CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 4th day of November 2015 and the 30th day of June 2016, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of David Patrick Said.

The said Court finds that David Patrick Said aged 37 years, late of 14 Douglas Street, Marion died at Sturt Gorge Recreation Park, Flagstaff Hill, South Australia on the 4th day of April 2012 of multiple injuries. The said Court finds that the circumstances of his death were as follows:

1. Introduction

1.1. David Patrick Said was 38 years of age when he died at the Sturt Gorge Recreation Park on 4 April 2012. He was seen by police officers to have jumped or fallen from the wall of the Sturt Gorge Dam. An autopsy was carried out by Forensic Pathologist Dr Heath, who reported the cause of death as multiple injuries[1] and I so find. Police officers had been attempting to engage with Mr Said immediately before his death to persuade him to leave the Dam wall for his own safety, and so that they could detain him pursuant to the Mental Health Act to take him to a hospital for treatment and assessment. I think it is clear that Mr Said was either attempting to evade apprehension by the police or was "in the process of being apprehended" at the time of his death. In either case his was a death in custody within the meaning of that expression in the Coroners Act 2003, and this inquest was held as required by section 21(1)(a) of that Act.

[1] See Exhibit C3a

2. Background

2.1. From about the age of 21 Mr Said began to exhibit signs that he was suffering from a mental disorder. He was diagnosed with chronic disorganised schizophrenia. After the diagnosis he had multiple hospital admissions, mostly in the context of not having complied with prescribed medication treatment resulting in disturbed behaviour.

2.2. In 2010 Mr Said's general health had been deteriorating for some time. He was admitted to the Flinders Medical Centre as a result of this and his increasingly disorganised behaviour which resulted in poor self-care. He was becoming obsessed with the health of the family dog at this time. This obsession would result in him becoming angry with his elderly parents (with whom he was residing) when they attempted to handle the dog. On one occasion he assaulted his father. His medication was changed. In particular the dose of Risperidone was increased but without any noticeable improvement in his mental state. As a result he was changed to Haloperidol with a reasonably good response. He was commenced on a depot regime and agreed to maintain that regime voluntarily.

2.3. In late 2011 he was again detained at the Flinders Medical Centre with increasingly disorganised behaviour. He was fixated on the family dog's health, he had harmed himself and was threatening suicide. The dog's health had been declining in 2011 with the onset of diabetes, and this exacerbated Mr Said's obsession. He told his treating clinicians that he was committed to looking after the dog, and claimed that when the dog died, he would kill himself as there would be no other reason for him to live.

2.4. In March 2012 Mr Said's mother and his sister attended a case conference with his treating psychiatrist and a mental health nurse and psychologist who were involved in his treatment plans. The purpose of the meeting was to plan for the management of Mr Said's reaction to the inevitable event of the dog's death. They discussed the option of detaining Mr Said immediately after the dog's death but this was not preferred by the family. They were hoping to keep him at home and monitor his reaction. It was agreed that Mr Said's sister would contact the treating team immediately after the death of the dog to put them on notice.

3. Events leading to Mr Said's death

3.1. Sadly the dog died on 2 April 2012. As planned, the sister notified the treating team, and by all accounts, Mr Said did not do anything to cause his family undue concern until the morning of 4 April 2012. At around 10am he left the house in his own vehicle, but the family were concerned that he might be going to harm himself. Accordingly at 10.46am a call was made to police to advise that he was missing and that the family had concerns for his safety. At 10.51am police communications message 494 was raised and a missing person report was commenced. At 10.55am there was a call to Mr Said's sister seeking information that may assist police in locating her brother. At 10.56am a patrol was tasked to the home address and a patrol supervisor, Sergeant Murgatroyd, acknowledged that he was aware of the tasking and he issued an all patrols message about Mr Said.

3.2. Probably as a result of police calling Mr Said's mobile phone, he contacted police shortly after 12pm to say that he was at Sturt Gorge. He terminated the call without saying anything else.

3.3. A patrol was tasked to the Sturt Gorge Dam and at 12.35pm Sergeant Murgatroyd advised police communications that he was now the forward commander of the incident. At 12.36pm Senior Constable Robinson advised that he had sighted Mr Said sitting on the ground on top of the Dam wall. Sergeant Murgatroyd directed that police not approach Mr Said and was advised that the police were out of Mr Said's sight.

3.4. At 12.42pm Sergeant Murgatroyd provided a situation report to police communications and requested that police negotiators be brought to the scene. At 12.51pm he reported to police communications that when an approach was made to Mr Said, his response was to climb over the railing and was standing on the edge of the dam wall. The officers immediately retreated.

3.5. Negotiators started talking to Mr Said at 1.02pm and at 1.15pm STAR Group officers were considering whether they could effect a retrieval of Mr Said before he jumped or fell. However, they concluded that they would not be able to get to Mr Said quickly enough to prevent him jumping if that was his intention.

3.6. At 1.39pm Mr Said had told one of the negotiators that he had taken some of the tranquilisers that had been prescribed for the family dog. The police who had Mr Said under observation thought that his actions and demeanour were suggestive of him being under the effect of some drug. Members of the STAR group then developed a plan to move in and grab Mr Said if he became sufficiently groggy to be in danger of falling. At 3.09pm Sergeant Murgatroyd requested that portable lighting be brought to the scene, as he anticipated that the situation would not be resolved before nightfall.

3.7. At 3.29pm the STAR group were advised by the negotiator that as a result of what he was hearing from Mr Said it would be prudent for officers to withdraw and maintain covert observations.

3.8. Unfortunately at 3.45pm Mr Said was seen by Senior Constable Spencer to go over the dam wall. In his statement, Senior Constable Spencer described what he saw as follows: "I was watching SAID when I saw him push away from the railing and roll over the edge of the dam wall"[2]. Senior Constable Spencer then reported over police radio that Mr Said had jumped.

3.9. Sergeant Murgatroyd gave evidence at the inquest. He explained that it was his intention to detain Mr Said under the Mental Health Act 2009 if he could be safely removed from the dam wall. He explained the efforts made by police to resolve the situation. He confirmed that he was the forward commander for the 3 hours that police had Mr Said under observation. Sergeant Murgatroyd said that he was aware from what the negotiators were telling him that Mr Said seemed to be determined to jump off the ledge. He said that police kept trying to persuade him not to. Sergeant Murgatroyd contacted Mr Said's clinicians.

3.10. Sergeant Murgatroyd said that the STAR members were experts in retrieval and rescue. Their assessment was that they could not get near Mr Said. They considered bringing in the police helicopter but ruled this out because it might have caused Mr Said to jump. There was also the consideration of the effect of the downdraft from the helicopter's blades that might have caused Mr Said to fall.

3.11. Sergeant Murgatroyd summarised the situation by saying that Mr Said was in a spot where no one could get to him.

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[2] See Exhibit C31a

3.12. I am satisfied that Sergeant Murgatroyd and all other police involved in the situation did their best to help Mr Said. All possible efforts were made, and nothing was left to chance. I commend the work of the officers involved, and it was clear from Sergeant Murgatroyd's evidence that he and all members of his team were terribly distressed and saddened that they were not able to prevent Mr Said's death.

4. Recommendations

4.1. I have no recommendation to make in this matter.

Key Words: Death in Custody; Psychiatric/Mental Illness; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 30th day of June, 2016.

State Coroner