FINDINGS of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

STEPHEN CHARLES MAWER

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Stephen Charles Mawer, with an inquest held at Burnie in Tasmania, make the following findings:

Hearing Dates

28, 29 March 2022 and 1 April 2022

Representation

Counsel Assisting the Coroner - C Lee

Introduction

1. Stephen Charles Mawer, aged 45 years, died on 21 February 2020 as a result of severe burns, caused by setting himself on fire after having doused himself with petrol in the rear yard of his residence in Somerset. At the time of his actions, his residence was surrounded by numerous police officers who were attempting to communicate with him and to take him into custody.

The role of the Coroner

2. Section 21(1) of the *Coroners Act* 1995 ("the Act") gives a coroner jurisdiction to investigate a death where it appears to the coroner that the death is reportable. Mr Mawer's death was a reportable death on two grounds: firstly, his death was unnatural; and secondly, he was, immediately before death, a person held in custody.[1]

3. By section 3 of the Act, a person held in custody means, *inter alia,* a person in the custody or control of a police officer. Mr Mawer, at the time of his hospitalisation following his self-immolation, fell within that definition. He was not free to leave the hospital, even if he had been physically able to do so. This is because he would have properly been taken into protective custody under the *Mental Health Act* 2013 and/or arrested and taken into custody on breach of an existing Police Family Violence Order (PFVO) in favour of his wife.[2]

[1] Section 3 of the Act defines "reportable death".
[2] Section 17 of the *Mental Health Act* 2013

4. I am also satisfied that Mr Mawer was a person held in custody at the time of causing his own fatal injuries at his residence. His house was surrounded by multiple armed police officers and he was not free to leave. He was aware of the presence of the officers and was effectively under their control. Had he not ignited himself, he would have been detained upon leaving his residence upon one or both of the grounds referred to above.

5. The death of Mr Mawer requires a coroner to hold a public inquest under section 24 of the *Act*. Section 24(1) provides, relevantly, that:

> *"… a coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Tasmania or it appears to the coroner that the death, or the cause of death, occurred in Tasmania or that the deceased ordinarily resided in Tasmania at the time of death and –*
>
> …
>
> *(b) the deceased was immediately before death a person held in care or a person held in custody;*

6. I was therefore required to hold an inquest into Mr Mawer's death.

7. Under section 28(1) a coroner investigating a death must find, if possible:

   (a) the identity of the deceased; and

   (b) how death occurred; and

   (c) the cause of death; and

   (d) when and where death occurred; and

   (e) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act 1999.

8. Further, by section 28(2), a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

9. By section 28(3), a coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

10. Section 28(5) requires a coroner to report on the care, supervision or treatment of the person while the person was a person held in custody.

Scope of inquest

11. The inquest focussed upon the circumstances leading up to and surrounding Mr Mawer's death and, for the purposes of the required report under section 28(5), the inquest examined police strategies and actions at the scene whilst they had surrounded Mr Mawer's residence and were anticipating detaining him.

Evidence in the investigation

12. The documentary evidence tendered at inquest comprised 58 exhibits. The exhibit list is annexed to this finding.

13. At inquest, the following witnesses provided oral testimony:
    - Dr Satish Kumar, Mr Mawer's general practitioner;
    - Mrs Jessica Mawer, wife of Mr Mawer;
    - Senior Sergeant Anthony Stewart, Police Commander at the scene;
    - Sergeant Andrew Smith, manager of the scene;
    - Acting Sergeant Emilie Dellar, primary police negotiator at the scene;
    - Sergeant Kelly Taylor, investigating officer attached to Professional Standards; and
    - Acting Commander George Cretu, of Professional Standards, who commented upon Sergeant Taylor's investigation.

Background

14. Stephen Charles Mawer was born in Burnie, Tasmania on 26 July 1974. He was the eldest of three children to Carol and Charles Mawer. In 1984, Mr Mawer's parents separated and later divorced. He grew up in Rossarden with his mother and sisters, Michelle Bennett and Sheralyn Mawer. He is described as having a normal, active childhood, although he struggled with dyslexia and had some trouble with school. As an adult, he worked in various forms of employment, including labouring and as a security guard. He had a history of illicit substance abuse and excessive alcohol consumption.

15. At the time of his death, he was living with his wife, Jessica Mawer, and their two daughters-Mackenzee, born in 2005, and Mackaylee, born in 2007. He was in receipt of a disability support pension and was cared for by his wife.

16. Since about 2011, Mr Mawer's mental health was, in general terms, poor and was marked by suicidal ideation, episodes of self-harm and at least one suicide attempt.

17. Mr Mawer was first seen by his general practitioner, Dr Satish Kumar, on 21 February 2012. Dr Kumar took over his care and regularly reviewed Mr Mawer until his death. Dr Kumar recorded his diagnoses as being depression and anxiety with issues of impulse control and anger management problems. Dr Kumar gave evidence that Mr Mawer was generally accepting of treatment and compliant with medication. The evidence indicates that Mr Mawer had been seen by psychiatrists and psychologists over a number of years, although it appears that he may not have engaged with mental health professionals to the optimal extent. As will be discussed, a deterioration in his mental health before his death appears to have been related to allegations of sexual offending on his part as well as his recent disclosure of sexual abuse allegedly perpetrated upon him as a child.

18. The evidence revealed a number of mental health crisis events in his life involving police and medical personnel, four significant incidents being as follows:

(a) In December 2014, Mr Mawer took an overdose of prescription drugs after arguing with his wife and was subsequently hospitalised.

(b) In October 2015, Mr Mawer inflicted stab wounds to his chest with a bladed knife following an argument with his daughter and was subsequently hospitalised.

(c) In July 2017, Mr Mawer engaged in self-harm by gouging his face and chest with tweezers. He armed himself with two large kitchen knives and brandished them in a window. He pulled down the blinds, locked windows and told the police he would burn the house down while he was inside. Negotiators, ambulance and fire officers attended and after a period of two hours, he was coaxed from the residence and conveyed to hospital for mental health assessment.

(d) On 30 January 2020, Mr Mawer took an overdose of drugs and inflicted lacerations to his upper limbs and chest after having an argument with his wife. His wife had left the bedroom and he then proceeded to lock the door to the bedroom with a butter knife. Mrs Mawer managed to break through the door shortly after it was locked and found Mr Mawer lying on the bed with cuts to his arms and the presence of a large quantity of blood. Mr Mawer told Mrs Mawer *"You don't need me here – no one needs me here"*. He then began to drift in and out of consciousness and an ambulance was called and conveyed him to the North West Regional Hospital (NWRH). This incident appeared to be a genuine attempt to end his life by medication overdose.

19. As a result of the incident on 30 January 2020, a PFVO was made which included protective conditions, including that Mr Mawer not directly or indirectly threaten, harass, abuse or assault Mrs Mawer and not damage property belonging to her. As noted above, that order was still in force at the date of Mr Mawer's death.

Allegations of sexual offending by Mr Mawer against three children

20. In 2017, Tasmania Police received a complaint from a child, A, that Mr Mawer had indecently assaulted that child. Another child, B, also alleged indecent assault by Mr Mawer and police statements were taken from both children.

21. In June 2019, Mr Mawer was interviewed by police in relation to the alleged offending and a police file was submitted to the Office of the Director of Public Prosecutions (DPP) in August 2019 to determine whether charges should be laid against him.

22. In November 2020, whilst the DPP was finalising advice regarding whether Mr Mawer should be charged, a third child, C, made a statement to police concerning sexual assault and rape by Mr Mawer over many years. If the allegations were true, the conduct represents the most serious type of criminal offending against a young child that might be imagined. There is no evidence that Mr Mawer was aware of the fact that C had made the complaint. It is not my function to make findings regarding the allegations. However, I observe that C's complaint on its face was a plausible, coherent account, replete with detail.

23. In relation to C's allegations, a further police investigation commenced, which was ongoing at the time of Mr Mawer's death. He was likely unaware of the allegations made to police by C. However, if he had perpetrated the extensive abuse alleged, this may well have been a matter weighing heavily upon him.

24. The evidence indicates that Mr Mawer did not know as a matter of fact prior to his death that he would face charges in respect of offending against A and/or B. However, he was fully aware that a decision was pending.

25. On 24 February 2020, three days after Mr Mawer's death, the DPP advised that there was sufficient evidence to justify a charge against Mr Mawer in respect of Child A but not Child B.

Mr Mawer's mental health care and treatment before his death

26. Mr Mawer was discharged from the NWRH Acute Medical Unit on the morning of 1 February 2020, a little over 48 hours after his medication overdose. The discharge summary notes that Mr Mawer's wife was to manage his medications generally and that psychiatric medications were not to be restarted again until review by the Crisis Assessment and Treatment Team (CAT team) and his general practitioner. The medical records provide clear details of the follow-up and monitoring of Mr Mawer both by the CAT team and Dr Kumar.

27. Initially, the CAT team attempted to make contact with Mr Mawer on 3 February without success. It made a further attempt on 4 February without success, but sent a text message asking him to contact them. Mr Mawer returned the text message and reported that he was feeling much better, denied suicidal ideation, and agreed to present for an assessment.

28. On 5 February, Mr Mawer was assessed by the CAT team and told team members that he was feeling better without medication and wanted to trial no medication. He said that he felt worse when taking the medication and had not taken any psychiatric medication since the overdose in January. He denied suicidal thoughts. He spoke of contributory stressors, such as experiences in childhood and that he had been accused of inappropriately touching Child A and Child B. Overall, he reported feeling better and indicated that he would benefit from counselling. The assessment was thorough and his prior history of self-harm and suicidal thoughts was noted.

29. The CAT team commenced plans to review Mr Mawer regarding his trial of no medication and to organise his counselling and psychiatric treatment.

30. On 6 February, the CAT team called Mr Mawer to follow up review plans. He did not answer. He was formally discharged from the care of the CAT team on 7 February, with the plan that he would be monitored by his general practitioner who would prepare a mental health care plan.

31. On 10 February, he returned the call from 6 February to the CAT team administration and reported that he was fine. Although he had been discharged from oversight by the CAT team, he was advised that if he called back as he indicated he

would, the team would conduct a mental state assessment and reinforce the need to see his general practitioner.

32. On 14 February, Dr Kumar reviewed Mr Mawer for a mental health care plan. At this review, Dr Kumar facilitated the psychologist and psychiatrist referrals with a view to fast track the scheduling of appointments. Dr Kumar accepted the plan to trial no medication. In his evidence at inquest, Dr Kumar provided the opinion that it was reasonable for Mr Mawer to cease taking psychiatric medications in his particular circumstances. He said that it was not an unusual treatment plan for some patients. Dr Bell, coronial medical consultant, provided a report on this issue and agreed that it was appropriate to trial cessation of psychiatric medication because of Mr Mawer's significant issues with his medication.

33. At the consultation on 14 February, Dr Kumar also requested Mr Mawer to complete the K10 and DAS tests which revealed high scores for depression and anxiety. However, Mr Mawer said that he was generally feeling better and did not report suicidal ideation. Dr Kumar said that, at this consultation, Mr Mawer understood the discussion and treatment proposals, and was rational in his interactions.

34. I am satisfied that Mr Mawer received good care and treatment for his mental health during the time relevant to this inquest - from his hospital admission on 30 January until his death. I do not criticise the decision by Mr Mawer's treating health professionals to support his wish to cease his medications. His mental state was being properly monitored. There is no evidence that the cessation of his medications played a part in his mental state at the time of his death, as opposed to him suffering a general deterioration over time and additional stressors. Nothing more could have reasonably been done to assist him.

Circumstances surrounding death

35. It appears that Mr Mawer's mental health had deteriorated markedly in the two years before his death. During this period, he had commenced perpetrating physical violence upon Mrs Mawer, who described these episodes of violence in her evidence.

36. In the two months before his death, Mrs Mawer recounted that Mr Mawer had become addicted to the video game *Fortnite*, an online video game involving repeated depictions of violence. She said that he would spend about 10 hours per day playing and his addiction had become a significant problem in the relationship. Mrs Mawer partly attributed his declining mental health to his addiction to the game.

37. In the weeks before his death, Mr Mawer reported to close family members, including his mother and father, that he had been sexually assaulted as a child. He had informed Mrs Mawer of this fact several years previously. Further, it is evident that he was fearful of a jail sentence on his own possible sexual assault charges and told Mrs Mawer that he would not go to jail. It is clear from Mrs Mawer's evidence that she was very concerned about her husband's mental health before his death and was pressing him to make the appointments with the psychologist and psychiatrist in accordance with his mental health plan referrals. However, he did not make the appointments and told Mrs Mawer that he was not ready to do so.

38. On 20 February 2020, Mrs Mawer was present in the backyard of their home, undertaking outdoor tasks, when Mr Mawer had said to her *"I just don't want to be here anymore. Everything's getting too hard and I don't want to be here anymor*e". She gave evidence that she had partially filled a jerry can of fuel for the lawnmower and asked whether it was safe for her to have the fuel around. In this regard, she was aware that Mr Mawer had, over previous days, seen a news story from Queensland involving self-immolation. Mr Mawer had replied that it was safe, and that he would not do anything "*stupid*". She said that Mr Mawer became less distressed after a talk and appeared to be quite well. They finished the yard work together and Mrs Mawer said that her husband's mood appeared to be stable.

39. On the morning of 21 February 2020, Mrs Mawer described Mr Mawer as being in an extremely elevated state, commenting that *"he was a completely different person"* and *"his eyes had changed"*. She said that he was *"just jacked so full of adrenaline"* and further said *"I couldn't speak to him. I couldn't say anything because there was just nothing there."*

40. Later in the morning, an argument developed between them regarding their financial difficulties, with Mrs Mawer stating that they needed to sell some items to reduce debt. She suggested that Mr Mawer sell his PlayStation. Mr Mawer became extremely angry at this proposal and demanded the keys to his Subaru. This vehicle was unregistered and Mrs Mawer said that he was not supposed to drive it for this reason as well as on medical grounds. Because of this, Mrs Mawer had hidden the keys to the vehicle in the glovebox of her own vehicle. She told Mr Mawer she did not know the location of the keys.

41. She then drove to the residence of Mr Mawer's sister, Sheralyn Mawer (Sheralyn), a short distance away and arrived at about 10.00am. Present at that residence was Sheralyn, Michelle Bennett (Mr Mawer's other sister), Mr Mawer's mother and a female friend. Mrs Mawer told them that Mr Mawer was in a rage, and described the abuse perpetrated by him upon her in recent times. Mrs Mawer also left the keys of the Subaru with them to prevent Mr Mawer from driving. Mrs Mawer told them that Mr Mawer was on his way over to Sheralyn's house.

42. Within 15 minutes, Mr Mawer arrived at Sheralyn's residence, having walked there, and behaved in an extremely aggressive manner. All present in the house described Mr Mawer making threats to burn down 41 Bells Parade, and to *"burn out"* unspecified people. He was described as ranting, raving and swearing. He raised his fist at his mother, demanding his car keys. The evidence of those present corroborates Mrs Mawer's assessment of his mood as being so highly elevated and angry that he was not responsive to normal cues or to reason. He then left the house suddenly to make his way back to his own house. Mrs Mawer had previously returned to the house for the purpose of collecting her two dogs in order to secure them from a potentially dangerous situation. It was apparent to the occupants of Sheralyn's house that Mr Mawer was in mental health crisis.

43. At about 10.59am, Michelle Bennett called police in relation to the threats Mr Mawer had made to burn down the property at 41 Bells Parade.

44. Mr Mawer returned on foot to 41 Bells Parade shortly thereafter and entered through the back door of the property. He was abusive to Mrs Mawer who was placing her two dogs in the vehicle. Mr Mawer himself owned a bull mastiff dog which had aggressive tendencies and which Mrs Mawer did not take with her. As will be discussed, the highly aggressive nature of Mr Mawer's dog caused increased difficulty in police responding to the incident that subsequently unfolded.

45. As Mrs Mawer was leaving the house, Mr Mawer grabbed a kitchen knife and said to her "d*on't fucking worry about me. You just go."*

46. At 11.12am Sergeant Andrew Smith arrived at the scene, followed by Acting Sergeant Emilie Dellar and Senior Constable Kellie Little at 11.13am. Other officers followed.

47. At the time of the arrival of the first officers, Mr Mawer had gone inside the house, shutting the front door and wedging the knife in it to prevent it from being opened. When asked by police if Mr Mawer had a weapon, Mrs Mawer informed them he had a kitchen knife.

48. The property at 41 Bells Parade is a single story brick dwelling with the front of the property enclosed by a low brick fence. The eastern side of the property has access to the rear via a concrete driveway which was blocked by a 6 foot chain-mesh gate covered in shade cloth ("the driveway gate"). The western side of the property was obstructed by an aluminium, pool-type fence. Both the eastern and western boundaries of the property are fenced by six-foot fencing separating the property from neighbouring residences. The property has a large backyard with a concrete area and landing directly outside the back door.

49. The whole incident that followed leading to Mr Mawer's self-inflicted fatal injuries was captured from different perspectives on the body worn cameras of the officers involved. The body worn camera footage from six officers was tendered in evidence and provided an accurate visual and audio representation of the incident. Not only does this footage allow accurate findings to be made about the incident and timing of key points, but has likely saved many hours in court time at inquest and spared most of the officers involved from the necessity to give evidence. It also confirms the accuracy of the detailed affidavits and interviews given by the officers concerning this incident who were subject to the required Tasmania Police Professional Standards requirements and protocols.

50. The following description of the incident accords with the body worn camera footage. I am grateful to Sergeant Kelly Taylor, investigating officer, and Mr Lee, Counsel Assisting, for their helpful analysis of the important points depicted in the various pieces of footage.

51. The officers principally involved in the incident, and who were subsequently interviewed by Professional Standards were Senior Sergeant Anthony Stewart, Sergeant Andrew Smith, Acting Sergeant Emilie Dellar, Senior Constable Adam Lloyd, Senior Constable Kellie Little and Constable Travis Van Tholen. Constable Olivia Davies was nearby and involved in obtaining and relaying information from Mrs Mawer to the officers managing the scene.

52. Initially, the officers arriving at the scene gathered at the front of the property on Bells Parade. The information received, correctly, concerning Mr Mawer's threats were, variously, that he would burn the house down and throw petrol on himself, police and others.

53. At 11.13am, Senior Constable Little walked down the driveway towards the rear of the house. She observed Mr Mawer in the backyard carrying an axe and a small jerry can. She noticed that he was of very large build. Mr Mawer, in fact, weighed 133 kg and was 1.81 metres in height.

54. At 11.14am Sergeant Smith, the officer in charge of managing the incident, requested that Tasmania Fire Service be advised of the incident and placed on standby. Sergeant Smith requested negotiators to attend the scene for the purpose of entering negotiations with Mr Mawer. He also asked police officers to go to the rear of the house to maintain observations. He himself walked down the side of the house to the driveway gate. At this time, Mr Mawer was giving commands to his dog to rush at police, yelling at Sergeant Smith to *"fuck off"* and threatening to throw petrol over police officers. He then walked out of the back door and threw a bucket of water at Sergeant Smith over the driveway gate.

55. At 11.18am Acting Sergeant Dellar and Senior Constable Adam Lloyd, both trained police negotiators, commenced negotiations with Mr Mawer, positioning themselves in the driveway next to the driveway gate. Acting Sergeant Dellar performed the role of primary negotiator.

56. By 11.20am, a cordon was established around the property as follows: Senior Constable Little was positioned at the fence on the rear eastern corner, Constable Van Tholen was positioned at the fence on the rear western corner. Senior Sergeant Stewart, Sergeant Smith and Acting Sergeant Weston were positioned at the front of the property.

57. At 11.30am Sergeant Smith spoke by phone to Constable Davies who had been in the process of speaking separately to Mrs Mawer away from the scene and who obtained important details relating to Mr Mawer. These included his mental health history, recent hospitalisation and current PFVO.

58. At 11.25am Tasmania Fire Service (TFS) was requested to stage at the Esplanade in the vicinity of Bells Parade. Ambulance Tasmania was also advised of the incident and placed on standby.

59. Mr Mawer did not engage with negotiators to any significant extent, despite constant efforts by Acting Sergeant Dellar to call to him inside the house to try and have him engage in conversation. Mr Mawer did, however, asked for Mrs Mawer to return to the house to collect his dog. Quite appropriately, he was told that this was unable to occur but arrangements could be made for the Council dog catcher to attend and take the dog. Mr Mawer then took the dog back inside the house and locked the door. Mr Mawer did not engage with negotiators to any extent after this conversation.

60. At 11.33am Senior Sergeant Stewart arrived on the scene, assumed the role of Police Scene Commander and discussed plans for the operation with Sergeant Smith.

61. The officers all maintained their cordon positions and at 11.50am Senior Constable Little and Constable Van Tholen observed Mr Mawer moving around inside the house covering windows in the back of the house with towels. All other windows had the curtains or blinds drawn.

62. Acting Sergeant Dellar continued to try and make contact with Mr Mawer by calling in a clear and loud voice for him to come out and reassuring him that the police officers wished to ensure that he was okay. She also spoke to him frequently about securing the safety of his dog, Zara. However, at 11.52am, Mr Mawer opened the back door and told Acting Sergeant Dellar that she had a *"nagging voice"* and to *"go away"*. Mr Mawer released the dog from the house and roused the dog to run at the back fence where Constable Van Tholen was positioned. The dog obeyed the command and returned to the house. Mr Mawer then went inside and closed the back door.

63. Having viewed the footage, it is obvious that the dog acted upon Mr Mawer's commands, appeared to be vicious, and had the capacity to inflict significant injury on the officers present.

64. At 11.53.24am Mr Mawer exited the back door alone. He had possession of a small, green jerry can. He stood outside the back door and poured petrol over his body. He threw the green jerry can into the backyard. He then went back inside through the back door for approximately three seconds and at 11.53.49 re-emerged in flames. Only Senior Constable Little had observations on Mr Mawer's movements at the back porch from her position at the rear fence. She conveyed by radio all of her observations clearly, accurately and contemporaneously.

65. At the time of Mr Mawer emerging from the house on fire, police officers had been in attendance at the incident for a total of 41 minutes.

66. There was an immediate response from the officers which was most impressive in the circumstances. Senior Constable Little immediately scaled the barbed wire rear boundary fence and, despite the risk posed by the dog, ran straight to the driveway gate to open it for the officers gathered on the other side of it. She was, however, unable to open the gate.

67. At 11.54.06am Senior Constable Little was handed a fire extinguisher from over the locked driveway gate and by 11.54.09 she had deployed the extinguisher whilst running towards Mr Mawer. She deployed that fire extinguisher for at least 21 seconds. It may then have become empty of foam and Senior Constable Little ran to the shed on the property and sourced a blanket to further extinguish the fire on Mr Mawer. In the meantime, Constable Van Tholen had also come over the fence from the rear of the property at his cordon position and attempted to connect the garden hose to extinguish the flames.

68. At 11.54.12am another extinguisher was retrieved from a police vehicle on the street. At 11.54.17am a further extinguisher was handed over the fence by a neighbour. Two

seconds later the officers successfully forced down the driveway gate and entered into the rear yard. The total time taken to bring down the gate was 19 seconds.

69. At 11.54.28am officers deployed the neighbour's extinguisher onto Mr Mawer. Six seconds later the third extinguisher sourced from a police vehicle was deployed onto Mr Mawer. The fire was then extinguished. Whilst Mr Mawer was alight and subsequently he was conscious and repeatedly said to the officers "*I'm sorry*".

70. During the incident, the officers who had entered the property expressed concern about the danger posed by the dog, which was not visible. It was not until 11.56.26am that it was confirmed that the dog was inside the residence and secured.

71. At 11.57.20am fire crews who were stationed nearby attended the scene and placed oxygen onto Mr Mawer at 11.58.15am. Police assisted in cutting away Mr Mawer's clothes and gently spraying water over his burns. At 12.02.40am he was attended to by paramedics and transported to the NWRH.

72. Upon his presentation to hospital, he was assessed as having severe burns posteriorly and anteriorly, mostly of full thickness. He was expected to die and was provided with intravenous analgesia by way of palliative care. He passed away at 7.21pm that evening.

Post-mortem examination

73. Forensic Pathologist, Dr Andrew Reid, who examined Mr Mawer in the Hobart mortuary assessed him as having 80-90% full and partial thickness burns across his body. He reported that most people with this extent of burning do not survive.

74. Further, Dr Reid reported:

> *"When burns of this extent are not immediately fatal (as in this case) the underlying mode or mechanisms of death include respiratory and metabolic complications of severe thermal injury to the airways and lung parenchyma causing respiratory failure progressing to multi-organ failure. Haemodynamic effects of tissue fluid loss associated with blistering caused by the burns is also another contributing factor to the fatal outcome."*

75. Dr Reid noted that there were no other injuries, and that the cause of death was due to burns. I accept his opinion, and find that Mr Mawer had suffered such extensive burns that he had no chance of survival.

76. Toxicological analysis found no alcohol or illicit drugs in Mr Mawer's blood.

77. At the time of inquest, I received a supplementary report from Dr Reid regarding Mr Mawer's chances of survival in the event of the fire being extinguished more quickly. Dr Reid stated that the effects of the burns and subsequent complications begin at the time of ignition because the person is immediately engulfed in flames. He commented that the opportunity for first responders to extinguish flames in a case of self-immolation before any burning injury occurs is extremely limited due to the immediate inhalation injury which cannot be prevented. Even if it was possible to

extinguish the flames at an earlier time, Mr Mawer would still have died from his injuries.

Comments

Police actions and strategies at the scene

78. The officers involved managed the situation in an exemplary manner. The overall strategy, information gathering, decision-making, negotiating and physical actions were beyond reproach.

79. They were confronted with a dangerous situation. Mr Mawer was armed with a large kitchen knife, an axe, a fuel can, possibly a chainsaw, and was urging his dog to attack them. They remained measured and calm in their decision-making and yet acted with an appropriate sense of urgency. As submitted by Mr Lee, the officers could not have simply departed from the property leaving Mr Mawer to remain there. His state of mind was unstable and he posed a danger to himself, his family and the general community. There was no option but for the officers to take him lawfully into custody.

80. Conversely, it would have been a foolish tactical decision for the officers to attempt to enter the property. They were unaware of dangers within the property, its layout and did not have special operations capabilities.

81. Thus, the only option for the attending officers was to follow the ICEN model – an acronym for "isolate, cordon, evacuate and negotiate". This response model was recognised as appropriate for the situation and the officers were clearly versed in its implementation. It is apparent that Sergeant Smith commenced sound decision-making pursuant to the ICEN model immediately upon arrival at the scene.

82. It is to be noted that the situation was made more difficult to manage as Mr Mawer had no landline or mobile phone in the home with which to establish contact. Further, he had a hearing impairment, and at some stage he had left his hearing aid on the bench. It is nevertheless likely that he heard some or all of Acting Sergeant Dellar's words. At the very least, he was aware of her presence, had the opportunity to engage with her but refused to do so. Her communication technique was good, consistently focussing upon enquiring whether he was alright and that his dog, Zara, was safe. She could not have done any more to engage with Mr Mawer.

83. In addition to the difficulties communicating with Mr Mawer, his dog was an added complication in managing the situation. Sergeant Smith and other officers discussed Mr Mawer's attachment to the dog and reasoned that while it was there, he may have been less likely to start a fire. They reasoned, soundly, that if the dog was gone he may have felt that there was nothing to live for. In any event, they planned for a retrieval of the dog, and made arrangements for the local dog control officer to attend the scene in anticipation of removing it from the property if necessary.

84. Sergeant Smith performed his role most competently whilst under considerable pressure in a dynamic situation. He remained composed and thoughtful in his approach. He instigated timely discussions around an interim plan should Mr Mawer

exit the property and also a retrieval plan for the dog. He also asked Acting Sergeant Weston to commence a surrender plan in respect of Mr Mawer for sign-off. Despite the difficult situation, Sergeant Smith was still able to help work through the surrender plan with Acting Sergeant Weston. He was also in the process of formulating a direction to all officers to convey expected requirements of safely managing the incident. Further, he had ordered a drone from Devonport and this was in the process of being prepared for delivery to the scene.

85. In his evidence, Senior Sergeant Stewart explained that the stand-off period of 41 minutes was a short time in the context of his significant experience with incidents of this type. He said that often incidents involving similar stand-offs have exceeded 24 hours and patience is required. He said that Mr Mawer was not showing that he would surrender at any imminent point.

86. Senior Sergeant Stewart as Scene Commander was authoritative, calm and strategic at the scene. He has significant experience in the area and has overseen the state's negotiator training. The benefit of having his expertise in assessing the overall picture and providing guidance to officers was obvious from the footage. The command and control structure at the scene created by both Senior Sergeant Stewart and Sergeant Smith was clear and effective.

87. The actions of Senior Constable Little and Constable Van Tholen should also be commended. Without any hesitation whatsoever, and despite the presence of the unmuzzled dog, they ran into the property to help Mr Mawer. I particularly note the speed at which Senior Constable Little was able to obtain and deploy the extinguisher, being only 21 seconds from sighting the fire.

Professional Standards investigation

88. Sergeant Kelly Taylor was one of four police officers from Professional Standards who responded to the incident and was tasked with preparing a report for the coroner.

89. In summary, Sergeant Taylor reported that:

- The police officers in the matter acted lawfully, appropriately and in accordance with policy and procedure;
- There was no breach of the Code of Conduct pursuant to the *Police Services Act* 2003;
- There were no suspicious circumstances surrounding Mr Mawer's death; and
- That no recommendations need to be brought to the coroner's attention.

90. The Tasmania Police Manual[3] sets out the procedure to be undertaken following a death in custody, and the subsequent management and investigation of such incidents. Pursuant to these requirements the following occurred:
    - The scene was secured pending the arrival of investigators from the Professional Standards command, and was subject to forensic examination;
    - Body worn camera footage was managed and reviewed by Professional Standards, with access restricted to investigators;
    - Alcohol and drug testing of officers attending the scene occurred in accordance with section 50 of the *Police Service Act* 2003;
    - The involved officers were interviewed by Professional Standards, with the assistance of western district personnel immediately after their attendance at the scene;
    - The Police Association of Tasmania was advised of incident and the involved officers were represented by the President and Chief Executive Officer of that organisation;
    - Wellbeing support was provided to officers involved;
    - Family members participated in Professional Standards interviews on 22 February 2020;
    - The Integrity Commission was notified of the death by Commander Dooley of Professional Standards; and
    - A death in custody notification was made to the Australian Institute of Criminology on 22 February 2020.
91. Inspector George Cretu was Acting Commander of Professional Standards at the time of the investigation. In his oral evidence at inquest he stated that he had read Sergeant Taylor's report and considered it to be comprehensive, fair and balanced. He also considered that Inspector Wright, who fully reviewed Sergeant Taylor's investigation, summarised events well and provided a fair assessment.

Foreseeability of Mr Mawer's self-immolation

92. Mr Mawer had engaged in self-harm accompanied by suicidal ideation on a number of previous occasions. As discussed, the evidence indicates that his state of mental distress was worsening in the period before his death. He had been hospitalised for a suicidal drug overdose three weeks before his death and, on the day before his death, made statements to his wife to the effect that he no longer wished to live. On the day of his death, he exhibited an unprecedented state of anger and distress such that he was unresponsive to all attempts to calm him. He articulated intentions to throw petrol on himself in addition to the other threats. He was in a suicidal and irrational state.

[3] Section 7.4.

93. The officers involved in the incident planned for the materialisation of Mr Mawer's threats. The involvement of TFS demonstrates such planning. It is clear, however, that none of the officers involved in the incident expected Mr Mawer to emerge from the house in flames at the time that he did so. Relevantly, a period of only 25 seconds elapsed between pouring the petrol on himself and emerging from the house alight. Even though the officers were taken by surprise, the response was swift, as described.

94. Mrs Mawer, at inquest, said that even if Mr Mawer had been unsuccessful that day in ending his life, his suicide was inevitable. The evidence as a whole indicates that her view was well founded, such was Mr Mawer's ongoing state of mental distress and suicidal ideation. Senior Sergeant Stewart, in his evidence at inquest, questioned whether Mr Mawer actually intended to set himself alight or whether he wished only to create a threatening scene by holding a cigarette lighter near his petrol-soaked body. Notwithstanding Mr Mawer's immediate apologies and apparent regret at his actions whilst he was on fire, I am quite satisfied that Mr Mawer intended to end his life.

Fire extinguishers

95. One point considered at inquest was whether the fire extinguishers in the police vehicles should have been positioned close to the officers rather than left in the vehicles on the street. Perhaps in hindsight, having the extinguishers in closer proximity might have been considered a good idea. However, TFS was nearby and the other pressing issues of scene management were fully occupying the officers. As it was, the retrieval of the extinguishers was quick and regardless of their location, the officers still had to enter the property over difficult fences and a locked driveway gate. The issue of the proximity of fire extinguishers to the officers bore no connection to Mr Mawer's fate.

TFS positioning at the scene

96. It was clearly apparent from the evidence that the fire truck was not situated where it was directed to be situated by police. While the initial requested position was to be on the esplanade near the surf club, that location was quickly changed to the end of Bells Parade, near number 35. This was much closer to the scene and yet, appropriately, just out of view of Mr Mawer. The three attempts to request that the fire truck attend the designated location did not result in that eventuating. There was, as a result, a delay in TFS attending the scene and Mr Mawer. Whilst that delay did not have consequences in this case, it may well have been critical.

Communications between police and TFS

97. The issue with the incorrect positioning of the fire truck was caused by the inability to have direct communication between the police at the scene and the TFS personnel in the fire truck. All communication had necessarily to be made by police at the scene to their Radio Room which, in turn, conveyed the information to FireComm, the TFS communications network. FireComm then relayed the information to the fire personnel at the scene. It is not difficult to understand why clear communication, so important in an incident such as this, became confused and resulted in this unsatisfactory situation.

98. I heard evidence from Sergeant Taylor that after the Dunalley fires, it was recommended that a new radio network be implemented to enable direct communication between emergency services. I observe that the recommendation was made in the 2013 Tasmanian Bushfires Inquiry report published in October 2013. I heard evidence that the network is intended to be operational in October this year.

Formal findings required by section 28(1) of the *Coroners Act* 1995:

a) The identity of the deceased is Stephen Charles Mawer;

b) Mr Mawer died in the circumstances set out in this finding;

c) The cause of Mr Mawer's death was self-inflicted burns; and

d) Mr Mawer died on 21 February 2020 at Burnie in Tasmania.

Concluding comments and acknowledgements

99. The circumstances are not appropriate make any recommendations pursuant to section 28 of the Act.

100. I comment pursuant to section 28(5) of the Act that the care, supervision and treatment of Mr Mawer whilst he was held in custody was of an excellent standard for the reasons given.

101. I commend all of the officers for their actions at the scene. It was apparent that their sole aim was to resolve the situation with Mr Mawer being taken safely to hospital. They could not have done any more to have changed the outcome. Most unfortunately, the method chosen by Mr Mawer to end his life has left a number of the officers significantly affected by the trauma of the incident. I hope that, with the conclusion of this investigation, they are able to recognise that their actions were exemplary in all respects and that the outcome was inevitable.

102. I appreciate the high level of assistance given by counsel assisting, Mr Cameron Lee. I also acknowledge the thorough and competent investigation of Sergeant Kelly Taylor.

103. I convey my sincere condolences to the family and loved ones of Stephen Charles Mawer.

Dated: 29 April 2022 at Hobart in the State of Tasmania

Olivia McTaggart

Coroner

Annexure A

LIST OF EXHIBITS

Record of investigation into the death of Stephen Charles MAWER

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	REPORT OF DEATH	CONSTABLE GLENN MARTIN
C2	LIFE EXTINCT AFFIDAVIT	DR AUGUSTUS KIGOTHO
C3	AFFIDAVIT OF IDENTIFICATION	WENDY DENBY
C3A	AFFIDAVIT OF IDENTIFICATION	COLIN O'CONNOR
C4	POST MORTEM AFFIDAVIT	DR ANDREW REID
C5	TOXICOLOGY REPORT	NEIL MCLACHLAN-TROUP - FSST
C6	MEDICAL REPORT	TASMANIA HEALTH SERVICE
C7A	MEDICAL REPOERT	DR SATISH KUMAR
C7B	MEDICAL RECORDS	BURNIE GP SUPER CLINIC
C7C	MEDICAL RECORDS	BURNIE GP SUPER CLINIC
C8	AFFIDAVIT	JESSICA MAWER
C8A	AFFIDAVIT	JESSICA MAWER
C9	AFFIDAVIT	CAROL MAWER
C10	AFFIDAVIT	MICHELLE BENNETT
C11	AFFIDAVIT	KANDY KELEHER
C12	AFFIDAVIT	KELLIE DICKER
C13	AFFIDAVIT	SANDRA DICKER
C14	AFFIDAVIT	MICHAEL TAYLOR
C15	AFFIDAVIT	DAVID ALLEN
C16	AFFIDAVIT	S/SRGT ANTHONY STEWART
C17	AFFIDAVIT	SRGT ANDREW SMITH (PENDING)
C18	AFFIDAVIT	A/SRGT EMILIE DELLAR

C19	**AFFIDAVIT**	**S/CONST ADAM LLOYD**
C20	**AFFIDAVIT**	**S/CONST KELLIE LITTLE**
C21	**AFFIDAVIT**	**CONST TRAVIS VAN THOLEN**
C22	**AFFIDAVIT**	**SRGT KELLY TAYLOR**
C22A	**REPORT**	**SRGT KELLY TAYLOR (15.06.2020)**
C22B	**REPORT**	**SRGT KELLY TAYLOR (15.12.2020)**
C23	**REPORT**	**CLAIRE FULTON - FSST**
C24	**AFFIDAVIT + PHOTOGRAPHS**	**CONST LINDSAY NEEDHAM**
C25	**AFFIDAVIT + PHOTOGRAPHS**	**CONST DEAN WOTHERSPOON**
C26	**BODY WORN CAMERA FOOTAGE**	
C27	**000 CALL + RADIO DISPATCH RECORDINGS** **TRANSCRIPT OF RADIO DISPATCH**	
C28	**AUDIO INTERVIEW AND TRANSCRIPT**	**JESSICA MAWER**
C29	**AUDIO INTERVIEW AND TRANSCRIPT**	**CAROL MAWER**
C30	**AUDIO INTERVIEW AND TRANSCRIPT**	**MICHELLE BENNETT**
C31	**AUDIO INTERVIEW AND TRANSCRIPT**	**KANDY KELEHER**
C32	**AUDIO INTERVIEW AND TRANSCRIPT**	**S/SRGT ANTHONY STEWART**
C33	**AUDIO INTERVIEW AND TRANSCRIPT**	**SRGT ANDREW SMITH**
C34	**AUDIO INTERVIEW AND TRANSCRIPT**	**A/SRGT EMILIE DELLAR**
C35	**AUDIO INTERVIEW AND TRANSCRIPT**	**S/CONST ADAM LLOYD**
C36	**AUDIO INTERVIEW AND TRANSCRIPT**	**S/CONST KELLIE LITTLE**
C37	**AUDIO INTERVIEW AND TRANSCRIPT**	**CONST JOHN VAN THOLEN**
C38	**TIMELINE OF EVENTS**	
C39	**EMAIL**	**A/INSPECTOR A STEWART**
C40	**POLICE REPORT FILE**	
C41	**REPORT**	**DR ANTHONY BELL**
C42	**REPORT**	**INSEPECTOR WRIGHT**

C43	**AFFIDAVIT**	**TANEKA STARR**
C44	**REPORT**	**TAS AMBULANCE**
C45	**REPORT**	**TAS FIRE SERVICE**
C46	**TIMELINE OF POLICE INTERACTIONS WITH MAWER**	
C47	**OCCURRENCE REPORT – TAI1401329538**	
C48	**OCCURRENCE REPORT – TAI1501373488**	
C49	**OCCURRENCE REPORT – 522599**	
C50	**OCCURRENCE REPORT – TAI1601428060**	
C51	**OCCURRENCE REPORT – TAI171468590 FVMS**	
C52	**FVMS REPORT 11506 CHILD SAFETY REFERENCE**	
C53	**AFFIDAVIT**	**SHANNON DENBY**
C54	**AFFIDAVIT**	**CHILD C**
C55	**POLICE FAMILY VIOLENCE ORDER REPORT (30 June 2020)**	
C56	**TASMANIAN FIRE SERVICE MAP**	
C57	**AFFIDAVIT**	**DR ANDREW REID**
C58	**PACER INFORMATION**	