



## **FINDING OF INQUEST**

*An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 31<sup>st</sup> day of May 2023, the 1<sup>st</sup>, 2<sup>nd</sup> and 6<sup>th</sup> days of June 2023, and the 20<sup>th</sup> day of December 2024, by the Coroners Court of the said State, constituted of Ian Lansell White, Deputy State Coroner, into the death of Kobee Michael David Huddy.*

*The said Court finds that Kobee Michael David Huddy, aged 20 years, late of 2 Chelsea Court, Munno Para West, South Australia died at the Royal Adelaide Hospital, Port Road, Adelaide, South Australia on the 25<sup>th</sup> day of May 2019 as a result of a gunshot wound to chest. The said Court finds that the circumstances of his death were as follows:*

### **1. Introduction**

- 1.1. Kobee Huddy was only 20 years old when he died on the morning of Saturday, 25 May 2019.
- 1.2. Following a request by his mother, Ms Belinda Huddy, I will refer to Mr Huddy as 'Kobee' for the remainder of the Finding.
- 1.3. Kobee's cause of death was due to a single shot fired by Sergeant Darren Mead<sup>1</sup> of South Australia Police<sup>2</sup> at 9:44am in an extremely tense armed encounter between them on Green Avenue, Seaton.<sup>3</sup> The shot was fired from his SAPOL issued firearm, namely a Smith and Wesson MP 40 semi-automatic pistol.<sup>4</sup> The gun was chambered to fire .40 calibre centre fire ammunition and had an attached magazine. The shot hit the left

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<sup>1</sup> Sgt Mead

<sup>2</sup> SAPOL

<sup>3</sup> Green Ave

<sup>4</sup> 'the gun' or 'his gun'

chest of Kobee, who at the time was brandishing a large knife in his left hand and advancing on Sgt Mead. He died in the Royal Adelaide Hospital<sup>5</sup> about two hours later.

- 1.4. The circumstances of his death are tragic. Kobee was Ms Huddy's only child. He was born on 11 February 1999 and lived with her his whole life. Kobee had significant mental health issues which became more difficult for him and his mother during his teenage years. His father, Mr Shaun White, had only spasmodic contact with him during his life. The last contact was in November 2017. This was an upsetting issue for him growing up. When Kobee was a young boy, Mr White moved to Sydney for employment, and then to Queensland. He last saw him in person in 2014.<sup>6</sup>
- 1.5. In 2019, Kobee lived with his mother and her father. Unfortunately, Kobee's mental health difficulties caused him to behave erratically. This was coupled with his use of illicit drugs, in particular, cannabis and methylamphetamine. This resulted in troubling behaviour and thoughts, including suicidal ideation, self-harm and suicide attempts.
- 1.6. His mother and grandfather did all they could to help him, including arranging and monitoring his mental health care, providing employment opportunities, and always trying to assist him when he was in troubled times.
- 1.7. Their pastoral care was exemplary. It was greatly appreciated by Kobee. He loved them. His death has profoundly affected them. Ms Huddy was present throughout the Inquest and was represented by Mr McCloud of counsel as an interested party. I acknowledge the evidence of his death would have been particularly hard for her to hear.

## **2. Basis for the Inquest**

- 2.1. This Inquest was mandatory at law. Pursuant to Sections 3 and 21 of the Coroners Act 2003,<sup>7</sup> an Inquest must be held into the cause or circumstances of a death of a person in SAPOL custody. This includes a situation where SAPOL are apprehending somebody, as Sgt Mead was attempting to do with Kobee.

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<sup>5</sup> RAH

<sup>6</sup> Exhibit C29 - Affidavit of Mr White dated 15 July 2019

<sup>7</sup> The Act

### 3. **Hindsight bias and outcome bias**

- 3.1. These concepts are extremely important to apply in consideration of the evidence at an Inquest, especially here in examining the actions of Sgt Mead and Kobee just prior to the shooting, as well as the shooting itself on Green Avenue.
- 3.2. I refer to the Australasian Coroner's Manual (2015 edition)<sup>8</sup> to help describe the meaning and effect of hindsight bias namely, that it is:

'the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly where coroners are considering a signed way or making a first comments that may damage a person's reputation.

...In hindsight, it may seem obvious that a certain action should have been taken, but at the time it was, in fact, not nearly as clear.

Coroners should attempt first to understand circumstances as they appear at the relevant time to the people who were there.<sup>9</sup> This is especially so if a coroner is contemplating making adverse comments about people involved in the event in question.

Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.<sup>10</sup>

- 3.3. This explanation and warning about hindsight bias I find to be particularly important to apply to the evidence of the circumstances of Kobee's death.
- 3.4. Outcome bias is also important to consider. That is the tragic outcome of Kobee's death should not affect an evaluation of the reasonableness of the actions under consideration. In other words, I should be mindful of avoiding the tendency to judge a decision made by someone due to its outcome rather than the assessment of the quality of decision at the time it was made.

### 4. **Standard of proof for evidence at the Inquest**

- 4.1. The standard of proof to be applied in making coronial findings is the civil standard, the balance of probabilities. In considering making findings which imply or express criticism of individuals, I am guided by the principles enunciated in *Briginshaw v*

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<sup>8</sup> Authored by Hugh Dillon and Marie Hadley; 'the Manual'

<sup>9</sup> Emphasis shown in the text by the authors

<sup>10</sup> The Manual at page 10

*Briginshaw*<sup>11</sup> and I shall not make an adverse finding against a witness or an organisation unless the evidence leads me to a comfortable level of satisfaction that the finding should be made.

## **5. Kobee's cause of death**

- 5.1. As required under the Act, I must make a formal finding concerning Kobee's cause of death. After he died that morning of 25 May 2019, he was taken to Forensic Science South Australia. At 9:30am on Monday, 27 May 2019 forensic pathologist Dr John Gilbert conducted a post-mortem examination of him.
- 5.2. He found that the gunshot entry was at the left anterior chest and created with a path passing through the underside of the left fourth rib, the upper lobe of his left lung and passing through his left eighth rib. The bullet caused substantial damage to his left lung and the left ventricle of his heart.
- 5.3. Dr Gilbert found his death *'was due to a gunshot wound to the chest. Factors contributing to the death included blood loss from the lung injuries and impaired cardiac function due to the left ventricular contusion'*.<sup>12</sup>
- 5.4. I accept the findings and opinion of Dr Gilbert and formally record Kobee's cause of death to be gunshot wound of the chest.

## **6. Kobee's treatment at the Royal Adelaide Hospital on 25 May 2019**

- 6.1. Kobee was taken from the scene on Green Avenue to the RAH by South Australia Ambulance Service<sup>13</sup> MedSTAR emergency medical retrieval.<sup>14</sup> I will say more about his treatment by SAPOL and SAAS immediately after he was fatally injured but note now their responses were exemplary in administering first aid to him.
- 6.2. Kobee arrived at the RAH at about 10:30am and was taken immediately to a resuscitation room where experienced trauma surgeon Dr Peter Bautz immediately performed a resuscitative thoracotomy. This successfully re-established his blood

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<sup>11</sup> (1938) 60 CLR 336

<sup>12</sup> Exhibit C1a- Post-mortem report of Dr Gilbert

<sup>13</sup> SAAS

<sup>14</sup> MedSTAR

circulation. He was then transferred to theatre where Dr Bautz continued his efforts to save him by aortic occlusion and internal cardiac massage.<sup>15</sup>

- 6.3. Despite the best efforts of Dr Bautz and those assisting him, Kobe was unable to be saved. His life was declared extinct at 11:39am. I accept that this emergency treatment at the RAH was all that could have been done to preserve his life.

## **7. Kobe's mental health history**

- 7.1. I have already touched upon Kobe's mental health history. I will detail more of it now, but only to the extent necessary to show his difficulties throughout his life. The sources of this summary are the many statements obtained by SAPOL in its coronial investigation of his death and the all-encompassing 60-page report<sup>16</sup> from Detective Senior Sergeant Justin Ganley<sup>17</sup> of the Major Crime Investigation Branch<sup>18</sup> who led the investigation.

- 7.2. DSS Ganley summarised that in the two years prior to his death, Kobe:

‘... had over 25 interactions with the health system for a variety of suicide attempts, including by drug overdose, self-inflicted cuts to his arms and legs and by attempting to hang himself. The deceased had been diagnosed as suffering from Borderline Personality Disorder (BPD), which was regularly aggravated by his binge drinking and consumption of illicit drugs.’<sup>19</sup>

- 7.3. In short, BPD is:

‘... a mental health condition that affects the way people feel about themselves and others, making it hard to function in everyday life. It includes a pattern of unstable, intense relationships, as well as impulsiveness and an unhealthy way of seeing themselves. Impulsiveness involves having extreme emotions and acting or doing things without thinking about them first.’<sup>20</sup>

- 7.4. The evidence revealed that his long-term general practitioner,<sup>21</sup> Dr Johnny Wong, first saw him in 2008 for many standard childhood issues of health. In September 2015 Kobe requested a referral from Dr Wong to Headspace, a well-known mental health service for youths and young adults.

<sup>15</sup> See Exhibit C25 – affidavit of Dr Bautz

<sup>16</sup> Exhibit C94

<sup>17</sup> DSS Ganley

<sup>18</sup> Major Crime

<sup>19</sup> Exhibit C94, page 3

<sup>20</sup> Mayo Clinic excerpt from overview of BPD on its website

<sup>21</sup> GP

- 7.5. Dr Wong provided a comprehensive affidavit concerning his professional care and treatment of Kobee,<sup>22</sup> together with consultations with other GPs at his clinic. On 24 December 2015, Kobee reported to him that his mental health had worsened since September 2015 and he was using cannabis daily, sometimes in combination with other illicit drugs.
- 7.6. In 2016, Kobee regularly saw Dr Wong and his colleagues for various general physical health matters. On two occasions, namely in April and September, the consultations were specifically concerning his mental health. He was prescribed the antidepressant Effexor.
- 7.7. In July 2017 Kobee reported having suicidal thoughts triggered by involvement with SAPOL due to drugs and the passing of his great-grandmother. Dr Wong noted that his grieving was extreme, which is consistent with BPD. He rejected advice to attend hospital to seek psychological treatment and was '*quite resistant in giving up the drugs*'.<sup>23</sup>
- 7.8. In the months of July and August 2017, Dr Wong described a cycle of Kobee having an acute episode or incident such as a drug overdose or self-harm. This would cause him to go to hospital to be treated for physical injuries. On discharge, Kobee was referred back to him. Dr Wong then referred him for mental health treatment which had a positive effect.
- 7.9. Kobee had a difficult time in October 2017, causing him to be hospitalised due to impulsive reactions to stressful relationship issues. His reactions included overdosing on drugs and having suicidal ideation. His impulsive behaviour, mixed with drug and alcohol use, caused him to be referred to Drug and Alcohol Services South Australia<sup>24</sup> with supporting care for psychological treatment, and to Headspace for further counselling. This was considered a better option than hospitalisation in a mental health ward.
- 7.10. On 26 December 2018, Kobee was hospitalised at the Queen Elizabeth Hospital<sup>25</sup> due to an attempted overdose on Panadol after an extensive drinking session. He was

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<sup>22</sup> Exhibit C30

<sup>23</sup> Exhibit C30, page 11

<sup>24</sup> DASSA

<sup>25</sup> QEH

legally detained under an Inpatient Treatment Order<sup>26</sup> until 27 December 2018 as he had regained his composure and was polite and cooperative with QEH staff. He expressed a desire to seek help for his suicidal ideation and self-harm. He gave a history of recently losing his driver's licence, which cost him his employment. This loss of employment affected him greatly causing dark thoughts and poor behaviour.

- 7.11. Once the ITO was removed, he remained a voluntary inpatient until 2 January 2019. On discharge he agreed to seek help from Anglicare concerning suicidal ideation, as well as being referred to his GP and the Salisbury Community Mental Health Team.
- 7.12. In March 2019 Kobbie self-harmed with razor blades and Panadol on the background of excessive drinking causing two episodes of being hospitalised due to legal orders at the Lyell McEwin Hospital.<sup>27</sup> On each occasion he became well enough to gain status as a voluntary patient prior to discharge with referral to follow-up care.
- 7.13. On 21 April 2019 he engaged in a long drinking session with his friend Alex Wilson. This culminated in an injury to his arm that he deliberately inflicted on himself with a broken beer bottle. He was taken by ambulance to the RAH Emergency Department<sup>28</sup> and treated for his wound. He was discharged for follow-up care with his GP after sobering up and disclaiming any further feelings of suicide.
- 7.14. As can be seen from the descriptions of events causing his admissions, Kobbie got himself into difficulty with drugs and alcohol abuse. Once the effects had worn off, he was a good patient who appreciated the care given to him by the medical staff and was discharged with the intentions of seeking help to control his behaviour. This underscored the generally held view that he was a good young man who found it difficult to control his emotions and reactions to stressful and/or disappointing situations. I remind myself that during this period he was only 18 to 20 years old.

## **8. May 2019 admissions**

- 8.1. Kobbie had three hospital admissions in the month of his death. I will deal with them in slightly more detail due to the proximity of them to his death. These admissions do have a similar pattern to the above-described admissions in that they are triggered by

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<sup>26</sup> ITO

<sup>27</sup> LMH

<sup>28</sup> ED

excessive use of drugs and alcohol, followed by extreme behaviour which moderated once the effects wore off.

8.2. 14 and 15 May 2019

On 14 May 2019, Kobee presented to the LMH after his mother had called SAAS when she noted he had been self-harming on his arms in the shower. This self-harm related to undisclosed work issues. As the physical harm was superficial, he waited in ED before discharging himself without the opportunity of consultation with mental health personnel.

8.3. He returned to LMH later that evening after consuming alcohol at a ‘pub’, smoking cannabis, and taking painkillers. His behaviour at the LMH heightened on two occasions, causing Code Black<sup>29</sup> alerts. Fortunately, on the second occasion, Kobee recognised a mental health nurse, Mr Paul Davies, from previous admissions. This significantly calmed him, and consequently de-escalated the situation to the extent he was willing to be assessed by Mr Davies, including undergoing an alcohol breathalyser test. His reading from that test was 0.17%.

8.4. Given this level of intoxication Mr Davies believed that Kobee should stay overnight and be subject to further mental health assessment when sober, together with obtaining a medical clearance concerning his injured arms. Ms Huddy also wished for an overnight admission as she was concerned with further opportunities for self-harm whilst intoxicated.

8.5. Dr Millie Nakatsuka, resident medical officer of Psychiatry, took over care of Kobee from Mr Davies on 15 May 2019. Prior to her assessment of him she had reviewed notes of his attendance on 14 May 2019, together with electronic notes available to her of his community treatment.

8.6. She was therefore aware of his BPD, together with his anxiety and depression. As she described, people with BPD ‘*struggle to control emotions and to cope, and they often react in negative ways, such as self-harming, drinking or taking risky behaviour (sic)*’.<sup>30</sup>

8.7. She took a history of the workplace issue that started this chain of events, namely that he had reversed a forklift into a pole at work. He described to her the supports he had

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<sup>29</sup> Request for emergency assistance

<sup>30</sup> Exhibit 37, paragraph 21, affidavit of Dr Natatsuka

for his mental health, namely Dr Wong, who he regarded as ‘great’, community support from Anglicare suicide prevention service, PsychMed, together with informing her he was on the waiting list for Dialectical Behaviour Therapy.<sup>31</sup>

8.8. DBT is a therapy designed for those suffering BPD to accept their condition and deal with their behaviour based on that acceptance, with the aim of reducing extreme reactions to stressors in their lives.

8.9. In her thorough assessment, Dr Natatsuka spoke with Kobee and his mother together and separately about his history and struggles. After these discussions she was satisfied that Kobee was fit to be discharged and go home. She explained her decision as follows:

‘So after talking to both of them, my impression was that the acute risk of suicide was low; he no longer had suicidal thoughts, he felt safe and his mother was happy for him to go home. I believed he was suitable for discharge, going home with his mother. However, I considered that there was a chronic risk of self-harm and misadventure (including death) based on his previous history, his mental illness of BPD, the alcohol abuse and the long-term inability to cope with stress. On the positive side, he had a very supportive family, a good GP and he was linked with PsychMed and Anglicare prevention services in the community. The best treatment for BPD is DBT, which he was on the waiting list for, and he appeared committed to commencing psychological therapy.’<sup>32</sup>

8.10. 18 May 2019

On the morning of 18 May 2019, SAAS attended on Kobee at 11:01am having been called at 10:26am due to issues of self-harm and suicidal ideation. He told the attending SAAS officers that he wanted to go to Melbourne to ‘*jump off a tall building*’.<sup>33</sup> Unfortunately, after being initially cooperative and wishing to be treated, Kobee refused to leave the ambulance upon arrival at the QEH. Further, he produced a razor blade from his underwear and began to self-harm on his right arm. After security were summoned, he dropped the razor blade and voluntarily walked into ED. Given the circumstances, a care and control order was imposed on him under the Mental Health Act. Although not obviously intoxicated, he gave a history of alcohol consumption on the previous day and that morning. A note in the records indicated his level of alcohol when tested was 0.112%.<sup>34</sup>

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<sup>31</sup> DBT

<sup>32</sup> Exhibit C37, paragraph 38

<sup>33</sup> SAAS Patient Clinical Record note in QEH casenotes - Exhibit C97 at page 11

<sup>34</sup> Exhibit C97, page 23

- 8.11. Kobee provided a brief history since his discharge from LMH on 15 May 2019, namely that he had been on sick leave from work and felt low on 17 May 2019. He had been out with his friend at night in Adelaide, including attending a nightclub in Hindley Street. He returned to his friend's house, but when she had to leave for work he started to self-harm. He contacted her and she subsequently became concerned and contacted SAAS. Ms Huddy became aware of the situation as well.
- 8.12. The QEH monitored him as his blood alcohol level fell. Ms Huddy was present during his recovery. Just before 6pm he was discharged home into her care. A home visit from Anglicare was organised for Monday, 20 May 2019.<sup>35</sup> The discharge was against Ms Huddy's wishes, which she made known to the QEH.
- 8.13. Ms Huddy described his actions and movements from the discharge. On 20 May 2019 he had a consultation with Dr Wong and was issued with a sick certificate for that day and up to Wednesday, 22 May 2019.<sup>36</sup> Dr Wong's consultation notes confirm he issued this certificate as well as seeing him again at 4pm on 22 May 2019 where he noted that Kobee was '*mentally better, under the care of mother, going to football today*'.<sup>37</sup> That evening he registered to play with the Munno Para Soccer Club.
- 8.14. 23 May 2019 - Kobee's last admission to hospital  
Kobee was taken by his mother to LMH where he was treated for further self-harm injuries to his left forearm. Dr Sadashiva regarded these injuries as superficial, but liable to be infected easily. She therefore treated him with six stitches to prevent that outcome. She described him as '*very calm, cooperative and compliant*' and '*forthcoming with information*'.<sup>38</sup> He told her that he had lost his job the day before, became upset and self-harmed at home. She believed he was not suicidal, a view shared by his mother at that time.
- 8.15. Dr Sadashiva was aware of his mental health issues and consulted with a mental health ED nurse about his presentation that day. She was later informed that the mental health department '*were satisfied that there was no need for admission or other mental health intervention from their perspective*'.<sup>39</sup> She discharged him on the understanding that

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<sup>35</sup> Exhibit C97, page 29

<sup>36</sup> Exhibit C95

<sup>37</sup> Exhibit C95, page 2

<sup>38</sup> Exhibit C38 - affidavit of Dr Sadashiva

<sup>39</sup> Exhibit C38, paragraph 10

Ms Huddy was going to take him home and then to Dr Wong in due course to remove the stitches.

8.16. Friday, 24 May 2019

Ms Huddy took Kobee home and gave him two Melatonin tablets in the early hours of that Friday morning. She had to go to work early and heard from him at about 11am. He reported being drowsy and indicated he was going to have a late breakfast and told her not to rush home. That evening he cooked dinner for Ms Huddy and his grandfather. She described they *'had a good night'*.<sup>40</sup>

8.17. After dinner, he announced he was going to the Playford Hotel to play eightball with his friend Haydon Cranney, often referred to as *'Cranny'*.<sup>41</sup> Mr Cranney later described the night to SAPOL, stating he picked Kobee up at about 6:30pm. They then went to a hotel in Davoren Park, had a few drinks and played on poker machines. Kobee reported to his mother by SMS at 8:26pm that he had won some money and wanted to stay out longer.

8.18. Despite her return message asking him to come home as he had promised earlier, he reassured her that he would be all right and indicated he would be home around midnight. He and Mr Cranney went into Adelaide's CBD, in particular Hindley Street. On the way in Kobee indicated that he wanted *'to kill myself but I couldn't go through with it myself'*. Mr Cranney responded by giving him his *'usual pep talk, telling him that he shouldn't do it or think that way'*.<sup>42</sup>

8.19. Saturday, 25 May 2019

At 12:24am, Ms Huddy sent Kobee an SMS asking where he was. He indicated he was with *'Cranny'*, and he was continuing to win money on poker machines. She again asked him to come home as she was tired. He chose to stay out despite Mr Cranney also wanting to go home at that time. At about 2:30am, Mr Cranney decided to go home. As he was leaving, Kobee hugged him twice, telling Mr Cranney that he loved him.

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<sup>40</sup> Exhibit C4

<sup>41</sup> Also spelt 'Cranney' in various exhibits

<sup>42</sup> Exhibit C3 - Statement of Mr Cranney to SAPOL on 27 July 2019, paragraph 20

- 8.20. Kobee decided to stay, stating that he was going to his girlfriend Krista's house later.<sup>43</sup> They had been in a relationship for about six weeks.
- 8.21. The next known event concerning Kobee was when he sent a text his mother at 5:16am that Krista '*came and got meeee (sic)*'. Ms Huddy replied at 5:21am, clearly upset that he had been out all night. Kobee was still at a hotel on Hindley Street as CCTV cameras showed him at 5:33am to 5:35am drinking alone before briefly approaching female patrons whom he knew.
- 8.22. At this time security guards approached him. DSS Ganley believed the footage should be interpreted as the guards asking him to leave, which he did in a polite manner after sending a message on his phone to Krista. The footage showed that he was clearly intoxicated when he left. He made his way down Hindley Street on foot, and he appeared to be in a good mood.
- 8.23. At 5:40am Krista received a phone message requesting her to pick him up in the city. She did so and took him to get something to eat before going back to her home at Tapleys Hill Road, Seaton. Once home, she discovered that he had a pair of scissors hidden in his underwear which she quickly took and put away. He also did a couple of strange acts, including throwing a dartboard over the back fence. She had to leave for work at 8am and was worried about his '*weird*' behaviour. He indicated to her before she left that he wanted some cigarettes. He had unsuccessfully tried to get car keys from her housemate, so she rang her Aunty Sarah to ask her to check in on him as she lived nearby. She agreed.
- 8.24. Prior to the time of the arrival of Aunty Sarah, Kobee made a significant call to the Mental Health Triage Service<sup>44</sup> at 8:05am. This call was recorded and will be discussed in detail.
- 8.25. Coincidentally, a friend of Krista's, who I will refer to as '*S*', rang at the same time and offered to check on him as well. S arrived at 9:45am in a silver Mercedes-Benz. Aunty Sarah was at the house by that time. They ended up taking him in the Mercedes on the pretence they were going to get cigarettes. The real purpose was to him take to the QEH instead. Krista had spoken to him just prior to their arrival and was very concerned about him and told him to go to bed. At one stage that morning he was

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<sup>43</sup> Krista Hunt-Burgoyne, "Krista"

<sup>44</sup> MHTS

holding a knife, but did not use it in any harmful way, before putting it down shortly after.

**9. 8:05am - Mental Health Triage service call**

- 9.1. Kobee made this call without any prompting from Krista. It lasted 9 minutes and 44 seconds.<sup>45</sup> I have listened to this call in Court and many times since. This call is summarised in DSS Ganley's report,<sup>46</sup> as well as by the call-taker, Ms Petrie, a qualified social worker, in affidavit evidence.<sup>47</sup>
- 9.2. Before describing this call in some detail, I want to acknowledge that the MHTS is meant to be the initial information source for callers who may require information about accessing mental health care providers for themselves or another. As the name suggests, is an initial point of contact in the assessment of what needs to be done to deal with a situation as it presents at that time. Kobee was put through to SAAS at the end of the triage call. I believe that was the correct decision, however the phone call was subject to stern criticism about the way Ms Petrie conducted it. This included DSS Ganley,<sup>48</sup> Ms Huddy, and even an expert review by experienced psychiatrist Dr Marcia Fogarty,<sup>49</sup> Medical Lead of the Mental Health Clinical Program of the Central Adelaide Local Health Network.<sup>50</sup> Dr Fogarty concluded that Ms Petrie's phone manner appeared to her '*at times to be dismissive and abrupt*' to the point that it was her opinion that it was '*below the standard that I would expect from a mental health clinician*'.
- 9.3. In coming to that conclusion, Dr Fogarty took into account that Kobee was asking for counselling which is outside the purpose of MHTS and there was at times confusion about his address.
- 9.4. Ms Petrie was also given a right of response to this criticism. She maintained that her intention was not to be '*disinterested*' or '*rude*'. She maintained that she was trying to find the best option to assist Kobee, as well as researching his medical records of his last visit to LMH on 23 May 2019. She believed a '*direct and forceful approach was*

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<sup>45</sup> The Triage Call

<sup>46</sup> Exhibit C94, page 8

<sup>47</sup> Exhibits C9 and C9a

<sup>48</sup> Transcript, pages 54-55

<sup>49</sup> Exhibit C109

<sup>50</sup> CALHN

*what was required on this day for Kobee to have the opportunity to be safe and treated for this acute proper crisis presentation’.*<sup>51</sup>

- 9.5. In the end, she put him through to SAAS which I believe was the correct decision. Unfortunately, he did not maintain the call.
- 9.6. I thought carefully about the impact of this call in the context of the preceding events and the unfortunate circumstances leading up to his fatal confrontation with SAPOL only hours later.
- 9.7. It is very important to consider the earlier directions about hindsight and outcome bias in analysing the MHTS call both in isolation and the context of this morning. It is naturally distressing for Kobee to be heard desperately seeking help but in the end deciding not to speak to SAAS.
- 9.8. Ms Huddy, through submissions of counsel,<sup>52</sup> acknowledged that strictly this call was finalised in a conventional manner by the referral to SAAS. However, her position was that more could have been done by Ms Petrie, including trying to ensure that he stayed on the call so that SAAS could get to him. She submitted that the dialogue of her son announcing to her he had BPD and felt incapable of stopping himself self-harming meant that Ms Petrie did not do enough for him.
- 9.9. Although she stops short of suggesting Ms Petrie’s manner caused him to abandon the call, it would not be surprising if he was greatly disheartened by the call. It may explain his decision to unilaterally stop the triage call.
- 9.10. I believe that Ms Petrie’s conduct of this call was not satisfactory. In making this finding I have taken into account her explanation<sup>53</sup> and the principles of *Briginshaw v Briginshaw* as mentioned earlier in this Finding.
- 9.11. It was correctly acknowledged by Ms Huddy that this call was one factor ‘*in an incident that was contributed to by multiple factors*’ and cannot be said to be ‘*the root cause or sole factor in this event*’.<sup>54</sup>

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<sup>51</sup> Exhibit C9a – Affidavit of Ms Petrie sworn 27 July 2023

<sup>52</sup> Transcript, pages 230-231

<sup>53</sup> Exhibit C9a

<sup>54</sup> Transcript 231

## 10. **Kobee's call to Lifeline at 8:28am**

10.1. Kobee called this service and spoke to them for just shy of 27 minutes.<sup>55</sup> There is no audio recording of this call, no doubt due to sound policy reasons.<sup>56</sup> However, Lifeline does have the capacity to refer matters to emergency services should that be necessary either during or immediately after such a call.

10.2. I refer now to DSS Ganley's summary of the Lifeline call based on his investigation, namely, that Kobee told Lifeline he was:

'...currently suiciding; he had a gun and would shoot police or ambulance if they attend. He also stated that he had tablets, he was ripping open stitches from cutting himself and talking about hanging himself with a pillow case. At approximately 8:54am, this information along with the road and suburb, was subsequently relayed to SAPOL communications (Comcen) by Lifeline.'<sup>57</sup>

10.3. DSS Ganley noted that some problems arose as Comcen was advised that the then-unknown caller was female. This information was provided by the Lifeline shift supervisor as the call was taking place with the call taker.

## 11. **Kobee's calls to SAPOL**

11.1. At 8:55am Kobee rang 000. The call lasted 3 minutes and 45 seconds. During this call he was aggressive and threatening, stating he was in possession of a firearm and was 'about to start firing on c\*\*\*'. He wanted the SAPOL Comcen call-taker to 'send me some cops for bloodshed'. He gave his name and address and repeated that he was 'not doing good'. The SAPOL call taker was composed and able to elicit enough information to immediately pass on. SAPOL started to gather vital information, particularly through phone location data. This call was classified as indicating both a potentially violent situation and a mental health episode.

11.2. Western District SAPOL patrols received this data via audio at about 9:05am.

11.3. At 9:07am Kobee rang 000 again. This call lasted 95 seconds. He continued his aggressive and threatening language from the first call, telling the call taker to 'send your boys, bro'. Once this call was completed, a number of further communications and checks were done to find his exact address. This even included a call to Ms Huddy

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<sup>55</sup> 'Lifeline call'

<sup>56</sup> Affidavit of Ms Julie Goodchap, Deputy Company Secretary of Lifeline, sworn 11 October 2019 - Exhibit C10

<sup>57</sup> Exhibit C94, pages 8-9

at 9:33am where she confirmed his likely location was at his girlfriend's house, 201A Tapleys Hill Road. MHTS and Lifeline were also contacted to gather information about him. In consultation with Ms Huddy, SAPOL planned to apprehend at that address then take Kobee to hospital for a mental health assessment.

## **12. SAPOL attendance on Tapleys Hill Road**

- 12.1. At 9:42am SAPOL began active plans to apprehend Kobee based on information that he was at his girlfriend's house. Western District SAPOL officers were contacted to be part of the proposed action of cordoning off that house. It was stipulated that ballistic vests should be worn, given Kobee's threats concerning a gun. At that time, Kobee was considered a low-risk person with the potential to become high-risk. This was also the time that Kobee left the house with Aunty Sarah and S who drove the silver Mercedes-Benz. Kobee was in the front passenger seat. Prior to his departure, he was drinking Moscato directly from the bottle, including taking a large swig immediately before they walked out the front door. He was described at this stage by Aunty Sarah as being *'drunk, agitated, cocky and smart-arsed with his responses'*.<sup>58</sup>
- 12.2. As expressed earlier, Kobee was told that they were going to get cigarettes for him as a deception for their intent to take him to the QEH. They were not aware of any SAPOL plans or actions.

## **13. Sgt Mead's actions prior to discharging his gun**

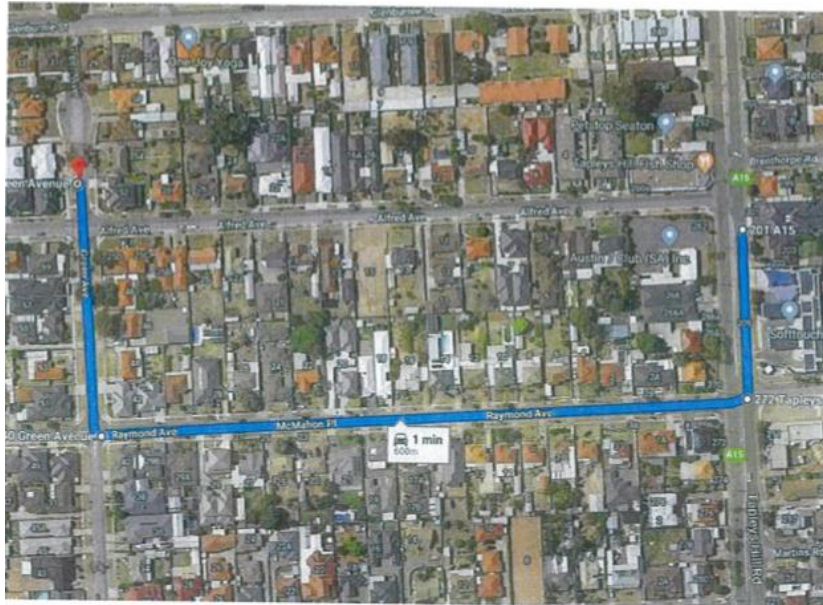
- 13.1. SAPOL Communication's evidence reveals the rapid series of events that followed<sup>59</sup> in the minutes from 9:42am. I shall set out those events, as follows:
- **9:42:00** – Sgt Mead observed and reported the Mercedes leaving the driveway, which he followed in his marked SAPOL car. He had been requested to drive past the premises to obtain information about the cars parked in the driveway. Everyone in the Mercedes realised that they were being followed. The cars follow the route as set out over the page.<sup>60</sup> Sgt Mead was alone in the SAPOL car.

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<sup>58</sup> Exhibit C94, page 12

<sup>59</sup> Exhibit C103

<sup>60</sup> Appendix A from C94



- **9:42:38** – Ms Huddy called her son on his mobile. He did not answer.
- **9:42:45** – Sgt Mead stopped the Mercedes at the intersection of Green Avenue and Alfred Avenue, Seaton. It is now convenient to insert a photograph of the scene where the cars were positioned when stopped. This photograph also outlines the position of other SAPOL cars that arrived very shortly after the confrontation began.<sup>61</sup>



<sup>61</sup> Appendix B from C94

Sgt Mead approached the Mercedes' driver's door. S lowered the window. Kobee had indicated to the women prior to Sgt Mead's approach '*Don't worry, I've got this one*'. S was '*visibly upset and crying*'. Sgt Mead asked Kobee for his name and realised he was subject of the SAPOL's response. He asked him to get out of the car. Kobee responded, '*I'm the one you're looking for*' and got out. Sgt Mead was not wearing a body worn video camera<sup>62</sup> because he was not yet trained to operate one.<sup>63</sup> He was also not certified to use an Electronic Control Device,<sup>64</sup> commonly known as a Taser. On that basis, he did not possess an ECD that day.

- **9:43:24** – Ms Huddy called her son again. It was not answered.

Sgt Mead had his gun ready to be drawn as Kobee got out of the car. I accept his explanation for doing so, that he gave his SAPOL superiors hours later, as very logical and reasonable. The information he had heard from SAPOL Communications indicated Kobee may have a gun as he claimed. As it turned out, he did not, but had a large knife that he was brandishing. The knife was produced after Sgt Mead ordered Kobee to kneel at the back of the Mercedes. Kobee refused and advanced on him as Sgt Mead was retreating with the gun now drawn. S and Aunty Sarah did not know he had the knife with him.

- **9:43:35** – Sgt Mead told SAPOL Communications during his retreat '*It's a knife, I've got a knife*'.
- **9:43:43** – Sgt Mead tells SAPOL communications during his retreat '*801, I need your help guys*'. '*801*' is a code that an officer is in distress. It means any SAPOL office nearby must immediately make their way to the officer in distress.<sup>65</sup>
- **9:44:00** – In response to his 801 call, SAPOL officers Sergeant Melissa Morgan and Probationary Constable West<sup>66</sup> arrived. Once out of the car they both sprinted towards Sgt Mead and Kobee. BWV was activated and the video of their approach was tendered in Court. Due to running, the picture is very difficult to concentrate on but does show the scene at the time Sgt Mead fired the shot. Inserted below are two still photographs taken from that footage<sup>67</sup> that DSS Ganley believes was the

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<sup>62</sup> BWV

<sup>63</sup> Video record of interview of Sgt Mead 1:30pm on Saturday, 25 May 2019 - Exhibit C92c; see also C94, page 16

<sup>64</sup> ECD

<sup>65</sup> DSS Ganley at Transcript, page 91

<sup>66</sup> PC West

<sup>67</sup> Exhibit C103

view that Sergeant Morgan was ‘likely to have had at the moment Mead discharged his firearm’.<sup>68</sup> The men’s figures have been edited consistent with the wishes of Ms Huddy. Sgt Mead is positioned on the left, and Kobee on the right.



- **9:44:04** – Sgt Mead communicated shots fired.
- **9:44:09** – Ms Huddy, again, tries to call her son.
- **9:44:36** – SAAS was urgently summoned to the scene.
- **9:44:52** – Kobee told officers performing CPR ‘*I’m sorry*’.
- **10:34am** – Kobee arrived at RAH in a SAAS ambulance under SAPOL escort.

<sup>68</sup> Exhibit C94, page 17

#### **14. Sgt Mead's description of the circumstances of firing the shot**

14.1. Sgt Mead told his superiors that day that he believed he saw the arrival of Sergeant Morgan and PC West in the SAPOL car in his peripheral vision as he was moving backwards.

14.2. I will now set out his explanation given on record at about 1:30pm that day:

'And so, and I had hoped that the first attending patrol would have a Taser. So my intention, at that very point it was to keep moving backwards until a patrol could come to assist me and use a Taser. I could hear the siren in the background, and he continued to walk towards me. I'm a, the whole time I'm continually yell, "Drop the knife, drop the knife". He picked up the pace and I've had to keep walking backwards and I kept walking backwards and I did, I think in my periph, I didn't think, (stops) I know in my peripheral I saw a fleet or a vehicle turn up. At that point he appeared to take two or three very quick steps towards me and we were about. I, I believe four metres away, and I continued to walk backwards but by the third step he was at a point where I believed I couldn't avoid the knife and that I was in imminent danger of my life being threatened by that knife, so I've levelled and sighted and rele..., a, ahm make one shot from a squeeze of the trigger. I've released the trigger, pulled the firearm down into a cover scanning position, to assess and reassess the situation again. The male I saw dropped the knife, place his left hand to his chest which I saw the round hit the male in the chest, he's dropped to the ground and then I've seen Senior Constable MORGAN with a Taser out.'<sup>69</sup>

#### **15. Issues**

15.1. Was the shot fired by Sgt Mead justified?

15.2. In short, I believe it was in these circumstances.

15.3. This is consistent with the conclusion of DSS Ganley<sup>70</sup> and Detective Inspector Mark Gallagher who conducted an inquiry on behalf of the Commissioner of Police.<sup>71</sup>

15.4. The basis for my finding on this topic considered the law of self-defence<sup>72</sup> that involved assessing Sgt Mead's state of mind and an independent assessment of his conduct in the circumstances Sgt Mead believed existed at the time he fired the shot. Kobbie was threatening him by advancing with quick steps and holding a 200mm knife with a blade

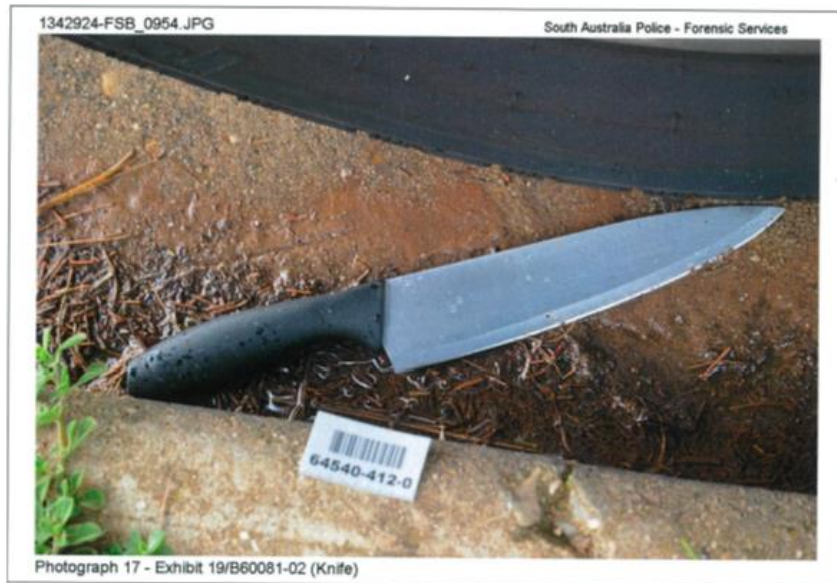
<sup>69</sup> Exhibit C92, page 7, lines 203-218, and Exhibit C92c (video)

<sup>70</sup> Exhibit C94, pages 48-50

<sup>71</sup> Exhibit C104, 104a – 'Commissioner's Inquiry'

<sup>72</sup> Section 15 of the Criminal Law Consolidation Act 1935

length of 130mm<sup>73</sup> in a position to stab him. I insert a photo of the knife recovered by SAPOL to best convey the situation faced by Sgt Mead.<sup>74</sup>



- 15.5. Koebe was 179cm tall and weighed 95kg. He was considerably bigger than Sgt Mead as it appeared on the SAPOL BWV of other officers. His blood alcohol level was high, given that less than an hour later a sample of blood taken at the RAH revealed a BA reading of 0.22%, over four times the legal limit for driving.
- 15.6. Therefore, I accept the answer of Sgt Mead as set out in paragraph 14.2 of this Finding, together with his total explanation of events in both SAPOL interviews, as satisfying me his actions in dealing with Koebe up to and including the discharge of his gun were legally justified as self-defence.
- 15.7. I note again he did not have an ECD due to lack of up-to-date training.<sup>75</sup> As at 25 May 2019 SAPOL's Western District, where he worked in Port Adelaide Patrols, had seven ECDs in total, but only three were issued. One of the ECDs issued was defective. Therefore, it is easy to conclude that even if Sgt Mead was eligible to receive an ECD that day, he may well have not been given one or, if so, there was a one-in-three chance he would have received the defective one. I note that Sgt Mead had been trained in using ECDs but as he had been stationed at the City Watch House, he was not permitted, by policy, to possess one on duty there. His eligibility certificate to use an ECD had

<sup>73</sup> See report of SAPOL Crime Scene Examiner Brevet Sergeant Robyn Buller, Forensic Response Section – Exhibit C90

<sup>74</sup> Exhibit C90a, photo 17

<sup>75</sup> See summary in Commissioner's Report; Exhibits C104 and C104a

lapsed. He had reattended the mandatory retraining course to renew his eligibility but did not complete it due to a brief illness.

15.8. Was ECD use for this situation appropriate in any event?

15.9. I acknowledge that this would be seen by many as a simple proposition to agree to without further information. This issue is more complex, especially as at the time Kobee was confronting him, he was essentially facing a one-on-one situation.

15.10. DSS Ganley gave evidence on this topic.<sup>76</sup> He explained that an ECD needed to connect with both barbs at the end of wires on the subject to be effective. Furthermore, its range has a maximum of 7.62m. Weather, particularly wind, can affect the accuracy of its use. If an ECD does not connect effectively, vital time in an emergency is lost.

15.11. Here Kobee was advancing, quickening his steps, brandishing a knife. A failed use of an ECD would have prevented Sgt Mead being able to defend himself with the gun.

15.12. DSS Ganley further explained training on use of a firearm is when *'the distance ... to unholster our firearm and fire two rounds into an attacking target is ... 20 to 21 feet'*,<sup>77</sup> or approximately six to seven metres.

15.13. The estimated distance between Sgt Mead and Kobee was about four metres at the time of the shot. This is also what Sgt Mead estimated. I have already set out his explanation in paragraph 14.2 of this Finding. He also made it clear in his interview he did not want to speculate about what he would or would not have done if he was in possession of an ECD.

15.14. In the end, I find it is not fair to say an ECD should have been used if he possessed one, considering DSS Ganley's evidence on this topic.

15.15. Did Kobee deliberately threaten Sgt Mead with that knife as a means to orchestrate his death by being shot by SAPOL?

15.16. Originally, DSS Ganley thought Kobee's motive at the point he was threatening Sgt Mead with the knife was to *'provoke a lethal response from a law enforcement*

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<sup>76</sup> Transcript pages 164-166

<sup>77</sup> Transcript page 165

*officer, which unfortunately in this case was Mead*'.<sup>78</sup> In evidence, he reconsidered his view.<sup>79</sup>

15.17. He reconsidered that Kobee's last 24 hours were inconsistent with such an intention. Also, he had never threatened nor used violence against SAPOL previously.

15.18. Ms Huddy submitted through Mr McCloud that:

'Kobee didn't have that type of intention, and that his behaviour that morning was a reflection of his declining psychological state, his impulsive behaviour, and the manner in which he would tend to act out and behave recklessly in that state. Detective Ganley properly acknowledged that Kobee had been making several future plans, which would suggest that he did not have any intention to invoke a lethal response, and we agree with that more recent consideration of the evidence of Detective Ganley, and thank him for reconsidering this conclusion. In my submission Kobee's behaviour can be properly characterised as impulsive and reckless conduct, as was described by Mr Longson. And I agree with Mr Longson's characterisation that this was a perfect storm of factors that came together on that morning and resulted in Kobee placing himself in harm's way, rather than it being characterised as suicide by cop or anything similar to that.'<sup>80</sup>

15.19. I agree with these submissions and evidence from DSS Ganley. The series of bad decisions Kobee made were impulsively considered and combined with a series of circumstances involving others including SAPOL that resulted in this tragedy.

15.20. Was it correct for Sgt Mead to follow and stop the Mercedes?

15.21. In my view, it was a good and proper decision for Sgt Mead to follow and stop the Mercedes in these circumstances. It is important to remember what Sgt Mead and SAPOL knew or did not know about the true intent and situation of Kobee. In particular, SAPOL did not know whether Kobee had somehow come into possession of a firearm that morning despite not having a firearms licence, nor any history of firearms offences. SAPOL could not assume he did not have a firearm.

15.22. Sgt Mead was requested by Sergeant Morgan to drive by the address to obtain number plates of any vehicles in the driveway and communicate that information for the benefit of planning the SAPOL response. He did as requested. This coincided exactly with the point of the Mercedes leaving the property for a purpose not known to SAPOL.

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<sup>78</sup> Exhibit C94, page 49

<sup>79</sup> Transcript, pages 135-136

<sup>80</sup> Transcript, page 234

- 15.23. I believe it would have been poor police work for Sgt Mead to let the car go into the community in these circumstances, namely after an occupant of the house had threatened to use a firearm indiscriminately, particularly against SAPOL. In other words, I believe he had no choice other than to follow the car and stop it as soon as possible.
- 15.24. His decision to do so was also with the likely knowledge that other SAPOL officers had mobilised from the nearby rendezvous point to get to him as quickly as possible.
- 15.25. Once he did stop the Mercedes, he approached the driver's side door and quickly saw that S was highly distressed, which may have been for very sinister reasons, such as being directed to drive against her will at gunpoint. Once he saw Kobee, he correctly identified that he was the person of interest and asked him to get out of the car.
- 15.26. As we know, the encounter escalated extremely swiftly from that point to be a highly dangerous and volatile situation. Sgt Mead did not have time on his hands to wait.
- 15.27. My analysis of this brief time period has sought to emphasise the need to consider Sgt Mead's position at that time, eliminating the factors of hindsight and outcome bias. I am comfortably satisfied that in considering Sgt Mead's position in this manner, he should not be subject to any criticism concerning his decision to follow and stop the Mercedes and then ask Kobee to get out.

## **16. Aftermath of Kobee's death**

16.1. This is a matter that must be considered under the Act as being relevant to the circumstances of Kobee's death.<sup>81</sup> I believe the aftermath is relevant for Ms Huddy and her family as well as Sgt Mead and his family.

### **16.2. Aftermath for Ms Huddy**

The aftermath on Ms Huddy has been profound. She has strongly advocated for him that his actions that morning were not part of plan to induce SAPOL to kill him by a firearm. I have agreed with her on this point. She has also advocated to improve the plight and treatment of those suffering with BPD. She has remained determined to do so in his honour.

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<sup>81</sup> Section 3(3)

- 16.3. I have heard submissions on her behalf by Mr McCloud, which were greatly appreciated. I have also seen the moving interview she gave to the ABC on 7 September 2023.<sup>82</sup> In the ABC interview she outlined the distress of being told of his passing and the devastating long-term consequences for her health of suffering complex trauma, PTSD and depression. At the time of the interview, she commented how difficult it was for her to obtain expert mental health care from psychologists and psychiatrists due to lengthy waiting lists.
- 16.4. I believe the ABC interview is important and admissible for me to consider on this topic under the enabling provision of Section 24 of the Act as the Court has been given the ability to inform itself in an inquest of '*any matter as it thinks fit*'.
- 16.5. She described having nightmares about his death and that she is full of sorrow and hurt. She told the interviewer she asks the question to herself of '*How could I have prevented it?*'. I wish to comment that from all the information that I know about her from the Inquest, she did everything she could for her son. She has kept his room at her house the way it was on 25 May 2019.
- 16.6. She believed that if her son was seen by the mental health clinic at the LMH on 23 May 2019, the events would not have ended up with his death on 25 May 2019. In the ABC interview she was visibly angry and upset when she heard the MHTS call, labelling it '*disgusting*' and '*heartless*'. In submissions, it was described by Mr McCloud as '*a cry for help*'<sup>83</sup> by Kobee.
- 16.7. This is a legitimate reaction and submission by Ms Huddy. I do remind myself that Kobee did decide to call Lifeline at 8:28am and expressed suicidal ideation during this long call. I do also note his high intoxication level would have augmented tendencies to be impulsive. Importantly, at the time he left the house he believed he was simply going to get some cigarettes, no doubt with the intention of immediately smoking. This strongly suggests that he had abandoned suicidal thoughts.
- 16.8. In other words, his call to MHTS was one of many events that morning. I find in the end it should not be elevated to be anything other than an opportunity where events might have changed had the call been fully successful with Kobee speaking to SAAS

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<sup>82</sup> The ABC interview

<sup>83</sup> Transcript, page 227

directly. This finding is independent of how anyone classifies the manner in which the call was conducted.

16.9. This finding is consistent with Ms Huddy's submission to the Inquest that her son's death '*was not caused by one single factor or single person alone. That ... would be an unfair way to view the events of that day*'.<sup>84</sup>

16.10. Finally, Ms Huddy describes having '*20 years of bliss with him*' in the interview and wants to '*save other lives*'. I find Ms Huddy's strength through this adversity, her love and devotion to her son, and a determination to help others coping with BPD to be extremely impressive.

16.11. Aftermath for Sgt Mead

I saw the immediate impact of the shooting on both Kobee and Sgt Mead. As I have already noted, Kobee said '*I'm sorry*' to the SAPOL officers who immediately assisted him after he fell. Those final words showed his true nature underneath all the difficult problems BPD, drugs and alcohol had caused him.

16.12. Sgt Mead was not able to give evidence at this Inquest as sadly he died unexpectedly of natural causes on 20 April 2023, approximately six weeks before the Inquest began. He was 49 years of age. I accept he would have made himself available to give evidence and be cross-examined by counsel for Ms Huddy.

16.13. As other SAPOL officers went to the fallen Kobee, Sgt Mead moved to a nearby driveway. As was seen on BWV,<sup>85</sup> he was leaning against a fence, totally distraught. Under this distress he said, '*He started taking quicker steps*'. This description was supported by civilians who witnessed the encounter. He had never been forced to discharge a firearm before in his 19-year career at SAPOL.

16.14. During the Inquest I raised with counsel my desire to hear from Sgt Mead's wife concerning the aftermath of this day on him and their family. Ms Huddy made no objection.<sup>86</sup> Mrs Allan-Mead has chosen to respond, and I am grateful by her willingness to do so. In a detailed response to the Court she outlined that Mr Huddy's

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<sup>84</sup> Transcript, page 227

<sup>85</sup> Sgt O'Connell – Exhibit C46a

<sup>86</sup> See Transcript, page 42, dated 31 May 2023

death occurred on their youngest daughter's 2<sup>nd</sup> birthday. This coincidence caused a significant impact on him.

16.15. His life was not easy for him after this day. He struggled with grief, stress and fear for the wellbeing of himself and his entire family, including extended family.

16.16. Sgt Mead's wife felt the added impact of concerns about her husband's mental health on top of raising a busy young family and her full-time work. She had to seek counselling through her employer's Employee Assistance Program as she was '*very burnt out and anxious*'.<sup>87</sup>

16.17. From her observation, Sgt Mead's mental health suffered and progressively worsened over the next four years. He remained with SAPOL, sometimes having to perform public duties. He also accessed '*Workcover for depressive symptoms and saw a psychologist regularly*'. She was anxious about whether he might develop suicidal thoughts. In April 2023 he was diagnosed with complex PTSD after a prolonged period of nightmares, flashbacks, intrusive thoughts and constant rumination about this day. He also on occasion became irritable, short-tempered and was liable to mood swings. After his unexpected death of natural causes on 20 April 2023, she and his family had to grieve through the period that the Inquest was held and publicly reported on. This was very difficult for them.

16.18. She explained:

'Darren became a police officer due to his desire to help people and be a service to the community. This incident had a very significant impact on his mental health and sense of identity as well as significantly impacting mine and our family members mental health and wellbeing also.'

16.19. From what I saw in the interviews, Sgt Mead was a caring and dedicated SAPOL officer.

## **17. Concluding comments**

17.1. I have thought carefully about the duty of the Court under the Act to consider whether recommendations should be made that '*might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest*'.<sup>88</sup>

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<sup>87</sup> Exhibit C109

<sup>88</sup> Section 25

- 17.2. There have been suggestions concerning how to treat young citizens with mental health issues in general, including Dr Naso advocating for inpatient mental health care facilities for those up to 25 years of age. This concept was briefly considered by Dr Fogarty, on behalf of CALHN, who indicated that for any concept to be adopted, further expert evidence from Australia and New Zealand on this topic would have to be carefully considered.
- 17.3. Therefore, I believe I am not in a position to make a recommendation on this topic in this Inquest but note the significance of such comments coming from the highly respected Dr Naso.
- 17.4. I further note a reference in the ABC interview by SAPOL of the trial of mental health nurses accompanying SAPOL patrols in the Northern Districts area had produced *'significant benefits in terms of inter-agency collaboration and outcome for consumers'*. If that is so, then I encourage SAPOL to continue developing this strategy if feasible. I note though the circumstances of Kobee's encounter with SAPOL on 25 May 2019 may have made it difficult to impossible for a mental health nurse to safely engage with him once he was out of the car on Green Avenue.
- 17.5. I have reviewed the care provided to Kobee on the documented occasions by the public hospitals. I believe they showed a careful and caring attitude towards him in the difficult presentations, sometimes warranting legal orders to be imposed on him whilst he recovered.
- 17.6. Ms Huddy has advocated for long-term solutions of the mental health system as she expressed in the ABC interview. Headspace, who Kobee was referred to by Dr Wong in 2017, made representations to the Commonwealth Government on this topic that were being closely considered according to the Federal Health Minister, the Honourable Mark Butler in the ABC interview. Therefore, Ms Huddy has powerful experts making representations to the Commonwealth Government supporting her view.
- 17.7. In light of this, I make no recommendations to the South Australian Government or the Commissioner of Police.

17.8. The Court acknowledges the pain suffered by the families of Kobee and Sgt Mead and wishes them strength in continuing to cope with the loss of their loved ones.

*Key Words: Death in Custody; Police; Shooting; Mental Health*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and*

*Seal the 20<sup>th</sup> day of December, 2024.*

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*Deputy State Coroner*

Inquest Number 02/2023 (1048/2019)