The Coroners Act 2009

IN THE LOCAL COURT OF NEW SOUTH WALES
CORONIAL JURISDICTION

Name of Deceased:	**Morgan James Hill**
File Number:	**0832/2009**
Hearing Dates:	**15, 17 - 19 August 2011 & 29 August – 2 September 2011**
Location of Inquest:	**Glebe & Parramatta**
Date of Finding:	**9 September 2011**
Coroner:	**Magistrate Scott Mitchell, Deputy State Coroner**

Appearances:

- Ms A Johnson of Counsel instructed by Ms J Maroon of the Crown Solicitor's office, appeared to assist the Coroner
- Mr J Gormly of Senior Counsel instructed by Mr N Ford for the Hill family
- Mr R Hewson instructed by Mr T Mineo for Dr Thew
- Mr P Biggins of Counsel for NSW Police Department

Note: *Order made in accordance with Section 75(5) Coroners Act 2009*
I make an order permitting a report of the proceedings to be published without restriction.

INQUEST INTO THE DEATH OF MORGAN JAMES HILL

FINDINGS

1. At 8.39pm on 27 March, 2009 at Fisherman's Road, Malabar, Morgan Hill, who was born on 25 January, 1983, died of a self-inflicted gun shot wound to the head. He was 26 years of age, one of five children and the only son of Barry and Janet Hill of 16 Nurla Avenue, Little Bay.

The inquest

2. This is an inquest into Morgan's death - *mandatory* because Morgan died in the course of a police operation. Ms. A. Johnson instructed by Ms. J. Maroon of the Crown Solicitor's Office appeared to assist the Coroner and other legal representatives were Mr. J. Gormly of Senior Counsel instructed by Mr. N. Ford for Morgan's family, Mr. R. Hewson instructed Mr. T. Mineo for Dr. Thew and Mr. P. Biggins of Counsel for *NSW Police*. The Officer in Charge was Detective Sergeant Kel Stanley Graham who, in my opinion, performed that difficult task magnificently.

3. Those appearing at the inquest to give evidence included:-

- The Officer in Charge, Detective Sergeant Kel Stanley Graham;
- Patricia Bulpit, a General Administrative Support Officer at *Eastern Suburbs Local Area Command*;
- Sgt. Craige Robert Hansen, one of Morgan's team leaders and something of a mentor;
- Sgt. Jennifer Cracknell, another team leader;
- Inspector Malcolm Smith, a duty officer and the Human Resources Manager at *Eastern Suburbs Local Area Command*;
- Dr. Natalie Shavit, a police psychologist;
- Dr. Naresh Verma, a police medical officer;
- Sgt. Russell Brown;
- Det Chief Inspector Graeme Abel;

- Superintendent Jenny Hayes;
- Morgan's mother, Janet Hill;
- Dr. David Thew, Morgan's General Practitioner;
- The Senior Police Medical Officer, Dr. William Kirby;
- Dr. Steven Barron,a psychologist with extensive police experience; and
- Professor Susan Hayes, Associate Professor of Behavioural Sciences in Medicine at the University of Sydney.

4. The formal documents which include the *P79A* report, the *Identification Certificate*, the *Autopsy Report* prepared by Dr. R.J. Van Vuuren, pathologist of the Department of Forensic Medicine at Glebe and the accompanying Certificate of Analysis of the Division of Analytical Laboratories are, jointly, EXHIBIT 1 and the Coronial brief is EXHIBIT 2. A letter from Ms. Julie Carroll, Assistant Secretary of the Police Association of NSW is EXHIBIT 7.

Morgan Hill

5. Morgan lived with his parents at Little Bay. He grew up in the area and joined the NSW Police Force on 29 April, 2005. He was attached to Eastern Suburbs Local Area Command. He was popular with his commanders and superiors and also with his fellow junior officers and the extensive evidence which has been gathered describes him as gentle, sensitive, honest and intelligent. Almost all the witnesses who worked with him describe him as a proud and private person but, clearly, he had an ability to endear himself to his colleagues, particularly with female staff members, some a little older than he, such as Patricia Bulpit and Sergeant Jennifer Cracknell who told the inquest that they had been very fond of him. Several of his superior officers such as Sergeant Craige Hansen, his extremely experienced team leader, had quite a bit of time for him. Morgan seems to have had a particular ability to make friends, both police and civilian, and his closest male friend was his first cousin, Anthony Boshell whom, in his final text, he described as *"…my brother and the best mate I've ever had..."*

6. Mrs. Hill, his mother, told the inquest that Morgan was a sensitive, thoughtful young man, very articulate with good communications skills. He made good friends easily and people liked him. Mrs. Hill said Morgan was a very engaging person. Evidently he was

highly intelligent having been Dux as well as Vice-Captain of his secondary school and Captain of his primary school. In his final year at school , he won a number of academic prizes including the *Archbishop of Sydney's Prize for Student Excellence.* Morgan enjoyed swimming, football and, perhaps especially, golf and he and Anthony were passionate about repairing and racing cars. At school he had been a debating champion.

7. Morgan's mother told the inquest that he had a strong sense of loyalty, integrity and of self-worth and among the best compliment she could pay him was that he had an ability and a strong desire to serve others and she sees that as one of the reasons, perhaps the principal reason, he joined the Police Force.

8. Morgan had been in a long term relationship with a woman by the name of Lydia Grammano and that relationship ended in about December 2007 or early January 2008 leaving him feeling a bit sore and sorry. In about March or April, 2008 he and Jennifer Cobb, then a probationary constable, realised that they were attracted to each other and commenced a relationship, characterised by some hesitations and false starts as each tried to be honest and open with the other, which continued, at least in terms of mutual care and affection, right up until his death. Morgan's relationship with Jennifer Cobb seems to me to have been supportive, truthful and affectionate. I agree with Dr. Barron that, if Morgan found some frustration in sometimes being unable to further the relationship as far and as fast as he might have liked, she remained supportive and an important source of solace for him.

9. Morgan loved his job, loved the police, loved his family – parents, sisters, nieces and nephews and he loved his friends and, not surprisingly, he was greatly loved in return. Clearly, he will not be forgotten.

Stigma

10. Detective Sergeant Graham, the *Officer in Charge* is a police officer of over twenty five years service, a former executive officer in the *Police Association* and an extremely thoughtful and perceptive policeman. His lengthy statement in the Coronial Brief, like his *Critical Incident Investigation Report* is thorough, detailed and enlightened. And his

evidence given at the inquest, particularly when commenting on the recommendations he made in that report and when dealing with predicament presented to the *NSW Police* by officers, particularly young officers, vulnerable to a mental health issue, was very helpful indeed.

11. Mr. Graham spoke of *stigma* which is a long standing and deeply entrenched factor in the attitude of many police officers, young and old, in many police forces here and overseas. *Stigma* may attach to a number of matters including sexual orientation, racial background and, relevantly to this inquest, mental ill health. Mr. Graham believes that the phenomenon of *stigma* in police forces has its origin in the stressful nature of police work, the fact that, in many cases, a police officer finds himself/herself with no other potential employer than the police force of which he or she is already a member and, I think, the close, collegial nature of the police force and the degree to which police officers are set apart from their fellows in the general community.

12. In her statement on behalf of the police Association, EXHIBIT 7, Julie Carroll dealt with the phenomenon of *stigma* which she sees as endemic in the police community. She wrote *"there have been many improvements… …The prevalence of psychological injury and the need to seek help has been acknowledged within the NSW Police Force however the stigma attached to psychological illness continues."*

13. Mr. Graham told the inquest that these are the very factors – danger, isolation and exposure to sometimes dreadful human misery, which, in some instances, are inclined to prompt mental health problems and he said that police *culture* had long expected that police men and women will be or, at least, ought to be impervious to such things. And so, he told Mr. Gormly, many police officers will go to great lengths to hide mental health problems or emotional distress. A police officer, feeling seriously damaged, may decline to disclose his distress to anybody – friends, spouse, doctor, counsellor or superior officer. Some may find solace in alcohol and others will prefer to shoulder the burden silently and sadly while it weighs them down and sometimes destroys their careers, their effectiveness, their happiness and even their lives.

14. According to Mr. Graham, the *culture* is changing and things are improving. It seems to me that very impressive progress has been made in this area but still many officers

struggling to cope will prefer to keep silent rather than disclose their predicament to those who might help them – medicos, psychologists, counsellors or colleagues who might be required to report the matter to police commanders. But, he agreed with Mr. Gormly, this constitutes a huge problem for police forces because it increases their difficulty in identifying who has a problem and who needs help.

Privacy and *pastoral care*

15. Those who command *NSW Police* rightly recognise that *"mental illness and guns are a poor mix"* but, for the reasons I have outlined, there is only limited value in relying on a policy-imposed obligation of police officers to disclose any condition or medication likely to impact on their work performance or on relying on them voluntarily to disclose their difficulties to their superiors and so, as Mr. Graham explained, if an officer is suspected of having a mental illness, senior officers will separate that officer from his/her gun which means placing the officer on restricted duties – at least to allow the position to be clarified and an assessment to be undertaken. To do otherwise would be to threaten the public, the police officer involved and other members of the police service.

16. Mr. Graham told the inquest that what threatens that process is the issue of privacy. The issue is obvious. People, including people who happen to be police officers, are entitled to feel that a range of issues - family issues, issues of sexual orientation, financial issues and health issues among them, will remain private. But the rational administration of a big employer such as a police service will struggle to reconcile the right to privacy with the need for proper administration and Mr. Graham provided the inquest with a pointed example. Evidently, it used to be the rule that, in order to protect the privacy of a frequently absent police officer, when medical certificates were called for in order to explain absences from work, those certificates were required not to disclose the *reasons* for the absence from work. It was sufficient that a medical practitioner certify that there *was* a reason. But this proved to be unsatisfactory so that, since 15 December, 2009, privacy considerations have deferred to efficient administration and reasons must be disclosed. But, Mr. Graham reported, this change has had the effect of dissuading some officers from seeking medical advice and assistance for conditions whose existence they would prefer to remain confidential. So, again, privacy

considerations, important in themselves, have proven to be an obstacle to senior police officers in exercising *pastoral care* of officers needing help.

Early signs of trouble

17. In Morgan's case, the evidence demonstrates that, in the period July, 2007 until March, 2009, there were signs and indications that he had been experiencing difficulties with depression and that, as such, his mental health was deteriorating although, as Mr. Graham pointed out, few people could have seen the whole picture. By late July, 2007, there were absenteeism issues although laziness or lack of interest in his work seem to have been quite inconsistent with what I now know of Morgan. That he was a good worker, respectful of and respected by his superiors, good to work with, good at his at job and very proud to be a policeman is widely recognised.

18. On 15 October, 2007, Morgan was spoken to about his absences from work so it is clear that they had been noticed by his superiors. Then, on 26 June, 2008, Inspector Christine George put him on *mandatory certificates* for 3 months. That meant that, for the next three months, Morgan would not be entitled to any sick leave (as opposed to recreational leave) without a medical certificate. While Mr. Graham describes Inspector George's action in this regard as *"giving Morgan a soft option,"* it is reasonable to see the event as another indication that Morgan's difficulties were accelerating and increasingly being noticed by his superiors. But, as Mr. Graham acknowledged in answer to Mr. Gormly, even at that point Morgan was careful not to be too frank about his problems and, in doing so, he was acting quite normally given police *culture* at the time. Indeed, Mr. Graham pointed out that Morgan would have been quite right to feel that, were he to admit to mental health problems, he might be disadvantaged, stigmatised by his peers and his career put at risk.

Inspector Malcolm Smith

19. Within days of taking over as the commander of *Eastern Suburbs Local Area Command* in December, 2008, Superintendent Jenny Hayes initiated a detailed assessment of the health and welfare and the effectiveness of those under her command and Morgan Hill, who had been identified as somebody whose absences from work – 13 days off over a

twelve month period including 8 days for which no medical certificates had been presented, was suggested as a person worthy of enquiry. By direction of the commander, Morgan was interviewed by Inspector Malcolm Smith, the *human resources manager* for the *ESLAC* on 3 December, 2008. Mr. Smith described him as *"avoiding"* and *"defensive."* Mr. Smith reported that when asked *"Is there anything troubling you?"* Morgan had taken offence and answered that he didn't need any help. Sgt. Graham's view is that Morgan's response to Mr. Smith's inquiry, if correctly reported, was *"pretty typical"* of young officers in similar situations and, whether prompted by a sense of vulnerability lest his *secret* be disclosed or by lack of insight into the nature of his predicament, exemplifies a difficulty of the police service in keeping an eye on the health and welfare and fitness for duty of its officers.

20. Sometimes, high absenteeism will indicate laziness or a lack of interest in the job but sometimes, as in Morgan's case, it may be the only outward sign of a mental illness available to superior officers – until a catastrophic event. In Morgan's case there were other signs of depression, arguably many other signs, but, as Mr. Graham put it, nobody was privy to the *whole* of the picture so nobody was able to prevent the catastrophe.

21. Inspector Smith ordered Morgan to see the *Police Medical Officer* and put him on *mandatory certificates* for 6 months. Sadly, for the reasons I have expressed above, it is likely that this action did little to prompt Morgan to *open up* and seek help regarding his depression. Instead he may well have regarded Mr. Smith's intervention as harsh and punitive, reinforcing his resolve to keep his problems to himself. After all, as Mr. Graham said, to risk *stigma* and the possibility of career disadvantage *"is a big unknown for a young fella."*

22. But it is difficult to know what else Mr. Smith could have done. Morgan's unexplained absences from work indicated a problem and were of an order that suggested the problem may have been a serious one. Morgan himself was unwilling to disclose his difficulties and kept his own counsel and Mr. Smith's choices were to ignore the problem or to seek medical advice which might give him some idea as to what was wrong and what might be done to assist. I accept that he had Morgan's best interests very much in mind.

Dr. Verma

23. So, on 22 January, 2009, Morgan was reviewed by the *PMO* and cleared for full operational duties. This involved the restoration of his gun. Dr. Verma is the police medical officer who saw Morgan on 22 January, 2009. Dr. Verma told the inquest that his only recollection of the event was that Morgan was *"quite good looking, quite tall and not prepared to give consent"* to Dr. Verma providing a detailed report to superior officers.

24. Morgan explained his absences from work as largely the result of some minor ailments but he told Dr. Verma that he *"felt a bit down at times."* He disclosed the break-up of his relationship with Lydia in early 2008 and mentioned some other family-related sources of stress including the suicide of a cousin, a sister's self-harm and the estrangement of another sister from the family. Dr. Verma thought that Morgan's absences from work had probably been related to these stresses. He took Morgan through a number of *screens* - checklists of factors designed to elucidate a patient's psychological and emotional wellbeing, and conducted a clinical interview. The notes which he took are contained in the Coronial Brief. He found no psychotic features.

25. Dr Verma reported to Superintendent Hayes that Morgan was fit for operational duties and would be into the foreseeable future. Dr. Verma told the inquest that, since the patient's consent to disclose details of his mental state to a superior officer was not forthcoming, he was entitled to provide police commanders with his finding that Morgan was fit or unfit to return to full operational duties or to some restricted duties, whether on conditions or unconditionally, but, other than that, he was authorised to disclose no information. And that is what he did.

26. The Coronial Brief contains a copy of the advice which Dr. Verma would have provided had Morgan's consent been forthcoming but, essentially, it would have added little that was new. Dr. Verma's draft report, dated 29 January noted his finding that Morgan did not suffer from any psychological illness and was fit to resume full operational duties and to be restored to his firearm and, although the report added advice that Morgan should *"use EAP services and seek treatment from his GP as needed"* and *"was encouraged"* to discuss matters with superior officers, the finding was unequivocal and not contingent on

that advice being taken. Dr Verma didn't feel that Morgan had *"a psychological illness"* and, therefore, didn't feel that he had a need to consult a psychologist. Instead, he thought that, during 2008, Morgan had experienced *"adjustment reactions"* from which, on each occasion, he had made a good recovery. Dr. Verma could find neither a history nor any affect related to depression and he thought that Dr. Cotton, Morgan's previous *GP* may have been mistaken in prescribing antidepressants. So confident was he of that view that he saw no reason to speak to Morgan's *GP* and would not have done so even had Morgan had given the necessary consent.

27. The consent form which was handed to Morgan at the commencement of his interview with Dr. Verma but which he declined to sign recites that "the purpose of this assessment is to determine your physical and/or psychological fitness to work safely as a police officer with regard to yourself, your fellow officers and the public" and Dr. Verma confirmed the limited nature of the service provided by the PMO which was to assess but not to treat. Dr Verma, an occupational physician, works only two days per week for NSW Police and the rest of his professional week is taken up within the NSW Fire Brigades where, again, he is restricted to making assessments rather than providing therapy. Indeed, it was in 2007 that he was last engaged in therapeutic medicine when he worked at a rehabilitation clinic. There he dealt primarily with persons physically injured at work although there were some cases of work-related psychological illness. Even then, Dr. Verma was not routinely engaged in prescribing anti-depressant medication. Nevertheless, he told the inquest that he has a "general understanding of the range of anti-depressants on the market."

28. As a police medical officer, the bulk of his assessments relate to psychological injury and Dr. Verma confirmed that he has no qualifications as a psychiatrist or a psychologist. He has never administered the MMPI-2 test and, indeed, would be unqualified to do so. Nor has he studied the test although he has observed other people administering it. He has never analysed the raw data derived from such a test and, again, he is not trained to do so.

29. As *police medical officers*, Dr. Verma and his colleague Dr. William Kirby perform much the same duties although Dr. Kirby may attend to some additional administrative duties. When Dr. Verma commenced his appointment, Dr. Kirby gave him an informal

orientation, explaining some of the work a *PMO* is required to perform, but there was no written instruction either from Dr. Kirby or from *NSW Police*. His orientation extended to two days at *City Central Local Area Command* where he observed what was going on and *"some time"* at the *Bomb and Riot Squad* where he observed the highly stressful work there. In addition, Dr. Verma observed a *"Psych Shoot"* which is an exercise in the nature of a *walkthrough* where an officer has fired his/her gun, an object of the exercise being to monitor the reaction under stress of the particular officer. Apart from those matters, I think Dr. Verma would agree that most of his experience has been gathered on the job and in his office.

30. A very large part of Dr. Verma's work is assessing whether individual police officers are fit to hold a firearm and whether they should be on full operational duties with a gun or restricted duties without one. To make these assessments, he routinely relies on his clinical interview with the individual officer, the *questionnaire* which he administers to the officer and, where a test such as the *MMPI-2* test is undertaken, the analysis of the test result by the psychologist administering the test. In Morgan's case, there was no psychological test and no psychologist's advice to inform Dr. Verma's findings.

31. A difficulty under which I perceive a *PMO* labours is that there is no objective standard against which to measure findings and no guidelines as to what *NSW Police* sees as fitness or unfitness and, as far as Dr. Verma was able to say, there are no policies in that regard. It is clear and Dr. Verma accepts that merely because a police officer experiences some psychological difficulties or exhibits some psychological deficits, one cannot say that he or she is necessarily unfit but there appears to be no guidance as to how tolerant of imperfection the *PMO* should be in passing judgment on an officer's fitness. Dr. Verma said that, should an officer show signs of a psychiatric condition which may or may not be inconsistent with fitness, then the *PMO* will make a decision by taking into account chronicity, the seriousness of the symptoms, the social context of the officer and whether he has effective supports, the incidence of alcohol and/or drugs, the officer's engagement with a *GP* or psychologist or other relevant health professional, his or her degree of insight, the impact which medication has had and is likely to have and the likelihood of compliance with a regime of medication. The fact remains that these are extremely subjective matters and I think there is a need for clear cut policies and guidelines to assist the *PMO*. As it is, Dr. Verna seemed quite unclear as to what were

the criteria for the assessment he was called upon to make and seemed to believe that the predominant issue was the presence or absence of a *"diagnosable psychiatric condition."*

32. The form which Dr. Verma used when he interviewed Morgan explores some matters which I would have thought were likely to be relevant in making the assessment but omits many others. For instance, there is no reference in the form to whether there has been any change in the officer's attitude towards his firearm and/ or his duties and, if there has, why. If an officer shows a disinclination to wear his gun, which Dr. Verma suggests is not uncommon, one would want to know what had happened on the last occasion on which he or she had worn it. But matters of this type are missing from the form and indeed, there is only the most oblique reference to guns at all – whether one owns a weapon and whether one goes hunting or causes harm to animals. The form asks nothing about the officer's use of guns at work and Dr. Verma admitted that, in his interview with Morgan, the matters of guns and of his attitude to his gun and to guns in general were not mentioned.

33. It seems then that, in assessing Morgan's fitness, Dr. Verma was at a considerable disadvantage. He was aware that many young men may tend to down play their emotional problems. Often they will be too young and inexperienced to recognise that they have a problem or, if they are aware of it, too young and inexperienced to know how serious it may be. Or they may be brave and resolved to *soldier on*. If they work in an organisation like the police force, they may well be fearful of stigmatization and that their careers may be damaged. Dr. Verma agreed that all these factors have a tendency to interfere with the quality of the history presented to the doctor and so it may have been with Morgan. The *PMO* can expect to receive some but, if Superintendent Hayes' referrals of Morgan are an indication, not very detailed information from the senior officer making the referral and, essentially, what the *PMO* gets is largely based on self-reporting in interview and, where a psychological test is administered, the police officer's self-reports to the person administering the test. Dr. Verma agreed that a *PMO* would be advantaged by receiving input from the officer's *GP*, his work colleagues, superiors, parents, family and friends and from having access to the *GP*'s treatment plan and the officer's sick leave record. But none of these was provided to him.

34. Dr. Verma did not consult a psychiatrist when assessing Morgan. No psychiatrist is on the staff of *NSW Police* and, although it is not unheard of that a *PMO* will refer an officer to a psychiatrist in private practice, that did not happen in Morgan's case. I think a reference by a *PMO* to an outside psychiatrist in the context of a fitness assessment is the exception rather than the norm. Dr. Verma made his assessment of Morgan's fitness with very little personal knowledge of Morgan and relying largely on his own medical assessment of *no diagnosable psychiatric condition* and, thus, in an area of medicine in which he was a stranger and which is usually the preserve of psychiatrists.

35. Dr. Verma was aware that Morgan had seen a *GP* at *Malabar Medical Centre*, Dr. Cotton in March 2008 and had discussed depression. Dr. Cotton had prescribed *Mirtazon* which Morgan discontinued in May, 2008. When asked what impact a regime of medication might have on an assessment process, Dr. Verma told the inquest that, while the use of anti-depressants is not necessarily inconsistent with fitness to hold a firearm, the use of some medications – particularly psychotropic medications as distinct from anti-depressants, is inconsistent with fitness but he struggled to distinguish anti-depressants from psychotropic medications and to categorise *Efexor* (venlofaxine) as one or the other and he admitted that these matters are really the province of a psychiatrist rather than an occupational physician such as himself.

36. Having seen and assessed Morgan, Dr. Verma prepared a draft report for Superintendent Hayes which, for want of consent, he never sent. In that report he described Morgan as *"fit for operational duties and is unlikely to need any extended periods of absence."* Dr. Verma expressed the view that Morgan was *"likely to have had adjustment reactions in the past from which he appears to have made a good recovery each time"* and that *"the officer does not suffer from any current psychological or chronic physical illness."* In the report he went on to say that Morgan should *"use EAP services and seek treatment from his GP as needed"* and he was encouraged to discuss any problems he might encounter with superior officers but Dr. Verma told the inquest that his opinion as to fitness had not been contingent on that advice being accepted.

37. Because Dr. Verma believed that, for privacy reasons, that report could not be issued, he sent an e-mail to Superintendent Hayes on 22 January, 2009 stating in bald terms

and without explanation or qualification *"I can advise that (Morgan) is fit for operational duties and will be into the foreseeable future."*

38. It is worthwhile to pause and consider the advice which Dr. Verma might have offered Superintendent Hayes. This was not only that Morgan was not suffering from any psychological illness but that he had never suffered from such – merely having encountered some *"adjustment reactions."* As it was, he certified that Morgan was fit and *"will be fit into the foreseeable future."* He formed these opinions and made these pronouncements without having spoken to Morgan's *GP*, his family members, his work colleagues or his superiors, in the face of long standing sick leave issues and in the face of Morgan's unwillingness to allow him to contact the *GP* and unwillingness to consent to a detailed report being sent to the Commander and in circumstances where he knew Morgan had faced and might still face significant stressors. Further, Dr Verma was aware that Morgan's police superiors did not suspect him of malingering so that his excessive sick leave was suspected by them as pointing to a medical problem. And he was aware that his expertise in psychiatric matters was minimal and that the bulk of his data was based on Morgan's self-reports. His time spent with Morgan amounted to about one hour and the information which had been provided by Ms. Hayes had necessarily been very sketchy. Having those matters in mind, it is not clear to me how Dr. Verma could have reached his conclusions and, particularly his prognosis.

39. Dr. Verma told the inquest that a basis of his conclusions had been that he had failed to find a *"diagnosable psychiatric condition."* Quite apart from the paucity of information with which he was working in a field of medicine in which he was a comparative stranger, it is not clear to me that the presence or absence of a diagnosable psychiatric condition is a helpful concept in making the assessment. He admitted to Mr. Gormly that there is an array of debilitating conditions falling short of diagnosable psychiatric conditions where officers might still be unfit and may need significant help by way of advice, support, counselling and perhaps medication. Some of these people might be described as psychologically vulnerable and, as such, may well be unfit to carry a firearm. Dr. Verma admitted that, when he assessed Morgan, it was clear that he had a variety of such debilitating conditions. And yet, in the report he wanted to send to Superintendent Hayes and in the e-mail which he did send her, Dr. Verma made no mention of any of these and his assessment that Morgan was *fit* and would remain fit

hardly takes any of those debilitating conditions into account. He told the inquest that he described as Morgan as *"fit"* not only because he couldn't find a diagnosable psychiatric condition but also because it seemed to him that Morgan could rely on significant supports. I think that two things need to be said about that - firstly that Dr. Verma didn't really know very much about the quality of those supports and the awareness of such support persons that their support might be sought or might be needed and secondly that he didn't know whether Morgan would be prepared to enlist those supports and he had good reason to fear that he might not. To the extent that Dr. Verma thought that Morgan might need monitoring, that was surely inconsistent with the prognosis about fitness into the foreseeable future.

Gathering Difficulties

40. Between December 2008 and March, 2009, Morgan took five days sick leave, with a medical certificate, and, on 2 December, 2008, one day of recreation leave for which no certificate was necessary and, otherwise, worked in accordance with his roster. During that period, his mother was ill and a sister was admitted to *Royal North Shore Hospital* after an apparent attempt at self-harm. There were indications to those close to him that he was facing challenges but outwardly he was coping. He shed a lot of weight, grew his hair longer and took more care than usual with his dress and appearance but some thought these were good signs that he was taking care of himself. He was smoking heavily – not a good sign, and drinking more than he usually did but these things happen with young men and don't always indicate a serious problem. Occasionally he said things which, with the wisdom of hindsight, may now be seen as significant – telling his sister "*…nothing is going well for me, my work, family and personal life. I'm so sick of not being happy"* and, again, telling Ebony Boyter *"Everybody thinks about doing it (suicide)). I've thought about it…,"* but none of these statements seemed as significant then as they do now.

Dr. Thew

41. Dr. Thew, Morgan's general practitioner, has practiced at *Malabar Medical Centre* since 2000 and saw Morgan on 3 March and 25 March, 2009 for depression. His practice has seen Morgan on various other occasions and he has seen each of Morgan's parents

and three of his sisters and is familiar with the family. He was aware that Morgan was a police officer and, when he saw him in March, 2009, was aware that Morgan had previously seen a partner in the practice, Dr. Chris Cotton, in February, 2008 regarding depression. Dr. Cotton had prescribed *Mirtazon* and it unclear for how long Morgan used that medication.

42. When on 3 March, 2009 Morgan visited him, Dr. Thew had not been aware that Morgan had been referred to the *Police Medical Office* and assessed by Dr. Verma and, of course, neither could he have known that, on the very next day, 4 March, Morgan would be sent back to the *PMO* for further assessment. On 3 March, it was clear to Dr. Thew that Morgan was not suffering from a *bipolar* condition. Dr. Thew saw nothing to suggest the presence of *mania* and he thought Morgan was suffering from *melancholic depression*. Dr. Thew made that diagnosis having regard to what he saw as a flattened affect with no highs, his view (not necessarily shared by Mr. and Mrs. Hill) of *"a strong family history"* and Morgan's reports of diminished performance at work. Morgan told him that work colleagues had noticed a change in his mood. Dr. Thew was prepared to accept that there may have been reactive features to the depression and he pointed to Morgan having mentioned the breakdown of his relationship with Lydia and his sister's illness as *"trigger events"* but he maintained his view that the condition was essentially endogenous. This is a view disputed by the family and, as Mr. Gormly of Counsel submitted, *"we just don't know."*

43. Dr. Thew thought that Morgan's depression was *"significant"* and he prescribed *Efexor XR 37.5mg*, gave him a certificate excusing his absence from work for five days from 3 to 8 March, arranged an appointment for Morgan to see a psychiatrist, Dr. Olav Nielssen (which, in the event, never happened) and asked him to return in a week which he failed to do. In fact, Morgan called on Dr. Thew for a follow up on 25 March only after Dr. Thew had telephoned him to find out how he was getting on. While Dr. Thew thought that Morgan's depression was *"significant,"* he believed, even as late as 25 March, that he was functioning with good supports both at home and at work.

44. Given his diagnosis, Dr. Thew thought that *Efexor* was a more apt medication than *Mirtazon* or *Zoloft* and he was more familiar with it at any event. The reference to *Efexor* in *MIMS* and the product information accompanying the drug contains the warning to

monitor for suicide. An accompanying risk of suicide is an unwelcome feature of *Efexor* and this is and was quite well known in the community although I have no way of telling Morgan's state of knowledge on the matter. At any event, Dr. Thew seems to have been well versed on the topic and, very cautiously, he prescribed just one half of the minimum dose intending to gauge Morgan's tolerance before increasing the dose to the suggested minimum dose of 75mg..

45. Dr. Thew admitted that he did not expressly warn Morgan about the heightened risk of suicidality involved in *Efexor* use although he says that he did counsel him generally about potential side effects. In his statement, he says that *"I always arrange a follow up consultation and I tell my patients to contact me or another medical practitioner, immediately, if they encounter adverse symptoms from medication or a clinical deterioration."* He told the inquest that, if he did not mention that, on taking *Efexor*, Morgan might feel suicidal, *"it was implicit."* I doubt that an implicit warning was a satisfactory recognition of the catastrophic side effects which sometimes accompany *Efexor* and it would have been preferable had he given Morgan a specific and detailed warning regarding suicidality. Dr. Thew admitted that, with the wisdom of hindsight, he should have done more to warn Morgan about the dangers posed by *Efexor* but, by asking Morgan to return within a week, he was giving himself the opportunity to observe Morgan's progress and, by arranging an early appointment with Dr. Nielssen, he was putting in place an additional safety net. Perhaps a useful further safety net might have been to warn Morgan's family that he had been prescribed *Efexor* but that would have required Morgan's consent which he might well have withheld. At any event, Dr. Thew did not think that the risk were such as to necessitate that course and, as he told the inquest, *"plenty of people on anti-depressants live alone."* And I think he was entitled to place considerable reliance on Morgan's good sense and apparent willingness to cooperate in therapy.

Superintendent Hayes

46. On 3 March, 2009, Superintendent Hayes learned that Morgan had unexpectedly terminated his shift and the duty officer, Inspector George, a friend of the Hill family, disclosed to her that Morgan *"had not been himself lately,"* that a family member had

recently died, that he had been losing weight and that *"people were concerned about him."* Ms. George impounded his firearm which was later endorsed by Superintendent Hayes. Another Duty Officer, Inspector Flood, told Ms. Hayes that Morgan had been depressed.

47. Accordingly, on 4 March, Superintendent Hayes *"spoke to Morgan… …about her concerns for his welfare and psychological and emotional ability to carry out his functions as a fully operational police officer"* and she indicated the need to restrict his access to his firearm. Morgan was distressed but even then was prepared to make only a partial disclosure to Ms. Hayes. He told her he had been distressed by the attempted suicide of his younger sister and a relationship breakdown with a work colleague and he told her that he had *"other personal issues."* He told her that he was being treated by his own doctor who had prescribed anti-depressants and that he had made an appointment to see a psychiatrist, Dr. Olav Nielssen, and he reminded her that he had been cleared by the *PMO* only a month or so before. But he declined to identify the anti-depressant medication which had been been prescribed by Dr. Thew or to tell her what those *"other personal issues"* were, failed to provide authority for his *GP* to discuss his situation with her, declined his consent to Ms. Hayes discussing his situation with the *PMO* and maintained his stance that he was not comfortable availing himself of counselling from the *Employee Assistance Program*. In other words, Morgan was very guarded in what he told Superintendent Hayes and she, in turn, was quite limited in the information she had as to the true nature of his situation.

48. Doing the best she could, Superintendent Hayes referred Morgan to the *police medical officer* and removed his firearm but she softened the blow by allowing him to take recreational rather than sick leave until 23 March, 2009 and, to spare him embarrassment, she allowed his firearm to remain in the locker, secured by Inspector Bonello's padlock. By that means, it was thought, police officers using the locker might not realise that Morgan's gun had been taken away from him.

49. Lest it be thought that Superintendent Hayes' actions in removing Morgan's gun, referring him to the *PMO* and insisting that he take some leave were punitive actions, I am satisfied that on this occasion as on the occasion in December, 2008 Ms. Hayes saw her function as not so much to monitor sick leave as to monitor a junior officer's welfare

and that she was concerned, not merely to reduce Morgan's sick leave but to find out what was wrong and to make sure Morgan got the help he needed. It was not in her mind that Morgan was taking sick leave when he was not sick or that he was merely shirking. Having heard her evidence, I do not see Ms. Hayes attitude towards Morgan as punitive. I accept, too, that the primary factor in Superintendent Hayes' decisions to remove his gun and send him back to the *PMO* was, as she assured the inquest, *"for Morgan's safety and welfare."*

50. Superintendent Hayes told the inquest that in deciding to remove Morgan's gun, she believed she had been acting prudently and in his interests. She had suspected a medical problem which he confirmed during their interview. She sent him off to the *PMO* in the hope that his problem would be identified. She was looking for a way to help him and she told the inquest that, at the time of the referral, she had certainly not decided to put him off work. On the other hand, his separation from his firearm was standard in the circumstances.

51. Superintendent Hayes' evidence is that the decision as to whether Morgan should be restored to full operational duties or to restricted duties was a decision for herself as the Local Area Commander. She expected from the *PMO* a purely medical opinion on the basis of which, she would be required to make her decision. She would have wished for more and clearer information from Morgan himself, from those caring for him including Dr. Thew and from the *PMO* but her understanding was that, absent Morgan's consent, she could not have that and would have to make her decisions as best she could on limited information. She told the inquest that she favours a regime where better and clearer information is available to those who must make the decisions. When he gave his evidence, Dr. Stephen Barron suggested that a decision like this should be made by a *police medical officer* but Ms.Hayes maintained that the decision she had to make was properly one for herself as commander. Having in mind the need to respect the chain of command and the diversity of matters to be considered in coming to such a decision, some of which relate to the welfare of others, I respectfully agree with her.

52. Morgan went on leave in accordance with Ms. Hayes' proposal. He spent some of his leave in the Blue Mountains visiting his cousin Anthony Boshell. It is not clear whether he or Dr. Neilssen failed to keep their appointment but somehow the appointment was

missed. Morgan reported to the *PMO* on 11 and 18 March. He may or may not have been entirely frank with Dr. Kirby and with the police psychologist, Dr. Natalie Shavit, but they pronounced him as fit to return to full operational duties and to have his gun restored to him.

The psychological testing

53. Natalie Shavit is a psychologist employed by *NSW Police* in the *Health and Wellbeing Unit* of *Workforce Safety Command*. She holds high academic qualifications including Science/Law bachelor's degrees, a master's degree in Counselling Psychology and a doctorate in Clinical Psychology. On 11 and 18 March, 2009, Morgan was interviewed by *PMO* Dr. Kirby who, on the second of those occasions, referred him to Dr. Shavit. According to Dr. Kirby, he spoke to Dr. Shavit before hand and *"briefed her on the essentials of the case and my opinion that I felt he was of a stable mental state and suitable for full operational duties."* Whether sharing his opinion with Dr. Shavit before she administered her test is *best practice* is open to doubt. Professor Hayes expressed concern regarding the practice of the *PMO* briefing the psychologist *before* the administration of the test and stressed *"to ensure that the opinions of the two professionals remain independent, especially as the PMO in this case was an occupational physician rather than a psychiatrist."* In that context, Dr. Kirby's evidence as to the closeness with which he and Dr. Shavit worked is not reassuring.

54. Dr. Shavit then administered the *Minnesota Multiphasic Personality Inventory Test 2 (MMPI-2)* in which Morgan was faced with over 500 propositions and asked to say whether they were true or false. Professor Hayes is sceptical as to whether the *MMPI-2* test is the most appropriate test at any event and she sees the test as particularly susceptible to *faking*. In her view, *"faking is most likely to arise in situations where there are substantial incentives for distortion"* which was certainly the case here. According to Professor Hayes, it is important to administer the test "*in a clinical setting."* The test appears to have been administered without Dr. Shavit and Morgan having had much opportunity to establish a *rapport* which, Professor Hayes says is important *"in order to deflect any supposition that the psychologists was more interested in administering a computer test than understanding a client's needs through face to face interaction."* Morgan is said to have telephoned his friend, Emily Boyter and to have told her that the

test was *"crap"* and that he had finished it in 20 minutes but, according to Dr. Shavit, it would ordinarily have taken between 60 and 90 minutes to complete and I think Morgan may have been indulging in a bit of bravado here. The point, though, is that he completed the test and a record of the answers he gave is included in the Coronial Brief. The *MMPI-2* test includes an instrument designed to enable Dr. Shavit to *"validate"* Morgan's responses which means to check them for internal inconsistencies and, to the extent that they really could be *validated* in that fashion, she did so. Later, Dr. Shavit conducted a clinical interview with Morgan, the principal purpose of which was to corroborate the accuracy of the test results. Although Dr. Shavit agreed with me that no test of this nature is infallible, she satisfied herself on the basis of the validation instrument and her interview that the test results were accurate and she came to the conclusion that, as far as she could tell, Morgan, while not in perfect psychological health, was essentially *fit*. By contrast, Professor Hayes' opinion is that *"the MMPI-2 test should be administered as part of a battery of tests rather than as an isolated assessment instrument."* She does not see the *MMPI-2* test, no matter how faithfully administered and carefully validated, as capable of providing anything more than an indication which would need corroboration in the form of further tests as well as professional assessments before producing a reliable result and she was not convinced that the *MMPI-2* test was the most apposite instrument in an assessment if *fitness* at any event.

55. Dr. Shavit went further and pronounced Morgan fit to resume his police duties and to have his firearm restored to him. That she did this is a testament to her confidence in the utility of the *MMPI- 2* test and the validity of the test results - a confidence which it is not necessary to share and seems to ignore her very sketchy knowledge of what is involved in operational policing duties and in the possession of a gun and of what Morgan might face on his return to work. She told the inquest that she had been aware that Morgan was a *general duties* officer but that she had only an imperfect understanding of what that meant. She admitted that she knew little about the rules and regulations regarding the use of firearms by general duties officers and did not know the degree to which, while in service, Morgan was likely to be exposed to stressful sights and situations and difficult decisions relating to his possession and use of a firearm. Nor could she have known much about the particular stresses and strains which Morgan might experience in the context of his work in a busy suburban police station. At the

same time, Dr. Shavit, in making her recommendation, did not know the views of Morgan's *GP* or his parents or those who were close to him. She was aware that he was taking *Efexor* but could not have been sure how he was tolerating it and she was not to know the extent of psychiatric services available to him. To the extent that her views were based on test results and her clinical interview, their origin was largely in Morgan's *self-reporting* whereas she knew that young men will often be less than reliable when discussing their own emotional frailty, the more so if they happen to be serving officers in a police force where stigmatization is still a fact of life albeit a diminishing one and where Morgan was entitled to see a risk to his career prospects. Further, I think Dr. Shavit might have done well to refrain from pronouncing Morgan fit for a return to full operational duties which she did not clearly understand.

Dr. Kirby

56. Dr. William Kirby the senior police medical officer, is an occupational physician. It was he who undertook the assessment of Morgan in March, 2009 and he saw him on 11 and 18 March. He estimates that, as a *PMO*, 90% of the matters referred to him relate to psychological/mental health issues. Dr. Kirby reiterated that a *PMO* has no therapeutic role and, instead, his principal task is to provide police commanders with assessments of officers' fitness for work.

57. Dr. Kirby told the inquest that, in preparing assessments, his principal focus is not the potential for self-harm but, rather, the officer's ability to function as a police officer in accordance with his/her training. Risk of self-harm is of professional interest to him only insofar as it impacts on the subject officer's ability to do his job and is more appropriately the province of the officer's own clinician. So too is therapy.

58. According to Dr. Kirby, there is no objective criteria to be applied and no set benchmark standards against which to measure an officer's fitness and, he said, it is largely a matter of gaining a degree of empathy with the officer so as to gather information – in large part from the officer him/herself, and assessing whether the officer, when faced with a critical situation - one in which there is a degree of danger when a quick response is demanded, will be able to respond in accordance with his/her training. As he

explained, *"I need to assess whether the actions of the officer in question are likely to be sufficiently within the norm."*

59. Dr. Kirby provided an *interim* advice to Superintendent Hayes on 19 March, 2009 in which he certified Morgan as fit for full operational duties and fit to have a firearm. He advised Ms. Hayes that a full written report was to follow but that the report *"will not detract from their (sic) immediate return to full duties given the LAC has no other concerns other than those noted in the referral."* Dr. Kirby explained to the inquest that, on 11 March, he had undertaken a mental state examination and that, so far as his ability to carry out his duties in accordance with his training was concerned, *"there was no need to make a statement concerning his operability as a police officer as he had elected to have two weeks leave and I was satisfied with his professional, family and peer support."* Dr. Kirby told the inquest that, when first seen, Morgan was very early in his therapy and there was a lot going on in his life so that, instead of being immediately restored, he should take some leave and return in a week or so for a follow up assessment. Dr. Kirby wanted to give the *Efexor* time to take effect. Dr. Kirby's evidence is that he had thought that the follow up assessment would probably be favourable and that he had anticipated that Morgan would then return to work but, if Morgan told his commander on 11 March that he had been pronounced fit, that was probably something of an exaggeration.

60. Then, on 19 March, 2009, after his second interview with a *"much improved"* Morgan, when both he and Dr. Shavit found *"his mental state and mood satisfactory,"* Dr. Kirby sent his interim advice which cleared Morgan for work and commenced the preparation of the *final* report which, in the event, he never completed and sent. Having in mind the terms of his *interim* report where no terms or conditions were recommended or noted, it is clear that Dr. Kirby had not been minded, when preparing his *final* report, to recommend the imposition of any conditions on Morgan's return to full operational duties. Instead, the final report would almost certainly have confirmed what Dr. Kirby had seen as Morgan's stable mental state and consequently his fitness to have a gun. At most, Dr. Kirby's *final* report might have accompanied his certification of Morgan as fit with a *plan* which may have included a suggestion that there be some monitoring.

61. Now Dr. Kirby knew little of Dr. Thew's plans for Morgan. He didn't know what Dr. Thew thought about Morgan's mental state. He didn't know the dosage of *Efexor* prescribed or the period during which Dr. Thew expected Morgan to use the medication. He certainly didn't know that Dr. Thew had prescribed such a low dose with the expectation that it might be doubled once Morgan's tolerance was established. He didn't know the identity of the Morgan's psychiatrist nor whether Morgan had contacted or would contact him and he didn't know what if anything the psychiatrist might propose with regard to psychotherapy. Nor did he know whether it was Dr. Thew or the psychiatrist who had prescribed the *Efexor*. Further Dr. Kirby had no therapeutic role to play and therefore could hardly have varied another clinician's plan even if he had known what that plan was or how the clinicians might vary it from time to time. For those reasons, it is hard to see how he could have provided a useful plan for Morgan.

62. Dr. Kirby told the inquest that, although the decision to return Morgan to full operational duties was one for the commander,

63. he had been aware that she would be influenced by his advice and he had anticipated that she would follow it. He had not spoken to the *GP*, had not spoken to Morgan's parents and had not spoken to the Commander. The only information he had was *very sketchy* information from Ms. Hayes and Morgan's not necessarily reliable self-report and the view of the psychologist which he himself may have influenced. Although it might have been prudent to await a report from the psychiatrist which he understood was likely to become available, he went ahead and *cleared* Morgan.

64. It is not clear to me that, in assessing Morgan's fitness, Dr. Kirby was not in danger of falling into much the same error as Dr. Verma in equating fitness for duty with the absence of a mental illness. He spoke of an officer as unfit to carry a weapon when prescribed *benzodiazepine* or frankly *psychotic* or *Bipolar 1* or *2.* This standard is not dissimilar to the standard apparently applied by Dr. Verma who spoke of a *"diagnosable psychiatric condition."* and it seems to me, on the basis of what happened to Morgan, that if such are the standards applied in the assessment of the fitness of police officers for full operational duty and to carry a firearm, then those standards are unhelpful.

65. Both Dr. Kirby and Dr. Verma were clear that, in about 90% of the cases where an assessment of fitness is required, the issue is the mental or psychological health of the police officer involved. In those circumstances, it is surprising that none of the *PMO*s is a psychiatrist. Dr. Kirby himself, although a highly experienced occupational physician, has no formal training in either psychiatry or psychology other than some *mental health elements* which he said arose in the course of his studies leading to his fellowship of the *Royal Australian College of General Practitioners* and, of course, in his studies as an undergraduate.

66. Dr. Kirby told the inquest that *"we can refer somebody to a psychiatrist any time we want to"* and he gave me to understand that a referral to a psychiatrist is more likely to be made by a *PMO* where it is clear that therapy is indicated rather than in the preparation of assessments. Where an assessment of fitness is the issue, access to a psychiatrist is not so simple and Dr. Kirby said that, only when he is in doubt will he refer to a psychiatrist to assist in the preparation of an assessment. I think that a difficulty with that policy may be that a *PMO* looking for *frank psychosis* or *bipolar* or, as in Dr. Verma's case, a *"diagnosable psychiatric condition"* may fail to see what a psychiatrist would see and so mistakenly certify as fit an officer who manifestly is not. In that connection, I note that Dr. Kirby is unprepared to accept, even with the wisdom of hindsight, that, on the day on which he cleared him, Morgan was not fit. He told Mr. Gormly of Senior Counsel for the family that, on 18 March, 2009, Morgan was not mentally ill. Instead, Dr. Kirby maintains that, on the days when he saw him, Morgan had a *"mental condition"* but, nevertheless, *"was functioning well."* He was not able to say what may have happened to alter the position between 18 March, 2009 when he cleared him as fit and 27 March when Morgan died.

67. Dr. Kirby conceded that to have a psychiatrist *"on tap,"* whether as an employee of *NSW Police* attached to the *police medical officer's* unit or as a private practitioner available to be consulted by *PMO*s and to see police officers in the day to day business of preparing fitness reports, *"would be very helpful."* I think it is essential.

68. Mr. Gormly of Senior Counsel for the family submitted that the *PMO's* section of the *Health and Wellbeing Unit* is *"dysfunctional."* It certainly exhibits some fundamental flaws. In the first place, although a great deal of its work relates to matters of mental

health, it employs no psychiatrist and access to psychiatrists in private practice, except where a *PMO* recommends therapy, is far from certain. And thus, Drs. Kirby and Verma are routinely engaged in making judgments appropriately within the province of psychiatrists – something for which they are not trained. Secondly, there appears to be no clear criteria as to what is meant as *fitness* and what the *PMO* is being asked to assess and the evidence demonstrates significant confusion among the two *PMO*s in this regard. Thirdly, there is confusion among *PMO*s regarding the vital matter of privacy and confidentiality and what information can and should be disclosed by the *PMO* to superior officers and whether consent of the police officer being assessed is required. And, fourthly, to the extent that psychologists are employed to assist in assessments by administering a test – in Morgan's case the *MMPI-2*, there may be considerable doubt as to their independence of the *PMO,* their understanding of what is involved for police officers in *full operation duties* and in the responsible possession and use of firearms and, particularly given the absence of psychiatric oversight, their selection of the particular test to be employed and the mode of its administration.

Privacy

69. Superintendent Hayes told the inquest that a great concern for her in Morgan's case was the difficulty in obtaining a clear picture as to what may have been troubling him and the degree of his distress. It was her evidence that, when she sent him to the *police medical officer*, the primary issue had been his welfare. His record of absences from work and, then, what she had heard from various people, police officers and civilians, about apparent changes in his mood, personality and performance at work all suggested that he was in distress and struggling. When she spoke to him, he was not very forthcoming and she felt that, for his good and the good of his work mates, she needed to know what was wrong and what could be done to assist him. Inspector Smith was similarly motivated.
70. Evidently, Morgan was reluctant to disclose to Superintendent Hayes or Inspector Smith or even to Sergeant Hansen or anybody else a good deal of what we can now see was vital information as to how he was feeling, who he was seeing or not seeing and what treatment he was receiving. Further, privacy considerations hampered those who had a concern for his welfare in gathering a clear and complete picture of what was happening to him. His superiors felt that he could not be required to provide information

and, evidently, he did not feel inclined to give his consent to his superiors or to the *PMO* gathering information from his *GP.* When he saw Dr. Verma, Morgan withheld his consent to Dr. Verma providing to the commander other than the most basic information about his condition.

71. Morgan appears to have given his consent to Dr. Kirby making a disclosure to Superintendent Hayes although it is clear that he did not authorised his *GP* to divulge information were he to be approached by Dr. Kirby and he wasn't asked to tell Dr. Kirby or Dr. Verma the name and address of Dr. Thew let alone of Dr. Nielssen. When it came to his interviews with Dr. Kirby, Morgan did sign the consent form which was presented to him and I am not sure why. Perhaps his decision was influenced by Dr. Kirby's policy which is to refuse to interview an officer where consent is withheld and to refer the matter back to the commander with reasons. Perhaps he was persuaded by Dr. Kirby of the wisdom of sharing the information. Or perhaps, by that time, he was passed caring so difficult was his situation.

72. It is quite clear that, except in extraordinary circumstances, a private practitioner like Dr. Thew or Dr. Nielssen is bound by the duty of confidentiality and may not divulge confidential information provided by a police officer/ patient to that officer's superior officers or anybody else. It seems not to have been so clear whether *police medical officers* were in the same category. Dr. Verma thought that they were and evidently still thinks that they are and he felt bound to withhold all but the sketchiest information to Superintendent Hayes. Superintendent Hayes believed and may still believe that she was entitled only to such information from the *PMO* as Morgan was prepared to allow her. Dr. Kirby's attitude is harder to gauge. On the one hand, he told the inquest that he avoids what he sees as a problem by refusing to commence the assessment process unless consent is provided either expressly or impliedly. But he also said that, when he is provided with confidential information by a police officer who he is assessing, he will pass that on to the officer's commander, irrespective of consent, provided the information is relevant and within the scope of the referral. Evidently, this remains his position and it is his practice to advise the police officer of this position at the commencement of an interview. Fundamentally, Dr. Kirby's view is twofold – firstly that, by attending on the *PMO*, the police officer is tacitly providing consent to the provision of relevant confidential information to the superior officer who made the referral and,

secondly, that, as an employee of *NSW Police,* Dr. Kirby himself is under a duty to pass on the information irrespective of his fellow employee's wishes. He was unaware that this was not Dr. Verma's view.

73. The *Health Records and Information Privacy Act 2002* deals with the collection, use, storage and disclosure of health information by both public and private institutions. I know of no reason why it might be thought not apply to *NSW Police*. The Act would permit the exchange of otherwise confidential information between various police officers and employees of *NSW Police* and, thus, between a *PMO* and a commander referring an officer to the *PMO,* irrespective of the officer's refusal to consent and irrespective of the source of that information, whether reported to the *PMO* by the officer or by a third party such as the officer's medical practitioner so long as the information was lawfully obtained. Ordinarily, the information exchanged between one person, in this instance the *PMO*, and the other, in this case the commander, must be required for the same purpose as it was originally acquired and may not be used for a secondary purpose except with consent or where the primary and the secondary purposes are so closely aligned that its use for a secondary purpose is to be reasonably expected or in cases of imminent risk to the life, health and safety of an individual.

74. In Morgan's case, I would have thought that, under the Act, both Dr. Verma and Dr. Kirby were entitled to provide to Superintendent Hayes such information on his mental health status as Morgan had given them whether he consented or not. I think that the *consent form* employed by Dr. Kirby should be scrapped in favour of a clear and frank explanation of the rights of the police officer and as to what can be disclosed by the *PMO* and what cannot. To the extent that police medical officers and senior police officers may be unaware as to what information should and what may not be passed from the former to the latter, it is important that *NSW Police* clarify the true position for them and ensure that they are aware it.

75. The position is quite different, though, when it comes to obtaining information regarding the health of police officers from outside sources. In Morgan's case, Dr. Thew was bound to maintain Morgan's confidences and, absent an emergency, was not permitted to make disclosures to his family or to police without Morgan's consent and the *Health Records and Information Privacy Act* does nothing to affect that situation. Had he, with

Morgan's consent, provided information to the *PMO*, then it seems likely that the *PMO* would have been at liberty to pass that on to the commander.

76. There is a third situation which relates to Morgan's entitlement to decline to make disclosures and give consent to outsiders such as private medical practitioners to provide information to his superiors and to the police medical officers. As I understand it, he might have been required to disclose his use of *Efexor* but, in general terms, he could not be required to make further disclosure.

77. Whether there should be further erosion of a police officer's right to privacy by requiring him or her to disclose to a commander or to a *PMO* details of his health or mental health status or requiring him or her to authorise his/her private medical practitioner to provide such details is a vexed question. It is submitted on behalf of the family that such should be the case and the arguments in favour of that proposition have to do, ultimately, with providing senior officers with better information when deciding to return an officer to full operational or restricted duties and restoring or retaining his/her firearm. In his evidence, Dr. Barron was a strong advocate of such *"reform."*

78. The opposite view was perhaps best represented by Ms. Carroll of the Police Association of New South Wales who reported that "within the current culture, compulsory access to medical information… …will require in officers either not seeking treatment or failing to disclose that they are in treatment. They may also edit within the context of a treatment environment. Confidentiality and control over access to medical information is a critical theme that is raised by our members. Unfortunately, too often we see confidentiality breached and damaging rumours spread throughout commands. Officers are well aware of the difficulties that are experienced around maintaining confidentiality and this factor will act as a major barrier to disclosure and reporting…

79. …Even within the context of injuries that are clearly work related in nature, there is a reluctance in some officers to make a claim for compensation due to the access to medical information that is part of the normal claims process. Often officers avail themselves of other forms of leave in an effort to allow themselves an opportunity of seeking treatment and recovery …" rather than pursuing remedies which will involve the sacrifice of privacy.

80. Ms. Carroll's comments seem to me to illustrate the degree of reluctance among many police officers to abandon their entitlement to privacy and the heightened risk of *"driving officers underground."*

81. The *OIC*, Sgt. Graham, agreed with Mr. Gormly that, in assessing the mental health of a police officer, mere reliance on what that officer has to say is unwise. For reasons to do with *stigma* and fear that their professional reputation and careers may be damaged, police officers suffering a mental health deficit are likely to be unreliable reporters of their own condition. Rather, in devising a system of assessing the mental health of officers, it is wise to provide for and encourage the input of third parties. Further, Mr. Graham thought that, in designing a system to assist a mentally ill officer, it is not useful to rely on that officer's ability or willingness to comply voluntarily with directions. Rather it might be desirable to design a system of directions which carry obligations of compliance by the officer in question.

82. But, having in mind privacy issues, Mr. Graham was not so sure that he agreed with Mr. Gormly's suggestion that it would be useful were *NSW Police* to consider requiring officers to provide management with authority to access relevant medical and psychological and other information relevant to the safety and welfare of those officers. Presently the requirement of police officers to provide to their superior officers private information as to their mental health condition is limited to reporting the use of prescription medication which would impair functioning. This is of limited utility since it is difficult to enforce compliance and because *impairment of functioning* is a very inexact and subjective term. Those whose functioning is impaired are precisely those least likely to recognise that condition and report it. But Mr. Graham's attitude is that, in considering any change to the existing arrangements, close consideration would have to be given to protecting the privacy of officers.

83. Mr. Graham told the inquest that a police officer is required to report to his or her superior any information which suggests that a colleague is unfit for duty whether that unfitness proceeds from drugs or alcohol or from some other impairment including a mental illness or disorder. Mr. Gormly asked whether such policy might usefully be varied to provide that such reports be made instead to the *police medical officer* but, in

Mr. Graham's view, it is properly a matter relating to the *chain of command* so that the present policy should not be altered.

84. It seems to me that the prospect of wholesale opposition among the very group of people best informed on these issues in the event of a diminution of a police officer's right to privacy is very real and that any such change would be likely to have the adverse effect of driving *underground* the officers most in need of help.

85. Mr. Gormly of Senior Counsel for the family acknowledged the problem of driving police officers *underground* and submitted that, even if a further erosion of a police officer's rights to privacy is impractical, some significant benefit might result from a robust approach to opening the paths of communication between police officers and their superiors, particular regarding their health, welfare and fitness. Perhaps a system of assigning new officers to the oversight of a mentor, a role such as Sgt. Hansen seems informally to have adopted with regard to Morgan would be of assistance in this regard although the sad fact is that such *mentoring* was ultimately ineffective in Morgan's case.

The last days

86. Morgan returned to work on 23 March, 2009. Although he ultimately retrieved his gun by means of bolt cutters, it was not until after he had been cleared by the *PMO* as *"fit for work and to carry a gun"* and he was authorised to have it back. On 25 March, Dr. Thew phoned him to find out why he had not returned to see him and Morgan called in at the surgery where his was given a prescription for *Efexor – XR 75mg*, the recommended minimum dose. Next morning, he went off to work and his mother noticed his police badge lying open on his computer desk alongside a photo taken when he was a baby. Morgan spent the night of 26 March, 2009 with Jennifer Cobb at her place where he seemed, in turn, vulnerable, needy, and then cheerful and his old self. He complained to Jennifer that *"I don't think the medication is working… …everybody thinks I'm happy now but I feel so empty on the inside, it's like there's nothing there and I don't know how to make it go away. This is going to sound really silly but I can't cry."* Some of these matters, which seem so significant now, seemed not so significant at the time.

87. Next morning, Morgan had breakfast with his family, spent a short time speaking with his mother and hit some balls with his father at a local driving range. Later he had a conversation with his sister Genevieve when he told her that *"the depression is back."* He exchanged some text messages with his cousin Anthony Boshell and, although he was not due to commence work until 8pm, left home for Waverley Police Station at about 6 or 6.30pm. Sometime around 4pm he had composed a suicide note which he left on his computer. It read:-

88. *"I know you will never fully understand my decision and that you're going to be left feeling very upset and hurt. For that, I'm sorry. Being selfish like this is not how I want to be remembered but things are just too painful to go on living like this. And I can't see my life getting better or easier for me. It's nothing specific, just one shit thing happening after another. I've had enough of being unhappy, feeling lonely and living clouded in darkness. I know there are other people with worse problems than I have, but I guess I'm just not strong enough to deal with things.This is no one's fault but my own.Anthony can have any of my property that he wants. Everything else is for Mum and Dad to decide what to do with."*

89. At 7.28pm, Anthony Boshell received a text message from Morgan which read *"Dude, you're my brother and the best mate I've ever had. There is a .txt file on my computer desktop. I want you to read it when you get the chance, or tell my dad about it. Its important."* Mr. Boshell tried desperately to raise Morgan by phone but it seemed to him that Morgan was deliberately terminating his calls. He phoned Barry Hill but Mr. Hill was unable to gain access so, as soon as Anthony coulld get there, he booted up, saw an icon *Tone.txt* which was a nickname Morgan used to use for him, and opened up the *suicide note*.

90. By this time, Morgan had already, recovered his *Glock* 40 calibre service firearm from the gun safe, signed out a portable radio and, thus armed and dressed in his Court uniform, left Waverley Police Station. He sent a number of text messages to Jennifer Cobb but she was on duty at Glebe morgue and unable to do much more than simply acknowledge his messages but one of those messages read *"I love you and what I'm about to do is not your fault"* so she was extremely worried. She immediately sent a message for the Duty Officer at Waverley, Sgt. Russell Brown, which he recalls as a

warning that Morgan was *"very depressed –talking of suicide."* He noted that Jennifer was *"was crying and sounded very upset"* and he indicated at the inquest that, at this stage, he was not sure what to make of it all. But, at about the same time, Mr. Brown was informed that Mrs. Hill had telephoned to say that *"she was very frightened for Morgan's welfare and thought he might be very depressed and suicidal"* and then Mr. Brown discovered that Morgan was armed and was absent from the station so that he was in no doubt that an extremely serious situation had arisen.

91. At 7.52pm, Jennifer Cobb sent a text *"Don't do anything silly"* to Morgan who telephoned her but then hung up before she could answer. She phoned her friend, Constable Lucy Stansfield at home, explained the situation and asked her to drive over to Little Bay and see if Morgan was there. As Ms. Stansfield and her boyfriend drove towards Little Bay, she managed to raise Morgan by phone and he told her that he was a Clovelly. It was obvious that he was in trouble and when she told him that she could phone the police, he said *"What are the cops going to do, Luce? Triangulation on my phone will take 3 hours."* That was an exaggeration but Morgan was right to believe that, right along the coastline, triangulation would be a difficult and possibly prolonged process.

92. There was a search of Waverley Police Station which established that Morgan was nowhere to be found and Constable Carey was sent up the street to find that Morgan's vehicle was gone. As soon as Morgan terminated the call to Ms. Stansfield, she phoned Waverley Police Station to be told that police were already *"doing a triangulation on Morgan's phone* (initiated by Sgt. Brown) *and that (like her) they were heading out to look as well."*

93. The portable radio in Morgan's possession was deactivated by police so that he would not be able to monitor the police response to his situation and, shortly after 8pm, Superintendent Hayes was first advised on the matter when she received Sergeant Brown's phone call. She then briefed the Regional Commander by telephone.

94. At about 8.07pm he spoke to his sister by phone and he sounded very drowsy and was slurring his words and, eventually he told her *"I'm sorry, Gen, I have to go"* and terminated the call. Then Lucy Stansfield called him back and he told her *"Luce, it's too*

hard. Everyone says it will get easier but it's not getting easier." According to Ms. Stansfield, Morgan terminated the call at about 8.25pm.

95. Mr. Brown has little recollection of the precise timing of events on that evening but it appears that triangulation suggested that Morgan's vehicle was situated within a 1 km radius of a certain intersection in Malabar and that the *first callout* occurred at 8.25.43 when he and A/Sgt Capon drove to Malabar in *ES14* on *urgent duty* response and simultaneously, several other police vehicles responded to the call. Although it appears that the gravity of the situation had only gradually become apparent, it is clear that by this stage the enormity of what was happening and the urgency were clear to everybody. Before Mr. Brown's vehicle arrived at the western end of Fisherman's Road, Malabar where a road block had been installed, he heard *EB14* state that a shot had been fired.

96. The occupant of *EB14* was Senior Constable Petah Condie who was *"only a couple of minutes away"* when she heard the call to proceed to the vicinity of Victoria Lane, Malabar. Initially, the details provided in the radio call were quite wrong but mention of urgency, the possibility of self harm, a male police officer in part uniform and a loaded firearm were sufficient to alert listening police. The *DOI*'s instructions were *"no lights and sirens and to proceed as quickly as possible."*

97. Failing to find Morgan's vehicle in Victoria Lane, Ms. Condie drove along Ragan Street when she heard *EB104* announce *"We've located the vehicle. It's on Fishermans Parade, opposite the sewerage works."* EB104 was staffed by Detective Senior Constable Todd Mathers and Plain Clothes Constable Graham McGinty, both of Maroubra Police Station.

98. Senior Constable Condie drove carefully along Fisherman's Road but came across Morgan's vehicle unexpectedly parked on the southern curb of the road facing west. She had expected he would be parked further out towards the coastline, closer to the sewerage works. She drove past and her description of what she saw underlines, I think, Morgan's pain, her own bravery in facing a terrifying situation and the overwhelming tragedy of what was happening. Ms. Condie *"couldn't even make out if it was a male or female or any facial features. All I could see were big eyes starring like a rabbit in*

headlights. He wasn't looking at me as police, he was just starring. I would say he was in a zone, like he was looking through me."

99. Ms. Condie drove a little further down the road when she came across *EB104*. She stopped, alighted and took control. She directed Messrs Mathers and McGinty to don their bullet proof vests. She was particularly concerned because she was facing an unknown situation with the driver in the stationary vehicle armed, probably desperate and aware of on-coming police. There was no shelter and no capacity to go into the bushes and surprise him. She intended to perform a *"dangerous vehicle stop."* She told Messrs Mathers and McGinty but *"didn't give him a chance to respond as I was thinking 'I'm the supervisor and I have made the decision.' I thought we have to be safe and this is the safest way so that he didn't drive off and couldn't possibly injure someone else. In my mind he was contained in that area and I believed that I had to act quickly."*

100. Ms. Condie drive a little closer and then got out of *EB14* and approached Morgan's car on foot, accompanied by Mathers and McGinty. Mr. Mathers covered her behind a telegraph pole as she crept around her car in a attempt to gain access and fetch a loud hailer. *EB10* was on the air and Ms. Condie reported "we're going to approach the vehicle."

101. Ms. Condie then repeated her instruction to Mr. Mathers to keep them covered from behind the telegraph pole while she and Mr. McGinty went ahead. Her instructions were that she would make straight for Morgan's vehicle and McGinty *"would curve around* (from the other side of the road) *and be at the driver's side of the vehicle."* She started yelling *"Morgan, Morgan, It's the police. We're going to help you."* There was no answer and, after checking that Mathers and McGinty were in place and knew what they were supposed to be doing, Ms. Condie approached Morgan's vehicle with her firearm in one hand and a torch in the other. She used his vehicle to afford her a degree of cover.

102. She was about a metre away from Morgan's vehicle when she heard a very loud bang. She started yelling *"shots fired, shots fired"* into the radio and she thinks that she heard Graham McGinty do the same thing. She was lying on the ground, up against the

gutter and facing Morgan's vehicle and she *"started doing a commando crawl but going backwards."*

103. Gradually it became clear that the shot which had been fired had been Morgan shooting himself and that he was incapacitated and possibly dead. His head was against the window and, although Ms. Condie knew that *"he could be faking it,"* she went right up to the car, tried the door and discovered that it was locked. She could see through the window there was *"a huge amount of blood coming from his mouth and coming down his neck"* and that his firearm seemed to have fallen onto his left hand rather than being held by him. Police put down their firearms and Ms. Condie *"got on the radio and said 'Eastern Beaches 14. It appears that this officer is deceased.'"* Although there was an attempt at *CPR*, it is clear, I think, that Ms. Condie was correct and that Morgan had died.

104. Police officers including Sgt. Brown, Detective Chief Inspector Abel and the *OIC* were examined in relation to the police operation on 27 March, 2009. It was important to establish whether there was any significant delay in *raising the alarm* when Morgan first went missing but, allowing for the fact that the full appreciation of what was afoot came only gradually, I think there was not. It was important, too, to consider whether Ms. Condie's actions were appropriate and I think that she did all that could have been done and that she acted responsibly, compassionately and extremely bravely. It was deemed necessary to question whether there was any undue delay in *triangulation* but the evidence suggests that this proceeded efficiently and promptly – far more promptly than Morgan had anticipated.

105. Further, there was concern that, although brave, Constable Condie's method of approaching Morgan's vehicle was unwise, may have prompted him to take an unwise step and may have exposed her and her two companions to unnecessary danger.

106. Sergeant Graham's attention was drawn to the *Memorandum of Understanding* between Police, the NSW Ambulance Service `and NSW Health. EXHIBIT 3 At page 23 of that document one can find a protocol, the *Mental Health Emergency Response,* regarding the preferred method of dealing with a high risk situation involving an armed and apparently mentally ill person posing real or impending violence or threat to an individual

(including an individual police officer) or the public or where it is suspected that the person may attempt to take his own life. This protocol places police in the front line to deal with the situation and their task is *"to attend the scene, gather, analyse and disseminate relevant intelligence and assess support needed from other agencies."* Police are then enjoined to *"respond by containment and negotiation and, if any doubt exists as to whether the situation is high risk, the Tactical Operations Unit should be contacted via the Duty Operations Inspector at any hour."* As the events of 27 March, 2009 played out, that was impossible.

107. The incident commencing with the location of Morgan's car at Fisherman's Road, Malabar until his death certainly posed a high risk to Morgan himself and nobody could have been sure that Const. Petah Condie and her companions were not similarly at high risk as they emerged from their car and approached Morgan and her recollection is that she called *"Morgan. It's the police. We're here to help you."* If Ms. Condie is mistaken about some of the detail, I think it is clear that she was aware of a fellow police officer in trouble and was doing her best in all the circumstances to help.

108. Chief Inspector Abel who is the police negotiation commander pointed out that the *"Mental Health Emergency Response"* protocol is no more than an agreement between three agencies and is not a police operational protocol. It allows each of the three agencies to do perform their individual function in accordance with their own practices and protocols. In the case of *NSW Police,* as of March, 2009 the appropriate protocol was called *"Responding to High Risk Incidents"* and Mr. Abel's evidence is that, effectively, Constable Condie and her companions complied with it. Mr. Able went on to say that, in his opinion, it would have been inappropriate and premature to call in the police negotiators until first attending officers had arrived at the scene and assessed the situation. In the event, there was no time for that because Morgan fired the shot only one and a half minutes after being located at the scene.

109. Const. Condie and her two companions, Detective Todd Mathers and Detective Graham McGinty followed orders and acted with speed, bravery and compassion. To the extent that any particular protocol applied and was ignored, as Mr. Gormly suggested it might have been the case, it was because there was simply no time to invoke it. Instead, Ms. Condie appropriately adopted a mode of behaviour characterised by *"containment and*

negotiation." Sgt. Graham was closely questioned about all this by Mr. Gormly of Senior Counsel. He thought that, had the incident been prolonged, the *"Responding to High Risk Incidents"* policy might have been invoked but that, in the event, matters moved so quickly that there was no time to do that. He reminded the inquest that these sad events happened very quickly and he pointed to the undoubted bravery of the three officers involved and the peculiarly sad nature of Morgan's death.

110. In his submissions, Mr. Gormly opined that if what was dubbed *"a mental health response"* had been implemented on 27 March, 2009, *"the outcome might have been different."* So it might but, equally I think, it might have been worse. Nobody could have been sure what was happening to Morgan. Nobody knew whether he was accompanied or alone. Certainly, Ms. Condie did not know that. Nobody could have known whether another person might have been in danger or whether delay might lead to de-escalation or might serve to heighten risk. A *stand back* tactic might sometimes work to advantage but a policy of *stand back* is another thing entirely. In those circumstances, it would be brave indeed to disagree with the sober consideration of experienced senior police officers such as Messrs. Abel and Graham.

111. Morgan Hill was a very fine young man of whom his family has every right to be extremely proud. He death is a real tragedy for his family and his friends and a loss for the police service and community generally. Clearly he will not be forgotten.

Findings

I find that Morgan Hill who was born on 25 January, 1983 died at Fishermans Road, Malabar, *NSW* at about 8.39pm on 27 March, 2009 of a gunshot wound to the head, self-inflicted while suffering severe depression.

Recommendations

I make the following recommendations to the Commissioner of Police:-

1. **That a psychiatrist or psychiatrists be employed in the *Health and Well being Unit* of *Welfare Safety Command* or retained so as to ensure qualified psychiatric oversight of all police fitness assessments where mental health or emotional stability are an issue;**

2. **That appropriate criteria be developed and established to guide and inform *police medical officers* in assessing the fitness of police officers for various duties within the police force and the fitness of police officers to have possession of a firearm;**

3. **In particular, that the criteria so developed and established provide that fitness for duty and to carry a firearm is not merely a matter of the absence of a *diagnosable psychiatric condition* or mental illness;**

4. **That *police medical officers* be encouraged to explore with police officers referred by commanders for a fitness assessment the history of that officer and any current or recent medical diagnoses and treatment plan or plans and the identity of that officer's medical practitioner and to seek the consent of the police officer to that medical practitioner providing appropriate medical information to the *police medical officer* and that unwillingness to provide that consent be among the matters to be reported to the referring commander;**

5. **That psychologists assisting in the preparation of fitness assessments be accorded independence from *police medical officers*;**

6. **That *police medical officers* be reminded of the provisions of the *Health Records and Information Privacy Act 2002* and, so far as the provision of information to commanding officers is concerned, be encouraged to act in accordance with its terms;**

7. **That the practice of placing reliance on psychological tests in the preparation of fitness assessments be reviewed by an independent expert;**

8. **That the freedom of commanding officers to make their decisions as to the removal or restoration of firearms informed by considerations other than those dealt with by *police medical officers* be encouraged;**

9. **That commanding officers be reminded of their entitlement to the provision of information pursuant to the *Health Records and Information Privacy Act 2002*;**

10. **That consideration be given to the establishment of a mentoring system of young officers by more senior officers with a view to the guidance, support and oversight of the performance of those young officers.**

Magistrate Scott Mitchell,
NSW Deputy State Coroner.
Glebe
9 September, 2011.