out the observations. Ms Konemann gave evidence that an email was sent in September 2024 to identify the correct procedure and rectify the issue.[54]

213. The MSU COs ultimately acknowledged and did not challenge Counsel Assisting's suggestion that each of the officers not making observations in accordance with the RIT plan had let Tammy down.

214. I accept the evidence of A/Prof Sullivan, that Tammy's RIT plans were appropriate and changed over time to reflect her presentation. However, I find that the RIT plans were not followed.

215. In my view, the lack of physical observations of Tammy, as required by the RIT, is a serious failure on the part of CSNSW.

216. The Commissioner CSNSW appropriately accepted Counsel Assisting's assertion, consistent with the conclusion of the CSNSW Serious Incident Report, that had the required observations been conducted in accordance with the RIT plan, then medical

[53] Exhibit 6, p 2.
[54] Transcript 26/09/24 p 622.

intervention could have been expedited, and a different outcome could have been achieved. This is an appropriate concession and reflects well on the sincerity of CSNSW in attempting to learn from Tammy's tragic death.

Issue 4: Whether the policies and procedures of CSNSW and JHFMHN are adequate in relation to monitoring of inmates

217. The CSNSW Serious Incident Report concluded that the policies and procedures were adequate, but they needed to be followed vigilantly. They were not on this occasion.

218. In that report, the CSNSW Senior Investigator found:

    a. "… once resuscitation efforts commenced, the CSNSW officers who were actively involved in those efforts carried out their duties appropriately."

    b. "The CSNSW Policies and Procedures … [were] considered appropriate. However, this is only the case if such policies were followed particularly in regard to an officer's requirement for vigilance and to conduct the required observations of an inmate deemed at risk of self-harm according to the requirements of the individual ISP."

    c. "There [was] a failure to conduct physical and electronic observations on [Tammy]… If observations had been diligently maintained, then there is a likelihood medical intervention could have been expedited."[55]

219. The best policies and procedures have limited value when they are not complied with and that the risk to inmates increases where there is no oversight, auditing or accountability for non-compliance. They submitted that, especially for vulnerable inmates on RIT plans, this is both dangerous and unsatisfactory.

220. The Commissioner CSNSW accepted Counsel Assisting's submission, again consistent with the conclusion of the CSNSW Serious Incident Report, that the policies and procedures in place at that time were appropriate, however they were not followed.

221. The Commissioner CSNSW noted in their submissions that:

    a. The MSU Operations Manual was under review. That document will outline the policy and process components of the MSU, including inmate program eligibility, observation requirements and primary operational considerations.

    b. There are proposed changes to COPP 3.7 (Management of inmates as risk of self-harm or suicide) to remove all references to use of the Morse Watchman tool as a means of recording the observations.

    c. COPP 5.2 (Inmate Accommodation) now lists drinking excessive water as a behaviour of concern.

[55] Tab 72 – Serious Incident Report – Death in Custody, pp 37-38.

222. In those circumstances, I am confident in finding that Tammy's death was preventable. If observations had been carried out at the intervals required, it is likely that Tammy's excess consumption of water would have been identified, and she could have been prevented from continuing to consume water at the rate she did.

Issue 5: The adequacy of the healthcare provided to Tammy generally in SWCC as an Aboriginal woman with a history of mental health and substance abuse issues

223. The evidence established that during this last period Tammy was in custody, she wasn't seen by a psychiatrist for a mental health assessment and was never seen by a mental health nurse. Tammy's family submitted that this was unsatisfactory, and had either of those things occurred, Tammy may have been provided with necessary care.

224. Further the evidence in the inquest demonstrated there is an increasing number of inmates with mental health issues and that appropriately trained mental health professionals are best placed to identify mental health issues and triage patients based on the urgency and nature of their healthcare needs. Tammy's Family proposed that a trained mental health nurse should conduct the RSA for new inmates and submitted that in Tammy's case there was a missed opportunity at that stage to make better decisions about her medication and treatment needs.

225. Ms Konemann, in oral evidence, commented on the support being provided to women entering custody with mental health concerns, as well as abuse and trauma histories. She spoke of the lessons SWCC has taken away from Tammy's death, which she conceded was a "*terrible tragedy*". She stated that in the MSU, there is a therapeutic program of activities, including one on one therapy provided by psychologists and other specialists. There are activities such as mindfulness, meditation and art therapy to provide support to women who are struggling, as well as some community based engagement, which in her view really helped the women.[56]

226. Ms Konemann also told the Court of weekly "community meetings" for the women and attempts to engage more Aboriginal supports including a Regional Aboriginal Programs Officer and an identified SAPO role. The Court also heard evidence of a pilot peer support program that CSNSW have implemented at three facilities, including SWCC. The program is designed to provide an additional support to inmates by allocating a "buddy" they can reach out to if needed.[57]

227. While not related specifically to health services, the Court also heard from CSNSW that they have commenced a Women's Advocacy Service in conjunction with the Aboriginal Legal Service and Legal Aid and that their remit is quite broad. They attend SWCC at least once a week and, apart from providing legal advice, they can refer to other services.

[56] Transcript 24/02/26, p 109.
[57] Transcript 24/02/26, p 109-110.

The program arose from a recommendation that came out of the Special Commission into the offending of Wayne Astill at Dillwynia Correctional Centre[58] (Dillwynia Inquiry).

228. Counsel Assisting submitted the Court would be comforted about the way in which some recommendations from the Dillwynia Inquiry have meant that there is an improvement in the access to services for women in custody in SWCC, and particularly for Aboriginal inmates having access to more advocates for them.

229. Before proceeding to examine specific issues in relation the JHFMHN response to Tammy, it should be noted that two issues that appeared on the draft issues list in relation to Tammy's Aboriginality, and whether it was adequately recorded by JHFMHN staff at SWCC, were not prominent issues during the hearing and are consequently not addressed in these findings.

(a) Whether there was an appropriate response by JHFMHN staff to Tammy after she attempted self-harm on 11 December 2022?

230. The JHFMHN, in submissions, acknowledged that after Tammy's RSA, RN Timms booked her for an urgent primary health review instead of an urgent mental health review. The following morning, when she reviewed Tammy as part of a RIT, RN Timms realised her mistake and booked Tammy an urgent review by a psychiatrist. She also booked a drug and alcohol review. In evidence, RN Timms explained that she booked a review by a psychiatrist, rather than a mental health nurse, because she believed Tammy was going to need medication.

231. Dr Buan submitted that early assessment by a psychiatrist, the administration of Tammy's depot medication and regular review by a psychiatrist could reasonably be expected to have resulted in the identification and treatment of Tammy's mental health care needs, noting this would potentially have led to a different outcome for Tammy.

232. Ultimately Tammy's review by a psychiatrist did not occur until Dr Buan attempted contact with Tammy on the day of her death. The JHFMHN Service Director for Custodial Mental Health acknowledged that Tammy's appointment should have occurred sooner, and within 72 hours of RN Timms' urgent appointment booking.

233. I find that Tammy wasn't seen by a psychiatrist for a mental health assessment and was never seen by a mental health nurse and that this was unsatisfactory. Tammy should have had an early assessment by a psychiatrist. It is likely that with regular review by a psychiatrist, Tammy's mental health care needs would have been identified and treated and this would potentially have prevented this tragedy.

[58] Transcript 24/02/26, p 97-98.

Issue 6: The adequacy of the response by CSNSW and JHFMHN staff once Tammy was identified as unwell on the day of her death

234. On the day of Tammy's death, the MSU had been declared a "red zone", because an inmate had tested positive COVID-19, and quarantine conditions were in place.[59]

235. As noted above at [71]-[73], from 12:33am to 11:51am, Tammy consumed an estimated 20.1L of water. At around 8:40am, she was seen by a RIT and reported to be "calm, cooperative, [have] good eye-contact, clear speech, [be] compliant with RIT questions, alert and orientated to time place and person, [and] appropriately dressed." Her next RIT review was scheduled for 22 December 2022.

236. At around 10:04am, Tammy commenced vomiting which then continued through the morning. She defecated on the floor of her cell approximately 30 minutes later. She urinated through her clothing and at 11:55am, the CCTV shows Tammy collapsed on her bed and shortly after began to experience seizures.

237. At 12:24pm, it appears Tammy may have reached for, yet failed to activate, the duress alarm in her cell, however it is unclear whether Tammy's movement was intentional as she was continuing to experience seizures at this time. The alarm was later determined to have been operational.

238. Professor Ian Seppelt, an intensivist, provided an expert report in relation to hyponatremia and its effects. He opined:

> "By the time [Tammy] was having hyponatraemic seizures, starting from 12:24, she was at very high risk of dying. Even then there was a small chance she might have been saved but only by prompt ambulance transport to a hospital emergency department. In reality however, taking in to account the unavoidable delays in ambulance response times, that would have been too late. I submit that the latest point in time by which [Tammy] required medical intervention to prevent her death was at 11:57 when she started twitching. With a rapid response from a paramedic and prompt transport she had a chance of survival at that point, but not any later. Her treatment could not have been provided in a custodial environment. She needed the severity of her illness to have been recognised so she could have been treated in an acute care hospital."

239. The MSU COs submitted that Tammy needed medical attention anytime between 10:00am and 12:00pm. They accepted Counsel Assisting's submission that footage from Tammy's cell from 11:53am to 1:16pm was distressing, however, also noted that Prof Seppelt indicated that 11:57am was the latest time that Tammy could have been helped. They noted that Tammy was last observed by COs at 10:41am and that a RIT did not detect any issues when they conducted their review that morning.

[59] Tab 165 – JHFMHN Records – Volume 2, p 220.

240. At the time of Tammy's death, Dr Buan was a psychiatric registrar undertaking his specialist training to become a psychiatrist. He was employed by the Western Sydney Local Health District and was at SWCC on a six month rotation. He submitted he had very limited interaction with Tammy. He was tasked with her review as part of a routine mental state assessment, including a review of her medication.

241. Professor Neilsen stated in his report:

> "The inability to perform direct physical observations or to communicate with [Tammy], what seemed to be the neglect of attention to vomiting and incontinence and the failure to take note of her unusual behaviour despite the RIT requirement for CCTV and physical observations every 30 minutes may have contributed to her death, although I also note the very large amount of water consumed, and Professor Seppelt's view that [Tammy] would be unlikely to have survived after the onset of seizures, even if she received emergency care."

(a) Why staff did not attempt to immediately speak to Tammy when it was noted she had defecated on the floor?

242. Correctional Officer Wilson recounted his interactions with Tammy on the day of her death in a notebook statement, he stated:

> "Around 10.30am, we were issuing lunch to the inmates. I was with Officer Iqbal. I opened the door hatch for [Tammy]'s cell, and I immediately smelled faeces, and I observed her sitting on the toilet seat. The inmate got [sic] history of urinating and [defecating] on the floor so when I saw her sitting on the toilet I quickly closed the door and moved on to the next cell. Some inmates does [sic] not like to be feed [sic] by male officers so I went and got a female officer to serve the food to the inmates."[60]

243. I have no difficulty in finding, as submitted by Counsel Assisting, that it was completely inappropriate that Tammy, who was known to be suffering from a mental health condition, was left in that condition in her cell after that time.

244. At 12:20pm, CO Wilson, SCO Soh and PCO Iqbal walked past Tammy's cell as she was experiencing seizures. At 12:27pm, CO Wilson, CO Turner and PCO Iqbal, walked past Cell 5 as Tammy continued to have seizures on the bed. At 12:41pm, Tammy slouched between the bed and the floor. Correctional Officers Wilson and Iqbal again walked past the cell, oblivious to what was occurring because the view was obstructed by the closed blinds. By 1:00pm Tammy was face down on the floor of her cell. Correctional Officers continued to walk past the cell until at least 1:07pm.

245. The COs were unable to see into the cell because the blinds in the door window were closed. Those were the blinds that were not working and were subsequently removed.

[60] Tab 12J – Notebook Statement of Jacob Wilson, pp 4-5.

246. I find that Tammy should have received medical care from the time that she started vomiting and became incontinent, from 10.04am. Had the required observations been conducted in accordance with the RIT plan, then medical intervention could have been expedited, and a different outcome could have been achieved.

(b) Why staff did not immediately open the door to Tammy's cell when she was seen laying on the floor and unable to provide clear responses to Dr Buan?

247. Correctional Officer Wilson stated:

> "At about 1.12pm, CO Jessica Turner had brought up cell 5 on the monitors and realised [Tammy] was laying on the ground the same time a [JHFMHN] psychiatrist attended the unit and requested to speak to the inmate from cell 5. I took him to the cell [and] opened the hatch. We both attempted to speak to [Tammy], she was on the floor moving and was responding. It was not clear but seemed like there was vomit on the floor. We both walked back to the office and spoke to [JHFMHN] nurse Michelle Murphy [who] was in the office at the time. I informed her there was vomit inside cell 5 and it was concerning but I also informed her that there was movement.
>
> I also advised the nurse that the inmate was responding [but] did not have a proper conversation.
>
> Nurse advised that she had to go back to the clinic to get more equipments [sic] to assess her. I then conducted a handover with 1CO Lynda Grice as she was commencing shift.
>
> At around 1.37pm I heard a medical response called..."

248. At 1:16pm, the Dr Buan observed Tammy through the hatch. Dr Buan gave evidence that he attended on Tammy to conduct a psychiatric assessment, but when he arrived, he was told by other staff that Tammy appeared physically unwell, which was not his area of expertise. He was aware there was another inmate in the MSU who had COVID.

249. Dr Buan acknowledged in his submissions that when he saw Tammy on the day of her death, she was irreversibly unwell and incoherent. He attempted to communicate with her via the cell door hatch as instructed by the COs and Tammy could be observed lying on the floor of her cell and appeared unresponsive. Dr Buan submitted he did not have any knowledge of Tammy's circumstances, whether her presentation was a result of physical illness, or some other explanation, so he recommended she be assessed by JHFMHN nursing staff. He was unaware Tammy had suffered seizures that day. Dr Buan submitted he was in a difficult position. He recognised that Tammy was non-responsive and he understood that COVID-19 protocols limited his ability to interact with Tammy.

250. Counsel Assisting submitted that the Court should not be critical of Dr Buan.

251. However, Counsel Assisting also submitted that there was a completely inadequate response to Tammy after there was a recognition that she had vomited on the floor. She

submitted that CO Wilson could not possibly have noted any significant movement from Tammy, at least not any movement that should have given him any comfort that she was okay. She acknowledged that sometimes inmates may be uncooperative in responding to officers, but Tammy was an inmate who was known to be mentally unwell, who CSNSW were advised should have observations at least every 30 minutes, electronically and physically, and who had been seen to have defecated earlier that morning.

252. The MSU COs submitted Dr Buan conceded that when he and CO Wilson reviewed Tammy through the cell door hatch, he could have asked the MSU COs to open the door so he could do a more thorough check on Tammy and that he may not have conveyed the urgency of his subsequent request to nurses to review her. They submitted that there was no suggestion that Dr Buan lacked the necessary medical skills to be able to make appropriate observations as to the wellbeing of Tammy.

253. Dr Buan sought that the Court should make no adverse finding against him.

254. At 1:15pm, the CCTV shows that CO Wilson opened the cell hatch and attempted to engage with Tammy as she lay face down on the floor with her arms underneath her chest. Tammy's presentation at this time called for an urgent response. Dr Buan conceded that when he and CO Wilson reviewed Tammy through the hatch and saw her in the position she was in, he could have asked the CO to open the door. I make no adverse finding against Dr Buan and accept Counsel Assisting's submission that seeing what he did and being told what he was told, Dr Buan could not have known the other circumstances of what had been occurring in that cell earlier in the day. Noting the evidence of Prof Seppelt, in any event it was too late by that time to save Tammy's life.

(c) The timeframe between nursing staff being informed that Tammy required attention and staff attending Tammy's cell and was this appropriate?

255. The CSNSW Senior Investigator concluded in the Serious Incident Report:

> "… SCO Soh, [1CO] Turner and CO Wilson and to a lesser degree PCO Iqbal, while performing duties in the MSU, failed in their duty of care and obligation to maintain vigilance in accordance with [the] *Crimes (Administration of Sentences) Regulation 2014...*
>
> There is CCTV evidence which shows a failure to conduct physical and electronic observations on [Tammy] particularly in the period from 10:41 to 13:12 when there [was] an obvious deterioration in her physical wellbeing causing her to eventually collapse to the floor at 13:04..."

256. The Senior Investigator found that "[t]here was a failure by CSNSW officers to conduct ongoing physical checks on [Tammy] between 13:12 and 13:24 while waiting for the attendance of [JHFMHN] Nursing staff…" The conclusion reached was that, "[i]f

observations had been diligently maintained, there [was] a likelihood that medical intervention could have been expedited".

257. The OIC reached a similar conclusion after his interrogation of the CCTV footage, stating:

> "During my CCTV synopsis, I noted physical checks on Tammy were neglected, and not reflective of the recommended 30 minute periodic checks as per the RIT plans throughout her time in Cell 5. The last physical check/ engagement prior to her collapse was at 10:41am, when Tammy was provided with hot water. During this time, Tammy had defecated on the ground and appear[ed] to be in some form of discomfort. A total of 2 hours and 57 minutes passe[d] from Tammy's last physical interaction/check until CPR [was] performed.
>
> Moreover, the blinds on Cell 5 were closed from the moment of her admission. It was noticeable these blinds were broken as several corrective staff officers made attempts to open them without avail. To conduct a physical observation and to be able to see within the cell, staff had to place their head on the cell [door] and look through the gap between the blinds or engage through the hatch."

258. Registered Nurse Murphy gave evidence that after Dr Buan saw Tammy, CO Wilson attended the MSU Office and asked RN Murphy to review her, however RN Murphy told him she could not do so as she was doing the medication round and did not have personal protective equipment (PPE) or other equipment with her. She asked CO Wilson to contact the clinic nurse, to which CO Wilson replied, "*or you could just do it because you're here*". According to RN Murphy, CO Wilson told her that Tammy was lying on the floor and appeared to have vomited, was breathing, making responses and moving, but had not been able to speak with Dr Buan. When RN Murphy asked how long Tammy had been vomiting, CO Wilson said he was not sure and also said she had behavioural issues and had been throwing faeces in her cell. At no stage did CO Wilson indicate to RN Murphy that Tammy should be seen urgently, or that there was a medical emergency, and in RN Murphy's words, CO Wilson appeared to be "blasé" about the situation. At no stage was RN Murphy made aware that Tammy had been drinking excessive water.

259. Registered Nurse Makadia gave evidence that she was never made aware that Tammy had been drinking excessive water and that when approached by RN Murphy in the clinic, she recalled RN Murphy telling her that Tammy had been vomiting but did not recall any urgency being conveyed. On attending the MSU, RN Makadia recalled being told by CO Wilson that Tammy had behavioural issues, there was faecal matter in the cell and she had been vomiting since that morning. In oral evidence RN Makadia confirmed CO Wilson was the only officer she spoke to in the MSU that day.[61]

260. The NSW Health parties submitted that in oral evidence CO Wilson accepted that he did not make an urgent request. However, he denied telling RN Murphy that Tammy had

[61] Transcript 25/09/26, p 516.

behavioural issues or had been throwing faeces around her cell, and said Tammy "may" have been vomiting, but denied RN Murphy asked how long she had been vomiting.

261. Further, RN Murphy's version of these events would be preferred as RN Murphy made a note in her diary on the day the events occurred which was produced in evidence and is consistent with her account. It records:

> "Asked when pt started vomiting – he reviewed camera to see patient had defecated on floor. Said throwing it. Officer reports patient has been behavioural and has done same before".

262. According to RN Murphy, Dr Buan then attended the MSU Office and asked her to review Tammy and she replied she was going to the clinic and would then return to review her. Before she left the MSU Office, RN Murphy told CO Wilson to call a medical emergency if he had immediate concerns. However, CO Wilson's evidence was that he did not recall this being said. A medical emergency response was not called by CO Wilson.

263. Registered Nurse Murphy's version of these events is be preferred as RN Murphy made a note in her diary on the day the events occurred which was produced in evidence and is consistent with her account. Correctional Officer Wilson did not relay any urgency.

(a) What was the timeframe from the cell door opening to CPR being commenced and was that timeframe appropriate in the circumstances?

264. At 1:34pm, after RN Murphy had returned to the clinic and collected PPE, she and RN Makadia attended the MSU and approached the door to Tammy's cell. They were unable to see though the door blinds and asked a CO to attend.

265. At 1:35pm, CO Wilson opened the cell door hatch and walked away. The nurses viewed Tammy through the hatch. Tammy was on the floor of her cell and did not respond. As JHFMHN staff do not have access to keys to open cell doors, the nurses asked a CO to open the cell door.

266. At 1:36pm, CO Iqbal opened the cell.

267. At 1:37pm, RN Murphy entered the cell and observed vomit. She touched Tammy who was non-responsive. She checked Tammy's pulse and called for COs to assist in turning her over. She stated Tammy's eyes were closed, she was pale and appeared cyanosed.

268. At 1:38pm, RN Murphy commenced CPR and a medical response was activated.

269. There was 23 minutes from the time Tammy was first observed laying on the floor by COs at 1:15pm before CPR was commenced at 1:38pm.

270. There was a total of 1 hour and 20 minutes from the time Tammy collapsed on the bed, as seen in the CCTV footage, until RN Murphy commenced CPR.

271. At 1:43pm, NSW Ambulance was contacted by triple zero.

272. At 1:58pm, 15 minutes after the triple zero call was made, the first ambulance arrived. Despite their efforts, paramedics were unable to revive Tammy, and she was pronounced deceased at 2:25pm.

273. The NSW Health parties submitted that RN Murphy and RN Makadia took appropriate steps during the resuscitation efforts despite being unable to revive Tammy. Professor Seppelt's opinion, that the latest time Tammy could have received medical intervention to prevent her death was 11:57am, should be accepted. They submitted that at the time RN Murphy was asked to review Tammy, at some point after 1:15pm, and when RN Murphy and RN Makadia subsequently attended the MSU at around 1.30pm, Tammy's condition was unsurvivable, regardless of the action they took.

274. Further, that in those circumstances, there should be no criticism of the actions of RN Makadia or RN Murphy as each nurse responded appropriately to the information they were provided by CO Wilson, recognised the gravity of the situation Tammy was in once they arrived at her cell and the cell door was opened, and promptly commenced CPR.

275. I accept Prof Seppelt's opinion, that the latest time Tammy could have received medical intervention to prevent her death was 11:57am. However, there was 23 minutes from the time Tammy was first observed laying on the floor by COs at 1:15pm until CPR was commenced at 1:38pm. Even though Tammy's condition was unsurvivable by this stage, this is far too long, and in other circumstances, an extended time period like that could mean the difference between life and death.

FINDINGS REQUIRED BY SECTION 81(1)

276. As a result of having carefully considered all the documentary evidence, the oral evidence given at the inquest, and the submissions of the interested parties, I make the following findings pursuant to s. 81(1) of the Act:

Identity

The person who died was Tammy Michelle Shipley.

Date of death

Tammy died on 20 December 2022.

Place of death

Tammy died in the Mum Shirl Unit at Silverwater Women's Correctional Centre, Silverwater NSW 2128.

Cause of death

The medical cause of her death was hyponatraemia with antecedent causes of polydipsia and complications of schizoaffective disorder.

Manner of death

Tammy died in custody. The medical conditions that caused her death were not recognised, monitored or treated early enough to prevent her death.

RECOMMENDATIONS

277. Section 82 of the Act confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned.

278. At the completion of the inquest hearing, Counsel Assisting proposed nine recommendations pursuant to s. 82 which were circulated to the interested parties. After considering comments made by the various parties in relation to those recommendations, Counsel Assisting refined and consolidated the recommendations.

279. Having considered the submissions and consolidated proposed recommendations, I make the following ten recommendations pursuant to s. 82 of the Act.

To the Commissioner NSWPF

I. Give consideration to amending the relevant Standard Operating Procedures (SOPS) and the Police Handbook to clarify that arresting police are responsible for checking the COPS to identify any mental health issues of the person to be detained/arrested, given the possible relevance to risk assessment.

II. Give consideration to amending the relevant Charge Room and Custody Management SOPS, and/or the Police Handbook to clarify that the Custody Manager making a bail determination must check the COPS to identify any mental health history of the arrestee that may be relevant to bail in accordance with the requirement to give consideration to any of the factors under s. 18(1) of the *Bail Act 2013*.

III. Give consideration to amending the relevant Charge Room and Custody Management SOPS, and/or the Police Handbook to clarify that where any mental health history of an arrestee may be relevant to bail, such factors should be mentioned in the Facts Sheet prepared for Court.

IV. Give consideration to amending the relevant Charge Room and Custody Management SOPS, and/or the Police Handbook to clarify that the Custody Manager responsible for completing the “Custody Management Record” must

check the COPS to identify any mental health history of the arrestee that may be relevant to welfare and custody management; and record any "significant mental health incident."[62]

V. Consider an upgrade to the COPS so that there is a drop-down menu to easily record and look up any "significant mental health incident" for a member of the public who police are called out to attend on.

280. I note that at the time these recommendations were circulated to the interested parties the Commissioner NSWPF indicated that the Charge Room and Custody Management SOPS and the Police Handbook were under review and that the draft recommendations would be considered as part of that process.

281. Additionally, the Commissioner NSWPF accepted that there are benefits in making verified mental health information held in the COPS more readily available to police and potentially other agencies, however noted that the utility of any amendments to the COPS depends on the way the information is recorded in the COPS. This is pertinent to Recommendation V.

To DCJ and the Commissioner NSWPF

VI. That a review be conducted to determine the cause of discrepancies in Court outcomes recorded in the JusticeLink system being reflected in the COPS system, and on criminal history reports, and that DCJ and the NSWPF work together to rectify any deficiencies.

282. The Commissioner NSWPF submitted it would be pleased to work with the DCJ to resolve any issues identified in connection with this recommendation. The DCJ have indicated they would be available to meet to discuss the processes undertaken by Court staff.

283. The Commissioner NSWPF, in submissions, also proposed a recommendation be made to the Chief Magistrate (now Judge) of the Local Court of NSW connected to Recommendation VI. Noting my comments at [139], that proposed recommendation is not feasible nor practical.

To the Commissioner CSNSW and the Minister for CSNSW

VII. That a review be conducted of the environment of the Mum Shirl Unit at Silverwater Women Correctional Centre to determine what more can be done to improve therapeutic care of women in that Unit, including by providing training to

[62] "Significant mental health incident" to be defined as, for example, an incident of self harm; suicide or psychosis in the last 5 years, PACER callout or ambulance transport to a Mental Health Facility in the last 5 years and/or recorded diagnosis of a major mental illness.

Correctional Officers in the Unit in relation to trauma informed care of prisoners suffering mental illness.

VIII. That CSNSW require Officer Jacob Wilson to complete the "Awareness of Managing at Risk Offenders" course, within 6 months of returning to operational duties.

IX. That CSNSW reviews its policies and procedures for monitoring inmates on a RIT to ensure that observation requirements are properly validated through routine audits of monitoring records and regular reviews of CCTV footage.

284. Acknowledging the improvements the Commissioner CSNSW indicated have been made to the MSU since Tammy's death, the Commissioner CSNSW did not oppose Recommendation VII and it is nonetheless made to ensure that any changes are subject to continuous improvement aligned with outcomes of the recommended review.

To the JHFMHN

X. That the JHFMHN ensure that where a prisoner is identified as requiring an urgent psychiatric review, that prisoner is flagged for follow up by a psychiatric nurse in the event that the timeframe for review by a psychiatrist cannot be met.

285. Tammy's Family had advocated for a mental health nurse to conduct the RSA and to participate in the RIT process as these occasions provide a timely opportunity for intervention and referral to a psychiatrist if necessary. Tammy's Family called for the JHFMHN to receive adequate resourcing to ensure that patients with an urgent need can be seen in 1-2 days by a psychiatrist and, if necessary, can be transferred to a hospital.

286. Dr Buan also advocated for an initial assessment to be completed by a psychiatrist to facilitate timely diagnosis of mental health conditions and for an increased frequency of mental health assessment and review to protect prisoners from preventable harms arising from unmanaged mental health conditions. While I think that would be ideal, it does not appear to me that it would be feasible to require an initial assessment to be completed by a psychiatrist. It should be feasible to facilitate urgent review by a psychiatrist once that has been flagged by a psychiatric nurse, and that is what the recommendation is directed towards.

287. The JHFMHN submitted that that it is neither necessary or practical to mandate that a mental health nurse participate in the RIT process, nor conduct the RSA.

288. Recommendation X reflects these submissions. While it may be ideal to have mental health nurses participate in the RIT process, I recognise that there are resource challenges in mandating that, and it would not be practical to do so. What is essential, however, is that where someone in Tammy's perilous position is identified as needing

urgent psychiatric review, that occurs within an appropriate timeframe, so that they can begin treatment, including medication.

Concluding remarks on Recommendations

289. Although the recommendations in this inquest are firmly grounded in the evidence in Tammy's case, there should additionally be great impetus and urgency to implement them given the number of Aboriginal deaths in custody in NSW has never been higher. Reasons for that are multi factorial but include the rising number of First Nations prisoners on remand, as Tammy was.

ACKNOWLEDGEMENTS AND CONCLUDING REMARKS

290. I thank the OIC, former Senior Constable Salim Trad; Aboriginal Coronial Information Support Officers, Nicolle Lowe and Simone Kubecka; the interested parties and their representatives; Counsel Assisting, Dr Peggy Dwyer SC; and Yvette Edgell, Clara Potocki and Gulcan Shadiac from the NSW Crown Solicitor's Office for their commitment and care at every stage of this inquest.

291. I had the privilege of hearing from Tammy's family when they each spoke about Tammy as a daughter, a mother, a grandmother, an aunt and a sister. They spoke of their love and grief in such a moving way. Tammy's eldest son, Josh told the court that "my mum's story is one of strength, love, and the complexity of the human experience".

292. Watching the CCTV footage of Tammy's seizures in her last hours must have been devastating for Tammy's family. Yet they wanted to have that footage shown to the public, in an effort to highlight the harsh environment that female prisoners, including those with mental health issues in custody for shoplifting, may be subjected to. Tammy's family are committed to improving our understanding of what prisoners and their families may have to endure, and how counter therapeutic it was for their loved one. Their aim has always been to promote understanding and to help other families. Their unyielding determination to advocate for change, after what they had seen and heard about Tammy's last days, took extraordinary courage. This is a testament to their character and their love for Tammy.

293. I close this inquest.

Judge Teresa O'Sullivan

NSW State Coroner

19 November 2026

CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Tammy Michelle Shipley
Hearing date:	17 October 2024
Date of decision:	16 January 2025
Place of decision:	Coroners Court of NSW, Lidcombe
Decision of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – interlocutory application - jurisdiction – sufficient interest - issues lists -– interim hearing – scope – recommendations
File number:	2022/384929
Representation:	1) Counsel assisting on the application: Dr Peggy Dwyer SC, instructed by Ms Yvette Edgell of the NSW Crown Solicitor's Office 2) Commissioner of Police, NSW Police Force: Mr Adam Casselden SC and Mr Matthew Harker of Counsel instructed by Mr Craig Norman of the Office of the General Counsel, NSW Police Force 3) Ms Vicki Shipley: Mr Steven Rees instructed by Ms Jacklyn Dougan-Jones of the Aboriginal Legal Service 4) Corrective Services NSW: Mr Phillip Nixon of DCJ Legal 5) Justice Health and Forensic Mental Health Network and South West Sydney Local Health District: Mr Jake Harris of Counsel instructed by Ms Kate Hinchcliffe of Makinson d'Apice Lawyers 6) Dr Lloyd Buan: Mr Matthew Hutchings of Counsel instructed by Ms Judith Alderson of Avant Law

Introduction

1. Tammy Michelle Shipley, a 47 year old Aboriginal woman, passed away on 20 December 2022 in the Mum Shirl Unit ("MSU") at Silverwater Women's Correctional Centre ("SWCC"). According to an autopsy report of Dr Lena Quinto, Ms Shipley died from hyponatraemia arising from primary polydipsia and complications of schizoaffective disorder and its treatment.[1]

2. As Ms Shipley died while an inmate in a correctional centre, an inquest into her death was mandatory pursuant to ss. 23(1)(a), 23(1)(d)(ii) and 27(1)(b) of the *Coroners Act 2009* (NSW) ("*the Act*"). The inquest into Ms Shipley's death ("the Inquest") was listed to be heard from 16 to 27 September 2024.

3. On 3 September 2024, the Commissioner of Police, NSW Police Force ("the Commissioner") forwarded an application ("the Application") to the Crown Solicitor's Office ("CSO") asserting that any examination or exploration by me and/or Counsel Assisting into the appropriateness or otherwise of the NSW Police Force's interactions with Ms Shipley was impermissible as it lacked jurisdictional power.[2]

4. The Application (outlined further below) sought to challenge my exercise of jurisdiction to enquire into the actions and/or inactions of the NSW Police Force ("NSWPF") in relation to their interactions with Ms Shipley in December 2022.[3] It sought;

    a. that a letter advising the Commissioner of her sufficient interest in this matter be withdrawn on the basis of a lack of jurisdictional power; and/or
    b. certain issues said to be "emerging" numbered 1, 2 and 3 on a draft issues list be removed on the basis of a lack of jurisdictional power; and/or
    c. the request for NSWPF policies that I deemed might be relevant, be withdrawn on the basis that it lacks a legitimate forensic purpose and/or the State Coroner or Counsel Assisting lacks jurisdictional power to consider the nominated areas; and

[1] CAWS2 at [43]; Tab 7: Autopsy Report p 2.
[2] Shipley Inquest - Application to State Coroner p 1.
[3] Transcript 17/10/24 p 746 ln 7-9.

d. that a request for a statement from a senior NSWPF officer addressing areas I consider may be relevant to my inquest be withdrawn on the basis that the request for it was "impermissible as it lacks jurisdictional power and a legitimate forensic purpose".[4]

5. The matter was mentioned on 12 September 2024. At that mention a regime was proposed to allow the Inquest hearing to continue and to defer hearing of the Application. A timetable for exchange of written submissions was set and the Application was fixed for hearing on 27 September 2024.

6. The Inquest proceeded from 16 to 27 September 2024. The brief of evidence was tendered in the proceedings without objection.[5]

7. On 27 September 2024, the Commissioner's representatives requested the Application be adjourned to a future date and, after eight days of hearing, the Inquest was adjourned part-heard to 6 and 7 February 2025.

8. The Application was ultimately heard on 17 October 2024.

9. The Application is dismissed. Below I set out the relevant background to Ms Shipley's death, the background to the Application and reasons for my decision.

Factual and Procedural Background

Ms Shipley's criminal history and interactions with NSW Police Force

10. The following facts in relation to Ms Shipley are taken from Counsel Assisting's written submissions and material within the brief of evidence. The majority of the facts asserted in relation to the Application were not challenged by the Commissioner either during the hearing of the Application or after. Where any challenge to asserted facts has been raised, those facts have not been included.

    a. Ms Shipley was an Aboriginal woman born in 1975 and aged 47 years at the time of her death in Corrective Services NSW ("CSNSW") custody.[6] Ms Shipley had an extensive history of mental health problems

[4] Shipley Inquest - Application to State Coroner p 1.
[5] Transcript 16/09/24 p 22 ln 45.
[6] Counsel Assisting Written Submissions dated 25 September 2024 ("CAWS") at [6].

and she was frequently admitted to hospitals and treated by community mental health services as a result.[7]

b. Ms Shipley first came to the attention of the NSWPF in September 1992 in relation to stealing and break and enter offences. Over the years she was charged with domestic related common assault, drug and shoplifting offences.[8]

c. Several of Ms Shipley's offences were dealt with under Mental Health legislation[9] which enabled a magistrate to divert matters away from the criminal justice system where a person was more appropriately dealt with in a mental health facility.[10]

d. In 2016, Ms Shipley spent four months in custody for an offence of stalk/intimidate. During that time, her diagnoses of Schizoaffective Disorder and Bipolar Affective Disorder, along with a history of cannabis, "Ice" and heroin use, was noted by the Justice Health and Forensic Mental Health Network ("JHFMHN").[11]

e. As a victim, Ms Shipley regularly came to the attention of the NSWPF over a period of approximately 25 years to April 2022, due to domestic violence she suffered at the hands of a former partner.[12]

11. Between January and November 2022, Ms Shipley came to the attention of NSWPF officers on four occasions:

a. On 13 January 2022, Ms Shipley was detained by police under s. 22 of the *Mental Health Act 2007* ("*MHA*") and transported to Campbelltown Hospital Emergency Department where she was found to be "a mentally ill person".[13]

b. On 5 October 2022, Ms Shipley was charged with shoplifting and served with a Future Court Attendance notice. The matter was finalised in Court on 21 November 2022.[14]

[7] CAWS at [12]-[13].
[8] CAWS at [8]-[9].
[9] Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (as it then was) (MHFPA).
[10] CAWS at [10]-[11].
[11] CAWS at [14].
[12] CAWS at [7].
[13] CAWS at [15].
[14] CAWS at [18].

c. On 22 October 2022, police attended on Ms Shipley after an altercation with her neighbours.[15] Ms Shipley was assessed by a PACER[16] team and ultimately referred to the Campbelltown Community Mental Health Emergency Team.[17]

d. On 26 November 2022, Ms Shipley presented to Macquarie Fields Police Station suffering hallucinations. She was voluntarily transported by police to Campbelltown Hospital Emergency Department.[18]

12. On 9 December 2022:

a. Sometime in the morning, Ms Shipley attended Macquarie Fields Police Station and asked to be arrested as she claimed she had goods in custody.[19]

b. At around 11:00am, Ms Shipley was arrested for enter inclosed lands and shoplifting offences at Target Glenquarie Centre. The goods stolen totalled $574 ("H76115633 offences"). She was released with bail conditions "not to enter Glenquarie Shopping Centre". The Facts Sheet for the charges stated: "*Police not aware of any drug or mental health issues of the accused*".[20]

c. In the afternoon, Ms Shipley re-attended Glenquarie Shopping Centre. She entered Woolworths and was again arrested for enter inclosed lands and shoplifting, as well as breach of bail on the offending from earlier that day. This time the goods stolen totalled $23.10 ("H91715522 offences").[21] At the time of her arrest, when asked by NSWPF officers if she wanted to go to gaol Ms Shipley replied, "*that would be nice*" and indicated to the arresting officers that she was going through a "detox".[22]

d. At 7:00pm, Ms Shipley was refused bail by an officer of the NSWPF[23] and admitted into custody at Campbelltown Police Station. The custody management record (which was later sent by NSW Police to CSNSW

[15] Tab 41B: COPS Event E91708662 p 1.
[16] Police, Ambulance, Clinical, Early, Response.
[17] CAWS at [19].
[18] CAWS at [20].
[19] Tab 43A: Statement of PCSC Bryan Villacres at [7]; Tab 44 - BWV Woolworths Glenquarie at timestamp 17:55:38.
[20] CAWS at [22]; Tab 42: Offence Details – H76115633.
[21] Tab 43: Offence Details – H91715522.
[22] CAWS at [23]-[26].
[23] Tab 74: Reason for Bail Decision by Police Officer p 1.

and formed part of their records) indicates she did not have a mental illness, was not on medication and had no medical issues.[24]

e. On 10 December 2022 at around 1:00am,[25] after approximately six hours in NSWPF custody, Ms Shipley was transferred to Amber Laurel Correctional Centre ("ALCC").[26] On the same day, she appeared before Parramatta Local Court. A transcript of the audio recording of those proceedings has been tendered in evidence[27] and the aide memoire prepared for me (not challenged by any party) is Annexure A to this decision. It reveals that Ms Shipley told the Magistrate that she was representing herself and initially indicated that she was applying for bail. When the Magistrate indicated to the Sergeant appearing that she would *"read the facts and records"* and the Sergeant stated that they would *"hand those up"*, Ms Shipley said: *"Yeah no I don't want bail"*. Ms Shipley appeared in Court for a little over one minute and the learned Magistrate concluded by stating that: *"In relation to the detention application I'll simply mark it not challenged"*.

13. It is apparent from the transcript that on 10 December 2022, there was no reference to Ms Shipley's mental health history by the Court or prosecutor. The matter was stood over to Campbelltown on Monday 11 December 2022.[28]

14. On 11 December 2022, Ms Shipley was transferred to Silverwater Women's Correctional Centre (SWCC). That same day, she attempted to take her own life on two occasions and displayed symptoms of psychosis.[29] Ms Shipley did not attend Court on that date.

15. On 12 December 2022, she was deemed by JHFMHN staff to be too mentally unwell to attend Court and a medical certificate for "non-attendance at Court" was provided to the Court by JHFMHN.[30]

[24] CAWS at [27].
[25] Tab 76: New Inmate Lodgement & Special Instruction Sheet p 1.
[26] CAWS at [28].
[27] Exhibit 9: Parramatta Local Court - 10 December 2022 - Unofficial Transcript.
[28] Exhibit 9: Shipley – Parramatta Local Court - 10 December 2022 - Unofficial Transcript.
[29] CAWS at [31]; CAWS2 at [29].
[30] Shipley – Campbelltown LC 141222 p 31; CAWS2 at [30].

16. On 13 December 2022, a remand warrant was issued for Ms Shipley to attend Campbelltown Local Court the following day in relation to the H91715522 offences.[31]

17. The last date Ms Shipley appeared in any Court was 14 December 2022 and again a transcript of the audio recording of that appearance was prepared for me and circulated to the parties[32], and the aide memoire is attached to this decision at Annexure B. On that date:

    a. Ms Shipley appeared before Campbelltown Local Court via audio-visual-link ("AVL"). She was again unrepresented and entered a plea of guilty for the H91715522 offences.[33]

    b. The NSWPF Facts Sheet for the H91715522 offences located on the Court file did not refer to Ms Shipley's mental health or drug use history.[34]

    c. The learned Magistrate fined Ms Shipley $100 for the enter inclosed lands offence and sentenced her to a Conditional Release Order for the shoplifting offence.[35]

    d. The H76115633 offences were not dealt with. The NSWPF Criminal History Bail Report printed at 8:37pm on 9 December 2022 and located on the Court file in relation to the H76115633 offences stated:

        > "POLICE BAIL: BAIL CONDITIONAL
        > PLACE RESTRICTION
        > NOT TO ENTER THE GLENQUARIE SHOPPING CENTRE" …;
        > and
        >
        > "NO BREACH BAIL ALTERNATIVES FOUND FOR CNI"[36]

    e. The Magistrate advised Ms Shipley she would need to return to Court in relation to the H76115633 offences in January 2023 and stated:

[31] CAWS at [36]; CAWS2 at [31].
[32] Campbelltown Local Court - 14 December 2022 - Unofficial Transcript.
[33] Campbelltown Local Court - 14 December 2022 - Unofficial Transcript.
[34] CAWS at [37]-[38]; Shipley – Campbelltown LC 141222, pp 14-16.
[35] CAWS2 at [33].
[36] Shipley – Campbelltown LC 141222 pp 26 and 28; CAWS2 at [35]; CAWS3 at [14].

"…as far as I'm concerned, that should mean you'll be released".[37]

f. After her appearance, Ms Shipley reported to CSNSW staff at SWCC that she "got bail" and would be going home. However, Ms Shipley was not released from custody as CSNSW Sentence Administration advised there were other charges pending to be heard in 2023 and she did not have bail on those.[38]

18. It is clear that in fact, contrary to the information on the NSWPF Criminal History Bail Report printed at 8:37pm on 9 December 2022 and located on the Court file, as at 14 December Ms Shipley did not have bail on the charge numbered H76115633.

19. On 20 December 2022, 11 days after Ms Shipley was arrested by NSWPF officers and entered custody, she died in the MSU at SWCC, ostensibly from complications arising from her mental illness.[39]

20. On 12 January 2023, Ms Shipley was convicted of the H76115633 offences and fined a total of $1,000,[40] 23 days after her death.

Application by Commissioner of Police

21. On 23 July 2024, the CSO wrote to the Commissioner's legal representatives, the Office of the General Counsel, NSWPF ("OGC"), notifying them the Commissioner may have a sufficient interest in the subject matter of the Inquest and that, as it was possible she may be the subject of criticism or adverse comments or impacted by proposed recommendations, she may wish to obtain legal advice and to seek leave pursuant to s. 57 of *the Act* to be represented at the Inquest.[41] That letter included a request for any NSWPF policies that concern the following:

- Entry into custody and/or custody management procedures;
- engagement with persons who have a mental illness;
- use of PACER teams; and

[37] Campbelltown Local Court - 14 December 2022 - Unofficial Transcript; CAWS2 at [34].
[38] CAWS at [39]-[40].
[39] CAWS2 at [43].
[40] Tab 39: Criminal history – Bail report – Tammy SHIPLEY pp 10-11.
[41] Letter to NSWPF - Sufficient Interest.

- engagement with persons withdrawing from illicit substances.

22. Noting "the 'Issues list' for the inquest [was] still being finalised", the letter also included a request for a statement from a senior officer within the NSWPF (institutional witness) addressing the following three issues:

    1. On the date of [Ms Shipley]'s arrest, were NSW Police aware of her mental health history, and could they have arranged an assessment of [Ms Shipley]'s mental health, pursuant to s 22 of the Mental Health Act 2007, or through use of a PACER (Police, Ambulance, Clinical, Early, Response) team?

    2. Should there be more options for NSW Police when dealing with a person like [Ms Shipley] who is suspected of criminal offending that is likely to be caused by a mental illness or disorder?

    3. What is the obligation (if any) on NSW Police to contact a support person for a suspect who appears mentally ill or disordered, and were relevant guidelines followed in this case? Should guidelines to cover this situation be drawn or amended?

23. On 8 August 2024, the OGC wrote to the CSO asserting, inter alia:

    > "The Commissioner notes that a coroner does not have general powers of inquiry in relation to the death of Ms Shipley. The *Coroners Act 2009* (NSW) does not authorise a coroner to undertake an inquiry into any possible causal connection, no matter how tenuous, between any act, omission, or circumstance on the one hand and the death of Ms Shipley. Any nexus between police action and Ms Shipley's death ended upon her leaving police custody, particularly as a result of the effluxion of time and intervention by other bodies, such that the stated interest of the coroner contained in your letter cannot be properly argued to rest within her Honour's jurisdiction."[42]

24. The letter requested that the "notice of sufficient interest" be withdrawn and further asserted that there was "no jurisdiction for the coroner to request the information sought".

25. On 16 August 2024, the CSO wrote to the OGC advising that my view remained that:

[42] Letter to CSO re SI letter in Shipley Inquest.

> "…the issues to be explored at the inquest will include an examination of the events that led to Ms Shipley's arrest and imprisonment in December 2022, including her likely mental health condition at the time."

26. That letter enclosed a "draft issues list" for the Inquest and revised the request for policies and a statement from the Commissioner.[43] The draft issues list included seven issues (and sub-issues), including the following:[44]

> 1. What led to [Ms Shipley]'s arrest and imprisonment in December 2022, and what was her likely mental health condition at the time?
>
> …
>
> 3. The adequacy of the response by Corrective Services NSW (CSNSW) to [Ms Shipley] from the date of her detention in December 2022 up until her death…?
>
> …
>
> 7. Whether any recommendations are necessary or desirable in relation to [Ms Shipley]'s death, pursuant to s 82 of the *Coroner's Act 2009*?

27. On 21 August 2024, I held a directions hearing. A solicitor from the OGC appeared on behalf of the Commissioner who was granted leave to appear in the proceedings. During that hearing, the Commissioner's representative advised that an "application" would be forthcoming. The Commissioner's representative indicated that the application would be seeking for the Commissioner to be removed from the Inquest proceedings. I made a direction that any such application was to be provided to the CSO by 30 August 2024. The matter was listed for further directions (if necessary) at 2:00pm on 12 September 2024.

28. On 30 August 2024, the Commissioner's representative advised that the application had been delayed and that the Commissioner sought an extension until 5:00pm on 3 September 2024. I granted that extension.

29. On 3 September 2024, the CSO received an application signed by the General Counsel, NSWPF.[45] The Application stated and sought the following:

[43] Letter to Katherine Garaty - 16 August 2024.
[44] CAWS2 at [3].
[45] Shipley Inquest - Application to State Coroner.

1. That any examination or exploration by the State Coroner and/or Counsel Assisting into the appropriateness or otherwise of the NSW Police Force's interactions with Ms Shipley including, but not limited to, her mental health, physical health, drug abuse, arrest, charging, bail determination and custody prior to her death is impermissible as it lacks jurisdictional power.
2. In respect of the letter to [the OGC] from the Crown Solicitor's Office dated 16 August 2024:
    a. the "request for policies and procedures" be withdrawn on the basis that it is impermissible as it lacks jurisdictional power and a legitimate forensic purpose; and
    b. the "request for a statement from a senior NSWPF officer" addressing the nominated four areas be withdrawn on the basis that it is impermissible as it lacks jurisdictional power and a legitimate forensic purpose.
3. In respect of the letter of sufficient interest addressed to the Commissioner from the Crown Solicitor's Office dated 23 July 2024:
    a. the letter be withdrawn on the basis of a lack of jurisdictional power; and/or, alternatively
    b. the issues said to be "emerging", listed and numbered 1, 2, and 3 be removed from consideration in the Inquest on the basis of a lack of jurisdictional power; or, alternatively
    c. the "Request for Policies" be withdrawn on the basis that it lacks a legitimate forensic purpose and/or the State Coroner and/or Counsel Assisting lacks jurisdictional power to consider the nominated four areas; and
    d. the "Request for Statement" be withdrawn on the basis that it lacks a legitimate forensic purpose and/or the State Coroner and/or Counsel Assisting lacks jurisdictional power to consider the nominated four areas.

30. The Application was accompanied by a "list of authorities" but did not include written submissions or any other supporting evidence.

31. On 5 September 2024, the CSO advised the Commissioner's representative that I wished to hear oral submissions on the Application at the directions hearing on 12 September 2024.

32. On 12 September 2024, shortly before midday, the Commissioner's representative emailed eleven pages of written submissions on "jurisdiction" ("CoPWS")[46] and a list of authorities to the CSO, on behalf of the Commissioner. The CoPWS were authored by Counsel for the Commissioner and submitted:

> "[50] The Court should order that:
>
> [50.1] any investigation into:
>
> i. the appropriateness of the NSW Police's interactions with Ms Shipley;
> ii. its institutional frameworks for dealing with persons suffering from mental illness; and
> iii. any similar investigation into the NSW Police;
>
> is excluded from the scope of the inquest into the death of Ms Tammy Michelle Shipley; and
>
> [50.2] the request for documents and a witness statement made to the NSW Police on 16 August 2024 is withdrawn."

33. At 2:00pm that day, the directions hearing proceeded however I was unable to address the Application as Counsel Assisting and the other parties had not had sufficient time to address the written submissions of the Commissioner.

34. To allow the Inquest to commence as planned on 16 September 2024, a regime was proposed to defer hearing of the Application to the end of the Inquest proceedings. The Application was fixed for hearing at 10:00am on 27 September 2024 (as at that time, the scheduled last day of the Inquest).

35. The Inquest proceeded as planned from 16 to 26 September 2024.[47] On the first day of the Inquest, the brief of evidence was tendered without objection. I heard from 23 witnesses over that period, including Ms Shipley's community general practitioner Dr Abdul Matin, and institutional witnesses from South West Sydney

[46] MFI-A: Written submissions on behalf of the Commissioner dated 12 September 2024.
[47] The Court did not sit on 20 or 23 September 2024.

Local Health District ("SWSLHD"); Justice Health and Forensic Mental Health Network (JHFMHN); and Corrective Services NSW (CSNSW).

36. On 25 September 2024, I received written submissions in relation to the Application from Counsel Assisting ("CAWS").

37. On 26 September 2024, I received written submissions in reply on behalf of the Commissioner, again authored by Counsel for the Commissioner ("CoPWSR").

38. On 26 September 2024, at the end of the seventh day of the Inquest, one witness remained to be heard. That witness was stood over to the following day. Counsel Assisting noted to the Court that witness would be heard first, at 10:00am, followed by the Application.[48]

39. On 27 September 2024, as proceedings for the day were about to commence, I was advised by Counsel Assisting that Senior Counsel for the Commissioner was not available to appear on the Application beyond midday and that consequently, if the remaining witness was to be heard first, the Commissioner sought to have the Application stood over to a future date. I adjourned the Application to the earliest available date of 17 October 2024.[49]

40. After the remaining witness that day, I adjourned the hearing of the Inquest, other than the Application, to 6 and 7 February 2025.[50]

41. On 10 October 2024, I received supplementary written submissions of Counsel Assisting ("CAWS2").[51]

42. On 16 October 2024, I received further submissions in reply on behalf the Commissioner, authored by Counsel for the Commissioner ("CoPWSR2").[52]

43. On 17 October 2024, the hearing of the Application proceeded, and oral submissions were heard from Counsel for the Commissioner, Counsel Assisting and a representative for Ms Shipley's family.

44. At the hearing of the Application, the following documents were marked for identification in the proceedings:

[48] Transcript 26/09/24 p 704 ln 19-34.
[49] Transcript 27/09/24 p 706 ln 32 – p 707 ln 2.
[50] Transcript 27/09/24 p 742 ln 5-15.
[51] MFI-B: Initial Submissions of Counsel Assisting.
[52] MFI-A: Written submissions on behalf of the Commissioner dated 16 October 2024.

MFI-A Three sets of written submissions on behalf of the Commissioner dated 12 September 2024, 26 September 2024 and 16 October 2024.

MFI-B Initial and Supplementary Submissions of Counsel Assisting.

MFI-C Chronology of Arrests and Court Appearances.

45. At the conclusion of proceedings that day I invited Counsel for the Commissioner to provide me a note indicating whether the Commissioner agreed with the factual matrix in Counsel Assisting's submissions (initial and supplementary). I indicated that the note should be provided by 5:00pm on 21 October 2024.[53]

46. On 21 October 2024, the Commissioner's representatives provided the Commissioner's "Note on the Asserted Facts in Counsel Assisting's Supplementary Submissions" ("CoPN") to the CSO. In CoPN it was stated that "it would be unsafe for the Court to make any finding about the conduct of the Police Prosecutor on 14 December 2022" as:

    a. The Court did not have before it:
        i. "a copy of the bench papers before the Magistrate on which the Magistrate would have noted any appearance by the Prosecutor;
        ii. an official transcript; or
        iii. a recording of the matters before and after Ms Shipley's appearance"; and

    b. "[t]he unofficial transcript does not reveal that the Prosecutor was even in the courtroom…"[54]

47. In response to CoPN, the Commissioner's representatives were provided access to an audio recording of Ms Shipley's appearance at Campbelltown Local Court on 14 December 2022 ("Court Recording")[55] along with a partially redacted Bench Coversheet ("Bench Coversheet")[56] from that day and offered the opportunity to provide a further note should they wish to do so.

[53] Transcript 17/10/24 p 760 ln 27 – p 761 ln 35.
[54] CoPN at [8]-[10].
[55] Campbelltown Local Court 141222.mp3.
[56] Shipley - Bench coversheet Campbelltown LC 141222_Redacted.

48. On 18 November 2024, the Commissioner's representatives provided a further note ("CoPN2")[57] to the CSO, maintaining the position taken in CoPN.

49. On 22 November 2024, all other interested parties were served CoPN, the Court Recording, the Bench Coversheet and CoPN2 and provided an opportunity to respond by 29 November 2024.

50. On 29 November 2024, Counsel Assisting provided a response to CoPN and CoPN2 ("CAWS3").[58]

51. On 12 December 2024, the Commissioner's representatives provided a further note in reply to CAWS3 ("CoPN3").[59]

Legislative Scheme

52. The role and function of a Coroner are set out in *the Act*.

53. The objects of *the Act* are set out in s. 3 and relevantly include:

> *c. to enable coroners to investigate certain kinds of deaths or suspected deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths,*
>
> *…*
>
> *e. to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies), …*

54. Section 21 of *the Act* confers general jurisdiction for a coroner to hold an inquest.

55. In this matter, ss. 23 and 27 of *the Act* confer additional jurisdiction and mandate that an inquest is required to be held by a senior coroner. Section 23 provides:

> *(1) A senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died (or that there is reasonable cause to suspect that the person has died)—*
>
> *(a) while in the custody of a police officer or in other lawful custody, or*
>
> *…*

[57] Shipley - Further Note on 14 December Appearance 18.11.24.
[58] Submissions of CA re CoP Notes - 29.11.24.
[59] NSW Commissioner of Police's Note in Reply dated 12 December 2024.

(d) while in, or temporarily absent from, any of the following institutions or places of which the person was an inmate—

…

(ii) a correctional centre within the meaning of the Crimes (Administration of Sentences) Act 1999, …

56. Section 27 provides that:

(1) An inquest concerning the death or suspected death of a person is required to be held in any of the following circumstances—

…

(b) if the jurisdiction to hold the inquest arises under section 23, …

57. Section 81 requires findings as to identity, date, place, manner and cause of the identified person's death and for those findings to be recorded in writing.

58. Section 82 allows the coroner to make recommendations and provides:

(1) A coroner … may make such recommendations as the coroner … considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.

(2) Without limiting subsection (1), the following are matters that can be the subject of a recommendation—

(a) public health and safety,

(b) that a matter be investigated or reviewed by a specified person or body.

Outline of submissions on the Application

Commissioner's submissions

59. I have carefully read each of the written submissions prepared on behalf of the Commissioner and listened to oral argument and will attempt to summarise the main points made. In summary, the Commissioner submitted that "any connection between Ms Shipley's death and the conduct of the NSW Police is simply too remote"[60] and that any investigation into NSWPF interactions with Ms Shipley and its institutional frameworks for dealing with persons suffering from

[60] CoPWS at [4]; Transcript 17/10/24 p 746 ln 34-44.

mental illness is beyond jurisdiction and should be excluded from the scope of the Inquest.[61]

A Coroner's jurisdiction

60. In relation to a Coroner's jurisdiction, the Commissioner submitted that:[62]

> *"*The jurisdiction of the Coroner is conferred by statute and informed by the common law. The [Act] sets the limits of power beyond which the Court is not authorised to exceed. To exceed those limits is to commit a jurisdictional error*: Hossain v Minister for Immigration and Border Protection* (2018) 264 CLR 123, [22]-[25].
>
> A senior coroner has jurisdiction to hold an inquest concerning a death if it appears that a person has died while in custody*: the Act, s 23(1)(a).* That power is confined by the scope and objects of the Act*: Barton v R* (1980) 147 CLR 75, 94; *Water Conservation and Irrigation Corporation (NSW) v Browning* (1947) 74 CLR 492, 505*."*

61. The Commissioner further asserted that the power of a Coroner to make recommendations does not enlarge the scope of a Coroner's jurisdiction,[63] submitting:

> *"*It is not a free-ranging general power but arises as a consequence of a coroner's primary function under the Act, being to make the findings required by s 81*: Conway v Jerram* [2011] NSWCA 319, [47]*; Harmsworth v The State Coroner* [1989] VR 989, 996*".*

62. Citing *Conway v Jerram*,[64] the Commissioner submitted *the Act* does not authorise a "roving Royal Commission"[65] into matters connected with the death, some of which must be considered "too remote from the event".[66] A line must be drawn by application of a common sense test of causation as identified in *March v E & MH Stramare* (1991) 171 CLR 506 (*"March v Stramare"*): cited in *Re Doogan; ex parte Lucas-Smith and Others (2005) 193 FLR 239 ("Doogan")*, [29].[67]

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[61] CoPWS at [7]-[8.2].
[62] CoPWS at [18]-[19].
[63] CoPWS at [23].
[64] [2011] NSWCA 319 (*"Conway v Jerram"*).
[65] CoPWS at [24]; see also CoPWSR2 at [6]-[7].
[66] CoPWS at [25].
[67] CoPWS at [36]; CoPWSR2 at [2]-[5] citing *Conway v Jerram* at [30]-[31] and [48]-[49] and *Re State Coroner; Ex parte The Minister for Health* (2009) 38 WAR 553, at [46]-[47]; Transcript 27/20/24 p 746 ln 37-39.

63. In *Doogan*, the Full Court of the Supreme Court of the Australian Capital Territory stated:

> "A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the "common sense" test of causation affirmed by the High Court of Australia in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506."

64. The Commissioner additionally submitted that: "Causation is largely a question of fact, to be approached by applying common sense to the facts of the particular case: *Hunt & Hunt Lawyers v Mitchell Morgan Nominees Pty Ltd* (2013) 247 CLR 613, [43]".[68]

65. The Commissioner asserted that the examination of matters occurring on 9 December 2022 and the question of whether Ms Shipley should have been in custody when she died conflates "a possible precondition to Ms Shipleys death with the common-sense test of causation" found in *March v Stramare* where Deane J stated:[69]

> "… the mere fact that something constitutes an essential condition (in the 'but for' sense) of an occurrence does not mean that, for the purposes of ascribing responsibility or fault, it is properly to be seen as a 'cause' of that occurrence as a matter of either ordinary language or common sense. Thus, it could not, as a matter of ordinary language, be said that the fact that a person had a head was a 'cause' of his being decapitated by a negligently wielded sword notwithstanding that possession of a head is an essential precondition of decapitation."

66. In oral submissions, Counsel for the Commissioner took me to the decision of *Harmsworth v State Coroner* [1989] VR 989 ("*Harmsworth*") in relation to the inquests into the deaths of 5 persons in custody. In that decision, Nathan J held at 995:

> "Before turning to the particulars, I shall dispose of the legal issues raised. Mr. Black has contended the power to investigate is limited to relevant

[68] CoPWRS2 at [12].
[69] CoPWSR at [11]; CoPWSR2 at [13].

enquiries relating to the causes or circumstances of the fire and deaths. Mr. Gillard contends the coroner's enquiries and requirements do, in fact, fall within that class. He contends the class of enquiries must be broadly construed, because a coroner will not know whether an enquiry is relevant, or whether it is likely to lead to the discovery of material likely to assist him in making his findings, until it is made.

The issue of causation as exemplified by the above arguments has vexed philosophers and judges since Socrates was obliged to drink the hemlock. I deal with this issue of causation, not by way of assessing the correctness or otherwise of the coroner's questions or requirements, but by dealing with the issue as being one of jurisdictional error of law. That is whether or not he had the ministerial power, to be exercised judicially, to investigate the issues he characterised as causative? ...

…The coroner's source of power of investigation arises from the particular death or fire. A coroner does not have general powers of enquiry or detection ..."[70]

67. Continuing, concerning the concept of "remoteness", Nathan J held:[71]

"The enquiry must be relevant, in the legal sense to the death or fire, this brings into focus the concept of "remoteness". Of course the prisoners would not have died if they had not been in prison. The sociological factors which related to the causes of their imprisonment could not be remotely relevant. This can be tested by considering how wide, prolix and indeterminate the inquest might be if each of the many facets of the individual personalities, of all those involved were to be considered. A coroner would be confronted with a need to enquire into the personal peculiarities of all of the prisoners who barricaded themselves in. Both those who relented and those who did not. Whether for example, one group or person suborned others, and if so why and how. The personalities of all of the prison officers who interacted with all of the prisoners could also be investigated. Even the interaction of all of the other prisoners at any time in Jika with the deceased. Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for much comment. Such

[70] Transcript 17/10/24 p 747 ln 10-19 citing *Harmsworth* at p 995.
[71] CoPWS at [42]; CoPSWR2 at [22]; Transcript 17/10/24 p 747 ln 18-31 citing *Harmsworth* at p 995-6.

discursive investigations are not envisaged nor empowered by the Act. They are not within jurisdictional power.

Enquiries must be directed to specific ends. That is the making of the findings as required and set out in s. 19(1).

The power to comment, arises as a consequence of the obligation to make findings: see s. 19(2). It is not free-ranging. It must be comment "on any matter connected with the death". The powers to comment and also to make recommendations pursuant to s. 21(2) are inextricably connected with, but not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner's prime function, that is to make "findings"…

… But the power to comment is incidental and subordinate to the mandatory power to make findings relating to how the deaths occurred, their causes and the identity of any contributory persons."

68. Counsel for the Commissioner continued:[72]

> "*Not all questions of causation can be related to time. As a general proposition the greater the time lapse between the event enquired of is from the allegedly causative factor, the less relevant as an initiating cause that factor will be.*"

69. In written submissions, it was put on behalf of the Commissioner that: "A factor which secures the presence of a person at a place when and where they are injured (or here, died), is usually not causally connected with the injury (or death): *March v E & MH Stramare*, at 516 (Mason CJ)."[73]

70. Applying the above principles, the Commissioner submitted that:

> "If the fact of Ms Shipley being in custody at the time of her death is a sufficient connection to enable an inquiry into the appropriateness of her arrest, then that must be true of every death in custody even if the time between arrest and death is 30 years."[74]

[72] Transcript 17/10/24 p 747 ln 31-33 citing *Harmsworth* at p 999.
[73] CoPSWR2 at [13].
[74] CoPWSR at [13].

71. The Commissioner referred to the "many" intervening factors between Ms Shipley's arrest and her death 11 days later in the care of CSNSW which "concern shortfalls with the treatment provided" to her by CSNSW and bear no connection to the conduct of NSWPF Officers. The Commissioner noted CSNSW owed a non-delegable duty of care to Ms Shipley.[75]

72. Counsel for the Commissioner was aware of evidence at the Inquest given by CSNSW staff that the NSWPF custody management record for a prisoner "can be an important record" to inform care provided by CSNSW to inmates, demonstrating the potential link between the information that NSWPF pass on to CSNSW and the care that a prisoner may receive. In response, the NSWPF asserted that "[c]ommon-sense causation remains the relevant test even where there are one or more intervening factors: *Medlin v State Government Insurance Commission* (1995) 182 CLR 1, 6."[76] The Commissioner asserted that errors in NSWPF records, in the face of intervening information obtained by CSNSW, had no role to play in the cause of Ms Shipley's death.[77]

73. In relation to Ms Shipley's mental health condition at the time of her arrest, the Commissioner noted that expert witness Associate Professor Sullivan gave evidence that police would not have immediately identified that she was suffering from mental illness[78] and the Commissioner asks "how the police could be expected to pick up on a mental state [on 9 December 2022] that Ms Shipley's treating practitioner did not 4 days earlier."[79]

74. The Commissioner contended that, applying "common sense and experience", neither Ms Shipley's arrest, nor her remand, "caused or materially contributed to her death" and that an inquiry into why she was in custody and remained there "is beyond jurisdiction".[80] It is asserted that the involvement of NSWPF is "*simply too remote in relation to the manner and cause of Ms Shipley's death*".[81]

[75] CoPWSR at [15]-[16].
[76] CoPWSR2 at [16]-[18].
[77] CoPWSR2 at [15] and [19-20].
[78] CoPWSR at [14].
[79] CoPWSR at [19].
[80] CoPWSR2 at [14]-[15].
[81] Transcript 17/10/24 p 746 ln 41 – p 747 ln 3.

Determining jurisdiction

75. The Commissioner submitted the first duty of a judicial officer in every judicial and quasi-judicial body, irrespective of the executive or investigatory nature of their functions, is to satisfy themselves they have jurisdiction.[82] Furthermore, as an inquest is entering its "curial phase" there should have been "a substantial investigatory stage by which the Coroner obtains some knowledge of the issues" so a Coroner is aware whether potential lines of inquiry at the inquest are not only relevant but "whether they are within jurisdiction."[83]

76. According to the Commissioner, while a Coroner has a discretion about what matters within jurisdiction are to be the subject of inquiry, such discretionary considerations are not relevant to the first task of determining whether a matter is within jurisdiction. The boundaries of a coroner's jurisdiction "are to be determined by application of a common-sense test of causation".[84]

77. The Commissioner submitted that relevance, or potential relevance, to manner of death and the recommendations function of the Court is not the test for jurisdiction, asserting:[85]

    a. "The power to make recommendations arises as a consequence of a coroner's primary function to make the findings required by s 81: *Conway v Jerram [2011] NSWCA 319, [47]; Harmsworth v The State Coroner [1989] VR 989, 996*. It does not enlarge the scope of a coroner's jurisdiction: *Doogan*, [41].

    b. As a result, it is "necessary, in each inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of the death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case": *Re State Coroner; Ex parte The Minister for Health* (2009) 38 WAR 553.

    c. Beyond that, and it becomes too remote: *Mullaley v State Coroner of Western Australia* [2020] WASC 264, [111]-[112]. Remoteness

[82] CoPWS at [27]-[29].
[83] CoPWS at [30]-[31].
[84] CoPWSR at [3]-[4].
[85] CoPWSR at [4]-[6].

demarcates the line in the sand beyond which the Court cannot inquire: see *Conway v Jerram* [2011] NSWCA 319, [49]."

78. The Commissioner further asserted that, contrary to the submissions of Counsel Assisting: "Asking whether [an] inquiry is "relevant", or "potentially relevant", or whether the Coroner "may wish" to understand certain matters, is to apply the wrong test."[86] Further, that "even applying Counsel Assisting's test of relevance, the proposed inquiries would fall outside of jurisdiction." Relevance to recommendations is not sufficient as a Coroner's power to make recommendations arises as a consequence of the findings required by s. 81 of *the Act*.[87]

79. Aside from submitting that examination of Ms Shipley's interactions with the NSWPF are beyond jurisdiction, the Commissioner further submitted that the Court can reach a concluded view in relation to jurisdiction prior to hearing any evidence from NSWPF witnesses. Citing his Honour Wright J in *Commissioner of Police v Attorney General for New South Wales* [2022] NSWSC 595; the Commissioner submitted there is a distinction between "nascent" and "curial" stages of the proceedings and asserts that *the Act* "requires the consideration and identification of issues at a relatively early stage."[88]

80. In relation to the authorities relied on by Counsel Assisting, the Commissioner submitted that suggestions of prematurity in deciding jurisdiction found in *Thales Australia Ltd v The Coroners Court & Ors* [2011] VSC 133, and the decisions in the *Inquest into the death of Kumanjayi Walker*, are not binding on this Court. Citing *Doogan* at [13], the Commissioner submitted that, while a Coroner has a discretion about what matters within jurisdiction are to be the subject of inquiry, a "coroner is not free to enlarge his or her own jurisdiction by the adoption of terms of reference…".[89]

81. Regarding the NSWPF's connection to the cause of death, the Commissioner submitted that the authorities relied on by Counsel Assisting "do not mandate,

[86] CoPWSR2 at [5].
[87] CoPWSR2 at [22]-[23] citing: *Conway v Jerram*, [47]; *Harmsworth*, 996.
[88] CoPWSR at [7]-[9].
[89] CoPWS at [32]-[33]; CoPWSR at [2]]; Transcript 17/10/24 p 747 ln 36-40.

nor suggest, a different conclusion" to that propounded by the Commissioner". In particular:[90]

a. *Atkinson v Morrow [2005] QCA 353* concerned very different factual circumstances to the Inquest. The Commissioner concedes "the conduct of [Queensland] police in that case was plainly relevant to the circumstances of the death" and, contrary to Ms Shipley's case, "there were not a multitude of known intervening factors like with Ms Shipley."

b. *The Inquest into the Death of Heather Winchester* "was also a very different case" where a coroner ruled that the issue in contention was "inextricably linked" to the circumstances of her death.

82. The Commissioner submitted there is no such connection in Ms Shipley's case whereby her "arrest and subsequent bail refusal by the Local Court were the reasons she was in custody between 10 and 20 December 2022, and not, based on a common-sense approach, reasons for her death." Accordingly, it is submitted that NSWPF involvement was "too remote to fall within the Coroner's jurisdiction".[91]

83. In oral submissions, Counsel for the Commissioner's submissions included a statement that:

> "*[n]othing that NSW Police did or did not do prior to [Ms Shipley] coming into the care of [CSNSW] can have any bearing on the manner and cause of her death. It's just simply too remote ...*"[92]

84. Counsel for the Commissioner further asserted that Counsel Assisting had failed to engage with the concept of remoteness required by the common sense test used to determine jurisdiction.[93]

Counsel Assisting Submissions

85. Counsel Assisting submitted that; "[f]ar from being a "*roving Royal Commission*" … the inquest was planned to run in an efficient and modest way, over a relatively short period of time (prior to objection raised by the NSWPF, the matter had been

[90] CoPWSR at [21]-[25].
[91] CoPWSR at [26]-[27].
[92] Transcript 17/10/24 p 748 ln 33-35.
[93] Transcript 17/10/24 p 751 ln 36-47.

listed for only eight days, which was to include evidence and oral submissions). Counsel Assisting suggested that the Application should be dismissed since the Coroner had jurisdiction to hold this mandatory inquest, the matters to be inquired into were not too remote and did not exceed jurisdiction and the request for documents and a statement from a senior police officer within the NSWPF are "likely to provide material assistance to the Court."[94]

86. Counsel Assisting rejected the Commissioner's submissions that she had "*failed to grapple with the chief complaint made on behalf of the Commissioner that the matter or the manner in which the inquest is being conducted suggests that it is beyond jurisdiction.*"[95]

A Coroner's jurisdiction

87. In relation to a Coroner's jurisdiction, Counsel Assisting submitted that *the Act* sets out the statutory basis of a Coroner's power and as Ms Shipley died in custody, an inquest into her death is mandatory pursuant to ss. 23 and 27 of *the Act*.[96] Counsel Assisting further asserted "*the case law is clear that once jurisdiction is established, the Court has a broad jurisdiction to determine what matters should be inquired into, relevant to the statutory function; manner and cause of death and recommendations.*"[97]

88. Counsel Assisting submitted that at the conclusion of the Inquest, the Coroner is required to record, *inter alia*, "the manner and cause of the person's death." The "cause" of death means the physiological cause or causes of death while the "manner" of death is "intended to encompass the circumstances surrounding the death, allowing for considerable discretion for the Coroner to determine the scope and focus of the inquiry." Section 82 of *the Act* provides power for a Coroner to make recommendations the Coroner "considers necessary or desirable to make in relation to any matter connected with the death … with which an inquest … is concerned."[98]

Authorities relating to scope of an inquest

89. Counsel Assisting referred me to the recent interlocutory ruling of Deputy State

[94] CAWS at [1] and [5].
[95] Transcript 17/10/24 p 749 ln 4-9.
[96] CAWS at [45]-[48] citing s. 81(1)(c) of *the Act*.
[97] Transcript 17/10/24 p 749 ln 11-18.
[98] CAWS at [49]-[50] citing Dillon and Hadley 'The Australasian Coroners Manual' 2015 p 112 and s. 82(1) of *the Act*.

Coroner O'Neil in the *Inquest into the death of Heather Winchester*[99] ("*Winchester*") in which his Honour conveniently sets out relevant authorities on scope. As that decision is unpublished, the relevant paragraphs are reproduced below.

> "[76] The relevant terminology in the NSW Coroners Act is "manner of death". In *Conway v Jerram*, after reviewing the authorities, Barr J concluded that:
>
> > "manner of death should be given a broad construction so as to enable the coroner to consider by what means and in what circumstances the death occurred." (emphasis added)
>
> [77] So far as the extent of the inquiry into manner is concerned, *Harmsworth* confirms that inquiries must be directed to the making of the statutory findings and cautioned against embarking on an inquiry that might never end and that might never enable coherent and concise findings to be made. In *R v Doogan*, the Full Court of the Australian Capital Territory Supreme Court warned against conducting a "roving royal commission".
>
> [78] Whilst these authorities make clear that the scope of an inquest is not unlimited, Waller notes that it is important that "manner of death" not be too narrowly construed.[100]
>
> [79] What is a permissible scope will turn on the facts of each inquest. Consideration of authorities is instructive as to what has been found to be within scope.
>
> [80] In *Atkinson v Morrow*[101], the deceased (Mr O'Sullivan) had captured police attention when he had complained that persons hiding in trees had a gun trained on him. Police attended and transported the deceased from the area where his complaint had been made, and later dropped him off in a Queensland country town, known as a place where long haul trucks picked up persons who wanted transportation to other parts of the state. The deceased was not seen alive again. The Queensland Court of Appeal confirmed that it was within permissible scope for a senior police officer to

[99] CAWS at [51]-[53] citing *Inquest into the death of Heather Winchester; Interlocutory decision of Magistrate O'Neil 20 February 2023* at [76]-[87] (unpublished).
[100] Waller's, Coronial Law and Practice, 4th Ed., 81.19.
[101] [2005] QCA 353.

be required to give evidence in relation to dealing with situations similar to that which had eventuated in relation to the death of Mr O'Sullivan.

[81] In *Thales Australia Limited v The Coroners Court* [2011] VSC 133, in an inquest that had become fragmented due to the manner in which Thales had made submissions, the Coroner had made findings as to cause and circumstances while at the same time indicating the inquest would be continued for further inquiry into occupational health and safety issues. On appeal Beach J was satisfied that it was open to his Honour to consider evidence on these issues.

[82] In *Harmsworth*, it was clear the deceased died in a fire in a prison following some prisoners barricading themselves and ultimately one of the prisoners starting a fire. On appeal, Nathan J accepted that an inquiry into the cause of each deceased prisoner's frustration would be a permissible area for inquiry, as would whether the levels of frustration and anger induced by the relevant incarceration required extra diligence and care by the Department of Corrections.

[83] In *Doomadgee v Clements*,[102] Muir J, whilst acknowledging that the power to comment was ancillary to the duty to make the statutory findings, expressed the view that the scope of an inquest is not confined to evidence directly related to the statutory findings.

[84] In *Doogan*,[103] the Coroner was inquiring into bushfires that had caused death and widespread damage in a Canberra area. In the course of its judgment on the question of apprehended bias, the Full Court of the ACT Supreme Court observed, by way of example, that consideration of the "circumstances in which the fire occurred" could have extended to referring to Australia Day traffic hampering the deployment of firefighting units.

[85] Finally in relation to authority I will refer to some comments of superior courts in relation to the role of the coroner.

[86] In *R v Doogan*,[104] in a ruling that the application was premature, the Court observed that it was neither necessary nor appropriate to go through either the evidence or issues list with a view to making rulings as

[102] *Doomadgee v Clements* (2006) 2 Qd R 352 at 360, [28].
[103] *R v Doogan* [2005] ACTSC 74 at [36].
[104] *R v Doogan* (2005) 158 ACTR 1.

to the relevance of each of the issues identified.

[87] In *Bauwens*,[105] the Northern Territory Supreme Court noted that a Coroner's Court fulfils the "important public function" of investigating the cause and circumstances of reportable deaths and that it is "generally … inappropriate to interfere with the gathering of evidence by a coroner" or to "seek from a coroner a ruling that one piece of evidence or another is inadmissible or irrelevant as if the coroner were conducting a civil or criminal trial"."

90. Additionally, Counsel Assisting's submissions included reference to the following observation of the Court of Appeal of England and Wales:

> "A decision on scope represents a coroner's view about what is necessary, desirable and proportionate by way of investigation to enable the statutory functions to be discharged. These are not hard-edged questions. The decision on scope, just as a decision on which witnesses to call, and the breadth of evidence adduced, is for the coroner. A court exercising supervisory jurisdiction can interfere with such a decision only if it is infected with a public law failing. It has long been the case that a court exercising supervisory jurisdiction will be slow to disturb a decision of this sort ."[106]

91. Counsel Assisting referred me to the decision of *Re State Coroner; Ex parte Minister for Health*, where Buss JA, with whom Martin CJ and Miller JA of the Western Australian Supreme Court agreed, expressed the opinion that the jurisdiction and obligation to find, if possible, how death occurred referred not only to the means or mechanism by which the death was suffered or inflicted but extended to the circumstances attending the death. A construction which entitled and required the coroner to find, if possible, by what means and in what circumstances the death occurred reflected the public interest "which is protected and advanced by a coronial investigation".[107]

[105] *Bauwens & Anor v The Territory Coroner* 2022 NTSC 92 at [62, 64].
[106] CAWS at [54] citing *Coroner for the Birmingham Inquests v Hambleton* [2018] EWCA Civ 2081 at [48].
[107] CAWS at [55] citing *Re State Coroner; Ex parte Minister for Health* (2009) 38 WAR 553; [2009] WASCA 165 at [42].

92. I was taken by Counsel Assisting to the decision of State Coroner Barnes' (as his Honour then was) in a ruling on the scope of the Lindt Café Inquest. His Honour stated:[108]

> "Without pleadings or the strict adherence to the rules of evidence to constrain and guide me, I must be conscious of the cost and delay unnecessary inquiry can cause. It is probably true that coroners do on occasions go too far down unproductive even unnecessary lines of inquiry. Conversely, coroners very regularly draw a line beyond which they decline to inquire, even though as a matter of strict logic they have not reached the beginning of the chain of causation. They do that by applying common sense and the legal concept of remoteness".

93. In relation to the issues arising in the Inquest, Counsel Assisting submitted that the case of *Atkinson v Morrow* [2005] QCA 353 is particularly relevant. In that matter, the Coroner presiding over an inquest had requested, and subsequently admitted into evidence, a statement of a senior police officer of the Queensland Police Service (Acting Chief Superintendent Kummerow) in relation to the "Queensland Police Service's policy guidelines (or the like) for dealing with similar situations" to those examined in relation to the deceased. At the inquest it was submitted on behalf of the Commissioner that the statement had nothing to do with Mr O'Sullivan's death and was irrelevant to the inquest. Rejecting the Commissioner's submission, the Coroner ruled that the statement of the Acting Chief Superintendent was admissible and that he required that senior officer to give evidence that was "relevant to the issue of how Mr O'Sullivan came to be at Mulgildie on the morning before it appears he died", and that he wished to be informed about police procedures that applied in the particular circumstances that arose for the police officers in relation to the deceased. The Police Commissioner unsuccessfully appealed to a single justice of the Supreme Court and then to the Queensland Court of Appeal. Referring to authority addressing the scope of a coroner's inquiry, the Queensland Court of Appeal stated:[109]

> "[7] In the present case, no question is raised that the State Coroner acted within jurisdiction conferred by s7(1) and s7B(1) in holding an inquest into

[108] CAWS at [56] citing *Inquest into the Deaths Arising from the Lindt Café Siege (Katrina Dawson, Tori Johnstone and Man Haron Monis*) (Coroners Court of NSW, 5 June 2015 per State Coroner Barnes).
[109] CAWS at [57] citing *Atkinson v Morrow* at [7]-[17].

the death of Mr O'Sullivan. The real issues here are whether the acting coroner at Gladstone exceeded the ambit of his jurisdiction (1) in making the request for the statement provided by Acting Chief Superintendent Kummerow; and (2) in deciding to admit it into evidence…

…

[13] The decision[110] seems to me, with respect, to be clear authority against the proposition contended for here by Mr Martin SC for the applicant Commissioner, which is that "how the death occurred" in s 24(1) does not mean "by what means and in what circumstances the death occurred"…

[14] … My conclusion is that on the first question on this appeal those decisions confirm that the acting coroner was correct in concluding here that it was part of his function in conducting the inquest into the death of Mr O'Sullivan to inquire into all the circumstances attending that death or which might have caused it. In deciding to do so, he did not exceed the jurisdiction conferred by s 24(1)(c), or potentially under s 43(2)(a)(ii), or otherwise under the [*Coroner's Act 1958*]. This conclusion accords with the decision of the learned judge below in refusing the application to review the acting coroner's decision in this matter.

[15] The second question concerns the admissibility of the Statement of Acting Chief Superintendent Kummerow. In it, he states that the Queensland Police Service policy and procedures "associated with the situation that confronted the police at Monto on 28 March 2003 are primarily contained in various service publications or manuals with names such as the Operating Procedures Manual, the Human Resources Manual and so on ...

…

[17] It may be thought that not much of this appears to bear directly on the circumstances of or attending the death of Mr O'Sullivan in this case. Mr Martin SC submitted that most, if not all of it, was in any event contained in statutory provisions, legislative instruments or published instructions that are or would have been available to the acting coroner, without troubling Acting Chief Superintendent Kummerow. But it may be

[110] The 'decision' referred to is *R v Graham* (1905) 93 LT 371. See *Atkinson v Morrow* at [8]-[12].

> that the acting coroner, in inquiring into the circumstances of the death of Mr O'Sullivan wished to know what it is that police in a distant part of the State are expected to do when "confronted" with a case like this. If, for example, there were, objectively speaking, indications that on 28 March 2003, Mr O'Sullivan was suffering from the effects of drug ingestion that were obvious to some others if not to the police officers concerned, it would not appear to have been helpful or "appropriate" that Mr O'Sullivan should have been taken and left alone in a more remote and even less populous part of the district."

Authorities relating to the status of an issues list

94. Counsel Assisting also relied on Deputy State Coroner O'Neil's explanation of the status of an issues list in *Winchester,* submitting the following "core principles" apply:[111]

    i. An issues list does not have any legal or statutory status; it is a document circulated prior to an inquest to foreshadow issues that might be explored by counsel assisting in the course [of] an inquest.

    ii. An issues list does not delimit the scope of an inquest and it can neither enlarge nor restrain a coroner's jurisdiction.

    iii. Issues may rise or fall away as evidence unfolds during the course of the inquiry, even at a late stage of proceedings.

    iv. An issues list is distributed as a matter of procedural fairness to advise participants of matters that may arise on the evidence.

95. Counsel Assisting submitted that it was a misunderstanding of the coronial jurisdiction to assert, as the Commissioner appeared to have done, that there is an inquisitorial phase that ends prior to the inquest, and then a curial phase of an inquest where further inquiries cannot be undertaken. Counsel Assisting drew my attention to authorities "*where courts have repeated that issues may arise throughout the inquest*".[112] Counsel Assisting cited the decision of Northern Territory Coroner, Judge Armitage, in *Kumanjayi Walker (Ruling No 2)*, [2022] NTLC 017, including the following passages:[113]

[111] CAWS at [58] citing *Winchester* at [32].
[112] Transcript 17/10/24 p 749 ln 34-41.
[113] CAWS at [60]; Transcript 17/10/24 p 749 ln 45-50.

> "[13] As the Full Court of the Supreme Court of the Australian Capital Territory noted in *R v Doogan; Ex parte Lucas-Smith*, [(2004) 157 ACTR 1], one difficulty with trying to conclusively determine the scope of an inquest at its outset is that it may 'become apparent ... that an issue identified in the list early in the proceedings was no longer relevant at the conclusion of the evidence.'[*R v Doogan; Ex parte Lucas-Smith* (2004) 157 ACTR 1, [13] (Higgins CJ, Crispin and Bennett JJ)]. Equally, evidence may emerge late in the inquest that may give rise to new issues. In light of the investigative character of an inquest, [*Domaszewicz v State Coroner* (2004) 11 VR 237, [81]] this is not surprising. In *Doogan*, the Full Court continued:
>
> > "…the mere admission of evidence that appears to canvass a range of issues extending beyond those specified in [the *Coroners Act*] does not demonstrate any error of jurisdiction. Indeed, a liberal approach to the potential relevance of evidence may sometimes be appropriate, particularly in the early stages of an inquiry when the Coroner is still seeking to identify what issues are likely to arise. [*R v Doogan; Ex parte Lucas-Smith* (2004) 157 ACTR 1, [34] (Higgins CJ, Crispin and Bennett JJ]"…

96. Counsel Assisting also referred me to the decision of Beach J in *Thales Australia Limited v Coroner's Court* [2011] VSC133 where his Honour said it was premature to object to evidence yet to be called where the question of what comment or recommendation might be permissible as a result of that evidence is not yet capable of determination. His Honour's reasoning includes:[114]

> "It is, at this stage, hypothetical to consider whether the calling of a particular witness or particular evidence might infringe the prohibition on not inquiring for the sole or dominant reason of making a comment or recommendation. Similarly, it would be premature to speculate on whether any particular evidence that might or might not be called might or might not be 'connected with the death".

Application of principles to facts of the Inquest

97. In relation to the draft issues list for the Inquest, Counsel Assisting submitted that "the circumstances of Ms Shipley's entry into custody became more rather than less relevant" as the Inquest progressed,[115] stating:

[114] Transcript 17/10/24 p 750 ln 1-19.
[115] CAWS2 at [37].

> "As the hearing of the Inquest proceeded, and the issues were explored, matters connected with [Ms Shipley]'s death which involved the actions and policies of the NSWPF were both illuminated and refined."[116]

98. Counsel Assisting submitted that there are several reasons why the interaction between the NSWPF and Ms Shipley may be relevant to manner of death, and to the recommendations function of the Court, noting that the Court will not be able to reach a concluded view until the evidence is heard.[117]

99. Firstly, Counsel Assisting submitted that:

    a. "The evidence is persuasive that on 9 December 2022, the date of [Ms Shipley's] arrest and detention into NSWPF custody, [she] was suffering from chronic schizophrenia and bipolar disorder and was in an acute phase of her illness";[118]

    b. "[t]hat acute phase of [her] illness continued from her arrest until the date of her death";[119] and

    c. that the NSWPF may have "missed an opportunity to divert [her] from the criminal justice system" and back into the mental health care system either by "having her scheduled, or by providing information to the Magistrate who could have considered that in making a determination on bail and access to legal representation."[120]

100. Counsel Assisting noted the evidence of the expert psychiatrist A/Prof Sullivan and submitted that there is no expectation that NSWPF officers would have known of Ms Shipley's mental illness by her presentation on 9 December 2022 alone.[121] However, she pointed out that NSWPF records included references to previous occasions when NSWPF officers had dealt with Ms Shipley when she was mentally ill, which may have provided police with information relevant to her presentation on 9 December 2022, and to subsequent treatment and care that she could have had access to.[122]

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[116] CAWS2 at [8]; Transcript 17/10/24 p 750 ln 32-35.
[117] CAWS at [62].
[118] CAWS2 at [9] and [33].
[119] CAWS2 at [10].
[120] CAWS at [63]-[64].
[121] CAWS2 at [11]-[13].
[122] CAWS2 at [38].

101. Second, Counsel Assisting submitted that it was a mistake by police to record on Ms Shipley's 'Custody Management Record' on 9 December 2022 that she had no history of mental illness when she clearly did, and that information was available from a search of police records. Counsel Assisting pointed out that it is not yet clear why the Custody Management Record appears to have been completed incorrectly by a NSWPF officer at the watch house.[123] Prior to her arrest on 9 December 2022, Ms Shipley had interactions with NSWPF officers three times in 2022 alone where her mental health issues were apparent and required intervention.[124]

102. Third, Counsel Assisting submitted that the error made by police means that documentation provided to CSNSW about Ms Shipley's mental health was incomplete and that information is utilised by CSNSW intake staff.[125] Even if it did not ultimately make a difference to Ms Shipley (because CSNSW staff eventually found out about Ms Shipley's schizophrenia from a review of their own records), the failure to pass on accurate police history may be the subject of a recommendation, and relevant to the coroner's death prevention function.

103. Fourth, The NSWPF Criminal History Bail Report located on the Court file in relation to the H76115633 offences stated "POLICE BAIL: BAIL CONDITIONAL". Counsel Assisting asserted that the NSWPF prosecutor appearing at Campbelltown Local Court on 14 December 2022 did not alert the Magistrate to the fact that Ms Shipley had been issued a detention application for breach of bail in relation to the H76115633 offences. That meant that the Magistrate laboured under the incorrect belief that "as far as [they were] concerned, that should mean [she would] be released" on 14 December. It is still not clear why that occurred and the Court may have been "misled by the documentation".[126]

104. Fifth, Counsel Assisting submitted that the Court may decide to make recommendations that "might prevent Aboriginal deaths in custody", noting I have power to make recommendations that are deemed to be "necessary or desirable"[127] and stating I may;

[123] CAWS at [65] citing Tab 44A: Statement of SC Tracey Evry and Tab 45: Custody Management Record – Campbelltown Police Station.
[124] Transcript 17/10/24 p 753 ln 39-42.
[125] CAWS at [66]-[67] citing Transcript 17/09/24 p 111 ln 21 – p 112 ln 2; p 116 ln 1-18; Transcript 17/10/24 p 753 ln 17-24.
[126] CAWS2 at [34]-[36] and [39]; see also CAWS3 at [9]-[13].
[127] CAWS2 at [40]-[42]; see also Transcript 17/10/24 p 756 ln 49 – p 757 ln 14.

> "…be interested in recommendations that may assist police to divert persons suffering from mental illness from the custodial system, or at the very least, to ensure that they pass on accurate information that will assist a subsequent decision maker."[128]

105. Counsel Assisting noted the publication of the NSWPF report "*Summary Internal Review of the NSW Police Force response to mental health incidents in the community*" and asserted it "underscores the prevalence of contact between police and mentally ill, mentally disordered and mentally disturbed members of the community", suggesting Ms Shipley is one such community member who may have benefited by referral to another agency with better expertise to deal with her mental illness.[129] Counsel Assisting asserted that the purpose of the request to the NSWPF is to understand what options were, or should have been, available to police to assist Ms Shipley with her mental health care that might have helped to prevent her death in custody, "to determine if there were missed opportunities to better care for her, and to support any recommendations that might assist someone in [Ms Shipley's] position (and Police's) in the future."[130]

Counsel Assisting's Response to the Submissions of Commissioner of Police

106. In response to CoPWS, Counsel Assisting submitted it was incorrect to suggest that the involvement of mental health providers who treated Ms Shipley prior to her arrest were too remote to "require a sufficient interest" letter. Counsel Assisting noted that a sufficient interest letter had been sent to (amongst others) the My Doctors Medical Centre where health practitioners had treated Ms Shipley in the months prior to her death, and to the South West Sydney Local Health District. Further some of those practitioners had given evidence and each acknowledged they may have missed opportunities to assist Ms Shipley, exemplifying the importance of a Coroner "taking a wider lens" and considering recommendations that lead to systemic change and death prevention.[131]

107. Counsel Assisting acknowledged that inquests should not be permitted to become a 'roving royal commission' but argued that it was misconceived to suggest there was a danger of that in this case, where the focus on NSWPF

[128] CAWS at [69].
[129] CAWS at [70]-[72].
[130] CAWS at [72]-[73].
[131] CAWS at [74]-[76]; CAWS2 at [44].

related to a short time period of 9 December 2022 when she was last arrested by police (only 11 days before Ms Shipley's death), through to 14 December 2022, the last date she appeared in Court, only six days before her death. That was a date when Ms Shipley was unrepresented and in circumstances where the police prosecutor appeared before the Court and would have provided certain information to the Magistrate.[132] The Magistrate disposed of the matter believing, on the basis of the information before him, that he was releasing Ms Shipley from custody.

108. In relation to the citing of *Harmsworth* by Counsel for the Commissioner, Counsel Assisting submitted that that there was a further relevant paragraph of that decision which indicates the Court was "*not suggesting a strictly narrow line of inquiry"*. That paragraph is as follows:[133]

> "If the coroner has come to a preliminary view that frustration and anger induced the prisoners to build the barricades and disrupt the air-conditioning system and that, in turn, led Wright to ignite the barricade and suffocate himself and his companions, then the sources of that frustration and anger could provide a line of enquiry, which is within the coroner's jurisdiction. Namely, that the frustration and anger led to dangerous behaviour resulting in death. However, I take that issue no further, it is for the coroner."

109. Counsel Assisting accepted that the Court in *Harmsworth* was highlighting circumstances in which an inquest might be deemed to include issues that are so remote that they are beyond scope, but in Ms Shipley's case the Court is "*not inquiring into the various sociological factors, at length, that led [Ms Shipley] coming into custody*".[134]

110. In response to the assertion in CoPN1 and CoPN2 that the Police Prosecutor may not have been in the courtroom at the Campbelltown Court Appearance, Counsel Assisting submitted that submission "is neither logical, nor helpful to the Court". Counsel Assisting submitted that:[135]

[132] Transcript 17/10/24 p 749 ln 24-33.
[133] Transcript 17/10/24 p 751 ln 14-18 citing *Harmsworth* at p 989.
[134] Transcript 17/10/24 p 751 ln 26-32.
[135] CAWS3 at [7]-[11].

a. first, it is open to the Coroner to take judicial notice of the fact that the proceedings to hear the criminal charges against Ms Shipley would not have continued without the prosecutor present at the bar table;

b. second, the Bench Coversheet indicates that a Prosecutor with a surname of "Sanders" was present at the Campbelltown Court Appearance; and

c. third, as criminal prosecutors in the Local Court are employees of the NSWPF, it is within the purview of the NSWPF to establish whether their own Prosecutor was present at the Campbelltown Court Appearance and to assist the Coroner in relation to that issue.

111. Finally, Counsel Assisting submitted that there is no dispute that I have jurisdiction to hold the Inquest (in fact it is a mandatory inquest) and the authorities make it clear that the scope of the Inquest, although not unlimited, is a matter over which I have broad discretion, guided by common sense.[136] Furthermore "[t]hat jurisdiction extends to examining the circumstances of [Ms Shipley's] arrest and imprisonment in December 2022, and her likely mental health condition at the time".[137]

112. Counsel Assisting submitted: "*It is clearly within a common sense test to look at the circumstances in which [Ms Shipley] came to be in custody since they are directly relevant to her death 11 days later.*"[138] Counsel Assisting explained how this is supported by the evidence of the expert psychiatrists Dr Large and A/Prof Sullivan, submitting:[139]

> *"The expert panel of psychiatrists who was called – Dr Large and Dr Sullivan - agree that [Ms Shipley] had suffered from a chronic mental illness for well over a decade, and that illness was schizophrenia. It manifested itself in various ways, including psychosis and depression. The experts agree that [Ms Shipley] was mentally ill or mentally disturbed when she entered into custody. She was in an acute phase of her psychosis.*

[136] CAWS at [77]-[78]; Transcript 17/10/24 p 751 ln 42-47.
[137] CAWS2 at [37].
[138] Transcript 17/10/24 p 751 ln 42-47 and p 757 ln 17-25.
[139] Transcript 17/10/24 p 751 ln 49 - p 752 ln 41.

They agree that she died as a result of behaviour that was directly linked to her psychosis, her schizophrenia. They agree that she could not have received good treatment for her schizophrenia in the MSU, the Mum Shirl Unit, in custody. They agree that she would've received better treatment in the community.

They agree that [Ms Shipley]'s presentation on 9 December 2022, 11 days before she died, could be attributed to her depressive condition – it was a depressive phase of the bipolar; so she was unwell. They agree that her psychosis would not have been obvious or may not have been obvious to police at face value – that is, the presentation itself did not reveal, necessarily, the psychosis. They also gave evidence then that underscores the need to check the record and history – that is, to have access to mental health history that might tell you more about [Ms Shipley]'s circumstances - and to make that record available to subsequent decision makers.

Those subsequent decision makers included NSW Police who were dealing with [Ms Shipley] on 9 December, but also the police prosecutor who was dealing with her at the bail court and subsequently including on 14 December, and the Magistrate…

[Ms Shipley]'s case was before the Magistrate on 10 December, on 12 December and on 14 December. On 14 December, the Magistrate who was sentencing [Ms Shipley] for her shoplifting offence and trespass on one day, believed that he was releasing her. He became aware of her mental health condition because [Ms Shipley] mentioned it. She said that she would, on release, go straight and get her buprenorphine. She explained that her mental health deterioration related to her coming off buprenorphine, and [his Honour] said: "As far as I am concerned, this means that you can be released" – and he was not corrected on that day.

Now, that issue is an issue that has emerged throughout the course of the inquest, but it is an issue that concerns New South Wales Police because there was a police prosecutor at the Bar Table…"

113. Furthermore, in relation to "*issues that emerged during the course of the Inquest*", Counsel Assisting stated;

"*Applying a common sense test, they could not be remote, and what the case law suggests is that there is considerable discretion for your Honour when you are applying that common sense test*."[140]

114. Counsel Assisting asserted that the Inquest "is being run in a way that is conscious of the jurisdictional limits and is confined and sensible" and that "the nature of the inquiry is clearly within scope".[141]

115. Consequently, Counsel Assisting submitted I should dismiss the Application.[142]

Family Submissions

116. The Aboriginal Legal Service, appearing on behalf of Ms Shipley's mother Vicki and her family ("the Family") made oral submissions at the hearing of the Application.

117. In relation to a Coroner's jurisdiction, the Family relied on the written and oral submissions of Counsel Assisting, submitting that Ms Shipley's "*arrest and detention by New South Wales Police was the first of a series of inextricably connected events by government institutions that failed [Ms Shipley] at the end of her life*".[143]

118. In relation to Ms Shipley's presentation at the time of her arrest, the Family submitted that the Commissioner's assertion that arresting police would not have immediately identified she was suffering a mental illness, selectively addressed the evidence adduced at the Inquest.[144]

119. The Family asserted that the NSWPF had "both longitudinal and recent institutional knowledge about Ms Shipley's mental health" which should have informed decisions police made in relation to her. Mr Rees stated:

"*The failure of police dealing with [Ms Shipley] on 9 December through to the police prosecutors in court, to have regard to or even be aware of [Ms Shipley's] known mental health history, means that opportunities were lost to make better informed decisions.*"[145]

[140] Transcript 17/10/24 p 762 ln 1-4.
[141] CAWS at [77]-[78].
[142] CAWS at [79]; CAWS2 at [45]; CAWS3 at [15].
[143] Transcript 17/10/24 p 758 ln 25-27.
[144] Transcript 17/10/24 p 758 ln 27-39.
[145] Transcript 17/10/24 p 758 ln 44-47.

120. In relation to the Commissioner's reliance on the authority of *Harmsworth* as to the relevance of sociological factors to a person's imprisonment, the Family submitted that it was the information the NSWPF possessed and what they "did or didn't do" with that information that was relevant, as opposed to "matters intrinsic to" Ms Shipley. More specifically:[146]

> "…*how do police use known information about a person's mental health to better inform decisions they make? How does that information get communicated within the [NSWPF] to inform downstream decision making in the justice system by legal representatives, police at court, the courts, judicial officers, [CSNSW] and [JHFMHN]?"*

121. The Family asserted that the statement "*Police are not aware of any drug or mental health issues of the accused*" which appears in the NSWPF Fact Sheet[147] for Ms Shipley's offending is false and it:

> *"…fails to inform, misrepresents, and has the potential to mislead people reading the document. That includes legal representatives who [Ms Shipley] refused to engage with but likely would have been provided with that document, [JHFMHN] staff at court, police prosecutors and the magistrates who dealt with [Ms Shipley's] matters.*"[148]

122. The Family further submitted that:

> *"Had [Ms Shipley's] mental health history been accurately recorded in the fact sheet, there was an opportunity to a legal representative who would have read it to make the magistrate, [JHFMHN] or [CSNSW] aware. The same is true of the police prosecutor who appeared on each of the occasions [Ms Shipley's] matters were before the court*.
>
> *The magistrate, properly informed, may have referred [Ms Shipley] to [JHFFMHN] or endorsed a warrant to be assessed for mental illness and medication on entry into [CSNSW's] ... There was a lost opportunity for each of those institutions to consider the known information and make more informed decisions on how to care for [Ms Shipley]. It could've affected the timeliness of any intervention.*"[149]

123. In relation to the use of information by the NSWPF, the Family submitted "*the Inquest is silent as to how police are trained to access, use and communicate*

[146] Transcript 17/10/24 p 758 ln 49 p 759 ln 11.
[147] Tab 42: Offence Details – H76115633.
[148] Transcript 17/10/24 p 759 ln 15-21.
[149] Transcript 17/10/24 p 759 ln 36-48.

information held by police information systems"[150] and the fact that Ms Shipley was sentenced in her absence on 12 January 2023, at Campbelltown Local Court, exemplifies there is a problem. The Family asserted no one, including the police prosecutor, notified the Court that day of Ms Shipley's death, even though the NSWPF had commenced investigating it some three weeks earlier.[151]

124. Ultimately the Family submitted that exploring issues in relation to the NSWPF's involvement in the matter "*may inform recommendations for change to ensure somebody in [Ms Shipley's] position in the future is better cared for*."[152]

Decision

125. Having carefully considered the written and oral submissions of Counsel for the Commissioner, I have determined to dismiss the Application. I decline to make the orders sought by the Commissioner as set out above at paragraph [32]. That is:

    a. I decline to order that any investigation into:
        i. the appropriateness of the NSWPF's interactions with Ms Shipley;
        ii. its institutional frameworks for dealing with persons suffering from mental illness; and
        iii. any similar investigation into the NSWPF;

        is excluded from the scope of the inquest into the death of Ms Tammy Michelle Shipley; and
    b. I decline to order that the request for documents and a witness statement made to the NSWPF on 16 August 2024 is withdrawn.

Reasons for my decision

The Court has jurisdiction

126. The powers of the Court are governed by the *Coroner's Act 2009* (NSW) *(the Act)*.

127. As Counsel Assisting submitted, since Ms Shipley died while she was in custody, this is a mandatory inquest. Section 23(1)(a) of *the Act* provides that a senior

[150] Transcript 17/10/24 p 759 ln 23-24.
[151] Transcript 17/10/24 p 760 ln 12-19.
[152] Transcript 17/10/24 p 760 ln 7-10.

coroner has jurisdiction to hold an inquest concerning the death of a person while in the custody of a police officer or in other lawful custody; s. 23(1)(d)(ii) provides that a senior coroner has jurisdiction where there has been a death in a correctional centre and 27(1)(b) of *the Act* provides that an inquest concerning the death of a person in custody "is required to be held" in those circumstances.

128. I must fulfil the functions provided for in *the Act*. As set out above, s. 81 of *the Act* requires me to make findings as to Ms Shipley's identity, date, place, manner and cause of death.

129. It is well recognised that "cause of death" relates to the medical or physical cause, while "manner of death" is a term that "should be given a broad construction so as to enable the coroner to consider by what means and in what circumstances the death occurred".[153]

130. Clearly the scope of my inquiry is not unlimited. As Nathan J warned in the decision of Harmsworth, inquiries must be directed to the statutory findings I am required to make and I must be careful not to embark on an inquiry that might never end, or one where I might never be able to make coherent and concise findings.[154] I am aware that I do not have the powers of a "roving royal commission" and I have been reminded of the warnings issued in *Doogan* against attempting such an inquiry.[155]

131. While the authorities referred to above make it clear that the scope of an inquest is not unlimited, there is also ample authority to the effect that I have considerable discretion to determine the scope of my inquest. The learned authors of *Waller's*, the leading NSW text book on the Coroner's jurisdiction, note that it is important that "manner of death" not be too narrowly construed.[156] I accept, as did State Coroner Barnes in the *Lindt* decision cited above, that this was well expressed by the authors of another leading Australian text on coronial matters when they said: "The question is one of remoteness and is not readily susceptible to definition".[157]

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[153] *Conway v Jerram* (2010) 78 NSWLR 689.
[154] *Harmsworth v the State Coroner* [1989] VR 989.
[155] *Harmsworth v the State Coroner* [1989] VR 989.
[156] Waller's, Coronial Law and Practice, 4th Ed., 81.19.
[157] Death Investigation and the Coroner's Inquest, Freckleton and Ranson, Oxford University Press, Melbourne 2006, 548, cited in the *Lindt* decision at [16].

132. Further, it is appropriate to recognise (as did State Coroner Barnes in the *Lindt* decision) that a Coroner may need to investigate matters wider than the issues on which they will ultimately make statutory findings. In *Atkinson v Morrow* [2005] QSC 92 Mullins J stated:[158]

> "That the scope of the inquest is for the purpose of establishing those matters (the findings) does not limit the evidence to that which is directly relevant to those matters. It is obvious that it may be necessary for evidence of a broader nature to be adduced before the coroner for the purpose of assisting the coroner to reach a conclusion on the specific matters on which findings are required".

133. Similarly, in *Doomadgee v Clements*,[159] in referring to the provisions in the Queensland *Coroners Act*[160] (s. 45) that correspond to s. 81 of the NSW *Coroners Act*, Muir J held that the scope of the inquiry under s. 45 is extensive and not confined to evidence directly relevant to the matters listed in s. 45(2).

134. It clearly emerges from the principles and authorities referred to above that an issue does not need to be directly causative of the death to be within the permissible scope of an inquest. It is clear from the authorities that "manner" has different content to "cause" and, in appropriate circumstances the exploration of manner may go beyond exploration of causative matters.[161]

135. This is consistent with the wording of *the Act*, and the Coroner's obligation to conduct a thorough investigation and pursue reasonable lines of inquiry to determine in what circumstances the death occurred. As Deputy State Coroner O'Neil stated recently in *Winchester*, "[t]here is a significant public interest in the Coroner conducting a thorough public inquiry". The importance of a thorough investigation for a death that occurs in custody is highlighted by the legislative provision that an inquest into a death in such circumstances is mandatory.

136. The scope of an inquest depends on all the circumstances of the case and requires the coroner to exercise discretion and to use "common sense" in determining the line beyond which it is not appropriate to inquire.

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[158] *Atkinson v Morrow & Anor* [2005] QSC 92 [30], cited by State Coroner Barnes in the *Lindt* decision at [18].
[159] [2006] 2 Qd R 352.
[160] *Coroners Act 2003* (Qld)
[161] A point made by Coroner O'Neil in *Winchester* at [88].

137. I accept the submission made by Counsel Assisting that it is within "a common sense test" and not beyond the scope of my jurisdiction, to look at the circumstances in which Ms Shipley came to be in custody.

138. On 20 December 2022, 11 days after Ms Shipley was arrested by NSWPF officers and entered custody, she died in the MSU at SWCC, ostensibly from complications arising from her mental illness. The institution of the NSWPF had information about Ms Shipley's history of mental illness, including her recent mental ill health, and had recorded that information, although, for reasons I wish to inquire into, that may not have been known to the relevant officers who were involved in dealings with her on 9, 10 and 14 December 2022.

139. I am satisfied that an examination of the events that led to Ms Shipley's arrest and imprisonment in December 2022, including her likely mental health condition at the time and examination of the appropriateness or otherwise of the NSWPF's interactions with Ms Shipley (including on 9, 10 and 14 December) is within permissible scope of this inquest and as such within jurisdiction.

140. At paragraphs [97]-[105] above, I have summarised the argument of Counsel Assisting in relation to the ways in which the information sought from the NSWPF is relevant to the 'manner' of Ms Shipley's death, or in other words, the circumstances surrounding her death.

141. I accept that the interaction between members of the NSWPF concerning Ms Shipley are within my jurisdiction. Specifically, I accept that there are legitimate lines of inquiry in relation to:

    a. First, with respect to the interaction between members of the NSWPF and Ms Shipley on 9 December 2022 when Ms Shipley came into custody. Although it is understandable that NSWPF officers dealing with her did not immediately recognise that she was mentally ill or mentally disordered, it is not clear to me why the custody records were marked as if she had no history of mental illness when the NSWPF as an institution had numerous and recent dealings with Ms Shipley where she was mentally ill, and her history of mental illness was well documented on NSWPF records.

b. Second, on 10 December 2022 when a police prosecutor appeared to assist the bail Court, the records handed to the Court by the police prosecutor do not refer to Ms Shipley's mental health issues and there is no mention of that important fact in Court. Ms Shipley appeared in Court unrepresented and declined to apply for bail, in circumstances where she may have been too mentally ill to make any informed decision in relation to representing herself or applying for bail. I note that she was not bought before the Court on 11 December 2022 and received a medical certificate deeming her to be too mentally unfit to attend court on 12 December 2022.

c. Third, on 14 December 2022, Ms Shipley was again before the Court. Again, she represented herself and so did not have any advocate there to assist her, or to assist the Court on her behalf. An audio recording of her Court appearance reveals that Ms Shipley was able to inform the Court about some aspects of her mental ill health. The NSWPF Criminal History Bail Report stated that Ms Shipley had conditional bail on another matter (H76115633). The Magistrate then sentenced Ms Shipley for the offence before him and determined that as far as he was concerned, she would be released from custody, but his Honour did not know, and was not informed by the police prosecutor, that Ms Shipley no longer had bail on the offence under H76115633, a minor shoplifting charge. Contrary to the apparent intentions of the Magistrate presiding on 14 December 2022, Ms Shipley was further detained and died in custody 6 days later in circumstances where (according the expert panel of psychiatrists) she could not get adequate treatment for her mental health condition and died as a result of it.

142. I also accept that there are matters related to the circumstances in which Ms Shipley came to be in custody that may be the subject of recommendations aimed at preventing the loss of life of others in a similar situation. Tragically, deaths in custody are all too common in the Coroners Court in this State, and Aboriginal people in particular continue to be overrepresented in the numbers of deaths. They are not just numbers to the families of loved ones grieving deeply for their loss and striving to understand if there are lessons to be learnt that might

save other families from experiencing that grief. As Counsel Assisting said in her opening of this inquest:

> "*"[W]e recognise that this inquest is one of too many where the Coroner is tasked with investigating the death of an Aboriginal person in custody. Thirty years on from the Royal Commission into Aboriginal Deaths in Custody, Aboriginal people are still massively over-represented in prisons in New South Wales and around the country. And we know that it is a source of pain for [Ms Shipley]'s family and to many other Australians. It is important to understand why [Ms Shipley] was in custody* …"[162]

143. It will be evident from this ruling that I reject the submission of Counsel for the Commissioner that one reason I should not inquire into the circumstances of Ms Shipley's court appearance on 14 December 2022 is that I could not be satisfied that a NSWPF prosecutor was present (or at least available) to assist the Court on 14 December 2022. The Commissioner asserts that it would be unsafe to make a finding in relation to the prosecutor being present on the basis of the information available to me at this time. It is clear from the Court papers that the name of a particular person was recorded on Ms Shipley's papers as someone who was the prosecutor in the matter. I have taken judicial notice of the fact that criminal matters should not proceed in the absence of a police prosecutor who is there to, inter alia, hand up the facts and record, and to assist as required. In any event, although the evidence strongly suggests a police prosecutor would have been available to assist the Magistrate on 14 December 2022, I have not reached a definitive conclusion on that issue at this stage. I intend to ask my Counsel Assisting team, and the Officer in Charge of the coronial investigation, to make the further necessary inquiries to clarify, if possible, the role and responsibilities of the prosecutor on that date.

144. Counsel for the Commissioner submitted that where an inquest is entering its "curial phase … there should already have been a substantial investigatory stage by which the Coroner obtains some knowledge of the issues".[163] Counsel for the Commissioner submitted that at the time of the Application "proceedings [were]

[162] Transcript 16/10/24 p 3 ln 46 – p 4 ln 2.
[163] CoPWS at [30].

no longer at a nascent stage; the curial stage of the proceedings [was] almost complete".[164]

145. Clearly there was a significant investigative stage in the Inquest before I commenced the hearing, leading to the production of a substantial brief of evidence, numerous witness statements, a draft issues list and a witness list. That does not mean, however, that the investigation or inquiry phase must cease when the hearing begins.

146. First, while it is true that a substantial part of the investigating is done before the inquest starts, it is the very nature of an inquiry that some issues emerge as the inquest/inquiry takes place. Unlike criminal cases, where the accused is entitled to know the case before it commences, or a civil matter where there are strict pleadings, an inquest is a jurisdiction that allows for an investigation, consistent with the "objects" of *the Act* set out in section 3.

147. Second, there is a good reason why courts have warned against prematurely determining all the issues before the hearing has commenced, since evidence being exposed and explored during the inquest may lead to certain issues being refined, or revealed, while others fall away. In the case of *Doogan*, cited above (and often during discussions on scope), the ACT Supreme Court stated that "*[e]ven when the inquiry has been formally convened and evidence is being adduced, the coroner may still be engaged in an investigation of potential issues, the scope of which will not have been defined by pleadings. Issues may continue to arise and be progressively clarified and refined …*". Similar comments were made by the Northern Territory Supreme Court in *Bauwens*, cited above. I accept, as Counsel for the Commissioner has said, that these are not binding authorities, but they are decisions that accord with a sensible reading of the relevant legislation, and a proper understanding of the nature of the coronial jurisdiction.

148. Third, one of the very reasons for some of the unanswered questions at the commencement of this inquest is that the NSWPF declined to provide the policies and procedures requested by the CSO on my behalf and declined to provide a statement of a senior officer. Instead, the Commissioner bought this application.

[164] CoPWSR at [8.3].

I am not critical of the decision to bring the Application, but it can hardly be suggested that my curial stage is almost complete, when I do not yet have all the information that I have sought to inform me.

149. Fourth, this case is an excellent example of the way in which some matters crystallise during the course of an inquest, while others assume less significance. It became increasingly evident to me that there may be real systems issues revealed by Ms Shipley's appearances at Court on both 10 and 14 December 2022.

150. A review of the custodial records shows that Ms Shipley was extremely mentally unwell when she left NSWPF custody and entered into the custody of CSNSW on 9 December 2022, and she remained mentally unwell until her death 11 days later. Yet on 10 December 2022, a day after she was taken into police custody, she appeared in the bail court unrepresented in circumstances where it is appears on the face of the transcript that the Magistrate was not informed of her mental health issues. The police prosecutor present makes no mention of her mental health issues. On 14 December 2022, Ms Shipley herself told the Magistrate of some of her mental health troubles and he sentenced her in a way that he said would allow her to leave custody. It is obvious from the face of the record that his Honour believed she had bail on another minor shoplifting charge and could be released. Again, Ms Shipley was not legally represented by someone who could advocate on her behalf.

151. As Counsel Assisting has repeatedly sought to emphasise, inquests are not adversarial and the inquiries directed to the NSWPF are not aimed at criticising its members, but rather at identifying opportunities to improve the care of persons who come into the custody of the NSWPF or CSNSW.[165]

[165] See for example Transcript 16/10/24 p 22 ln 16-19.

Orders

152. The Application is dismissed.



Magistrate Teresa O'Sullivan

State Coroner

Coroners Court of New South Wales

16 January 2025

ANNEXURE "A"

Inquest into the death of Tammy Michelle Shipley

CSO Ref: 202203874 | Court Ref: 2022/384929

Unofficial Transcript[1]

Parramatta Local Court: Saturday 10 December 2022

- **P1:** Unknown prosecutor #1
- **M1**: Unknown male #1
- **M2**: Unknown male #2
- **MA**: Magistrate
- **TS**: Tammy Shipley

Timestamp	Name	Transcription
0:11	P1	Are you with one of these? Are you Ms Shipley?
0:13	M1	No.
0:14	M2	No.
…	…	*(Paper shuffling and discussion re other matters)*
2:52	MA	Right, is this Ms Shipley?
2:54	TS	Speaking.
2:55	MA	Right Ms Shipley I'm told your representing yourself, is that right?
2:59	TS	That's right.
3:00	MA	Right are you applying for bail today?
3:02	TS	Um yes.
3:03	MA	Right, um, I'll read the facts and records Sergeant.
3:06	P1	Yes your Honour, I'll hand up those.
3:08	MA	Thank you.
3:09	TS	Yeah no I don't want bail.
3:11	MA	You don't want bail?

[1] Unofficial Transcript prepared by the NSW Crown Solicitor's Office. To be considered an aide-memoire to the audio recording..

3:12	TS	No I don't want bail.
3:15	MA	So you want to stay in custody?
3:16	TS	Yeah I want to stay in custody.
3:18	MA	Alright. Sergeant what's the proper venue for this?
3:22	P1	Ahh, Campbelltown your Honour.
3:24	MA	Alright I'll have your papers…
3:26	TS	Why am I in the Children's Court?
3:28	MA	Pardon?
3:29	TS	Why am I in the Children's Court?
3:30	MA	Because that's where we do the Bail Court from, you'll be at Campbelltown on Monday alright. That's Monday the 11th of December and you'll be on screen there nice and early in the morning I hope alright. Thanks Ms Shipley you can go outside the room now.
…	…	*(no speaking)*
3:56	MA	In relation to the detention application I'll simply mark it not challenged.
4:00	P1	Yes your Honour.

ANNEXURE "B"

Inquest into the death of Tammy Michelle Shipley

CSO Ref: 202203874 | Court Ref: 2022/384929

Unofficial Transcript[1]

Campbelltown Local Court: Wednesday 14 December 2022

- **MA**: Magistrate
- **TS**: Tammy Shipley
- **F1**: Unknown female #1

Timestamp	Name	Transcription
00:00	MA	… lawyer is that correct?
00:01	TS	No that's correct, I just wanna represent myself, I shouldn't really be here I made a mistake.
00:05	MA	Okay, that's fine. Um, you're entitled to represent yourself. Now, Ms Shipley I have two charges before me today, and I'm gonna read those charges to you and ask you whether you can enter a plea of guilty or not guilty to the charges.
00:22	TS	Yep.
00:23	MA	The first, first charge alleges that on the 9th of December this year, at Macquarie Fields you did without lawful excuse enter into the inclosed lands of Glenquarie Town Centre, situated Harold St Macquarie Fields without the consent of the Glenquarie Town Centre, the owner of the said inclosed lands. I, I'm assuming what that means is that you had a banning notice from there...
00:46	TS	No I was only banned from Target I wasn't banned from the mall.
00:50	MA	Yeah well it, it, it says here, the whole Glenquarie Town Centre…

[1] Unofficial Transcript prepared by the NSW Crown Solicitor's Office. To be considered an aide-memoire to the audio recording.

00:56	TS	I, now, I am now um banned from the mall but at the, at the time I was only banned from Target, and I did go into Target.
01:04	MA	Oh okay, you did go into Target so you…
01:06	TS	Yeah I just wanted to get some clean clothes because I had a daughter at home and her, and her baby detoxing from Ice and I just wanted some clean clothes for us.
01:14	MA	Okay, so you're pleading guilty with an explanation are you?
01:17	TS	Yep, yep.
01:18	MA	Thank you. I'll note that. And the second charge alleges that, on the 9th of December this year at Macquarie Fields you did steal certain property, the value of 23 dollars 10 cents. Namely a rolling pin, kitchen knife and a 70, 750ml bottle of olive oil, olive oil the property of Woolworths. How do you…
01:41	TS	Yep.
01:42	MA	…plead to that?
01:43	TS	Yep guilty.
01:44	MA	Thank you. Now I'm gonna have a look at the, the facts and your criminal record now and I'll…
01:51	TS	Yep, thank you.
01:51	MA	…see whether I can finalise it now or not.
01:56	TS	I hadn't had any, can I just say I hadn't had any Bupe for a week and I went into like a small psychosis, and I …
02:01	MA	Okay.
02:02	TS	…I thought someone was after me and I wanted to just be safe so I went to Woolworths to get charged.
02:06	MA	Okay.

02:07	TS	So I could come here and be safe.
02:08	MA	Okay well I'll…
02:09	TS	And I'm alright with my head now.
02:11	MA	Okay, well I'll just read these and I'll hear what you've got to say.
02:15	TS	Okay thank you.
02:16	MA	Um, I think I can say safely those other matters two o'clock.
02:21	F1	Thank you your Honour.
…	…	*(Discussion continues re another matter)*
03:00	…	*Silence*
03:32	TS	Sorry your Honour I was, um in, I was barred from the mall.
03:35	MA	Yeah that's, that's alright, I've just read the facts. That's Okay.
03:38	TS	Yep.
03:39	MA	When you went in there they've, they've barred you from the mall then you went back in.
03:42	TS	Yep, yep.
03:43	MA	Thank you.
03:47	TS	Because I felt unsafe in the community.
03:49	MA	Okay.
03:50	…	*Silence*
04:06	TS	I'm really hoping to get home to my granddaughter detoxing off Ice.
04:12	MA	Okay, just let me have a look. I'm reading your criminal record now.
04:16	TS	Yep thank you.
04:17	…	*Silence*
04:54	MA	Okay.
04:56	…	*Silence.*

05:09	MA	You've been in custody since err, you were arrested at 6pm on the 9th of December, correct?
05:17	TS	9th of December?
05:19	MA	9th of December you were arrested and you've been in, been in custody since.
05:24	TS	Ah yeah this, yeah, yep that's correct.
05:31	MA	So that was last Friday.
05:32	TS	Yep, that's correct.
05:41	MA	Okay.
05:42	TS	The pretty much reason why it all happened is because I didn't have the money to pay for my Bupe and it sent me into like a little psychosis.
05:49	MA	Okay, it looks like you…
05:52	TS	So from here, from here I'd go straight to the doctors and get straight back on it.
05:56	MA	Okay, you were out of, out of trouble for about 6 years and then you had a…
05:59	TS	Yep mmm.
06:00	MA	…a, a larceny here on the 5th of October…
06:04	TS	Yep.
06:05	MA	…where, where you got a fine in Court and you…
06:07	TS	Yep.
06:08	MA	…you've got these two larcenies and two trespasses from the 9th, okay…
06:14	TS	Yep.

06:14	MA	…one of them's already listed for the 12th of January next year where you…
06:17	TS	Okay.
06:17	MA	…were given bail and you went back to the shopping centre. Correct?
06:21	TS	Okay. Yep… Oh wha, what was that? I, I thought that got heard in my absence.
06:29	MA	Ahh…
06:30	TS	Do I go back to court on the 12th of January?
06:32	MA	12th of January it says, yeah.
06:34	TS	Oh I didn't know that, okay.
06:35	MA	Okay, well hopefully…
06:37	TS	Alright.
06:38	MA	…you remember that now.
06:39	TS	Yeah I will.
06:40	MA	Umm... Well trespassing it only carries a fine. I'm gonna find you $100 for that.
06:50	TS	Yep, thank you, your honour
06:53	MA	And the… larceny (inaudible).
06:57	TS	Shoplifting was just to get, that was just to get clean clothes for my family to put on because my daughter and my granddaughter just come home from hospital detoxing off Ice…
07:05	MA	Well..
07:05	TS	…I just wanted them to feel clean

07:07	MA	…I'll tell you what I'm gonna do. I'll take into account you've spent ah… into account… you've spent 9, 10, 11, 12th, 13th, 14… ah what's today, the 14th, so you've spent 6 days in custody, I'll take that into account… I'm gonna put you on a CRO, Conditional Release Order for 12 months, okay.
07:39	TS	Thank you your Honour…
07:39	MA	So…
07:40	TS	…thank you so much.
07:40	MA	…that says no offences, so…
07:42	TS	Yep.
07:42	MA	…you can't commit any offences and you gotta…
07:44	TS	Yep.
07:45	MA	… come to court if you get a notice. So do you understand all that?
07:48	TS	Yes I do your Honour.
07:49	MA	Okay, now, as far as I'm concerned, that should mean you'll be released.
07:55	TS	Thank you your Honour.
07:56	MA	Okay, thank you, you can go.
07:57	TS	Yep, thank you.
08:10	…	*(Next matter heard)*

Supreme Court
New South Wales

Medium Neutral Citation:	**Commissioner of Police, New South Wales Police Force v Attorney General of New South Wales [2025] NSWSC 1119**
Hearing dates:	25 July 2025
Date of orders:	26 September 2025
Decision date:	26 September 2025
Jurisdiction:	Common Law - Administrative Law
Before:	McHugh JA
Decision:	The summons is dismissed.
Catchwords:	COURTS AND JUDGES — Judicial review — Coroners Court — *Coroners Act 2009* (NSW), s 23 — Scope of coroner's jurisdiction — Whether jurisdiction limited by common sense test of causation of death — Whether matters coroner indicated she would consider and decide could be characterised as "concerning the death"
Legislation Cited:	*Coroners Act 1960* (NSW), ss 4, 11, 29 *Coroners Act 1980* (NSW), ss 4, 13, 22A *Coroners Act 1985* (Vic) (as at 18 September 2009), ss 19, 59 *Coroners Act 1985* (Vic) (as at 9 March 1989), ss 19, 21 *Coroners Act 1996* (WA) (as at 18 September 2009), ss 19, 22, 25, 52 *Coroners Act 1997* (ACT) (as at 5 August 2005), ss 18, 52 *Coroners Act 2009* (NSW), ss 3, 4, 10, 21, 23, 27, 49, 51, 78, 81, 82, 84, 85 *Interpretation Act 1987* (NSW), s 34 *Mental Health Act 2007* (NSW), s 22
Cases Cited:	*Chief Commissioner of State Revenue v Uber Australia Pty Ltd* [2025] NSWCA 172 *Conway v Jerram* [2011] NSWCA 319

Conway v Jerram (2010) 78 NSWLR 689; [2010] NSWSC 371
Decker v State Coroner of NSW (1999) 46 NSWLR 415; [1999] NSWSC 369
Harmsworth v State Coroner [1989] VR 989
Hurley v Clements [2010] 1 Qd R 215; [2009] QCA 167
Keown v Khan [1999] 1 VR 69
Lacey v Attorney-General (Qld) (2011) 242 CLR 573; [2011] HCA 10
March v E & MH Stramare Pty Ltd (1991) 171 CLR 506; [1991] HCA 12
Mirror Newspapers Ltd v Waller (1985) 1 NSWLR 1
Musumeci v Attorney General of New South Wales (2003) 57 NSWLR 193; [2003] NSWCA 77
R v Doogan; Ex parte Lucas-Smith (2005) 158 ACTR 1; [2005] ACTSC 74
R v Khazaal (2012) 246 CLR 601; [2012] HCA 26
Re State Coroner; Ex parte Minister for Health (2009) 38 WAR 553; [2009] WASCA 165
The Owners of the Ship "Shin Kobe Maru" v Empire Shipping Company Inc (1994) 181 CLR 404; [1994] HCA 54
WRB Transport v Chivell [1998] SASC 7002
X v Deputy State Coroner for New South Wales (2001) 51 NSWLR 312; [2001] NSWSC 46

Texts Cited:

Law Reform Commission, *Report of the Law Reform Commission on the Coroners Act, 1960* (1975)
New South Wales Legislative Assembly, *Parliamentary Debates* (Hansard), 20 February 1980
New South Wales Legislative Council, *Parliamentary Debates* (Hansard), 4 June 2009
NSW Law Reform Committee, *The Law and Practice Relating to the Examination before Coroners or Committing Magistrates* (1964)
P Herzfeld and T Prince, *Interpretation* (3rd ed, 2024, Lawbook Co)

Category:

Principal judgment

Parties:

Commissioner of Police, New South Wales Police Force (Plaintiff)
Attorney General of New South Wales (First Defendant)
State Coroner of New South Wales (Second Defendant,

	submitting appearance) Vicki Shipley (Third Defendant)
Representation:	Counsel: A Casselden SC; M Harker (Plaintiff) D Kell SC; J Caldwell (First Defendant) O Jones; L Dargan (Third Defendant) Solicitors: Office of the General Counsel, NSW Police Force (Plaintiff) Crown Solicitor's Office (First Defendant) Aboriginal Legal Service (NSW/ACT) (Third Defendant)
File Number(s):	2025/00037767
Publication restriction:	Nil.

HEADNOTE

[This headnote is not to be read as part of the judgment]

On 20 December 2022 Ms Tammy Shipley, an Aboriginal woman, died in custody in the Mum Shirl Unit of Silverwater Women's Correctional Centre (**SWCC**). In those circumstances, s 23(1) of the *Coroners Act 2009* (NSW) (**the Act**) confers jurisdiction on the State Coroner "to hold an inquest concerning the death". Section 81(1)(c) of the Act confers power on the Coroner to make findings as to the "manner and cause of the person's death". Section 82(1) confers power to make "recommendations … in relation to any matter connected with the death".

Ms Shipley had a history of mental health issues and drug use and had had many dealings with the NSW Police Force (**NSWPF**). On 9 December 2022, she was arrested for entering inclosed lands and shoplifting offences (**the H76115633 offences**). She was released with bail conditions, but later the same day was arrested a second time for similar offences and for breaching her bail conditions (**the H91715522 offences**). She was refused bail and was admitted into custody at Campbelltown Police Station. The custody management record (which was later sent to NSW Corrective Services (**NSWCS**)) indicated that she did not have a mental illness.

On 10 December 2022, after about 6 hours in NSWPF custody, Ms Shipley was transferred to Amber Laurel Correctional Centre where she was in the custody of NSWCS. On the same day, she appeared unrepresented before the Local Court and said that she did not want bail.

On 11 December 2022, Ms Shipley was transferred to SWCC where she displayed symptoms of psychosis. On 12 December 2022, she was deemed to be too mentally unwell to attend court.

On 14 December 2002, Ms Shipley appeared in the Local Court, again unrepresented, in relation to the H91715522 offences. The NSWPF facts sheet did not refer to Ms Shipley's mental health or drug use history. The Magistrate finalised the H91715522 offences and advised Ms Shipley that she would need to return to court in relation to the H76115633 offences. The Magistrate stated "…as far as I'm concerned, that should mean you'll be released." However, contrary to the information on the NSWPF Criminal History Bail Report, which was located on the court file, Ms Shipley did not have bail on the charges for the H76115633 offences. She was not released.

Ms Shipley died at SWCC, ostensibly from complications arising from her mental illness, ten days after she had left the custody of NSWPF.

The plaintiff, the Commissioner of Police, NSWPF (**the Commissioner**) made an application to the Coroner asserting that she lacks jurisdiction to inquire into certain matters including the dealings Ms Shipley had with NSWPF prior to her death in the period between 9 and 14 December 2022. The Commissioner submitted that the jurisdiction conferred by s 23(1) is constrained by a principle of remoteness from the person's death; that the test of remoteness was the *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506; [1991] HCA 12 test of common sense causation; and that applying that test, matters concerning the NSWPF were too remote from Ms Shipley's death.

The Coroner refused the Commissioner's application. By summons, the Commissioner sought judicial review.

McHugh JA held, dismissing the summons:

(1) Within the limits of the s 23(1) jurisdiction, the scope of the inquest is a matter for the coroner. The conferral of jurisdiction carries with it a broad discretion to identify the specific issues to be pursued. However, the discretion must be exercised judicially and for the purpose of performing the coroner's functions in holding an inquest: [38]-[40], [43]-[44].

> *Conway v Jerram* [2011] NSWCA 319, cited.

(2) The s 23(1) jurisdiction includes the authority to decide the factual matters forming the basis of the s 81(1) findings or any ultimate s 82(1) recommendations. The coroner's authority to decide also extends to issues that the coroner has identified in the proper exercise of discretion for the purpose of exercising the ss 81(1) or 82(1) powers: [45]-[48].

(3) The Commissioner's causal test of remoteness should not be accepted as the test of the limit of the s 23(1) jurisdiction. It is not required or justified by the text of the Act and is contrary to the Act's purpose and legislative history. No authority requires the contrary conclusion: [51]-[120].

> *Harmsworth v State Coroner* [1989] VR 989; *R v Doogan; Ex parte Lucas-Smith* (2005) 158 ACTR 1; *Re State Coroner; Ex parte Minister for Health* (2009) 38 WAR 553; [2009] WASCA 165; *Conway v Jerram* (2010) 78 NSWLR 689; [2010] NSWSC 371; *Conway v Jerram* [2011] NSWCA 319, discussed.
>
> *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506; [1991] HCA 12, cited.

(4) The words "an inquest concerning the death … of a person" in s 23(1) limit the jurisdiction conferred. They require a sufficient connection between the person's death and the matters to be decided at the inquest. The connection may become so tenuous or remote that, to that extent, the inquest can no longer be fairly characterised as concerning the person's death. The process of characterisation involves the application of common sense but does not involve a necessary test of causation: [121]-[122].

(5) The matters which the Coroner has indicated that she proposes to pursue and decide in the course of the inquest bear a sufficiently close connection to Ms Shipley's death that the inquest is fairly to be characterised as "concerning" her death. Those matters are within jurisdiction: [129]-[132].

JUDGMENT

1 On 20 December 2022 Ms Tammy Shipley, an Aboriginal woman, died in custody in the Mum Shirl Unit of Silverwater Women's Correctional Centre (**SWCC**). In those circumstances, s 23(1) of the *Coroners Act 2009* (NSW) (**the Act** or **the NSW Act**) confers jurisdiction on, relevantly, the State Coroner "to hold an inquest concerning the

death" of Ms Shipley, and s 27(1)(b) requires that an inquest be held. The main issue on this well-argued application for judicial review is the criterion delimiting the outer boundary of the s 23(1) jurisdiction.

2 The plaintiff is the Commissioner of Police, NSW Police Force (**the Commissioner**). She contends that the State Coroner (**the Coroner**), who is the second defendant, lacks jurisdiction to inquire into certain matters including dealings Ms Shipley had with the New South Wales Police Force (**NSWPF**) prior to her death, in particular in the period between 9 and 14 December 2022.

3 The third defendant, Ms Vicki Shipley, is the mother and senior next of kin of Ms Tammy Shipley. Ms Vicki Shipley had been granted leave to appear at the inquest and made submissions to the Coroner. As a party in this Court she had the primary carriage of the argument resisting the relief sought in the summons.

4 The Attorney General of New South Wales was joined as the first defendant to the summons at a time when the only other defendant, the Coroner, had appropriately filed a submitting appearance save as to costs. The Attorney's position is that he is not an interested party in, or otherwise involved with, the inquest, and does not advocate for a particular outcome in the judicial review application. However, the Attorney has not sought to be removed as a party as there are matters concerning the jurisdiction of the Coroners Court in respect of which the Attorney seeks to assist the Court. The Attorney's submissions proceeded appropriately on that basis.

5 As the Commissioner's challenge to jurisdiction fails, the summons must be dismissed.

Background

6 What follows is drawn from [10]-[51] of the Coroner's carefully considered and comprehensive reasons for her decision given on 16 January 2025 (**the Decision** or **D**), which it is not necessary to repeat in full. The basic facts are largely uncontroversial, and there was no attempt to challenge the Coroner's account of them on the summons in this Court. To the extent that any of these matters might be contested, I do not understand it to be disputed that there is sufficient reason to think that they might be established in the ordinary ways in the course of an inquest, which is enough for present purposes.

Ms Shipley's mental health and her history of dealings with police

7 Ms Shipley, who was 47 years old, had a long history of mental health issues including admissions to hospitals. She had also had many dealings with the NSWPF, commencing in 1992 in relation to stealing and break and enter offences. Over the years she was charged with domestic related common assault, drug and shoplifting

offences. Several of Ms Shipley's offences were dealt with under mental health legislation which enabled the magistrate to divert matters away from the criminal justice system where a person was more appropriately dealt with in a mental health facility.

8 In 2016, Ms Shipley spent four months in custody for an offence of stalk/intimidate. During that time, the Justice Health and Forensic Mental Health Network (**JHFMHN**) noted her diagnoses of Schizoaffective Disorder and Bipolar Affective Disorder along with a history of cannabis, "Ice" and heroin use.

9 Over a period of approximately 25 years Ms Shipley also regularly came to the attention of the NSWPF as a victim of domestic violence.

10 Between January and November 2022, Ms Shipley came to the attention of NSWPF officers on four occasions. These included police detaining Ms Shipley under s 22 of the *Mental Health Act 2007* (NSW) on 13 January 2022 and transporting her to Campbelltown Hospital Emergency Department where she was found to be "a mentally ill person", and police voluntarily transporting Ms Shipley to Campbelltown Hospital Emergency Department after she presented to Macquarie Fields Police Station suffering hallucinations on 26 November 2022.

11 The details of what occurred between 9 and 14 December 2022 are important. The Coroner addressed those matters at D[12]-[20], which are reproduced in full below (omitting footnotes).

> "12. On 9 December 2022:
>
> a. Sometime in the morning, Ms Shipley attended Macquarie Fields Police Station and asked to be arrested as she claimed she had goods in custody.
>
> b. At around 11:00am, Ms Shipley was arrested for enter inclosed lands and shoplifting offences at Target Glenquarie Centre. The goods stolen totalled $574 ('H76115633 offences'). She was released with bail conditions 'not to enter Glenquarie Shopping Centre'. The Facts Sheet for the charges stated: '*Police not aware of any drug or mental health issues of the accused*'.
>
> c. In the afternoon, Ms Shipley re-attended Glenquarie Shopping Centre. She entered Woolworths and was again arrested for enter inclosed lands and shoplifting, as well as breach of bail on the offending from earlier that day. This time the goods stolen totalled $23.10 ('H91715522 offences'). At the time of her arrest, when asked by NSWPF officers if she wanted to go to gaol Ms Shipley replied, '*that would be nice*' and indicated to the arresting officers that she was going through a 'detox'.
>
> d. At 7:00pm, Ms Shipley was refused bail by an officer of the NSWPF and admitted into custody at Campbelltown Police Station. The custody management record (which was later sent by NSW Police to CSNSW and formed part of their records) indicates she did not have a mental illness, was not on medication and had no medical issues.
>
> e. On 10 December 2022 at around 1:00am, after approximately six hours in NSWPF custody, Ms Shipley was transferred to Amber Laurel Correctional Centre ('ALCC'). On the same day, she appeared before Parramatta Local Court. A transcript of the audio recording of those proceedings has been tendered in evidence and the aide memoire prepared for me (not challenged by any party) is Annexure A to this decision. It reveals that Ms Shipley told the Magistrate that she was representing herself and initially indicated that she was applying for bail. When the Magistrate indicated to the Sergeant appearing that she would *'read the facts and records'* and the Sergeant stated that they would

'hand those up', Ms Shipley said: *'Yeah no I don't want bail'*. Ms Shipley appeared in Court for a little over one minute and the learned Magistrate concluded by stating that: *'In relation to the detention application I'll simply mark it not challenged'*.

13. It is apparent from the transcript that on 10 December 2022, there was no reference to Ms Shipley's mental health history by the Court or prosecutor. The matter was stood over to Campbelltown on Monday 11 December 2022.

14. On 11 December 2022, Ms Shipley was transferred to Silverwater Women's Correctional Centre (SWCC). That same day, she attempted to take her own life on two occasions and displayed symptoms of psychosis. Ms Shipley did not attend Court on that date.

15. On 12 December 2022, she was deemed by JHFMHN staff to be too mentally unwell to attend Court and a medical certificate for 'non-attendance at Court' was provided to the Court by JHFMHN.

16. On 13 December 2022, a remand warrant was issued for Ms Shipley to attend Campbelltown Local Court the following day in relation to the H91715522 offences.

17. The last date Ms Shipley appeared in any Court was 14 December 2022 and again a transcript of the audio recording of that appearance was prepared for me and circulated to the parties, and the aide memoire is attached to this decision at Annexure B. On that date:

a. Ms Shipley appeared before Campbelltown Local Court via audio-visual-link ('AVL'). She was again unrepresented and entered a plea of guilty for the H91715522 offences.

b. The NSWPF Facts Sheet for the H91715522 offences located on the Court file did not refer to Ms Shipley's mental health or drug use history.

c. The learned Magistrate fined Ms Shipley $100 for the enter inclosed lands offence and sentenced her to a Conditional Release Order for the shoplifting offence.

d. The H76115633 offences were not dealt with. The NSWPF Criminal History Bail Report printed at 8:37pm on 9 December 2022 and located on the Court file in relation to the H76115633 offences stated:

> 'POLICE BAIL: BAIL CONDITIONAL
>
> PLACE RESTRICTION
>
> NOT TO ENTER THE GLENQUARIE SHOPPING CENTRE' …;
>
> and
>
> 'NO BREACH BAIL ALTERNATIVES FOUND FOR CNI'

e. The Magistrate advised Ms Shipley she would need to return to Court in relation to the H76115633 offences in January 2023 and stated:

> *'…as far as I'm concerned, that should mean you'll be released'.*

f. After her appearance, Ms Shipley reported to CSNSW staff at SWCC that she 'got bail' and would be going home. However, Ms Shipley was not released from custody as CSNSW Sentence Administration advised there were other charges pending to be heard in 2023 and she did not have bail on those.

18. It is clear that in fact, contrary to the information on the NSWPF Criminal History Bail Report printed at 8:37pm on 9 December 2022 and located on the Court file, as at 14 December Ms Shipley did not have bail on the charge numbered H76115633.

19. On 20 December 2022, 11 days after Ms Shipley was arrested by NSWPF officers and entered custody, she died in the MSU at SWCC, ostensibly from complications arising from her mental illness.

> 20. On 12 January 2023, Ms Shipley was convicted of the H76115633 offences and fined a total of $1,000, 23 days after her death."

12 It should be noted that the Commissioner emphasises that Ms Shipley had been in the custody of New South Wales Corrective Services (**NSWCS**) from about 1 a.m. on 10 December 2022, after approximately six hours in NSWPF custody.

The Commissioner's application challenging jurisdiction

13 The Coroner made preparations to hold the inquest concerning Ms Shipley's death.

14 On 23 July 2024, the Crown Solicitor, assisting the Coroner, wrote to the Commissioner, stating that the Commissioner may have a sufficient interest in the subject matter of the inquest; identifying certain "issues emerging" that were relevant to the NSWPF; requesting certain policies or procedures of the NSWPF, including concerning engagement with persons who have a mental illness; and requesting a statement by a senior NSWPF officer. The Commissioner responded on 8 August 2024 that the Coroner had no jurisdiction to request the information sought or to conduct any inquiry in relation to the matters identified by the Coroner.

15 Correspondence ensued, and the identification by the Coroner of the issues which she proposed to consider in the course of the inquest (including the documents she sought), and by the Commissioner of the issues said to be beyond jurisdiction, evolved in ways that are not presently material.

16 On 3 September 2024, the Crown Solicitor's Office received an application signed by the General Counsel, NSWPF (**the Application**). As recorded at D[29]:

> "… The Application stated and sought the following:
>
> > 1. That any examination or exploration by the State Coroner and/or Counsel Assisting into the appropriateness or otherwise of the NSW Police Force's interactions with Ms Shipley including, but not limited to, her mental health, physical health, drug abuse, arrest, charging, bail determination and custody prior to her death is impermissible as it lacks jurisdictional power.
> >
> > 2. In respect of the letter to [the OGC] from the Crown Solicitor's Office dated 16 August 2024:
> >
> > > a. the 'request for policies and procedures' be withdrawn on the basis that it is impermissible as it lacks jurisdictional power and a legitimate forensic purpose; and
> > >
> > > b. the 'request for a statement from a senior NSWPF officer' addressing the nominated four areas be withdrawn on the basis that it is impermissible as it lacks jurisdictional power and a legitimate forensic purpose.
> >
> > 3. In respect of the letter of sufficient interest addressed to the Commissioner from the Crown Solicitor's Office dated 23 July 2024:
> >
> > > a. the letter be withdrawn on the basis of a lack of jurisdictional power; and/or, alternatively
> > >
> > > b. the issues said to be 'emerging', listed and numbered 1, 2, and 3 be removed from consideration in the Inquest on the basis of a lack of jurisdictional power; or, alternatively

> c. the 'Request for Policies' be withdrawn on the basis that it lacks a legitimate forensic purpose and/or the State Coroner and/or Counsel Assisting lacks jurisdictional power to consider the nominated four areas; and
>
> d. the 'Request for Statement' be withdrawn on the basis that it lacks a legitimate forensic purpose and/or the State Coroner and/or Counsel Assisting lacks jurisdictional power to consider the nominated four areas."

17 On 12 September 2024, in written submissions as to jurisdiction, the Commissioner identified the orders that she submitted the Coroner should make (at D[32]):

> "[50] The Court should order that:
>
> [50.1] any investigation into:
>
> i. the appropriateness of the NSW Police's interactions with Ms Shipley;
>
> ii. its institutional frameworks for dealing with persons suffering from mental illness; and
>
> iii. any similar investigation into the NSW Police;
>
> is excluded from the scope of the inquest into the death of Ms Tammy Michelle Shipley; and
>
> [50.2] the request for documents and a witness statement made to the NSW Police on 16 August 2024 is withdrawn."

18 The Coroner was unable to address the Application before the inquest was planned to commence on 16 September 2024. A regime was put in place to defer hearing the Application to the end of the inquest proceedings, which otherwise proceeded from 16 to 26 September 2024. After several rounds of written submissions, the Application was eventually heard on 17 October 2024.

19 On 16 January 2025 the Coroner dismissed the Application, saying at D[125] that she declined to make the orders sought by the Commissioner as set out at D[32].

20 As the arguments put to the Coroner are largely reflected in those advanced in this Court, it is unnecessary to address the way in which her Honour dealt with them in detail, save to note two matters.

21 First, it was common ground before the Coroner that the jurisdiction conferred by s 23(1) was limited by a principle of remoteness from the death of the person. The Commissioner submitted that the applicable test was the common sense test of causation as identified in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506; [1991] HCA 12 (***March v Stramare***): at D[62]-[64]. In the application of that test, the Commissioner submitted that examination of the question whether Ms Shipley should have been in custody when she died would conflate a possible precondition to her death (i.e., satisfaction of the "but for" test) with the common sense test of causation (at

D[65]), which the Commissioner submitted was not satisfied in the circumstances. That being so, examination of Ms Shipley's interactions with the NSWPF would be beyond jurisdiction.

22 The Coroner did not accept the Commissioner's submission. As her Honour said at D[57], s 81 of the Act requires findings as to the identity, date, place, manner and cause of the identified person's death, and for those findings to be recorded in writing. As to the words "manner and cause of the person's death" in s 81(1) of the Act, her Honour said that "manner of death" should not be too narrowly construed (at D[131]), and that in appropriate circumstances the exploration of the "manner" of death may go beyond exploration of causative matters: at D[134]. Her Honour accepted that the question was one of remoteness but said that it was not readily susceptible to definition: at D[131].

23 Her Honour also accepted the submission made by counsel assisting that it was within "a common sense test" and not beyond the scope of her jurisdiction to look at the circumstances in which Ms Shipley came to be in custody: at D[137].

24 Her Honour then said the following (footnotes omitted):

> "138. On 20 December 2022, 11 days after Ms Shipley was arrested by NSWPF officers and entered custody, she died in the MSU at SWCC, ostensibly from complications arising from her mental illness. The institution of the NSWPF had information about Ms Shipley's history of mental illness, including her recent mental ill health, and had recorded that information, although, for reasons I wish to inquire into, that may not have been known to the relevant officers who were involved in dealings with her on 9, 10 and 14 December 2022.
>
> 139. I am satisfied that an examination of the events that led to Ms Shipley's arrest and imprisonment in December 2022, including her likely mental health condition at the time and examination of the appropriateness or otherwise of the NSWPF's interactions with Ms Shipley (including on 9, 10 and 14 December) is within permissible scope of this inquest and as such within jurisdiction.
>
> …
>
> 141. I accept that the interaction between members of the NSWPF concerning Ms Shipley are within my jurisdiction. Specifically, I accept that there are legitimate lines of inquiry in relation to:
>
> a. First, with respect to the interaction between members of the NSWPF and Ms Shipley on 9 December 2022 when Ms Shipley came into custody. Although it is understandable that NSWPF officers dealing with her did not immediately recognise that she was mentally ill or mentally disordered, it is not clear to me why the custody records were marked as if she had no history of mental illness when the NSWPF as an institution had numerous and recent dealings with Ms Shipley where she was mentally ill, and her history of mental illness was well documented on NSWPF records.
>
> b. Second, on 10 December 2022 when a police prosecutor appeared to assist the bail Court, the records handed to the Court by the police prosecutor do not refer to Ms Shipley's mental health issues and there is no mention of that important fact in Court. Ms Shipley appeared in Court unrepresented and declined to apply for bail, in circumstances where she may have been too mentally ill to make any informed decision in relation to representing herself or applying for bail. I note that she was not bought before the Court on 11 December 2022 and received a medical certificate deeming her to be too mentally unfit to attend court on 12 December 2022.

> c. Third, on 14 December 2022, Ms Shipley was again before the Court. Again, she represented herself and so did not have any advocate there to assist her, or to assist the Court on her behalf. An audio recording of her Court appearance reveals that Ms Shipley was able to inform the Court about some aspects of her mental ill health. The NSWPF Criminal History Bail Report stated that Ms Shipley had conditional bail on another matter (H76115633). The Magistrate then sentenced Ms Shipley for the offence before him and determined that as far as he was concerned, she would be released from custody, but his Honour did not know, and was not informed by the police prosecutor, that Ms Shipley no longer had bail on the offence under H76115633, a minor shoplifting charge. Contrary to the apparent intentions of the Magistrate presiding on 14 December 2022, Ms Shipley was further detained and died in custody 6 days later in circumstances where (according [*to*] the expert panel of psychiatrists) she could not get adequate treatment for her mental health condition and died as a result of it.

142. I also accept that there are matters related to the circumstances in which Ms Shipley came to be in custody that may be the subject of recommendations aimed at preventing the loss of life of others in a similar situation. Tragically, deaths in custody are all too common in the Coroners Court in this State, and Aboriginal people in particular continue to be overrepresented in the numbers of deaths. They are not just numbers to the families of loved ones grieving deeply for their loss and striving to understand if there are lessons to be learnt that might save other families from experiencing that grief. As Counsel Assisting said in her opening of this inquest:

> '*[W]e recognise that this inquest is one of too many where the Coroner is tasked with investigating the death of an Aboriginal person in custody. Thirty years on from the Royal Commission into Aboriginal Deaths in Custody, Aboriginal people are still massively over-represented in prisons in New South Wales and around the country. And we know that it is a source of pain for [Ms Shipley]'s family and to many other Australians. It is important to understand why [Ms Shipley] was in custody …*"

25 Secondly, addressing a submission made on behalf of the Commissioner distinguishing an "investigatory stage" from the "curial phase", her Honour said at D[146]: "it is the very nature of an inquiry that some issues emerge as the inquest/inquiry takes place." Her Honour went on to say (footnotes omitted):

> "149. … this case is an excellent example of the way in which some matters crystallise during the course of an inquest, while others assume less significance. It became increasingly evident to me that there may be real systems issues revealed by Ms Shipley's appearances at Court on both 10 and 14 December 2022.
>
> 150. A review of the custodial records shows that Ms Shipley was extremely mentally unwell when she left NSWPF custody and entered into the custody of CSNSW on 9 December 2022, and she remained mentally unwell until her death 11 days later. Yet on 10 December 2022, a day after she was taken into police custody, she appeared in the bail court unrepresented in circumstances where it is [*sic*] appears on the face of the transcript that the Magistrate was not informed of her mental health issues. The police prosecutor present makes no mention of her mental health issues. On 14 December 2022, Ms Shipley herself told the Magistrate of some of her mental health troubles and he sentenced her in a way that he said would allow her to leave custody. It is obvious from the face of the record that his Honour believed she had bail on another minor shoplifting charge and could be released. Again, Ms Shipley was not legally represented by someone who could advocate on her behalf.
>
> 151. As Counsel Assisting has repeatedly sought to emphasise, inquests are not adversarial and the inquiries directed to the NSWPF are not aimed at criticising its members, but rather at identifying opportunities to improve the care of persons who come into the custody of the NSWPF or CSNSW."

26 It should be noted that the Commissioner identified the matters which she said were beyond the Coroner's jurisdiction in different terms at different times (to some extent reflecting developments in the focus of the Coroner's attention). They included the

matters referred to at par 1 of the Application and at par 50.1 of the Commissioner's submissions quoted at D[32]. I also understood them to include, in this Court, the matters referred to at D[138]-[142] and D[150]. I have not found it necessary for present purposes to do more than to describe all of those matters as the **Contested Issues**.

The Commissioner's summons seeking judicial review

27 The Commissioner filed a summons seeking judicial review of the Decision. Some of the grounds identified and the relief sought in the summons were not pressed. The Commissioner's ultimate position was that the Decision should be set aside and remitted to the Coroner for reconsideration according to law. The Commissioner relied on the following grounds:

> "1 The Second Defendant has no power as part of the inquest into the death of Ms Tammy Michelle Shipley to inquire into, and make findings or recommendations in respect of:
>
> a. the appropriateness of the NSW Police Force's interactions with Ms Shipley, including the conduct of NSW Police Prosecutors; and
>
> b. the NSW Police Force's institutional frameworks for dealing with persons suffering from mental illness;
>
> in circumstances where each is too remote from the death of Ms Shipley 11 days after she entered custody under the care of NSW Corrective Services.
>
> 2 The Second Defendant, in determining the scope of the inquest to include the matters in Grounds 1(a) and (b), failed to apply a common sense test of causation, and in so doing applied the wrong test of jurisdiction.
>
> …
>
> 4 The Second Defendant, in determining the scope of the inquest, misconstrued 'manner of death' in the *Coroners Act 2009* to include the circumstances in which Ms Shipley came to be in custody, as opposed to the means, or alternatively, the circumstances, of Ms Shipley's death."

28 It was clear from the way in which the Commissioner put her argument that the test of what was "too remote from the death of Ms Shipley" (and thus the correct "test of jurisdiction") for the purposes of Ground 1 was asserted to be the "common sense test of causation" referred to in Ground 2. It was also clear that the point of statutory construction raised in Ground 4 concerned the words "the manner and cause of the person's death" in s 81(1)(c), and that that point was made in support of the asserted test identified in Ground 2.

29 The Commissioner proceeded on the footing that the success or failure of the summons turned ultimately on the test of remoteness. That is, that it was necessary to show that the Coroner had applied the wrong test in order to show a legal error constituting jurisdictional error.

Meaning of "jurisdiction" in s 23(1)

30 The Commissioner's grounds of review use the terms "power" and "jurisdiction" without distinguishing between them; cf. *Lacey v Attorney-General (Qld)* (2011) 242 CLR 573; [2011] HCA 10 at [48] per French CJ, Gummow, Hayne, Crennan, Kiefel and Bell JJ. It is convenient to say something at the outset about the meaning of the word "jurisdiction" in the context of coronial proceedings, and to identify some matters that must be within jurisdiction, before turning to consider whether the Commissioner's causal test of remoteness correctly identifies the outer limit of the jurisdiction conferred.

31 The conferral of coronial jurisdiction should be understood in light of the close connection between the coroner's investigative functions and the inquisitorial aspects of an inquest. Section 10(1) of the Act relevantly provides:

> **10 Functions of State Coroner and Deputy State Coroners**
>
> (1) The functions of the State Coroner are—
>
> …
>
> (b) to ensure that all deaths, suspected deaths, fires and explosions concerning which a coroner has jurisdiction to hold an inquest or inquiry are properly investigated, and
>
> (c) to ensure that an inquest or inquiry is held whenever it is required by this Act to be held or it is, in the State Coroner's opinion, desirable that it be held, and
>
> …

32 The investigative aspect of the coronial function is supported by s 51(2), which provides: "A coroner may give a police officer directions concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings."

33 In this case s 23(1) of the Act confers jurisdiction on the Coroner "to hold an inquest" into Ms Shipley's death as follows:

> **23 Jurisdiction concerning deaths in custody or as a result of police operations**
>
> (1) A senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died (or that there is reasonable cause to suspect that the person has died)—
>
> (a) while in the custody of a police officer or in other lawful custody, or
>
> (b) while escaping, or attempting to escape, from the custody of a police officer or other lawful custody, or
>
> (c) as a result of police operations, or
>
> (d) while in, or temporarily absent from, any of the following institutions or places of which the person was an inmate—
>
> (i) a detention centre within the meaning of the *Children (Detention Centres) Act 1987*,
>
> (ii) a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999*,
>
> (iii) a lock-up, or
>
> (e) while proceeding to an institution or place referred to in paragraph (d), for the purpose of being admitted as an inmate of the institution or place and while in the company of a police officer or other official charged with the person's care or custody.

(2) In this section—

> ***police operation*** means any activity engaged in by a police officer while exercising the functions of police officer other than an activity for the purpose of a search and rescue operation.

34 The extent of the conferral of jurisdiction is thus a question of construction of the words, "has jurisdiction to hold an inquest concerning the death … of a person". Those words confer authority to perform the functions of a coroner holding such an inquest. For example, even in the absence of further provision in the Act, those functions would include receiving evidence for the purpose of the inquest.

35 The Commissioner's Ground 1 asserts that the Coroner has "no power [*i.e., no authority*] … to inquire into, and make findings or recommendations in respect of" various subject matters. As will be seen, Ground 1 raises the extent of the Coroner's authority to perform two distinct but closely related functions of a coroner "hold[ing] an inquest": identifying the particular issues to be decided, and deciding the issues so identified.

36 The latter function accords with the primary legal meaning of the word "jurisdiction" when used in connection with a court: "authority to decide". In the context of adversarial proceedings litigated in a court, jurisdiction is the authority to decide some controversy between the parties, who will in some way have identified the issues to be decided.

37 By contrast, while the Coroners Court is an inferior court of record (*Mirror Newspapers Ltd v Waller* (1985) 1 NSWLR 1 at 6 per Hunt J; *Decker v State Coroner of NSW* (1999) 46 NSWLR 415; [1999] NSWSC 369 at [6] per Adams J), the juristic nature of an inquest is not merely adversarial, and there are no parties. As was said in *Musumeci v Attorney General of New South Wales* (2003) 57 NSWLR 193; [2003] NSWCA 77 at [33] per Ipp JA (Beazley JA agreeing), an inquest is a hybrid process containing both adversarial and inquisitorial elements. Coroners nevertheless exercise judicial power, notwithstanding the executive nature of their functions, and the proceedings in the Coroners Court involve the administration of justice.

38 In the absence of issues defined by parties, and given the hybrid inquisitorial aspect of an inquest, one of the functions of a coroner holding an inquest is to identify the specific issues to be pursued (that is, the matters to be the subject of evidence and submissions and then decided). It was thus not disputed in this case that, within the limits of the coroner's "jurisdiction to hold an inquest concerning the death … of a person", the scope of the inquest is a matter for the coroner: *Conway v Jerram* [2011] NSWCA 319 (***Conway CA***) at [48] per Young JA. That is to say, subject to any express provision (such as the requirement to make the findings in s 81(1) discussed below, or

the exclusion of certain matters by s 78), the conferral of "jurisdiction to hold an inquest" carries with it a broad discretion to identify the specific issues to be pursued at the inquest. Those issues may evolve as the investigation and the inquest itself proceed.

39 Relevantly for present purposes, the words "jurisdiction to hold an inquest" in s 23(1) thus mean not only the authority to decide matters arising at an inquest, but also the authority to determine, within the limits of the s 23(1) jurisdiction, which particular issues are to be decided.

40 However, the latter aspect of the coroner's authority is not free-standing. Although the coroner's discretion as to the scope of the inquest is broad, the discretion must be exercised judicially and for the purpose for which the discretion is conferred. As to the first point, among other things, the discretion cannot be exercised arbitrarily or capriciously. As to the second point, the coroner's discretion to identify the particular issues to be pursued and decided at an inquest is incidental to performing the coroner's functions (that is, exercising the coroner's powers or performing the coroner's duties) in holding an inquest. The coroner's discretion to identify issues to pursue must be exercised for that purpose.

41 Two powers which the Act confers on a coroner were central to the argument on the summons about the outer limits of a coroner's jurisdiction to hold an inquest concerning the death of a person. Sections 81 and 82 relevantly provide as follows.

> **81 Findings of coroner or jury verdict to be recorded**
>
> (1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so—
>
> (a) the person's identity, and
>
> (b) the date and place of the person's death, and
>
> (c) in the case of an inquest that is being concluded—the manner and cause of the person's death.
>
> …
>
> **82 Coroner or jury may make recommendations**
>
> (1) A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.
>
> (2) Without limiting subsection (1), the following are matters that can be the subject of a recommendation—
>
> (a) public health and safety,
>
> (b) that a matter be investigated or reviewed by a specified person or body.
>
> (3) The record made under section 81 is to include any recommendations made by the coroner or jury. The record must not indicate or in any way suggest that an offence has been committed by any person.
>
> (4) The coroner is to ensure that a copy of a record that includes recommendations made under this section is provided, as soon as is reasonably practicable, to—
>
> (a) the State Coroner (unless the coroner is the State Coroner), and

(b) any person or body to which a recommendation included in the record is directed, and

(c) the Minister, and

(d) any other Minister (if any) that administers legislation, or who is responsible for the person or body, to which a recommendation in the record relates.

42 It should be noted that the coroner "must" (i.e., has a duty to) exercise the power to make "findings … as to" the matters identified in s 81(1) (including as to "the manner and cause of the person's death"). By contrast, s 82(1) confers a discretionary power to make recommendations "in relation to any matter connected with the death". The potential width of the subject matters these provisions contemplate is discussed below.

43 For immediate purposes, it is important that ss 81(1) and 82(1) do no more than identify the object in view: to make findings in various categories or to make recommendations. As discussed above, within the limits of the s 23(1) jurisdiction, it falls to the coroner to identify the particular issues to be decided at the inquest for the purpose of exercising such powers. For example, the coroner has a discretion to identify the lines of enquiry to pursue, any competing hypotheses to consider, and any questions of primary fact to resolve with respect to the physiological "cause of the person's death" in s 81(1)(c).

44 However, as noted above, the discretion to identify issues to pursue must be exercised judicially and only for the purpose of performing the coroner's functions in holding the inquest. Again taking s 81(1)(c) as an example, one of the coroner's powers is to make findings as to the "manner and cause of the person's death". Thus, where a mountaineer's rope breaks and she falls to her death, it would plainly be for the purpose of exercising the s 81(1)(c) power for the coroner to identify as issues to pursue at the inquest the rated breaking strain of the climber's rope, the conditions in which it had been kept and whether it had been tampered with. The same might not be true where the climber died of cardiac arrest before commencing her ascent.

45 It must follow from the conferral of the s 81(1) power — and I did not understand this to be disputed — that the s 23(1) conferral of "jurisdiction to hold an inquest" extends at least to authority to decide the factual matters forming the basis of the ultimate findings required by s 81(1). It must equally follow from the conferral of the s 82(1) power that the "jurisdiction to hold an inquest" also extends to authority to decide the factual matters forming the basis of any ultimate s 82(1) recommendation.

46 Moreover, within the limits of the jurisdiction to hold an inquest that s 23(1) confers on a coroner, the coroner's authority to decide extends to issues that the coroner has identified in the proper exercise of discretion for the purpose of exercising the ss 81(1) or 82(1) powers.

47 For example, in light of a coronial investigation, the coroner might have identified several possible pathological processes as the potential "cause of the person's death" for the purposes of s 81(1)(c). It might be necessary to consider a complex of expert

medical evidence to decide which pathological process was the cause of death. The conferral of jurisdiction to hold an inquest in which the coroner is to decide the cause of death includes the authority to consider and make a decision upon the whole complex of evidence. Put another way, the conferral of jurisdiction authorising the coroner to decide that X was the cause of death necessarily confers authority to decide, as part of a process of reasoning by elimination, that Y and Z, two competing hypotheses, were not the cause of death.

48 Similarly, within the limits of the s 23(1) jurisdiction, the coroner has discretion to identify factual issues to be pursued and decided at an inquest for the purpose of exercising the discretion whether to make a s 82(1) recommendation. No doubt there may be a substantial overlap between the issues to be decided for the purpose of making s 81(1) findings (in particular, as to the "manner and cause of the person's death") and those to be decided for the purpose of making a s 82(1) recommendation "in relation to any matter connected with the death". But the latter may extend to at least some matters beyond the former, particularly where the recommendation is directed to systemic issues (as to which, see further below). For example, new hospital procedures adopted after a person's death might not themselves be within the "manner and cause" of death, but the fact and extent of the new procedures might well be relevant to whether or not to make a s 82(1) recommendation. Again, the jurisdiction s 23(1) confers to hold an inquest in which the coroner is given a discretion to make such recommendations includes the authority to decide factual matters that the coroner has properly identified as relevant to exercising the s 82(1) discretion.

49 As noted above, the Commissioner's grounds of review use the terms "power" and "jurisdiction" interchangeably. It was, however, made clear that all three grounds are directed to establishing that, applying the Commissioner's test of remoteness, the Contested Issues fall outside the limits of the Coroner's jurisdiction conferred by s 23(1). The grounds are not directed to the availability or exercise of specific powers. Thus, although the Application had sought that the Coroner withdraw, e.g., the request for a statement, it was made clear that if, contrary to the Commissioner's position, the Coroner had jurisdiction to pursue and decide the Contested Issues, the Commissioner did not suggest that the Coroner lacked power to make the request. (Such power was said to arise either by implication from the conferral of functions on the Coroner under s 10 of the Act, or pursuant to the directions power in s 49(1); it is unnecessary to decide.)

Consideration

50 The effect of the Commissioner's Ground 1 is to assert that the Coroner has exceeded (or is proposing to exceed) her jurisdiction by pursuing and deciding issues said to be "too remote from the death of Ms Shipley", namely, (a) the appropriateness of the NSWPF's interactions with Ms Shipley and (b) the NSWPF's institutional frameworks for dealing with persons suffering from mental illness. Read together, Grounds 2 and 4 assert that for this purpose the test of jurisdiction is what, as a matter of common sense, caused Ms Shipley's death.

Grounds 2 and 4

51 It is convenient to address Grounds 2 and 4 before considering Ground 1. I have concluded that the Commissioner's test of the outer limit of the coroner's jurisdiction should not be accepted. It is not required or justified by the text of the Act and it is contrary to the Act's purpose. It is convenient to address the Commissioner's arguments by reference to the issues discussed below.

The statute

52 The scope of the authority to pursue and decide issues which s 23(1) confers on the coroner is a question of statutory construction. The starting and ending points are the text, read in context. It is appropriate to begin with the statute, before turning to the legislative history and the secondary materials. As no party ultimately suggested that any binding authority determined the particular question before the Court arising under the Act, discussion of the authorities on which the Commissioner relies, most of which concern other statutory regimes, may largely be deferred until after consideration of the terms of the statute.

53 The words of conferral in s 23(1) are "has jurisdiction to hold an *inquest concerning* the death or suspected death of a person". The word "concerning" identifies a relationship between two subject matters. As with other relational terms, it is capable of capturing a potentially broad range of matters: see P Herzfeld and T Prince, *Interpretation* (3rd ed, 2024, Lawbook Co) at [4.420]. "Concerning" may be apt to describe a more direct relationship, and therefore to capture a narrower class of matters than, for example, "relating to". A synonym for "concerning", and one which is not inapposite in this context, is "about". However, the word must ultimately take its legal meaning from its context including the scope and object of the provision and the purpose it serves. The nature and closeness of the required relationship will generally depend on that context, including the purpose for which the relationship is being identified: cf. *Chief Commissioner of State Revenue v Uber Australia Pty Ltd* [2025] NSWCA 172 at [88] (relational term "under"). Moreover, as was pointed out in that case at [105], by

reference to what French CJ said in *R v Khazaal* (2012) 246 CLR 601; [2012] HCA 26 at [31], "[g]enerally speaking it is not desirable, in construing relational terms, to go further than is necessary to determine their application in a particular case or class of cases. A more comprehensive approach may be confounded by subsequent cases."

54 The definition of "inquest" in s 4(1) uses the same language as s 23(1): "***inquest*** means an inquest concerning the death or suspected death of a person". As a matter of text (as opposed to legislative history — see below) the definition takes the interpretation of the words "an inquest *concerning*" no further.

55 Section 23 itself gives no indication of the outer limits of the conferral, although the circumstances listed in paras (1)(a)-(e) suggest that the coroner's authority to decide extends to matters in some way relating to those circumstances. It might be noted that other than s 23(1)(c) ("as a result of police operations"), none of the circumstances identified in s 23(1) requires even a reasonable suspicion of any causal connection between those circumstances and the death.

56 As noted above, by s 27(1), "An inquest concerning the death or suspected death of a person is required to be held in any of the following circumstances— … (b) if the jurisdiction to hold the inquest arises under section 23". That provision repeats the language of "an inquest concerning" and, to that extent, takes the matter no further. But by requiring that an inquest be held when the jurisdiction arises under s 23(1), s 27(1) emphasises the significance of the circumstances in which the s 23 jurisdiction arises, being those in s 23(1)(a)-(e).

57 The general conferral of jurisdiction in s 21(1) of the Act again uses the same language ("has jurisdiction to hold an inquest concerning the death or suspected death of a person") and takes the matter no further:

> **21 Inquests concerning deaths or suspected deaths**
>
> (1) A coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that—
>
> (a) the person's death is (or there is reasonable cause to suspect that the person's death is) a reportable death, or
>
> (b) a medical practitioner has not given (or there is reasonable cause to suspect that a medical practitioner has not given) a certificate as to the cause of death.
>
> …

58 However, s 3 of the Act includes the following:

> **3 Objects of Act**
>
> The objects of this Act are as follows—
>
> …
>
> (c) to enable coroners to investigate certain kinds of deaths or suspected deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths,
>
> …

> (e) to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies),
>
> … .

59 Four points should be noted. First, there is nothing in the language of s 3 suggesting that the object in par (e) is subordinate to or constrained by the object in par (c). Secondly, both objects are capable of informing the purpose of the conferral of jurisdiction to hold an inquest, which is part of the context relevant to construing the word "concerning" in s 23(1). Thirdly, the objects in s 3(c) and (e) foreshadow the powers conferred by ss 81(1) and 82(1), which are relevantly set out above. Fourthly, the words used are "recommendations in relation to matters *in connection with an inquest*", which are arguably wider than the words in s 82(1) itself: "recommendations … in relation to any matter *connected with the death*".

60 It was submitted on behalf of the Attorney General, and not disputed, that ss 81(1) and 82(1) both confer powers on the coroner, one difference being that a coroner "must" exercise the power in s 81(1), whereas a coroner has a discretion whether to exercise the power in s 82(1).

61 As explained above, the jurisdiction conferred by s 23(1) must extend at least to authority to decide factual matters forming the basis of the ultimate findings in s 81(1); the factual basis and the content of any s 82(1) recommendations; and any issues properly identified by the coroner for the purpose of exercising the power to make the ultimate s 81(1) findings or the discretion to make any s 82(1) recommendation.

62 The question in the present case is whether, as the Commissioner contends, the jurisdiction which s 23(1) confers on the coroner is constrained by a principle of remoteness, such that the coroner has no authority to enquire into and make findings or recommendations in respect of a matter unless there is (or might be), as a matter of common sense, a causal connection between the matter and the death.

63 The Commissioner's argument focused on s 81(1)(c), which requires a finding as to "the manner and cause of the person's death". It was common ground that the word "cause" here means the physiological cause of death. Although different views might be held about whether the words "manner and cause" address two different concepts, or instead function as a composite phrase, it was not in dispute that these words extend beyond the physiological cause of death. Senior Counsel for the Commissioner acknowledged that these words have been construed to mean the circumstances surrounding the death. For example, in *Conway v Jerram* (2010) 78 NSWLR 689; [2010] NSWSC 371 at [52] (***Conway SC***), Barr AJ concluded that the phrase "manner of death" should be given "a broad construction so as to enable the coroner to consider

by what means and in what circumstances the death occurred". To the extent that Ground 4 contends for a narrower construction of the words "the manner and cause of the person's death", it must be rejected.

64 It may be noted that the circumstances surrounding a death are not confined to those which, as a matter of common sense, *cause* it. Let it be assumed that an elderly inmate, "temporarily absent from … a correctional centre" within the meaning of s 23(1)(d)(ii), dies of heart failure in a hospital. If the patient had been receiving the highest possible standard of medical care, the care provided could not sensibly be described as causing the death, as a matter of common sense. But the high standard of care provided would be a circumstance about which the coroner could make a s 81(1) finding as to the "manner" (or "manner and cause") of death. The very fact that the medical care was not causative of the death might be a significant matter.

65 Since s 81(1)(c) itself is not limited to circumstances that are causal, it does not support the Commissioner's causal test of the limit of jurisdiction. Nor do the other paragraphs of s 81(1). For example, where unidentified human remains are found, the matters that it may be necessary or appropriate to consider for the purpose of making a finding as to "the person's identity" are potentially wide-ranging, and may have nothing to do with the cause of death. Similarly, where the inquest concerns the "suspected death of a person", the matters relevant to determining "the date and place of the person's death" may or may not bear a relationship to the cause of death.

66 The scope of the power to make recommendations in s 82(1) is also contrary to the Commissioner's causational test of the limit of the jurisdiction conferred by s 23(1). The Commissioner submitted that the power in s 81(1) identifies the coroner's primary functions at an inquest (to make certain findings), to which the function of making a s 82(1) recommendation is secondary or ancillary. It may be accepted that the s 81(1) functions are "primary", in the sense that that description follows from the fact that s 81(1) is mandatory while s 82(1) is discretionary. But that description does not assist when considering the significance of s 82(1) for the purposes of construing the scope of the conferral of jurisdiction in s 23(1). Section 82(1) confers a power which is not in terms confined by the functions conferred by s 81(1). To the extent that the Commissioner submits that s 82(1) does not add to the analysis when construing the scope of the conferral of jurisdiction in s 23(1), the submission should be rejected. The oft-quoted statement in *The Owners of the Ship "Shin Kobe Maru" v Empire Shipping Company Inc* (1994) 181 CLR 404 at 421; [1994] HCA 54 bears repeating (footnotes omitted):

> "It is quite inappropriate to read provisions conferring jurisdiction or granting powers to a court by making implications or imposing limitations which are not found in the express words."

67 Far from suggesting that s 82(1) is confined by reference to s 81(1), the language used in s 82(1) is "may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to *any matter connected with the death* … with which an inquest or inquiry is concerned".

(1) The fact that the power is discretionary, and extends to recommendations the coroner considers desirable, suggests a degree of flexibility that is inconsistent with the narrow focus of the Commissioner's test.

(2) The words used to identify the relationship between the "matter" and the "death" are not "any matter *causing* the death", but "any matter *connected with* the death". The ordinary meaning of that language is capable of capturing subjects extending beyond the *March v Stramare* common sense test of causation. There is nothing in the text suggesting that those words should be given a narrower legal meaning.

(3) The very general language used in s 82(2) is again not subject to a causal limitation: "Without limiting subsection (1), the following are matters that can be the subject of a recommendation— (a) public health and safety, (b) that a matter be investigated or reviewed by a specified person or body."

68 Nor is there anything in the scope or objects of the Act, or its purpose as gleaned from its terms, suggesting that the s 82(1) power is to be confined by reference to s 81(1). To the contrary, the object in s 3(e) is, if anything, as noted above, expressed more broadly than is s 82(1) itself: "to enable coroners to make recommendations in relation to matters in connection with *an inquest* or inquiry", rather than "connected with *the death*".

69 The powers in ss 81(1) and 82(1) thus assist by identifying matters which must be within the coroner's authority to decide conferred by s 23(1). These go beyond the cause of death. The breadth of the subject matter of even s 81(1)(c) itself shows that the coroner's s 23(1) jurisdiction must extend beyond the cause of death to the circumstances surrounding the person's death. In the result, ss 81(1) and 82(1) are inconsistent with the causational test of remoteness proposed by the Commissioner.

The legislative history and the secondary materials

70 The legislative history also militates strongly against the causational test of remoteness for which the Commissioner contends. (See *Interpretation Act 1987* (NSW), s 34(1)(a) and (b)(i).)

71 Section 4 of the *Coroners Act 1960* (NSW) (**the 1960 Act**) defined "inquest" to mean an "inquest by a coroner into the manner and cause of the death of any person". Jurisdiction to conduct an inquest was conferred by s 11(1), using the same language: "jurisdiction … to hold an inquest into the manner and cause of the death of the deceased person". While s 29(1) required the coroner to record findings similar to those in s 81(1) of the current Act, including as to the manner and cause of the death, there was no express power to make recommendations. However, in the absence of an express statutory power, it was accepted that the coroner or coroner's jury could add a rider or recommendation to their finding or verdict. Although at common law such riders were not part of the finding of the coroner or the verdict of the jury, they could be recorded if their nature was concerned with avoiding repetition of a like event or circumstance: ***X v Deputy State Coroner*** *for New South Wales* (2001) 51 NSWLR 312; [2001] NSWSC 46 at [24]-[25] per O'Keefe J.

72 In *The Law and Practice Relating to the Examination before Coroners or Committing Magistrates*, a report published by the Chief Justice's NSW Law Reform Committee in 1964, concern was expressed that the effect of the 1960 Act might be to limit the scope of the inquiry to matters as to which the coroner was permitted or required to publish a finding. That was contrasted with the approach in fact being taken by coroners, "in inquiring in a broad way as to how, when, and where a death occurred". The Committee said that it was desirable in the public interest that coroners should continue to inquire as they did. The Committee gave the example of a man arrested for drunkenness and found dead in a police cell as a result of a cerebral haemorrhage. The Committee said that coroners could and should inquire into the circumstances giving rise to the condition which caused the death, and ascertain whether they disclosed a preventable hazard, or errors or weaknesses in systems or in administration affecting public safety.

73 In 1975, the New South Wales Law Reform Commission issued a report which considered the 1960 Act. The Commission recommended that the definition of "inquest" be amended to mean an "inquest by a coroner concerning the circumstances of the death of any person", and that the words "into the manner and cause of the death of the

deceased person" in s 11(1) be replaced with the words "concerning the circumstances of the death of the deceased person" (emphasis supplied). Although that form of words was not taken up by the Parliament, the underlying issue was.

74 The *Coroners Act 1980* (NSW) (**the 1980 Act**) introduced the language which now applies, after it was carried over into the current Act. In the Second Reading Speech to the Bill for the 1980 Act, the Attorney General said that the spirit of the Law Reform Commission's proposals for a less restrictive form of words had been adopted in the Bill, where an inquest was defined as "an inquest concerning the death or suspected death of a person": New South Wales Legislative Assembly, *Parliamentary Debates* (Hansard), 20 February 1980 at 4556. That became the definition in s 4(1) of the 1980 Act. Section 13 then conferred jurisdiction "to hold an inquest concerning the death or suspected death" of a person in certain circumstances.

75 The 1980 Act was amended in 1993 to confer an express statutory power in s 22A(1) to "make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death …" That is the language used in s 82(1) of the current Act.

76 In the Second Reading Speech for the current Act, the Attorney General said:

> "The capacity to make recommendations is *one of the most significant powers* conferred on coroners. The importance of this power is highlighted in clause 3, which, for the first time, identifies the power of coroners to make recommendations in connection with an inquest or inquiry as *one of the main objects* of the bill. The power to make recommendations provides coroners with the opportunity to identify *any systemic failures* in the health, law enforcement or other services *to prevent similar deaths* occurring in the future. The role of the coroner is not only to review the circumstances surrounding death; it is also to protect the living.
>
> …
>
> Coroners play a unique and important role in the judicial system. They focus on *the circumstances surrounding death* so that we can understand *why and how* a person died. *Coroners investigate death so that they can protect the living*. The investigations undertaken by coroners can detect hidden homicides and reveal evidence that can bring people responsible to justice. The capacity for coroners to identify the reasons why somebody died can lead to important changes that can prevent those circumstances from recurring. …"
>
> New South Wales Legislative Council, *Parliamentary Debates* (Hansard), 4 June 2009 at 15788-15789, emphasis supplied.

77 That legislative history confirms the following matters.

(1) The conferral of jurisdiction using the words "an inquest *concerning the death* or suspected death of a person" was intended to be free of any limitation perceived in the former language of "an inquest *into the manner and cause of the death* of the deceased person". That is inconsistent with a test of the outer limit of jurisdiction which turns on a causal connection.

(2) The intention was to confer jurisdiction to enquire in a broad way as to how, when, and where a death occurred. That included the circumstances surrounding the death, in order to understand not only how but why the person

died.

(3) One purpose of the conferral of jurisdiction is preventative. This purpose includes identifying and reporting on systemic weaknesses in government services (such as health and law enforcement) in order to protect the living. That purpose is inconsistent with a test of the coroner's authority to decide an issue that turns on a causal connection between the issue and the death. A coroner might recommend the adoption of some measure designed to increase awareness of a particular risk, being a risk connected with the person's death. It could not be said, as a matter of common sense, that the absence of the measure was what caused the death. Yet the authority to pursue and decide the factual matters supporting the recommendation, and to decide the content of the recommendation, would be within the jurisdiction conferred by s 23(1).

(4) The power to make recommendations is one of the coroner's most important powers, warranting recognition as one of the main objects of the Act. That is inconsistent with the Commissioner's submission as to the primacy of s 81(1) and its limiting effect on s 82(1).

The cases

78 The parties made submissions by reference to a large number of cases. It is not necessary to address each of them, as none is directly dispositive of the issues on the summons. In chronological order, the five which the Commissioner urged merited particular consideration are as follows.

Harmsworth v State Coroner

79 ***Harmsworth*** *v State Coroner* [1989] VR 989 concerned an inquest into the deaths of five prisoners who had died in the course of a fire which one of them had lit in a high security detention unit known as K Division. The plaintiff, who was the Director-General of the Office of Corrections, sought declarations that the coroner hearing the inquest

had exceeded his jurisdiction by admitting evidence of a number of matters relating to prison administration and operations. As at the date of the decision, the *Coroners Act 1985* (Vic) included the following provisions:

(1) By s 19(1), "A coroner investigating a death must find if possible" various matters, including "how death occurred", which largely correspond with those in s 81(1) of the current New South Wales Act.

(2) By s 19(2), "A coroner may comment on any matter connected with the death including public health or safety or the administration of justice."

(3) By s 21(2), "A coroner may make recommendations to the Attorney-General on any matter connected with a death which the coroner investigated, including public health or safety or the administration of justice."

80 Nathan J held that a coroner did not have "general powers of enquiry or detection"; instead, the "enquiry must be relevant, in the legal sense to the death or fire, this brings into focus the concept of 'remoteness'": at 995. His Honour gave as an example that the "sociological factors which related to the causes of their [*the prisoners'*] imprisonment could not be remotely relevant": at 995. His Honour said that the power to comment was "not free-ranging"; it must be comment "on any matter connected with the death": at 996. The powers to comment and to make recommendations were thus "not independent of the power to enquire into a death or fire for the purposes of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation. It arises as a consequence of the exercise of a coroner's prime function, that is to make 'findings'": at 996.

81 Nathan J did not formulate any more particular test of remoteness. However, in the course of addressing the particulars relied upon, his Honour identified a number of topics that would be beyond jurisdiction because of a lack of sufficient connection to the mandatory "findings". For example, his Honour said at 997 that "[i]nvestigations into the general management of the Correctional Services of Victoria either at the Coburg Complex or elsewhere relating to the classification or allocation of prisoners within the system could not be supported by an inquest directed to ascertaining the causes of death of these particular prisoners within K Division." On the other hand, his Honour said at 998:

> "If the coroner has come to a preliminary view that frustration and anger induced the prisoners to build the barricades and disrupt the air-conditioning system and that, in turn, led Wright to ignite the barricade and suffocate himself and his companions, then the sources of that frustration and anger could provide a line of enquiry, which is within the coroner's jurisdiction. Namely, that the frustration and anger led to dangerous behaviour resulting in death. … Therefore the coroner has the jurisdiction to investigate the frustration and anger which afflicted each of the deceased at the time the fire was lit

> but he does not have jurisdiction to enquire into the levels of frustration and anger which maximum security incarceration as practised at K Division, may have been [*sic*] induced in other prisoners in bygone years."

82 That an investigation of the sources of frustration would be within jurisdiction is not easy to reconcile with the Commissioner's test of remoteness, i.e., that the issue was, as a matter of common sense, a cause of the death sufficient to satisfy *March v Stramare*.

83 In the result, while *Harmsworth* demonstrates a concern to avoid "free-ranging" enquiries which, as Nathan J said at 996, "would never end", what it ultimately turned on was the sufficiency of the connection between the "line of enquiry" and the deaths which were the subject of the inquest: the "enquiry must be relevant, in the legal sense to the death or fire". But to the extent that his Honour expressed conclusions about the relationship between the power to make comments or recommendations on the one hand, and the power to make findings on the other, those must ultimately be seen as questions of statutory construction of the particular legislation.

R v Doogan; Ex parte Lucas-Smith

84 *R v* ***Doogan****; Ex parte Lucas-Smith* (2005) 158 ACTR 1; [2005] ACTSC 74 was concerned with a coronial enquiry into bushfires in the Canberra area. The relevant jurisdiction was conferred by s 18(1) of the *Coroners Act 1997* (ACT) (**the ACT Act**) which as at the date of judgment was as follows:

> **18 Coroner's jurisdiction in relation to fires**
>
> (1) A coroner shall hold an inquiry into the cause and origin of a fire that has destroyed or damaged property, if—
>
> (a) requested to do so by the Attorney-General; or
>
> (b) the coroner is of the opinion that an inquiry into the cause and origin of the fire should be held.

85 The Court held that "cause and origin" was not a hendiadys, but rather two separate concepts: at [23]. The "origin" meant the starting point of the fire; in that case, the locations of lightning strikes that ignited four fires that later converged. Their Honours acknowledged that more difficult issues arose in relation to the concept of causation, and that there may be debate about the extent to which an apparent chain of causation may be traced. Thus, "questions inevitably arise as to whether particular factors are too remote to be regarded as having been causative of the fire, as it developed, in any real sense.": at [24]. In that context, the Court held at [29]:

> "A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of

> some concrete rule, but by what is described as the 'common sense' test of causation affirmed by the High Court of Australia in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506".

86 That appears to be the source of the Commissioner's test of remoteness. But it is clear that that test was specifically directed to a conferral of jurisdiction expressed in terms of "an inquiry into the *cause* … of a fire". That is very far from the conferral of jurisdiction in s 23(1) of the current New South Wales Act, which is expressed in terms of "an inquest *concerning* the death".

87 It should also be noted that the Court held at [37] that s 52(2) of the ACT Act, which provided that "a coroner holding an inquiry shall find, if possible … (b) the circumstances in which the fire or disaster occurred" did not expand the jurisdiction conferred by s 18(1). Instead, it was held at [37] that "[t]he section only requires the coroner to make such findings to the extent permitted by the evidence adduced at the inquiry conducted under s 18(1), seen as relevant in the legal sense, to the 'cause and origin of the fire'." By contrast, again, the terms of the conferral of jurisdiction in s 23(1) of the current New South Wales Act are limited only by the words "*concerning* the death". For the reasons given above, the interpretation of that word is aided by the other provisions of the Act, including the powers to make s 81(1) findings and s 82(1) recommendations.

88 In the result, *Doogan* is of very limited assistance in construing s 23(1) of the current New South Wales Act. Indeed, the Court in that case was itself astute to point out the limited value of judicial decisions concerning the scope of coronial enquiries conducted under different legislation which might be broader in scope: see at [32].

Re State Coroner; Ex parte Minister for Health

89 In ***Re State Coroner****; Ex parte Minister for Health* (2009) 38 WAR 553; [2009] WASCA 165, the inquest in question was into the death of a man who had been shot and killed as a result of attacking a police officer with a knife while the officer was attempting to apprehend him. The deceased had suffered from a serious mental illness which had become progressively worse, including by developing more psychotic features. The State Coroner gave a report that made a number of statements about the deceased's medical treatment and the likelihood that the events that resulted in his death would not have taken place had the treatment he received been different: see at [16].

90 The issue was not as to the scope of the provisions conferring jurisdiction on the coroner. (Those provisions were in any event very different in form from those in New South Wales. It appears from the Court's reasons at [8]-[9] that as at the time of the judgment, s 19(1) of the *Coroners Act 1996* (WA) (**the WA Act**) conferred jurisdiction on the coroner to investigate a death in certain circumstances. Section 22(1) provided that

a coroner who had jurisdiction to investigate a death must hold an inquest where, among other things, it appeared that the death was caused, or contributed to, by any action of a member of the Police Force.)

91 Instead, the issue arose under s 52(1) of the WA Act, which provided: "Any person may apply to the Supreme Court for an order that some or all of the findings of an inquest are void." Section 52(3) identified various grounds on which such an order could be made. (It may be noted that there is no provision in the New South Wales Act corresponding directly to s 52 of the WA Act. Instead, s 85 of the New South Wales Act provides: "The Supreme Court may, on the application of the Minister or any other person, make an order that an inquest or inquiry that has been (or that has purportedly been) held be quashed and that a new inquest or inquiry be held if the Court is satisfied that it is necessary or desirable to do so in the interests of justice because of—", and there follow various grounds.)

92 A central question was identifying the "findings" to which s 52(1) applied. As at the date of judgment, s 25 of the WA Act relevantly provided as follows:

> **25. Findings and comments of coroner**
>
> (1) A coroner investigating a death must find if possible —
>
> (a) the identity of the deceased;
>
> (b) how death occurred;
>
> (c) the cause of death; and
>
> (d) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1998*.
>
> (2) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.
>
> …
>
> (5) A coroner must not frame a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of any offence.

93 (It might be noted that the language of s 25(1) differs significantly from s 81(1) of the current New South Wales Act.)

94 Buss JA (Martin CJ and Miller JA agreeing) described the findings referred to in s 25(1) as the "ultimate findings": at [28]. His Honour held that the "findings" to which s 52 referred were the ultimate findings in s 25(1): at [52]-[53]. His Honour relied on authority under the corresponding provisions of the *Coroners Act 1985* (Vic), on the footing that as at the date of judgment, s 25(1)(a)-(d) were relevantly identical to the Victorian s 19(1)(a)-(d), and s 52 of the WA Act was equivalent to the Victorian s 59: see at [25] and [51].

95 Although s 25(1) was not expressed in the language of "jurisdiction", Buss JA held at [52] that s 25(1):

> "states exhaustively the jurisdiction of a coroner in relation to the ultimate findings or decisions which a coroner investigating a death is entitled and obliged to make, if possible. The ultimate findings or decisions under s 25(1) circumscribe the matters connected with the death (including public health or safety or the administration of justice) in respect of which the coroner may comment under s 25(2) of the Act. That is, the coroner's role under s 25(2) is ancillary to his or her role under s 25(1) …"

96 Given the different language, structure and legislative history of the current New South Wales Act, it should not be held, by way of analogy or otherwise, that the ultimate findings made pursuant to the power in s 81(1) of the New South Wales Act circumscribe either the conferral of jurisdiction in s 23(1) or the matters "connected with the death" in respect of which the coroner may make recommendations pursuant to the power in s 82(1). The coroner's role under s 82(1) is not in that sense "ancillary to" the role under s 81(1).

97 It is worth noting that Buss JA accepted that the coroner may make many findings "in the sense that he or she takes a view of the evidence or particular aspects of it", but his Honour said that those were not the "findings" referred to in ss 25(1) and 52: at [53]. That is necessarily an acknowledgement that the conferral of authority on the coroner to decide the matters identified in s 25(1) extended to authority to decide anterior issues for the purpose of making the ultimate findings.

98 The need to identify the "findings" which could be declared void pursuant to s 52 of the WA Act led to a close analysis of the scope of the s 25(1) "ultimate findings". One of these was the requirement in s 25(1)(b) to find, if possible, "how death occurred". After a review (at [32]-[41]) of authorities including those in Victoria and Queensland (where the Act was also based on the Victorian legislation: at [37]), Buss JA concluded at [42]:

> "… s 25(1)(b) confers on the coroner the jurisdiction and obligation to find, if possible, the manner in which the deceased happened to die. This does not refer only to the means or mechanism by which the death was suffered or inflicted. It extends to the circumstances attending the death. In my opinion, a construction of s 25(1)(b) which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred reflects the public interest which is protected and advanced by a coronial investigation (especially an investigation into deaths where one or more of the conditions in s 22(1) of the Act are satisfied). …"

99 Another "ultimate finding" was the one in s 25(1)(c): "the cause of death". Buss JA did not take a narrow view of the cause of death. Quoting the decision of Lander J (Mullighan J agreeing) in *WRB Transport v Chivell* [1998] SASC 7002, his Honour said at [45]:

> "Some of the events immediately proximate in time to the death of the deceased will be relevant to determine the cause of the death of the deceased. But there will be other facts less proximate in time which will be seen to operate, in some fact situations, as a cause of the death of the deceased. That is a factual inquiry which only has, as its boundaries, common sense."

100 Citing *Doogan*, his Honour said at [46] that s 25(1)(c) does not, however, authorise a coroner to undertake a roving Royal Commission for the purpose of inquiring into any possible causal connection, no matter how tenuous, between an act, omission or

circumstance and the death of the deceased. Citing, among other authorities, *March v Stramare*, Buss JA said at [47]:

> "It will be necessary, in each inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of the death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case."

101 Several matters may be observed. First, what Buss JA said about the common sense test of causation was specifically in relation to par (c): "the cause of death". It was not directed to, for example, the scope of par (b): "how death occurred". His Honour had already construed par (b) broadly as extending to the circumstances attending the death, expressly distinguishing it from "the cause of death": at [41]-[42]. Secondly, even in respect of the "cause of death", his Honour contemplated that as a matter of common sense, in some circumstances "facts less proximate in time" might be seen as a cause of the death. Thirdly, his Honour acknowledged that part of the coroner's function in each inquest would be to "delineate", that is to identify, the matters that might be characterised as "at least potentially" causing death.

102 One final matter should be noted. Buss JA held at [48] that a statement that a particular act, omission or circumstance did not cause the deceased's death is not a finding as to "the cause of death". (See *Hurley v Clements* [2010] 1 Qd R 215; [2009] QCA 167 at [23]; *Keown v Khan* [1999] 1 VR 69 at [13] per Callaway JA (Ormiston and Batt JJA agreeing).) That conclusion must be understood in the context of the issue arising under s 52 of the WA Act (which conferred a power to order that some or all of the findings of an inquest were void). It is not necessary to decide whether the same view would be taken under the New South Wales Act, which has no equivalent provision.

Conway SC

103 The issue to be determined by Barr AJ was very different from the one in the present case. The Deputy State Coroner had dispensed with an inquest into the death of a girl, referred to as M, who was aged 16 years and five months: at [3]-[4]. M had died from head injuries suffered when the stolen car in which she was a passenger crashed. The plaintiff, who was M's mother, applied pursuant to s 84 of the current Act for an order that an inquest concerning the death of M be held. The statutory question was whether the court was "satisfied that it is necessary or desirable to do so in the interests of justice". In the course of submissions ultimately directed to that issue, counsel for the plaintiff accepted that it was neither necessary nor desirable to have an inquest to establish the identity of the deceased, the time and place of her death or the cause of

her death: at [40]. Instead, it was submitted that an inquest should be held to determine the "manner" of M's death, giving that word in the expression "manner and cause of death" a liberal construction.

104 After considering a number of decided cases, Barr AJ concluded that the phrase "manner of death" should be given "a broad construction so as to enable the coroner to consider by what means and in what circumstances the death occurred": at [52]. His Honour said that there were nevertheless limits to the coroner's jurisdiction. His Honour referred to general statements in *Harmsworth*, *Re State Coroner* and *Doogan*. At [56], his Honour said that in *Doogan*, the Full Court of the Australian Capital Territory Supreme Court had referred to a line that it was necessary to draw, at some point beyond which, even if relevant, "factors which came to light would be considered too remote to be regarded causative". His Honour did not elaborate on the word "causative". As noted above, what was said on this point in *Doogan* was specifically directed to a conferral of jurisdiction expressed in terms of "an inquiry into the *cause* … of a fire", which is very different from the conferral of jurisdiction in s 23(1) of the New South Wales Act ("an inquest *concerning* the death").

105 Barr AJ summarised the plaintiff's submission as to the reasons requiring the holding of an inquest at [59] as:

> "… whatever the Department did was inadequate and ineffective. [M] was a homeless girl who died in the crash of a stolen car. Her assigned youth worker found out only after the event where she had been living in the days leading up to her death. It was submitted that the absence of system or if proper or effective system to protect a person so clearly at risk due to homelessness, mental health problems and instability was a matter that fell within 'manner' of death."

106 His Honour dismissed the summons. At [61], he said:

> "… I am prepared for present purposes to regard all the claims made as established. The question remains whether the litany of matters relied on can bear upon the question that a coroner would have to ask, and if possible answer, at an inquest, namely, adopting the broad interpretation I have proposed, by what means and in what circumstances did the death of M occur. I have come to the conclusion that those matters cannot bear upon the question. They are in my opinion too remote and would be beyond the proper limits of the Coroner's jurisdiction."

107 It is important to understand that, in light of what had been accepted by counsel for the plaintiff, the only asserted purpose of ordering that an inquest be held would be in order to determine the "manner" of M's death. Hence his Honour's reference to the only "question that a coroner would *have to* ask" (the coroner's power to make recommendations being discretionary). Unsurprisingly, that issue was his Honour's focus when considering whether to exercise the s 84 power. What his Honour said in that context about the matters to which the plaintiff pointed being "too remote" was not stating a test of jurisdiction generally; it was addressed to the issue at hand. Even then, his Honour did not express the test of remoteness in terms of causation.

108 As to the power to make recommendations in s 82, his Honour said at [63]:

> "The power of a coroner to make recommendations about matters of public health and safety seems apt to enable the coroner to consider matters outside the scope of what may be considered necessary to determine the manner and cause of death. However, the power cannot arise until there is an inquest and there cannot be an inquest unless the evidence justifies it. In my opinion it does not."

109 In the result, Barr AJ's decision (1) supports a broad construction of "manner and cause"; (2) supports the view that the recommendations power is consistent with the conferral of jurisdiction to consider and decide matters beyond those necessary to determine the manner and cause of death; and (3) understood in its context does not support the Commissioner's submission as to a causational test of the outer limit of jurisdiction.

Conway CA

110 Ms Conway then sought leave to appeal. Leave was refused, with reasons given ex tempore by Campbell and Young JJA. What their Honours said must be understood as arising in the same context that had confronted Barr AJ at first instance (that is, a challenge to the coroner's decision not to hold an inquest). It is also subject to the limitations on the use that may be made of what is said in refusing leave to appeal.

111 Campbell JA summarised the provisions of the current Act at [12]-[21]. At [22], his Honour said "It will be seen from the foregoing summary of the Act, that the scope of the enquiry of the coronial inquest concerning a death, is limited to the matters identified in s 81." That was not the issue to be decided in the case and, even as far as that statement went, it did not explore the limit of "the matters identified in s 81". Moreover, his Honour had not referred to s 82 at all at that point. His Honour only did so at [42], in the context of saying that there were insufficient prospects that the primary judge's view (that before the power to make s 82 recommendations became exercisable, there first had to be proper grounds for holding an inquest) would be held incorrect to justify leave to appeal being granted.

112 Young JA agreed with Campbell JA and gave additional reasons, with which Campbell JA also agreed at [52]. Young JA made the following points at [47]-[50].

(1) The scope of an inquest depends on all the circumstances and is a matter for the coroner, to be exercised using discretion and commonsense.

(2) The primary purpose of an inquest is to determine "who is the deceased, [and] when and how he or she died", citing O'Keefe J's statement of the "primary duty" of the coroner (in terms that paraphrase s 81(1)) in *X v Deputy State Coroner* at [60].

(3) "It is important that extraneous factors do not get in the way of that primary duty." "As the ACT Full Supreme Court said in … *Doogan* [*at*] [28] … the coroner is not to conduct 'a wide ranging inquiry akin to that of a Royal Commission, with a view to exploring any suggestion of a causal link, however tenuous, between

some act, omission or circumstance and the cause', in that case, of a fire." "In the usual cases of death, a line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event", that is, from the death.

113 Young JA's first point identified above was directed to the coroner's broad discretion to identify issues within jurisdiction. His Honour's third point acknowledged the practical reasons why there must be an outer limit to the coroner's jurisdiction, which his Honour conceived in terms of remoteness from the death. But his Honour did not give a criterion of remoteness. In particular, his Honour did not say that the scope of the "primary duty" to which he had referred confined the coroner's authority to decide.

Conclusion as to authorities

114 The five decisions discussed above largely support taking a broad approach to concepts of "manner" or circumstances of death, particularly where the death occurs in an institutional setting where the operation (or failure) of systems or practices may have been one of the important circumstances surrounding the death.

115 One matter that all the authorities, both within and outside New South Wales, agree upon is the need for practical common sense limits to the matters the coroner is authorised to pursue and decide. Whatever the formulation in the particular case, each turns on the sufficiency of the connection between the issues to be pursued and decided and the death which is the subject of the inquest.

116 When the statements on which the Commissioner particularly relies in the five decisions are read in context, they do not support common sense *causation* as the test of the outer limits of the jurisdiction conferred by s 23(1) of the current New South Wales Act. Even within the significantly different legislative contexts of the three interstate decisions, the common sense test of causation should be seen, as in *Re State Coroner*, as directed only to some aspects of the coroner's authority to decide.

117 Within their own legislative contexts, the authorities outside New South Wales do suggest that the scope of statutory powers to make comments or recommendations may be confined by the subject-matters of the statutory powers to make ultimate findings (see also the observations in *Conway CA* at [22]). While I have concluded that

that approach to the relationship between ss 81(1) and 82(1) is not supported by the language, purpose or legislative history of the New South Wales Act, that may make little difference in practice. That is because of:

(1) the scope of the circumstances falling within the s 81(1) power to make findings (in particular, as to "the *manner* and cause of the person's death"); and

(2) the fact that the s 82(1) power to make recommendations is subject to two significant constraints, namely, (a) that the "matter" must be "connected with the death" (s 82(1)), and (b) that the inquest must be "concerning the death" (s 23(1), as to which, see below).

Conclusion as to test of jurisdiction: Grounds 2 and 4

118 The scope of the matters falling within a coroner's authority to decide depends on the interpretation of the words "jurisdiction to hold an inquest concerning the death or suspected death of a person" in s 23(1).

The Commissioner's causal test should not be accepted

119 For the reasons given above, the s 23(1) "jurisdiction to hold an inquest" extends to the authority to pursue and decide matters including the following:

(1) The factual matters forming the basis of the ultimate findings in s 81(1), bearing in mind that the words "the manner and cause of the person's death" in s 81(1)(c) extend beyond the cause of death and include the circumstances surrounding the death.

(2) Whether it is necessary or desirable to exercise the discretionary power in s 82(1) to make any recommendation and, if so, its factual basis and content, bearing in mind that the recommendation may be "in relation to any matter connected with the death".

(3) Any factual matters properly identified by the coroner for the purpose of exercising the powers or performing the duties of a coroner holding an inquest. These include anterior findings for the purpose of making the ultimate findings in s 81(1) or exercising the s 82(1) discretion to make recommendations.

120 Also for the reasons given above, the Commissioner's causal test of remoteness should not be accepted as the test of the limit of the coroner's jurisdiction. It follows that Ground 2 is not made out: the Coroner made no error in failing to apply such a test. To the extent that Ground 4 was advanced as a constructional reason in support of the test identified in Ground 2, Ground 4 is also not made out.

An "inquest concerning the death or suspected death of a person"

121 However, the words "*concerning* the death … of a person" are words of limitation. They confine the scope of the jurisdiction that s 23(1) confers on the coroner. Those words are echoed in both s 81(1) ("The coroner holding an inquest *concerning* the death … of a person must …") and s 82(1) ("… in relation to any matter connected with the death … with which an inquest … is *concerned*").

122 Those words require a sufficient connection between the person's death and the matters to be decided in the course of the inquest: the inquest must meet the description of an inquest concerning the death of the person. Whether a matter is within a coroner's authority to decide thus involves a question of characterisation of the inquest. At some point the connection between the death the subject of the inquest and the matters a coroner proposes to pursue and decide, or has purported to decide, may become so tenuous or remote that, to that extent, the inquest can no longer be fairly characterised as "concerning the death … of [the] person". The process of characterisation must be undertaken bearing in mind the nature and scope of the connections to the death contemplated by s 81(1) (in particular, as to "the manner and cause of" death) and s 82(1) (in particular, "any matter connected with the death"). The process of characterisation no doubt involves the application of common sense, but it does not involve a necessary test of causation.

123 I do not consider it possible to elaborate any more particular test of the limit of the conferral of jurisdiction, which would in any event likely amount to a gloss on the words "an inquest concerning the death".

124 Mr Jones, who appeared with Ms Dargan on behalf of Ms Vicki Shipley, proposed two alternative formulations of what he called the "nature of the required link", as follows (Tcpt, 25 July 2025, 28.6-17):

(1) "that the matters under investigation be concerned with or relevant to the assessment of the circumstances of the death"; or

(2) "that the matter under investigation may potentially be characterised as part of the circumstances of the death".

125 He said that the words "matters under investigation" were directed to capturing, in the present case, the actions of the police: at 28.32. Those words could be understood more generally to mean any factual question that a coroner was pursuing or proposing to decide.

126 Neither formulation finds a direct footing in the text of s 23(1) itself. Both refer to "the circumstances of the death", which is not the statutory language, but rather a product of the interpretation of, in particular, s 81(1)(c). Also, although Mr Jones submitted that the two formulations were of similar effect, that may not necessarily be so. The second

formulation ("*part of* the circumstances of the death") goes to the process of fact-finding for the purpose of s 81(1)(c). Depending on the meaning of "assessment", the first formulation ("relevant to the *assessment* of the circumstances of the death") might go either to that same process of fact-finding for the purpose of s 81(1)(c), or perhaps to the question whether to make a recommendation for the purpose of s 82(1).

127 Nevertheless, it suffices for present purposes to say that to the extent that a factual matter came within either formulation, the inquest would most likely be fairly characterised as "concerning the death … of [the] person", and so the particular matter would be within the coroner's authority to decide. But the converse is not necessarily so. In other words, I do not consider either formulation to be a test of remoteness which, if not satisfied with respect to a particular issue, would necessarily result in the coroner's lacking authority to decide the issue.

This case: Ground 1

128 Ground 1 in the summons is:

> "The Second Defendant has no power as part of the inquest into the death of Ms Tammy Michelle Shipley to inquire into, and make findings or recommendations in respect of:
>
> a. the appropriateness of the NSW Police Force's interactions with Ms Shipley, including the conduct of NSW Police Prosecutors; and
>
> b. the NSW Police Force's institutional frameworks for dealing with persons suffering from mental illness;
>
> in circumstances where each is too remote from the death of Ms Shipley 11 days after she entered custody under the care of NSW Corrective Services."

129 The matters which the Coroner has indicated that she proposes to pursue and decide in the course of the inquest, referred to at D[138]-[142] and D[150], bear a sufficiently close connection to Ms Shipley's death that the inquest would be fairly characterised as "concerning" her death. Those matters are within jurisdiction.

130 The mandatory s 81(1) findings include "the manner and cause of" Ms Shipley's death. That extends to the circumstances surrounding her death. The Coroner said at D[150] that it appears that "Ms Shipley was extremely mentally unwell when she left NSWPF custody and entered into the custody of CSNSW on 9 December 2022, and she remained mentally unwell until her death 11 days later." Her Honour said at D[138] that Ms Shipley "died in the MSU at SWCC, ostensibly from complications arising from her mental illness". The Coroner also said at D[141(c)] that that occurred "in circumstances where (according [*to*] the expert panel of psychiatrists) she could not get adequate treatment for her mental health condition and died as a result of it."

131 In light of those matters, the fact that Ms Shipley was in custody when she died is undoubtedly one of the circumstances surrounding her death. The circumstances in which Ms Shipley came to be, and to remain, in custody while mentally unwell in the

days preceding her death, although approaching the limit of the matters that are within the Coroner's s 23(1) authority to decide, bear a sufficient relation to her death that an inquest pursuing lines of enquiry into those circumstances in the limited manner the Coroner proposes is fairly to be characterised as an inquest concerning Ms Shipley's death. The pursuit of the lines of enquiry referred to at D[138]-[142] and [150] would not be arbitrary or capricious. Nor is there a basis to conclude that the Coroner proposes to pursue those matters for a purpose other than the purpose of performing the Coroner's functions in holding an inquest (such as exercising the s 81(1)(c) power to make findings as to the manner and cause of Ms Shipley's death or the s 82(1) power to make a recommendation in relation to a matter connected with her death). Nor would pursuit of those matters in the limited manner the Coroner proposes otherwise mean that the inquest was not fairly characterised as "concerning" Ms Shipley's death. The jurisdiction conferred on the Coroner by s 23(1) extends to authority to decide matters emerging from those lines of enquiry.

132 Ground 1(b) in the summons is to the effect that "the NSW Police Force's institutional frameworks for dealing with persons suffering from mental illness" are beyond the Coroner's jurisdiction. Expressed at that level of generality, the Commissioner's contention has some force. If the Coroner were proposing a general investigation of that subject, untethered from the circumstances of Ms Shipley's death, the inquest would cease to be one "concerning" her death. The same might be true of a general investigation, unlimited as to period or as to connection with her death, into "the NSW Police Force's interactions with Ms Shipley" (Ground 1(a)). But I do not understand the Coroner to be proposing any such general investigations. Instead, I understand the Coroner to be proposing to examine the NSWPF's dealings with Ms Shipley (including how she came to be and to remain in custody notwithstanding being mentally unwell) in the period 9 to 14 December 2022, and certain "policies or procedures" of the NSWPF insofar as they might have been specifically relevant to those dealings. Those matters are not so remote from Ms Shipley's death as to exceed the Coroner's jurisdiction. The inquest is still one "concerning" her death.

133 It follows that Ground 1 is also not made out.

Orders

134 In accordance with an agreement reached among the active parties, there should be no order as to costs.

135 None of the three grounds pressed in the summons is made out. The order of the Court is:

(1) The summons is dismissed.

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Amendments

13 May 2026 - [80] - "prisoner's" corrected to "prisoners'"

[83] - "lines" corrected to "line"

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