FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 into the death of Nicholas Aaron Scott

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the death of Nicholas Aaron Scott with an inquest held at Hobart in Tasmania make the following findings:

Hearing Dates

26 and 27 May 2025.

Representation[1]

E Burrows-Cheng - Counsel Assisting the Coroner

L Taylor - Tasmanian Prison Service (Secretary of the Department of Justice)

R Ralston - M Oppitz

Introduction

1. Mr Scott died when he was shot at close range by David John Coles with a 12 gauge shot gun. Coles was sentenced to a term of imprisonment for the killing of Mr Scott. It is not any part of my role to comment on the criminal proceedings relating to Mr Coles.

2. Mr Scott spent most of his life in and out of gaol. His most recent, and last, period of incarceration commenced on 30 June 2022 when he was arrested for being in possession of a quantity of methylamphetamine and charged with trafficking in a controlled substance. At that time Mr Scott was on parole having been released by order of the Parole Board four weeks earlier while serving a sentence in relation to aggravated carjacking.

Role of the Coroner

3. Before considering the circumstances of Mr Scott's death in further detail, it is necessary to say something about the general role of the coroner. In Tasmania, a coroner has jurisdiction to investigate any death, and hold an inquest, in relation to

[1] Mr Cox choose not to be represented by a legal practitioner. All the material relevant to his involvement in the inquest were provided, at his request, to his trade union.

that death if it appears to have been "*unexpected, unnatural or violent or to have resulted directly or indirectly from …* injury".[2] The circumstances of Mr Scott's death meet this definition.

4. A preliminary question arose as to whether or not at the time of his death Mr Scott was in custody or was in the process of escaping from custody. The significance of this point was that if either of those factual scenarios applied, then I would have had an obligation to first, hold an inquest and second, after holding the inquest, report on Mr Scott's care, supervision and treatment.[3] I determined that neither scenario was applicable since Mr Scott had made good his escape and there was a sufficient temporal and geographical disconnection between his being in custody and escaping and his death.

5. When conducting an inquest, a coroner performs a role different to other judicial officers. The coroner's role is inquisitorial. An inquest might be best described as a quest for the truth, rather than a contest between parties to either prove or disprove a case. In an inquest, a coroner is required to thoroughly investigate the death and answer the questions (if possible) that section 28(1) of the *Coroners Act* 1995 (the "Act") asks. Those questions include who the deceased was, how they died, the cause of the person's death, and where and when the person died. It is settled law that this process requires a coroner to make various findings, but without apportioning legal or moral blame for the death.

6. In any event, a coroner is required to make findings of fact about the death from which others may draw conclusions. A coroner may, if she or he thinks fit, make comments about the death or, in appropriate circumstances, recommendations to prevent similar deaths in the future.[4]

7. It is important to recognise that a coroner does not punish or award compensation to anyone.[5] Punishment and/or compensation are for other proceedings, in other courts, if appropriate. Nor does a coroner charge people with crimes or offences arising out of a death that is the subject of investigation.

8. As was noted above, one matter that the Act requires, is a finding (if possible) as to how the death occurred.[6] '*How*' has been determined to mean '*by what means and in*

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[2] Section 3 of the *Act.*
[3] Section 28(5) of the *Act*.
[4] Section 28(2) of the *Act*.
[5] Section 45(3) of the *Act*.
[6] Section 28(1)(b) of the *Act.*

what circumstances',[7] a phrase which involves the application of the ordinary concepts of legal causation.[8] Any coronial inquest necessarily involves a consideration of the particular circumstances surrounding the death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner.

9. The standard of proof at an inquest is the civil standard. This means that where findings of fact are made, a coroner needs to be satisfied on the balance of probabilities as to the existence of those facts. However, if an inquest reaches a stage where findings being made may reflect adversely upon an individual, it is well-settled that the standard applicable is that expressed in *Briginshaw v Briginshaw*, that is, that the task of deciding whether a serious allegation against anyone is proved should be approached with a good deal of caution.[9]

10. A coroner is not bound by the rules of evidence in holding an inquest and may be informed and conduct an inquest in any manner the coroner reasonably thinks fit. To be properly received at an inquest, the evidence must be capable in some way of assisting the coroner to determine the matters under section 28(1) or, in appropriate circumstances, to assist in making a comment or recommendation. It is well settled that a coroner has significant latitude in receiving evidence. The question of weight to be given to any evidence tendered at an inquest is a question for the coroner after receiving submissions from interested parties.

11. The final matter that should be highlighted is the fact that the coronial process, including an inquest, is subject to the requirement to afford procedural fairness.[10] A coroner must ensure that any person (any person can include a legal entity) who might be the subject of an adverse finding or comment is made aware of that possibility and given the opportunity to fully put their side of the story forward for consideration. To that end all persons and entities considered to have sufficient interest in the outcome of the inquest, and who may have been at risk of adverse comment, were identified well in advance of the inquest, provided with notice and invited to participate in that inquest. Their participation was facilitated by the complete disclosure of all material obtained as a result of the investigation under the Act.

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[7] *Atkinson v Morrow* [2005] QCA 353.
[8] See *March v MH Stramare Pty Ltd and Another* [1990 – 1991] 171 CLR 506.
[9] (1938) 60 CLR 336.
[10] See *Annetts v McCann* (1990) 170 CLR 596, *Attorney General v Copper Mines of Tasmania Pty Ltd* [2019] TASFC.

Evidence at the inquest

12. A number of witnesses gave evidence and were questioned at the inquest. In order, they were:

    a) Mr Craig Cox – Correctional Officer;
    b) Mr Martin Oppitz – First Class Correctional Officer;
    c) Ms Lara Smith – Correctional Supervisor;
    d) Ms Kasey Drew – Correctional Supervisor;
    e) Mr Jason Mills – Tasmanian Prison Service;
    f) Mr Andrew Gallagher –Tasmanian Prison Service; and
    g) Ms Jo Webb – Tasmanian Prison Service.

13. I will discuss the evidence of the witnesses later in this finding.

14. In addition to the verbal evidence given at the inquest a significant amount of written material was tendered. That material is annexed to this finding and marked with the letter A.

15. Well in advance of the inquest Mr Scott's senior next of kin (his mother) was notified of the fact that an inquest would be held in relation to her son's death. She took no part in the proceedings.

Background

16. On 29 November 2021, Mr Scott was convicted of aggravated carjacking and sentenced to three years and six months imprisonment. On 30 May 2022, he was released on parole subject to various conditions which, within a month, he breached and was consequently arrested. His parole was revoked on and from 1 July 2022.

17. On 3 November 2022, Mr Scott was moved from the Hobart Reception Prison to the Risdon Prison Complex where he was housed in the maximum security Huon Unit. On 1 December 2022, Mr Scott was admitted to the Royal Hobart Hospital after swallowing two razor blades wrapped in plastic. He remained at the Royal Hobart Hospital until his discharge on 20 December 2022 whereupon he was returned to maximum security in the Risdon Prison Complex.

18. A week later, on 27 December 2022, Mr Scott was again admitted to the Royal Hobart Hospital due to self-inflicted cuts to his upper chest. After his admission, he told staff that he had swallowed another razor blade. An x-ray confirmed that he had not

swallowed a razor blade but had swallowed a small piece of metal from a facemask which was not considered to cause him any risk. He was duly returned to the Risdon Prison Complex after receiving wound care.

19. Two days later, on 29 December 2022, Mr Scott told prison staff that he had swallowed more razor blades again. He was taken to the Royal Hobart Hospital by ambulance. While at the hospital, he swallowed a key to a paper towel dispenser. Another x-ray was performed and the presence of the key in his intestines identified. A decision was made to admit Mr Scott until he passed the key.[11]

Applicable policies

20. On 2 January 2022, Mr Scott was in the custody of the Tasmanian Prison Service at the Royal Hobart Hospital. He was a patient in room 3 of level 6A. The circumstances of his incarceration were governed by Director's Standing Order (DSO) 1.20.[12] That DSO, entitled "External Escorts, Medical Appointments and Hospital Admissions", was the relevant policy document in force dealing with Mr Scott circumstances at the time he escaped from custody.

21. Relevantly the DSO provides:

> *"Where two or more officers are assigned to supervise a prisoner, the prisoner is not to be left unsupervised at any time, except where sensitive treatment or examination is required, the prisoner is undergoing surgery or is incapacitated".*[13]

22. The DSO also provides that in the case of a prisoner having access to a room (such as for example a hospital room ensuite) without direct correctional supervision, then the supervising officer or officers must be stationed directly outside the door of that room.

23. It also requires the completion of a document known as an "Escort Risk Assessment" (Form 5BV) prior to a prisoner being transported. The evidence at the inquest was that the relevant assessment document was in fact completed but not included in the escort bag that accompanied Mr Scott to the hospital. The DSO also deals with the procedures that are to be followed in the event of an emergency including an escape. In summary, in the event of an escape, the DSO requires prison staff to be notified as soon as possible and the escorting officers involved to immediately notify Tasmania Police by calling 000.

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[11] All this information is extracted from his prison and medical records.
[12] Exhibit C49.
[13] *Supra*, Item 12 of appendix D.

24. The evidence was that a prisoner escort kit in a clear shoulder bag was present in Mr Scott's room. It included a prisoner profile, mobile phone, handcuffs, a duty log and a suicide and self-harm log.

25. A risk assessment had been carried out in relation to Mr Scott. It identified a two-person escort team was required, that he was to be handcuffed at all times and was not permitted to make any phone calls.[14] That risk assessment was not included in the escort bag. The evidence was that at the relevant time there was no requirement for the document to be included in the escort bag; the inclusion of the document is now mandatory.

26. Finally, the DSO required the escort mobile phone to be in the physical possession of a custodial officer at all times.

Circumstances of Death

27. At the time (approximately 6.10 pm on 2 January 2023) First Class Correctional Officer (FCCO) Martin Oppitz arrived at the Royal Hobart Hospital to commence a night shift, by then Mr Scott had spent a total of 25 days and part days as an inpatient in the Royal Hobart Hospital over the previous month or so. All of those days had been without incident.

28. Shortly after FCCO Oppitz arrived, Correctional Officer (CO) Craig Cox joined him. The shift that the men were due to work was a 12 hour shift from 7.00 pm to 7.00 am. It was the duty of both officers to guard Mr Scott both to protect the community and ensure his safety. I have concluded on the basis of the evidence at the inquest that both failed to perform their duty.

29. Before they arrived, Mr Scott had been fasting with a view to undergoing surgery that evening. However the surgery was cancelled and Mr Scott was permitted to eat, something he was doing when CO Cox arrived.[15]

30. When FCCO Oppitz arrived, Mr Scott was handcuffed by his left arm to the hospital bed. I am satisfied that upon arrival FCCO Oppitz said words to the effect "*why have they got you handcuffed*".[16] There followed a handover of sorts although I am satisfied that the handover between day and night shift was essentially ineffectual, although I do not think that the poor handover was to blame for what occurred; rather to my mind

[14] Exhibit C 48(h)(iii).
[15] Exhibit C 35.
[16] Exhibit C48, page 8.

it is indicative of a generally lax approach to the task at hand, an approach not confined to the officers on duty when Mr Scott escaped.[17]

31. CO Cox was not present for the handover although he was familiar with Mr Scott having dealt with him before in prison. CO Cox knew that Mr Scott was housed in the maximum security unit and his understanding was that he was in hospital due to a suicide/self-harm incident. CO Cox was handed the handcuff key by FCCO Oppitz and took (or at least had) responsibility for removing and reapplying the handcuffs as required.

32. I am satisfied that FCCO Oppitz was the senior officer, despite his assertions to the contrary. I have no doubt CO Cox treated him as the senior both due to his rank and his experience in the position.

33. The evidence was that both officers were at the hospital because both had accepted what was in effect an "*overtime*" shift at the hospital. Neither had worked with each other before and neither knew the other. I am satisfied that when FCCO Oppitz accepted the shift he was unfit for work by reason of having been stung on the left ankle by a bee. I note his evidence that he considered he was fit for the shift, but I reject that evidence. It sits uncomfortably with the fact that he removed his footwear to provide relief from the pain of the bee sting. He should not have been at work; however, he was.

34. Mr Scott's security rating (maximum) meant that he was supposed to be handcuffed at all times. Both officers were supposed to be vigilant and positioned in a way so as to prevent Mr Scott from escaping or harming himself.

35. I am satisfied that FCCO Oppitz, in addition to having removed his shoes sometime around 9.00 pm, was wearing headphones listening to music as well as having reclined the position of the chair in which he was sitting. CO Cox chatted to Mr Scott as they watched cricket. Mr Scott was handcuffed by his left hand to the hospital bed. He used the toilet frequently, something both officers considered to have been due to the medication he was taking. The atmosphere appears to have been relatively relaxed, of which I make no criticism.

36. However, there were matters which do give rise to concern. First, both officers knew, or should have known, that Mr Scott was not permitted to make a telephone call.

[17] See generally Exhibit C48 and in particular page 6.

Nonetheless, FCCO Oppitz permitted him to make a call at about 9.00 pm of approximately 20 minutes duration to his former girlfriend (and mother of his then three year old son) Ms Billi Jo Howlett. During that call, Mr Scott was evidently loud and strident and used an expression to the effect that someone was a "*fucking dog and is going to get murdered*" - although neither officer seemed to consider that the call gave rise to any concern.

37. Second, the escort log (the completion of which was a mandatory requirement) was not even commenced by either of the correctional officers until after Mr Scott had escaped.

38. Third, and most importantly in the context of his actual escape, both officers knew that there were no circumstances where Mr Scott was entitled to have his handcuffs removed. Despite this his handcuffs were removed and Mr Scott was allowed to sit at the table and write a letter, fully clothed.

39. The critical series of events commenced at about 10.35 pm when CO Cox again removed the handcuffs after Mr Scott asked to use the toilet. He also was again provided with his clothes. Mr Scott entered the room's en-suite. I am satisfied neither officer positioned themselves so as to protect the door or monitor properly Mr Scott in the toilet. As a result he was able to run out of the room (at 10.47 pm) towards a nearby stairwell and make his escape.

40. CCTV footage shows a clear six second gap before FCCO Oppitz in socks gave chase to Mr Scott. In the context of the escape, six seconds is a very long time indeed.

41. The same footage shows the officers discontinuing their pursuit of Mr Scott at the stairwell. Neither had the escort mobile phone in their possession.

42. In summary, if the officers had been doing their job properly, that is maintained the handcuffs on Mr Scott, positioned themselves so as to cover both the toilet and room doors, been appropriately vigilant, reacted quickly and actually given chase then it is reasonable to conclude that Mr Scott would not have escaped from the Royal Hobart Hospital.

43. Various excuses were offered by the officers and in particular FCCO Oppitz as to how and why it was that Mr Scott was able to escape. The common theme of those excuses was officers were somehow not to blame. I reject that evidence. As Counsel Assisting accurately submitted in my view, FCCO Oppitz was argumentative, dismissive and

generally evasive when he gave his evidence. He was a poor witness who refused to accept any responsibility on his part for Mr Scott's escape. CO Cox was also unimpressive as a witness, for example, telling investigators that he had no memory of Mr Scott writing a letter, fully dressed and uncuffed, nor any memory of FCCO Oppitz leaving the room at various times.

44. I am satisfied that both officers failed to adhere to DSO 1.20 in several material particulars. Those failures included allowing Mr Scott to have an unauthorised telephone call, removing his handcuffs, listening to music and removing shoes (FCCO Oppitz), not having the escort mobile phone in their possession, taking no steps to ascertain any information in relation to Mr Scott's risk of escape and once he had escaped not contacting 000 as soon as practical (or at all – another officer in fact rang the police). They also failed to exercise plain common sense.

45. I have already said that I accept that no risk assessment form was in fact present in the escort kit on the night in question and that this was a failure of process. That having been said, it is to my mind almost impossible to see what practical difference its absence would have made.

46. I should say that I reject unreservedly any suggestion that a lack of training (or in the case of FCCO Oppitz, experience) was in any way a factor in the escape. CO Cox had very recently completed his recruit course and the evidence makes it quite clear that he had received appropriate training in relation to the circumstances he found himself in the Royal Hobart Hospital on 2 January 2022. And put simply, FCCO Oppitz should have known better.

47. In any event, Mr Scott made his way to Salamanca where he borrowed a mobile phone from a member of the public, called a taxi and made his way to his former girlfriend's house at George Street, Granton. After using illicit drugs there, he was taken by Hayden Leigh Jetson on the back of a motor bike to the home of Brock Callum Davey at 123 Black Snake Road, Granton, a short distance away from George Street.

48. Within minutes of arriving at the address in Black Snake Road, Mr Scott was involved in a chaotic and violent scuffle with Mr Davey and Coles, the latter having arrived with a loaded double barrel sawn off shot gun. During the scuffle, Mr Scott hit Coles in the head with a bottle and threatened to stab someone. Mr Davey suffered wounds to his face. The scuffle spilled outside the house and at 1.35 am on Monday, 3 January 2023 Coles shot Mr Scott in the chest. He died almost instantly and Coles fled the scene.

Forensic and ballistic evidence

49. Police were quickly on the scene of Mr Scott's death. Officers from the uniform branch, as well as CIB, Forensic Services and the Ballistics Section all attended to carry out the investigation. The weapon used by Coles to kill Mr Scott was found in the backyard of the house next-door, near some children's play equipment. It was recovered by police. In both chambers of the weapon were fired 12-gauge cartridge cases. The weapon and fired cartridge cases were seized for subsequent ballistic investigation.[18]

50. Mr Scott's body was identified at the scene by Sergeant Rance Swinton,[19] before being taken by mortuary ambulance to the Royal Hobart Hospital. At the Royal Hobart Hospital highly experienced forensic pathologist Dr Donald Ritchey performed an autopsy. Dr Ritchey prepared a report after that autopsy which was tendered at the inquest.[20] In that report Dr Ritchey expressed the opinion, which I accept, that the cause of Mr Scott's death was a shot gun wound of the chest.

51. Toxicological analysis of samples taken at autopsy revealed that both methylamphetamine and cannabis were present in Mr Scott's body at the time of his death.

52. At the autopsy, Dr Ritchey recovered the plastic wad/shot cup from the wound track and multiple spherical shot pellets. Those items were handed directly to Sergeant Dutton of the Ballistics Section who was also present at the autopsy. Sergeant Dutton carried out extensive investigations in relation to the weapon, cartridges and scene of Mr Scott's death. He provided his usual detailed and instructive report which was tendered at the inquest.[21] Sergeant Dutton expressed the opinion, which I accept, that both cartridges had been fired by the shot gun recovered from the neighbouring yard and that it was discharged at a distance of somewhere between 3.25 m and 4 m from Mr Scott. There is no evidence that the weapon was ever lawfully registered.

53. The barrel of the weapon itself had been shortened, and the butt had also been removed. Despite these modifications, ballistic testing showed that it was not prone to accidental discharge and was fitted with an efficient safety catch. I am satisfied that Mr Scott's death was not the result of an accidental discharge of the weapon.

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[18] It was subsequently determined that although Coles only fired one shot at Mr Scott, he discharged the weapon shortly after as he was fleeing the scene.
[19] Exhibit C2.
[20] Exhibit C4.
[21] Exhibit C 27.

Formal Findings

54. On the basis of the evidence at the inquest I make the following findings required by s28(1) of the *Coroners Act* 1995:

    a) The identity of the deceased is Nicholas Aaron Scott;

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

    c) The cause of Mr Scott's death was a shotgun wound of the chest; and

    d) Mr Scott died, aged 26 years, on 3 January 2023 at 123 Black Snake Road Granton, Tasmania.

Conclusion

55. In the circumstances there is no need for me to make any further comment or recommendations.

56. In conclusion, I wish to express my thanks to all counsel involved in the inquest.

Dated: 29 August 2025 at Hobart in the State of Tasmania.

Simon Cooper
Coroner

Annexure A

LIST OF EXHIBITS

Record of investigation into the death of Nicholas Aaron Scott

No.	TYPE OF EXHIBIT	NAME OF WITNESS
C1	POLICE REPORT OF DEATH	DET SEN SGT D. LATHAM
C2	AFFIDAVIT OF IDENTIFICATION - POLICE	A/SGT RANCE SWINTON
C3	AFFIDAVIT OF IDENTIFICATION	ANTHONY C. CORDWELL
C4	POSTMORTEM AFFIDAVIT	DR DONALD M. RITCHEY
C4a	IPM	DR DONALD M. RITCHEY
C5	TOXICOLOGY REPORT	NEIL MCLACHLAN-TROUP - FSST
C6	MEDICAL RECORDS	THS
C6a	MEDICAL RECORDS – (Scans of ingestion of razor blades)	THS
C7	MEDICAL RECORDS	CPHS
C8	STATUTORY DECLARATION	SGT DARREN J. WILLIAMS
C8a	BWC	SGT DARREN J. WILLIAMS
C8b	AFFIDAVIT	SGT DARREN J. WILLIAMS
C8c	PHOTOGRAPH OF BROCK DAVEY	SGT DARREN J. WILLIAMS
C9	STATUTORY DECLARATION	CST MONIQUE K. FEATHERSTONE
C9a	BWC	CST MONIQUE K. FEATHERSTONE
C10	STATUTORY DECLARATION	CST TRACEY L. SMITH-REES
C10a	BWC	CST TRACEY L. SMITH-REES
C11	STATUTORY DECLARATION	S/CST ANNIKA COLES
C11a	BWC	S/CST ANNIKA COLES
C12	STATUTORY DECLARATION	CST SCOTT STEHN
C12a	BWC	CST SCOTT STEHN
C13	STATUTORY DECLARATION	CST RAQUEL M. O'NEILL
C13a	BWC – arriving at scene	CST RAQUEL M. O'NEILL
C13b	BWC – speaking with Stacey Maxwell	CST RAQUEL M. O'NEILL
C14	STATUTORY DECLARATION	CST JESSICA K. LEEK

C14a	**BWC – 2 videos**	**CST JESSICA K. LEEK**
C15	**STATUTORY DECLARATION**	**CST CAMERON BLIGHT**
C15a	**BWC – 8 videos**	**CST CAMERON BLIGHT**
C16	**STATUTORY DECLARATION**	**CST MATTHEW REARDON**
C17	**STATUTORY DECLARATION**	**CST CRAIG P. FRY**
C18	**STATUTORY DECLARATION**	**CST ELLEN M. OSBORNE**
C19	**STATUTORY DECLARATION**	**(CURRENTLY 1/C) ANNA M. SEYMOUR**
C20	**STATUTORY DECLARATION**	**1/C JACOB HARRIS**
C21	**STATUTORY DECLARATION**	**CST THOMAS D. M. SHERMAN**
C22	**STATUTORY DECLARATION**	**CST STACEY G. FOX**
C23	**STATUTORY DECLARATION**	**STACEY D. MAXWELL**
C24	**STATUTORY DECLARATION**	**KADE T. DAVEY**
C25	**STATUTORY DECLARATION – CRIME SCENE EXAMINER – FORENSIC SERVICES**	**CST IAN J. BELETTE**
C25a	**PHOTOS – 419 photos**	**CST IAN J. BELLETTE**
C26	**STATUTORY DECLARATION – SOUTHERN DRUG INVESTIGATION SERVICES – FORENSIC SERVICES**	**S/C TAMI M. NELSON**
C26a	**PHOTOS – 34 photos**	**S/C TAMI M. NELSON**
C27	**STATUTORY DECLARATION – BALLISTICS – FORENSIC SERVICES**	**SGT GERARD DUTTON**
C27a	**PHOTOS – 16 photos**	**SGT GERARD DUTTON**
C28	**STATUTORY DECLARATION**	**S/C BROOKE M. JOHNSON**
C29	**STATUTORY DECLARATION**	**RENEE M. BOWERMAN**
C30	**STATUTORY DECLARATION**	**MELISSA L. LUTTRELL**
C31	**STATUTORY DECLARATION**	**PAUL I. CANTRELL**
C32	**STATUTORY DECLARATION – SURVEILLANCE**	**ASHLEY SMALL**
C32a	**CCTV FOOTAGE – NICHOLS VISITING DAVEY**	**ASHLEY SMALL**
C32b	**CCTV FOOTAGE – BARROW ARRIVING AT DAVEY'S**	**ASHLEY SMALL**
C32c	**CCTV FOOTAGE – SCOTT AND JETSON ARRIVE AT DAVEY'S**	**ASHLEY SMALL**
C32d	**CCTV FOOTAGE – COLES AND BARROW ARRIVING AT DAVEY'S**	**ASHLEY SMALL**

C32e	**CCTV FOOTAGE – COLES LEAVING BLACK SNAKE ROAD**	**ASHLEY SMALL**
C32f	**CCTV FOOTAGE – BARROW AND JETSON LEAVING BLACK SNAKE ROAD**	**ASHLEY SMALL**
C33	**STATUTORY DECLARATION**	**SHIMARRA A. MCDONALD**
C34	**STATUTORY DECLARATION**	**1/C CORRECTIONAL OFFICER MARTIN J. OPPITZ**
C35	**STATUTORY DECLARATION**	**CORRECTIONAL OFFICE CRAIG A. COX**
C36	**STATUTORY DECLARATION – SURVEILLANCE**	**RHH – ADAM COAD**
C36a	**CCTV FOOTAGE – RHH LIFT FOYER 1**	**RHH**
C36b	**CCTV FOOTAGE – RHH LIFT FOYER 2**	**RHH**
C36c	**CCTV FOOTAGE – RHH ENTRY**	**RHH**
C36d	**CCTV FOOTAGE – RHH KGW RAMP**	**RHH**
C36e	**CCTV FOOTAGE – RHH KLW RAMP**	**RHH**
C37a	**CCTV FOOTAGE – COLLINS STREET/RIVULET**	**HOBART CITY COUNCIL**
C37b	**CCTV FOOTAGE – ARGYLE STREET AND COLLINS**	**HOBART CITY COUNCIL**
C37c	**CCTV FOOTAGE – BUS MALL – COLLINS STREET**	**HOBART CITY COUNCIL**
C37d	**CCTV FOOTAGE – COLLINS STREET EAST**	**HOBART CITY COUNCIL**
C37e	**CCTV FOOTAGE – COLLINS COURT NORTH**	**HOBART CITY COUNCIL**
C37f	**CCTV FOOTAGE – COLLINS COURT COFFEE SHOP**	**HOBART CITY COUNCIL**
C38	**STATUTORY DECLARATION**	**CORRECTIONAL SUPERVISOR LARA SMITH**
C39	**STATUTORY DECLARATION**	**SUPERINTENDENT NICOLE GORNIK**
C40	**STATUTORY DECLARATION**	**MEDICAL ORDERLY KYLE J. CHALLENGER**
C41	**STATUTORY DECLARATION**	**JAMES O. FIELDING**
C42	**STATUTORY DECLARATION**	**ALI RAZA**
C43a	**CCTV FOOTAGE – SALAMANCA – JACK GREENE AND CARGO**	**HOBART CITY COUNCIL**

C43b	**CCTV FOOTAGE – SALAMANCA – SALAMANCA MEWS – COURTYARD ROAD**	**SALAMANCA MEWS**
C43c	**CCTV FOOTAGE – SALAMANCA – SALAMANCA MEWS – COURTYARD PARK**	**SALAMANCA MEWS**
C44a	**000 – S. MAXWELL – FIRST CALL**	**TASPOL**
C44b	**000 – S. MAXWELL – CALL BACK**	**TASPOL**
C44c	**000 – S. MAXWELL – CALL BACK ENHANCED**	**TASPOL**
C45a	**CCTV FOOTAGE – NEIGHBOURING PROPERTY**	**POLICE**
C45b	**CCTV FOOTAGE - NEIGHBOURING PROPERTY – DRIVEWAY 1**	**POLICE**
C45c	**CCTV FOOTAGE - NEIGHBOURING PROPERTY – DRIVEWAY 2**	**POLICE**
C46	**CCTV FOOTAGE - GUN OVER FENCE**	**NEIGHBOUR**
C47a	**BWC - Arrest**	**CST STACEY G. FOX**
C47b	**BWC - Arrest**	**1/C JACOB HARRIS**
C47c	**BWC - Arrest**	**CST THOMAS D. M. SHERMAN**
C48	**TPS – INVESTIGATION REPORT**	**TPS**
C48a	**ADMISSION FORM (12.04.15)**	**TPS**
C48a(i)	**ADMISSION FORM (08-09.05.15)**	**TPS**
C48a(ii)	**ADMISSION FORM (2.07.16)**	**TPS**
C48a(iii)	**ADMISSION FORM (28.10.17)**	**TPS**
C48a(iv)	**ADMISSION FORM (6.07.18)**	**TPS**
C48a(v)	**ADMISSION FORM (10.12.18)**	**TPS**
C48a(vi)	**ADMISSION FORM (5.8.19)**	**TPS**
C48a(vii)	**ADMISSION FORM (10.12.21)**	**TPS**
C48a(viii)	**ADMISSION FORM (24.04.22)**	**TPS**
C48a(ix)	**ADMISSION FORM (1.7.22)**	**TPS**
C48b	**EPISODE SUMMARY (11.04.15)**	**TPS**
C48b(i)	**EPISODE SUMMARY (8.05.15)**	**TPS**
C48b(ii)	**EPISODE SUMMARY (2.07.16)**	**TPS**
C48b(iii)	**EPISODE SUMMARY (28.10.17)**	**TPS**
C48b(v)	**EPISODE SUMMARY (6.07.18)**	**TPS**
C48b(vi)	**EPISODE SUMMARY (10.12.18)**	**TPS**

C48b(vii)	**EPISODE SUMMARY (5.08.19)**	**TPS**
C48b(viii)	**EPISODE SUMMARY (9.10.19)**	**TPS**
C48b(ix)	**EPISODE SUMMARY (10.12.21)**	**TPS**
C48c	**INTELLIGENCE SUMMARY (07.01.23)**	**TPS**
C48d	**THERAPEUTIC SUMMARY (06.01.23)**	**TPS**
C48d(i)	**SASH OBSERVATION CHECKLIST (28.12.22)**	**TPS**
C48e	**HOSPITAL ADMISSION LOG (29.12.22)**	**TPS**
C48f	**CPHS NURSE NOTES (date unknown)**	**TPS**
C48g	**RISK TREATMENT PLAN (29.12.22)**	**TPS**
C48h	**EXTERNAL ESCORT RISK ASSESSMENT (27.11.22)**	**TPS**
C48h(i)	**EXTERNAL ESCORT RISK ASSESSMENT (29.11.22)**	**TPS**
C48h(ii)	**EXTERNAL ESCORT RISK ASSESSMENT (15.12.22)**	**TPS**
C48h(iii)	**EXTERNAL ESCORT RISK ASSESSMENT (29.12.22)**	**TPS**
C48i	**INTERVIEW NOTES – IAN THOMAS (17.01.23)**	**TPS**
C48j	**INTERVIEW NOTES – NICOLE GORNIK (13.01.23)**	**TPS**
C48k	**INTERVIEW NOTES – TRENT NEWMAN (16.01.23)**	**TPS**
C48l	**INTERVIEW NOTES – CHRISTOPHER REVELL (17.01.23)**	**TPS**
C48m	**INTERVIEW NOTES – JULIAN WILLIAMS (12.01.23)**	**TPS**
C48n	**INTERVIEW NOTES – LARA SMITH (12.01.23)**	**TPS**
C48o	**INTERVIEW NOTES – MARTIN OPPITZ #1 (17.01.23)**	**TPS**
C48o(i)	**INTERVIEW NOTES – MARTIN OPPTIZ #2 (20.01.23)**	**TPS**
C48o(ii)	**INTERVIEW NOTES – MARTIN OPPITZ #3 (unsigned) 30.01 (year unknown)**	**TPS**
C48o(iii)	**EMAIL – MARTIN OPPITZ (02.02.23)**	**TPS**
C48p	**INTERVIEW NOTES – Dr ONU (16.02.23)**	**TPS**

C48q	**INTERVIEW NOTES – CLYDE TUITE (16.01.23)**	**TPS**
C48r	**INTERVIEW NOTES – LAUREN CLARK (17.01.23)**	**TPS**
C48s	**INTERVIEW NOTES – DAVID CARTWRIGHT (03.02.23)**	**TPS**
C48t	**INTERVIEW NOTES –LARA HALL AND REMMY STEEL (09.01.23)**	**TPS**
C48u	**INTERVIEW NOTES – GEORGIA SALTER, MEGAN COOPER, TRISTAN STREFLAND (11.01.23)**	**TPS**
C48v	**INTERVIEW NOTES – CRAIG COX #1 (17.01) (year unknown)**	**TPS**
C48v(i)	**INTERVIEW NOTES – CRIAG COX #2 (31.01) (year unknown)**	**TPS**
C48v(ii)	**EMAIL – CRAIG COX (06.02.23)**	**TPS**
C48w	**PHONE CONVERSATION NOTES – M. CAUSBY (08.02.23)**	**TPS**
C48x	**STATUTORY DECLARATION – CRAIG COX (03.01.23)**	**TPS**
C48y	**STATUTORY DECLARATION – MARTIN OPPITZ (04.01.23)**	**TPS**
C48z	**STATUTORY DECLARATION – NICOLE GORNIK (03.01.23)**	**TPS**
C48aa	**INCIDENT REPORT – LARA HALL (03.01.23)**	**TPS**
C48ab	**INCIDENT REPORT – REMMY STEEL (03.01.23)**	**TPS**
C48ac	**INCIDENT REPORT – MARTIN OPPITZ (03.01.23)**	**TPS**
C48ad	**INCIDENT REPORT – CRAIG COX (03.01.23)**	**TPS**
C48ae	**INCIDENT REPORT – NICOLE GORNIK (03.01.23)**	**TPS**
C48af	**INCIDENT REPORT – LARA SMITH (03.01.23)**	**TPS**
C48ag	**WITNESS STATEMENTS – GEORGIA SALTER (12.01.23), ELLA CLACK (16.01.23), MEAGAN COOPER (19.01.23)**	**TPS**

C48ah	**EMAIL CORRESPONDENCE RE NIGHT SHIFT COVER – NICOLE GORNIK (05.01.23)**	**TPS**
C48ai	**EMAIL CORRESPONDENCE RE POSSIBLE MANIPULATIONS – KELLIE WATSON (05.01.23)**	**TPS**
C48aj	**EMAIL CORRESPONDENCE RE ESCORT STAFF BEHAVIOURS AT RHH – JASON MILLS (09.01.23)**	**TPS**
C48ak	**EMAIL CORRESPONDENCE RE ESCORT DIFFICULTIES – JASON MILLS (11.01.23)**	**TPS**
C48al	**EMAIL CORRESPONDENCE RE ABORIGINALITY QUESTION – AMANDA RIPPER (25.01.23)**	**TPS**
C48am	**CRAIG COX CONTROL AND CONSTRAINT ASSESSMENT**	**TPS**
C49	**DIRECTORS STANDING ORDER – EXTERNAL ESCORTS, MEICAL APPOINTMENTS AND HOSPITAL ADMISSIONS**	**TPS**
C50	**LETTER FROM RHH RE UPDATED MOU WITH TPS – SECURITY ARRANGEMENTS**	**TPS**
C50a	**LETTER FROM CORRECTIVE SERVICES to DOH regarding RHH SECURITY ARRANGEMENTS**	**TPS**
C51	**HOSPITAL ADMISSION LOG – BOOK 1**	**TPS**
C51a	**HOSPITAL ADMISSION LOG – BOOK 1 – FORM 5BB**	**TPS**
C52	**COMMENTS ON PASSING SENTENCE – COLES – 7.3.24 – J. PORTER**	**SUPREME COURT**
C53	**MEMORANDUM OF SENTENCE – DAVID I. COLES**	**SUPREME COURT**
C54	**NOTICE OF APPEAL – DAVID I. COLES**	**SUPREME COURT**
C54a	**EMAIL FROM SUPREME COURT – APPEAL WITHDRAWN**	**SUPREME COURT**
C55	**TRANSCRIPT – BILLI-JO R. HOWLETT**	**TASPOL**
C56	**TRANSCRIPT – HAYDEN L. JETSON**	**TASPOL**
C57	**TRANSCRIPT – SHAUN G. BARROW**	**TASPOL**
C58	**TRANSCRIPT – DAVID I. COLES**	**TASPOL**
C59	**AFFIDAVIT OF LARA SMITH DATED 26/05/2025**	**LARA SMITH (tendered at inquest on 26/05/2025)**

C60	**AFFIDAVIT OF KASEY DREW DATED 26/05/2025**	**KASEY DREW (tendered at inquest on 26/05/2025)**
C61	**DIAGRAM OF HOSPITAL ROOM (ANNEXURE 4)**	**TPS**
C62	**DIAGRAM OF HOSPITAL ROOM (ANNEXURE 5)**	**TPS**
C63	**POWERPOINT OF CORRECTIONAL OFFICER TRAINING**	**TPS**
C64	**TPS INTERNAL MEMORANDUM (dated 11/01/2023)**	**TPS**
C65	**ESCORTS POLICY IMPLEMENTATION SPREADSHEET**	**TPS**