FINDINGS AFTER INQUEST IN TO THE DEATHS OF TRENT SPEERING

AND MONICA SPEERING

1. Sitting as State Coroner, in July 2010, I heard evidence relating to the deaths of Trent Speering and Monica Speering from nineteen witnesses. An enormous amount of documentation was also tendered throughout the proceedings.

2. I was assisted by Mr Agius of Senior Counsel, Ms Dwyer of Counsel, and Ms Graham of the Crown Solicitor's Office.

3. Mr Sexton of Senior Counsel appeared on behalf of the NSW Ambulance Service, with Mr Pike, Mr Spitalis then Mr Biggins for the Police Service, and Mr Nicholls for two senior police officers, Superintendent Paroz and Inspector Puxty. Mrs Dorothy Bonser, who is Monica Speering's sister, attended the entirety of the inquest, accompanied by members of her family.

4. Section 81 of the *Coroners Act* 2009 requires that the Coroner must at the conclusion of an inquest record in writing the findings regarding the identity of the deceased, the date, place, cause and manner of death. As is so often the case, these proceedings mainly concerned the manner of the Speerings' deaths (the other issues being generally clear), that is, how their deaths came about, or what the circumstances were which led to them.

5. Section 82 of the *Coroners Act* allows the Coroner to make recommendations as considered necessary or desirable in relation to any matter connected with the death(s), being one of the objects of the Act, as set out in sub-section 3 (e).

THE FACTS

6. Trent Speering was born on 14 November 1967 to Monica Speering and her then husband. He was brought up by Monica Speering after his parents divorced, and his father had no further involvement with the family. He was reportedly devoted to his mother. He lived with her until he was 30 when he bought his own house. He held a lifelong ambition to be an Ambulance

Officer, and joined the NSW Ambulance Service in 1996. However, from 2000, colleagues began to make complaints and file written grievances about him, highlighting his temper, irrationality, harassment and bullying. Many refused to share shifts with him, and some expressed some fear of him.

7. Trent Speering's response was to counter-claim that the complainant had harassed and/or bullied him. Generally, his counter-claims appear to have been without substantiation.

8. In 2003 and 2004, Trent Speering made workers compensation claims for "stress anxiety". Psychologists who assessed him for the insurance company refuted the claims on the basis that any issues he had were not work related. Trent Speering refused to see a psychiatrist and returned after the second claim to full duty, in late April 2004, but continued to make further claims of harassment, discrimination and resulting stress. In the following years, there was a constant flow of complaints both against and by him. Ultimately, in August 2007, he was suspended on full pay, pending the outcome of investigations of allegations of aggressive, offensive and threatening behaviour towards other Ambulance Service staff. The PSCU was responsible for handling the complaints, and engaged Linda Petterson, a senior consultant with IAB Services, to investigate and prepare a report, which she delivered to the Ambulance Service in October 2007.

9. Other paramedics were aware that Trent Speering held a firearms licence, owned guns and belonged to a gun club. Some expressed concerns. Indeed, in 2003 or 2004 one station began a half-joke that he was "the man most likely to bring a Kalashnikov to work".

10. In November 2007, the Chief Executive of the Ambulance Service, Greg Rochford, wrote to Superintendent Patrick Paroz of the Blue Mountains Area Command, requesting that Police consider suspending Trent Speering's gun licence and removing his firearms. This was passed by Paroz to Inspector Puxty, who, in January 2008, advised Graeme Willis of the Ambulance Service that there was insufficient evidence to justify licence suspension.

11. In April 2008, for the first time, the Ambulance Service provided Trent Speering with a copy of the Petterson report, and notified him that he had fourteen days to make submissions concerning proposed disciplinary action, i.e. his dismissal. (He was subsequently given an extension of seven days.) Trent Speering met with Rochford and other senior management on 2 June. On 11 June Graeme Willis left a message on Trent Speering's answering machine to the effect that a decision had been made and the Ambulance Service wanted to meet with him to tell him the of the outcome.

12. On the same day, Trent posted numerous letters to fellow staff and management, family, a woman whom he admired, and various press organisations, most of which were vituperative and horrifying, disclosing his intention to kill his mother and then himself.

13. On receiving one of these letters on 12 June, a Daily Telegraph staff member rang the Police, who went first to Trent Speering’s home in Blaxland, then, finding the house unoccupied, to Monica Speering’s house in Baulkham Hills. Trent Speering’s car was parked outside his mother's house. Inside, police found Monica Speering’s body lying on the kitchen floor covered in a blanket and with her head on a pillow. There were two obvious gunshot wounds to her head. Vegetables she had been preparing for their dinner were lying half-peeled on the bench. In her bedroom, Trent Speering was found lying on the bed, dead from a gunshot wound to the head and with the gun still held in one hand.

14. A signed letter addressed to the NSW Coroner located at the scene read:

> “ I Trent Michael Speering hereby state that I do not want an autopsy carried out on my mother Monica Mary Speering or myself or have any of our organs harvested as this is my legal right. It will be obvious what the cause of death has been. My intention is to shoot my mother and then shoot myself. I trust you will grant my wish.
>
> Regards
>
> Trent Speering

15. A similar letter with further instructions regarding cremation, funeral arrangements, and Trent Speering's wishes for disposal of both his property and that of his mother, was sent to a solicitor.

THE ISSUES

16. The issues raised by the above factual circumstances and that were explored during the inquest are:

    1. The time of death of both Monica Speering and Trent Speering

    2. Whether Trent Speering was managed appropriately by the NSW Ambulance Service as a difficult employee.

    3. Whether the Ambulance Service had any notice prior to 12 June 2008 that Trent Speering might be a genuine threat to himself or others, and if so, whether it acted appropriately in response.

    4. Whether there was any causal connection between Trent Speering's management by the Ambulance Service, and the death of his mother and himself.

    5. Whether NSW Police acted appropriately upon receiving notification from the Ambulance Service that Trent Speering had a gun license and firearms, and that consideration should be given to suspension and seizure? Further, was the decision by the Police to take no action justified?

THE EVIDENCE

Family, friends and neighbours

17. In the opinions of Mrs Dorothy Bonser, Monica Speering's sister, and Mrs Patricia McGinty, a long term friend, Monica Speering was completely unaware of the fact that Trent Speering had been suspended from the Ambulance Service for months, or that he had had years of problems within the service, or that he knew he was about to be dismissed. They were also unaware of those issues. Both of them were quite certain that Monica

Speering would have talked about it to them, had she known, because Trent Speering was so important to her. Monica Speering was also probably unaware that Trent Speering had a medical condition known as Peyronies Disease (or penile curvature) for which he had had surgical intervention, and which apparently caused him both physical pain, and difficulties in forming relationships. As close as Trent and Monica Speering were, it became clear to me that he did not share with his mother anything of an emotional or problematic nature. It is impossible to say whether this was in order to protect her from anxiety, or himself from shame and embarrassment. This becomes important when psychiatric evidence is considered.

18. Mrs McGinty was speaking on the telephone with Monica Speering between 4pm and 4.30 pm on Wednesday 11 June. Monica Speering told her Trent was coming for dinner. Mrs McGinty also heard Trent, whose voice she was familiar with, say hello when he arrived at his mother's house. Monica told her that Trent had arrived for dinner, and the conversation ended. We know from the Donnellys, who were Monica Speering's neighbours, that at about the same time, Trent Speering had been seen to park his car in her driveway and enter the house, and that he was not seen again, nor the car moved. Mrs Donnelly observed a light on in Monica Speering's house at 7 pm, which was unusual, and which was still on the next morning. Mrs McGinty's sister, Toni Perrin, who lives in Young and was a friend of both Monica Speering and Dorothy Bonser, tried to telephone Monica Speering at 6.57pm that same evening, and the phone rang unanswered.

19. Adding together these facts, the police evidence that half-prepared vegetables were found on the kitchen bench, the letters which Trent Speering had posted on 11 June, and the forensic evidence of Dr Langlois, the experienced pathologist who performed the post mortem, I can be satisfied as to the approximate times of the deaths.

Work colleagues and Management

20. Ambulance officers Young, Williams and Bowen had each made comments to management of the Ambulance Service about Trent Speering's behaviour,

their own difficulties with him, and their observations that he possibly had a serious mental illness. As paramedics trained to detect mental health issues, they each felt that their observations should have been considered and acted upon. They were not. They were impressive witnesses, skilled and experienced in their profession and as concerned for Trent Speering as for their own safety and that of their colleagues. In evidence also is a plethora of complaints made against Trent Speering from 2000 onwards by fellow paramedics, alleging that he was verbally and physically aggressive, displayed irrational behaviour, failed to comply with directions, used unsafe work practices, was rude to patients and nurses, and many more complaints, to most of which Trent Speering responded with counter accusations which were never established. It is clear that management was well alerted to his behaviour at least by 2004.

21. Senior managers of the Ambulance Service, Mr Ken Wheeler, Mr Graeme Willis, Ms Louise Ashelford and the CEO Mr Greg Rochford, all gave oral evidence in which they agreed that Trent Speering was an extremely problematic and troublesome employee. Unfortunately, none of them were prepared to concede that despite these difficulties, he might have been more effectively dealt with throughout his employment. This was despite Dr Diamond's view that the way the Ambulance Service managed the disciplinary process, played a significant role in Trent Speering's ultimate actions.

22. Mr Willis did not regard it as part of his duties to draw to the CEO's attention the concerns raised by other paramedics, nor to act upon them, nor to recommend to the CEO a psychiatric assessment. Inexplicably, Mr Bowen's comment as to Trent Speering possibly suffering "psychological/personality disorders" was edited from a risk assessment. None of the risk assessments (save one produced on 12 June 2008, the day after the deaths) referred to any of the observations raised by the ambulance officer's as to Trent Speering's mental health. Indeed, none raised the issue of Trent Speering's mental state at all, despite that being provided for in the standard risk assessment forms.

23. The CEO, Mr Rochford, was therefore, apparently not fully informed of matters pertaining to Trent Speering. Disappointingly, he did not appear to accept that the service could benefit from changes to its management practices, or that changes made in recent years had been of limited significance in practice to facilitate more effective management of employees who have overlapping mental health and disciplinary issues.

24. On 7 August 2007, Trent Speering was finally suspended from duty on the recommendation of Mr Rochford, with an investigation to be commissioned. The Internal Audit Bureau (IAB) was asked to conduct that investigation, in particular in relation to allegations made by Ambulance Officers Williams and Patterson. By September, further allegations were referred to the IAB by Officers Young and Clarke. Following an interview with Trent Speering by Linda Petterson of the IAB, a report was provided by the IAB on 23 October 2007 to the Ambulance Service. The recommendation made in that report was that the Ambulance Service should consider taking disciplinary action against Trent Speering. The letter accompanying the report also flagged staff fears about Trent Speering being in possession of a firearms license and guns and staff concerns about his mental health. Recommendations were thereafter made by Ms Ashelford, who was acting in Mr Willis' position while he was on leave, that Trent's suspension be continued and that NSW Police be requested to suspend his firearms licence and seize his firearms. Ms Ashelford also recommended that the investigation report be withheld from Trent Speering when notifying him that disciplinary action was to be taken.

25. In early December 2007, Mr Rochford determined to:

    1. Withhold providing a copy of the IAB Report to Trent Speering on the basis of concerns for the safety of other staff;

    2. Direct Trent Speering not to approach any ambulance staff or station;

    3. Warn him that any approach may constitute a further breach of discipline or be referred to Police;

4. Organise a meeting with staff to identify concerns and discuss strategies for dealing with possible incidents; and

5. Write to Trent Speering advising him that the Service intended to take disciplinary action, which may lead to dismissal.

26. Mr Willis returned from leave and took back conduct of the file on 19 December. In early January, he followed up the matter of Trent Speering's firearms suspension by telephoning Springwood Police Station. Staff met with Mr Wheeler to discuss concerns about Trent, and some stated that he should be helped, and that they were not seriously afraid of him using guns. At the end of January, Trent Speering was told of all the decisions relating to the Report including that it would be withheld from him. Trent Speering complained about that in writing to Rochford and requested an interview with him. He also complained of the delay in the process and the lack of response to his previous letters and particularly his request to be provided with a copy of Ms Pettersson's report. He continued to write complaint letters throughout February 2008.

27. According to the Ambulance Service's own *Procedural Guidelines,* Trent Speering should have received a copy of the full report, a fact he was well aware of. Section 8.4, page 21 of the *Procedural Guidelines for Dealing with Misconduct as a Disciplinary Matter and the Taking of Disciplinary Action* states that before any disciplinary action is taken the employee is to have an opportunity to make a submission to the Service. A written notification to the employee advising of that opportunity "must state the details of the misconduct (The full Investigation Report with all attachments should be included)".

28. The Ambulance Service finally sought a legal opinion on their obligations in late February and was advised that Trent Speering should be provided with a copy of the Report. In March a letter was drafted addressed to Trent and attaching a copy of the report. However it was not until April that this was sent to Trent after he refused to meet with Ambulance Service staff to have

the report provided by hand. Trent forwarded a 25 page submission in response on 9 May 2008.

29. On 2 June 2008, supported by a union representative, Trent Speering attended a meeting with Greg Rochford, Graeme Willis and Mark Willis at Ambulance Service State Headquarters, at the end of which Mr Rochford indicated that he had not yet come to a conclusion in regard to the disciplinary matter. Three days later Trent Speering wrote him a very abusive, threatening letter but did not post it at that stage. Mr Rochford decided to dismiss Trent on 6 June, and sought advice and the preparation of a Risk Management Plan to co-ordinate the timing of giving that advice to Trent Speering, suggesting that a further meeting should be held with Trent to tell him of the decision. Mr Willis sent Trent a letter on 11 June 2008 seeking that final meeting and he also telephoned him at home, leaving a message on his answering machine.

Medical/Psychiatric Evidence

30. Dr Neil Langlois, a senior forensic pathologist, performed the autopsies on both Monica Speering and Trent Speering. His post-mortem reports show that:

    1) Monica Speering died of two gunshot wounds to the head, one to the back of the head with the characteristics of a 'distant' shot, and the other to the left side, above and in front of the left ear appearing to be either a contact, or close contact, shot, and

    2) Trent Speering died from one gunshot wound to the right side of his head, with characteristics of self-infliction. It may therefore be concluded that Trent Speering shot his mother from behind (while she was standing with her back to him at the kitchen sink), shot her again close up once she had collapsed to the floor, made her "comfortable' with pillow and doona on the kitchen floor, went to his mother's bedroom, lay on her bed and shot himself through the right side of his head. The firearm was found still in his right hand.

31. Dr Michael Diamond, an experienced psychiatrist, provided the court with an expert opinion or "psychiatric post mortem" and was heavily cross examined

by Mr Sexton for the Ambulance Service on that opinion. While it is acknowledged that psychiatry is an inexact science, Dr Diamond is an accredited and accepted expert witness, and his conclusions and opinions are to be given considerable weight. Dr Telfer, a psychiatrist whose advice to the Ambulance Service is also in evidence, substantially agreed with most of what was said by Dr Diamond.

32. Dr Diamond's diagnosis of Trent Speering is that he suffered both from a paranoid personality disorder (a mental condition) and depression (a mental illness) and that features of the former were exhibited throughout his employment with the Ambulance Service. The personality disorder had also been identified by two psychologists, Messrs Anning and Merritt, to whom Trent Speering was referred in 2003 and 2004, respectively, by the insurance company after he had made claims (and had them rejected) for sick leave based on “work-related stress”. Both Mr Anning and Mr Merritt recommended that Trent Speering be psychiatrically assessed. Files produced by the Ambulance Service suggest that neither these reports nor the substance thereof was ever considered by anyone at the Ambulance Service. It is likely that these reports were never received by the Ambulance Service and that no-one within the Service made inquiries about receiving them or a summary of the information contained therein.

33. However, Ambulance Service files did reveal that in late 2004, a recommendation was made by Paola Mercuri, an Injury Management Co-ordinator at the Ambulance Service, for Trent Speering to be psychiatrically assessed by HealthQuest, but that this recommendation was not acted upon. Nothing in the files explained why it was not. Trent Speering was never asked to see a psychiatrist, despite the comments from Messrs Anning and Merritt, and the recommendations of Mr Beesley and Ms Mercuri of the Ambulance Service.

34. On 6 March, Mr Mark Beesley, then an Area Manager, wrote a memorandum to Divisional Manager Ken Pritchard, drawing attention to complaints about Trent Speering. The memo states:

> “On the reports submitted officer Speering may have an underlying problem that needs to be addressed. Officer Speering has also filed complaints against other officers. The tone of these complaints is that the officers he works with are incompetent or ignorant. Officer Speering does not recognise that he may be the problem. In order for this matter to be resolved I am recommending that an independent authority investigate the complaints and that officer Speering be the subject of an examination to assess his fitness for duty".

Once again, it is extremely regrettable that this recommendation (from an experienced employee and a manager) was ignored and there is no explanation as to why that was the case.

35. Dr Diamond’s opinion was that Trent Speering’s disorder would have been very difficult to treat, even if he had been prepared to accept the diagnosis and/or the need for treatment. However a psychiatric examination may have led to a diagnosis of his mental problems and a firm basis for an assessment of his fitness to remain as a paramedic. It is also possible, of course, that Trent would have accepted treatment if it was made a condition of him remaining in employment. I accept Dr Diamond’s view, expressed in evidence and based on many years of experience, that if a job is particularly important to an employee, even a difficult one, they may well be prepared to engage in treatment if that is a non-negotiable condition of them remaining in the job.

36. Written evidence established that Dr Katelaris had performed surgery on Trent Speering in 1994 to correct penile curvature and thereafter in 2005 to remove some small adhesions between the foreskin and glands of his penis. Dr Katelaris reported that when he saw Trent Speering in 2005, Trent was given a small vaso-active injection to induce an erection and that the "appearance and quality of the erection was normal". After releasing the small adhesions, on further examination, the penis and foreskin appeared to be healing well and Trent did not express any unhappiness or dissatisfaction.

37. It appears from a letter signed by Trent and found at his house that he was dissatisfied with the work Dr Katelaris had done and that he blamed Dr Katelaris for his inability to form relationships with women. Dr Diamond suggests that, while the early issue Trent Speering had with his penis may

have contributed to his development of a personality disorder, it was more likely his personality traits, rather than anything else, that were responsible for his failure to form positive relationships with women and indeed with anyone. I accept Dr Diamond's evidence on this point.

Police

38. Trent Speering had had a firearms licence since 2004. He owned two Beretta pistols, and was a member of St Mary's Pistol Club. He renewed his licence in October 2007, providing as answers to the required questions, that his reasons for needing the licence and firearms were 1. “to allow participation in centrefire target competitions” and 2. “ to allow the humane dispatch of large feral pests such as pigs and goats”.

39. Superintendent Paroz was, in late 2007, the Area Commander for the Blue Mountains. Mr Rochford’s letter requesting consideration of suspension of Trent Speering’s licence was received by him, and passed on to Inspector Puxty. The concerns expressed by IAB in their Report about Speering’s psychiatric state were not passed on to Police in this or any other letter. On 20 October, Inspector Puxty advised Ms Ashelford that as no criminal offence had been alleged against Trent Speering, there appeared to be insufficient grounds for suspending his licence, but that if an AVO were to be taken out against him, this in itself would result in suspension and the seizure of his firearms. No written confirmation of this advice having been received by the Ambulance Service, Mr Willis phoned Inspector Puxty in early January and the advice was re-confirmed. Apart from these two senior officers, I also heard evidence from Inspector Banfield who oversaw the critical incident aspects of the investigation of Monica and Trent Speering's deaths and from Giovanni Mison of the Firearms Registry.

40. The evidence of Inspector Puxty and Superintendent Paroz was that the statements and observations by Young and Williams were not drawn to the attention of Police, that the IAB Report did not itself address the observations made by others about Trent Speering’s mental state and that the covering

letter sent by IAB (authored by Steve Kent), attaching the report and referring to potential mental health issues, was not sent on to police. The Police simply were not made aware by the Ambulance Service of the real concerns and fears about his actions. The basis for their decision making was limited to what they were told by the Ambulance Service, which was minimal.

41. Although there was apparently a practice that a COPS entry should be made when police refuse an application to suspend a licence, neither senior officer was aware of it. That practice was not written down or widely publicised within the NSW Police Force and Officers Puxty and Paros cannot be blamed for not knowing about it. The evidence of Ms Mison was that had a COPS entry been made, the Firearms Registry would have been alerted to the Ambulance Service suspension request. There is no evidence, however, that consideration by the Firearms Registry would have led to a different conclusion, given the material provided by the Ambulance Service.

42. Those instructing me have recently received a very helpful letter dated 25 August 2010, relating to suggested changes in policy that will ensure that all police are aware of a mandatory requirement for a COPS entry to be made whenever there is an application for suspension of a firearm, regardless of whether the application is refused. Further, the COPS entry would be done in a way that would automatically result in the Firearms Registry being notified. That letter notes that this suggested action has been endorsed and has the full support of the NSW Police Firearms Registry.

43. These proposed reforms are very sound but are not yet in place. I propose to make recommendations which are in similar terms to the suggestions set out in the letter of 25 August, and I trust that they will be acted on promptly in accordance with the views of the Firearms Registry.

Crime Scene Police

44. As we know, Trent Speering mailed a large number of letters on 11 July 2008, most of them abusive and insulting. The majority of these letters were to colleagues and managers at the Ambulance Service. One letter was addressed to the Daily Telegraph, and opened at 10.10 am on 12 July by an

employee, Daniel Creech. That letter specifically outlined Trent Speering's intentions. As outlined above, Mr Creech immediately faxed a copy of that letter to Crimestoppers, who found Trent Speering's Blaxland address, and contacted Springwood Police. Police were advised that Trent (who was licensed to use firearms and known to own two) had sent the letter to the media outlet threatening harm to his mother and to himself. Shortly after noon, police found Trent Speering's house unoccupied and with no car in the garage.

45. Once provided with Monica Speering's Baulkham Hills address by Ms Ashelford of the Ambulance Service, Detective Inspector Bostock of the Blue Mountains Area Command contacted Duty Officer Darren Middlebrook, the then Crime Manager of the Hills Area Command, and advised him of the concerns for the Speerings' welfare. He was further advised that Trent Speering was not at his home address but may be at the location of Monica Speering's house. By 1:20pm, police, including Dog Units, Polair, Negotiators and the Tactical Operations Unit, had set up a command post near Monica Speering's house at 9 Torrs Street and had established perimeters. No movement was seen in or near the house. The phone was unanswered. Of course this all took considerable time - a large number of police were involved, it was a potentially highly dangerous situation, many citizens, including children, were in the vicinity, and a search warrant had to be obtained. A search at the Blaxland house had revealed that Trent Speering's firearms were not in the gun cupboard, so Police were aware of the potential threats of use of firearms. Continuous attempts were made to contact someone in the house using a PA system, with no response. At 5:32pm forced entry was made and the bodies of both Monica and Trent Speering were found and confirmed deceased.

46. It is apparent that both Monica and Trent Speering were dead before Patricia McGinty's phone call to Monica at 6:57pm on 11 June 2008, and long before the police had any notification of Trent's stated intentions. The police acted in a timely and efficient manner in responding to the reference to Crimestoppers

on the morning of 12 June. No criticism whatsoever is made of the actions of Police on that day, and I agree with Inspector Banfield's opinion to that effect.

CONCLUSIONS

47. Trent Speering clearly had a severe mental disorder from which he had suffered for many years. He killed his mother because he believed that she would have no one to look after her after his suicide (and, as suggested by Dr Diamond, because she would not be able to bear what he had done). In fact, although Monica Speering was patently deeply attached to her son, as he was to her, she was an independent, active woman with many friends and interests.

48. Trent Speering must have been an extraordinarily difficult employee and work colleague. I was impressed by how many of his fellow paramedics, despite filing grievances against him for his appalling behaviour, also expressed real concern for him, and suggested to management that he needed help. Unfortunately, help was not forthcoming. It may not have been successful, but it surely should have been attempted.

49. In both opening and closing submissions those representing the Ambulance Service seemed to suggest that there was no causal connection between the actions of the Ambulance Service in not addressing the issue of Trent Speering's mental health, and the manner of his and his mother's deaths. I do not accept that suggestion if it is maintained.

50. Had the Ambulance Service acted upon the findings and recommendations of the two psychologists in 2003/4 or the recommendations of Ambulance Officer Beesley or of Paola Mercuri, or responded to the indications by Paramedics Young, Williams and Bowen that they thought Trent Speering had a mental disorder, it is likely that a psychiatric examination would have led to diagnosis at least of his mental problems. His employment with the Ambulance Service, apart from his relationship with his mother, was probably the most important thing in his life. His letters to the Ambulance Service throughout his suspension indicate an intensifying of agitation and increasing concern about the delay in resolving his matters. If we accept the view of Dr Diamond that

the long drawn-out term of suspension, coupled with the refusal to provide him with the IAB Report, exacerbated his paranoia, he must have come to the point of despair after realising that the process was moving inevitably to his dismissal. Frankly, hearing evidence of his actions, writings and use of the internet, there were moments when it seemed amazing that the court was not dealing with an even worse situation, such as a mass killing of ambulance personnel by Trent Speering. He obviously thought about it, threatened it, and had the capacity to do it.

51. The two psychologists writing in 2003 and 2004, and several of his work colleagues, made observations of his paranoid personality disorder in connection with observations of his aggressive and irrational behaviour. Had he been referred then to a psychiatrist, he may have been offered treatment as a condition of remaining a paramedic. His condition once recognised could have been monitored. If his personality disorder had been brought to the attention of the Police, there can be no doubt that his firearms licence would have been suspended or revoked and his guns seized, according to Superintendent Paroz. That that did not happen is not the fault of either Superintendant Paroz or Inspector Puxty, as they were limited by never having been given the material which would have put the request to suspend in context. The Ambulance Service could and should have passed on their observations, viewed in the context of all the material available to it about Trent Speering's reported behaviour.

52. It seems that once the decision was made to proceed against Trent Speering by taking disciplinary action, no thought was thereafter given to his wellbeing when it ought to have been obvious that he was suffering from a mental disorder. At no time did the Ambulance Service give consideration to the possible underlying causes of his persistent workplace conflicts.

53. I do not want to be understood as suggesting that these two tragic deaths were totally the fault of, or directly caused by, the Ambulance Service of NSW. Some staff members, like Ken Wheeler, showed genuine concern for Trent. Employees of the service, and in particular the on-the-ground paramedics, have a long and well-deserved history of service to the sick and injured. They

are highly trained, dedicated, skilled people and I take my hat off to them. Unfortunately, no doubt partly because of the extremely stressful nature of their work, there have been in recent years a number of suicides, accusations and problems leading to an Inquiry into the Management and Operations of the NSW Ambulance Service in 2008 and subsequently, a review of that inquiry earlier this year.

54. I am not convinced that management have sufficiently improved or changed their protocols as a result of recommendations made by that Inquiry. although there have been some recent efforts which are encouraging. In his letter of 28 August 2010, CEO Greg Rochford, refers to a "range of strategies" implemented by the Ambulance Service to manage "what are often complex and converging employment related matters". As he sets out, the Ambulance Service has separate mechanisms for managing conduct and capacity issues. That means that when an employee has a health issue, including a mental health issue, there is a particular mechanism for dealing with him or her. These matters are managed by 'Workforce' and the relevant operational managers. Available strategies include management in accordance with the drug and alcohol policy or sick leave policy, directing employees to attend for medical assessment, developing performance improvement plans or a combination of these options.

55. Alternatively, if the concern is of a disciplinary nature, an employee will be dealt with through disciplinary procedures. Misconduct matters, criminal and serious traffic charges are managed by the PSCU in accordance with the *Ambulance Services Regulation* 2005 (NSW) and the *Procedural Guidelines* for managing misconduct. The complexity arises when the two issues overlap.

56. For some employees, including Trent Speering, there is an overlap in conduct and capacity issues. For example, as was apparent in Trent's case, someone may be suffering from a psychological or psychiatric condition that causes them to behave strangely, in an aggressive manner or in some other way that concerns staff and/or patients. The Ambulance Service must develop adequate procedures to deal sensitively and effectively with that situation, since it is clear that they were not in place (or were not properly implemented)

at the time that Trent was being managed through the disciplinary process. What is required might be referred to as a “two-track” mechanism for dealing with employees that have overlapping health and disciplinary matters.

57. At my request, this issue was addressed in the letter of CEO Greg Rochford referred to above. Mr Rochford acknowledges that a two-track process (although that term might be an oversimplification) is required where concerns about capacity and fitness arise in the context of a misconduct issue or complaint. He writes that this is now dealt with by convening a meeting of the ‘Significant Allegations Advisory Committee’ to discuss all aspects of concern, and where necessary to review the employment history of the individual under investigation. This committee includes a senior PSCU officer, Manager of Healthy Workplace Strategies, Director of Patient Safety and the senior operational manager responsible for the employee.

58. It is encouraging to learn of the statistics reported by the Ambulance Service that show that a number of employees currently being dealt with in the disciplinary context, are also recognised as having overlapping issues of capacity or fitness for duties. Thus, provided an employee is identified as having those problems, the ‘two-track’ mechanism can operate. I have no evidence of an evaluation of that procedure to date and it appears to me that it would be helpful for one to be done.

59. What is of concern, however, is that evidence given by Paola Mercuri, the former Injury Management Co-ordinator, whose evidence I refer to above (see par 33) is to the effect that before leaving the Ambulance Service this year, there were a significant number of employees who had mental health concerns that were not being addressed by Management. In some instances, concerns she had expressed about an employee’s mental heath were ignored. Her expertise and experience was not acted upon. That was the case with regard to Trent Speering, whom she thought should have been psychiatrically assessed. Sadly, her concerns had also been ignored with respect to other employees. In her statement, which was tendered, she writes:

In my position and time with the Ambulance Service I have formed a strong view that Mr Trent Speerings situation could occur again. By this I mean I have a firm belief that there are currently other employees of the Ambulance Service still working who would benefit from psychological assessments (at par 20)*.*

60. It is very regrettable that in relation to Trent Speering, and seemingly other employees, the Ambulance Service has ignored its own staff, who have experience, some expertise and certainly common sense that should be of real value in determining which employees have mental health concerns that must be addressed. When Paula Mercuri recommended that Trent be psychiatrically assessed in 2004, she was ignored. When Ambulance Officers Young, Williams and Bowen expressed their concerns that Trent might have mental health problems, they were ignored. When Mark Beesley prepared a memorandum in 2004 recommending that Trent Speering be the subject of an examination to assess his fitness for duty", nothing was done to follow that up. Without an effective policy that gives weight to the views of respected employees who are ideally placed to recognise or at least 'flag' the problem, it is likely that mental health needs of some Ambulance employees will continue to be ignored.

61. This issue was not dealt with satisfactorily by the Ambulance Service in this Inquiry, either in oral evidence given by managers or in written submissions. The question that remains is what system can be put in place to ensure that the Ambulance Service acts on the valid concerns of employees in the future. Of course, there is always the possibility that one employee might be malicious or mistaken in reporting that another has mental health concerns. That is no reason, however, to not document their concerns and review them to see if they are meritorious. This is particularly the case when the concerns are expressed by respected long term, senior staff and, as in the case of Trent Speering, by more than one staff member who falls into that category.

62. Trent Speering was a bomb waiting to explode, and while the Ambulance Service management did not light the fuse, they did little to stamp out the flame. The Recommendations I make are to suggest improvements in the system rather than to criticise. Sections 3 and 82 (1) of the *Coroners Act* of 2009 provide the power to do so in order to prevent similar deaths. It is to be hoped that the Service will take those recommendations in that spirit accordingly.

FINDING

I find that Monica Speering died of gun shot wounds to the head, inflicted by Trent Speering, on 11 June 2008, in Baulkham Hills, Sydney.

I find that Trent Speering died of a self-inflicted gun shot wound to the head on 11 June 2008, in Baulkham Hills, Sydney.

ORDER PERMITTING PUBLICATION

It is my view that it is in the public interest for a report of these proceedings to be published and I so permit publication under Section 75(5) of the Coroners Act 2009.

Magistrate Mary Jerram — 3 September 2010

State Coroner NSW — Chambers, Glebe

RECOMMENDATIONS:

To the Commissioner of Police:

1. That the Commissioner of Police brings into effect a Standard Operating Procedure to ensure that when any police officer receives a report suggesting that a gun license may need to be suspended, that police officer:

    a) makes an entry in COPS regarding the report, and

    b) ensures that the Firearms Registry is notified of the decision taken with respect to the suspension, and consulted as to the suspension decision.

To the Ambulance Service of NSW/ Minister for Health:

1. That the Ambulance Service introduces training for all relevant management staff relating to their power to refer a staff member for psychiatric assessment, pursuant to the *Ambulance Services Regulation* 2005.

2. That the Ambulance Service introduces clear policies which ensure that reports made by paramedics or other staff relating to their concerns for the mental health of other employees are documented and promptly acted upon if meritorious.

3. That the Ambulance Service investigates the effectiveness of communication between the Risk Management Group and other arms of management, to ensure that the recommendations of Return to Work officers regarding the mental health of employees are taken into account at an early stage and specifically addressed in any management decisions or risk management plans concerning a respondent employee.

4. That AS NSW publicises to all staff any reforms introduced since the death of Trent and Monica Speering that relate to safeguarding the mental health of employees and improving disciplinary and remedial procedures.