STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ashley Newton Bryant
Hearing dates:	26-28 April 2017; 1-3 May 2017; 5 May 2017
Date of findings:	17 October 2017
Place of findings:	State Coroners Court, Glebe
Findings of:	NSW State Coroner, Magistrate Barnes
Catchwords:	CORONIAL LAW – intentionally self- inflicted death of a police officer; screening officers for mental health issues; post separation care of police officers
File number:	2013/379498
Representation:	Mr Ian Bourke SC, Counsel Assisting, instructed by Mr Jamie McLachlan on behalf of the Crown Solicitor Mr James Glissan QC and Mr Anthony Howell for the Family Ms Donna Ward for Dr Linda Brown and Dr Deborah Kors Ms Jane Needham SC and Mr David Mallon for the NSW Police Force Mr Matthew Hutchings for Dr Mark Scurrah

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The Coroners Act in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Ashley Bryant

Introduction

1. On 16 December 2013, Ashley Bryant, a highly respected former police officer, called 000 and told the operator that he was at Minyon Falls, and that he intended to take his life. He also said that he suffered Post Traumatic Stress Disorder (PTSD), and that he could no longer live with the trauma of it. He mentioned how the families of PTSD sufferers are also negatively affected and that they too needed more support.

2. A few minutes after this call, Mr Bryant called his friend Detective Inspector Kehoe, and told him of his intentions. Despite Detective Kehoe's efforts to reassure Ashley that they would get through this crisis, Ashley remained resolute and ended the call.

3. Police were despatched to Minyon Falls immediately and arrived at the viewing platform at the top of the falls about 35 minutes after the 000 call. There they found Mr Bryant's car and some of his property. At the base of the falls they found his dead body.

The inquest

4. From the outset there was no doubt as to the identity of the deceased or as to the date, place, medical cause or proximate manner of Mr Bryant's death. The inquest focussed on whether he received appropriate care after the impact of police work on Mr Bryant's mental health became or should have become apparent and whether with better care his death could have been prevented.

5. That focus required consideration of whether the NSWPF should have detected that Mr Bryant had suffered psychological injury because of his police work and whether it should have taken steps to redress that harm.

6. At various times prior to and during the proceedings the family of Mr Bryant sought to have included in the issues to be explored at the inquest the manner in which the insurers contracted to provide financial support for Ashley after his separation from the NSWPF discharged those contractual obligations, whether the medical practitioners who examined him on behalf of the insurers were truly independent, and whether the insurer was unduly adversarial in its processing of Mr Bryant's claims.

7. I concluded those issues were not properly within the scope of the inquest. They related to the contractual arrangements then in place. that have since changed. Assessing how those financial issues were administered would necessarily have prolonged the inquest very significantly with little prospect of any public benefit.

The evidence

Social history

8. Ashley Bryant was born in 1969 and grew up with his parents, who lived in Sydney and Port Macquarie. He has an older brother, Jason. He also had three older half-siblings. Mr Bryant described his childhood positively. He described his father as ‘old school’ and a good provider and his mother as supportive and loving.

9. Mr Bryant attended Westport High School where it seems he had some minor adjustment issues but otherwise his schooling was nothing out of the ordinary. He completed the Higher School Certificate.

10. Throughout his teenage years, Ashley was an enthusiastic participant in surf life saving and rose to be a patrol captain at quite a young age. He competed successfully in surf sports.

11. A history recorded by a police psychologist in 2006 appears to indicate that at 12 to 13 years of age at a Blue Light Disco or discos, Mr Bryant drank once per month a third to half a bottle of brown muscat. At 15-16 years of age, Mr Bryant went on a health kick and ceased drinking alcohol.

12. Mr Bryant joined the NSW Police Force (“NSWPF”) on 9 May 1988, graduating from the Police Academy on 22 August 1988. The next day, he commenced as a Probationary Constable at Manly Police Station.

13. In mid-1990, Ashley transferred to the Northern Region where he worked in the Tactical Response Group (“TRG”). In mid-1991, after the TRG was disbanded, he moved back to Manly Police Station as a General Duties Constable.

14. In November 1991, Ashley met Deborah, who was then a Nurse at Mona Vale Hospital. Two years later, on 20 November 1993, Ashley and Deborah married. They had three children - XXX born March 2001, YYY, born July 2004, and ZZZ, who was born April 2008.

15. Mr Bryant served with the NSWPF at a number of different locations during his 24 year career, including:–
    - Moree
    - Kempsey
    - Port Macquarie
    - Sydney City Central
    - The Rocks
    - Unsolved Homicide Squad
    - Bourke and
    - Ballina

16. Mr Bryant has been described as a very “driven” man, and a capable and accomplished police officer, receiving many commendations during his career. Ashley’s “driven” nature manifested itself not only in his attentive police work but also in physical exercise, in the form of running, cycling and surf-kayaking. In May

2013, Ashley participated in an "Iron Man" triathlon at Port Macquarie, and achieved a very impressive time after only a short period of training.

Depression, alcohol and PTSD

17. It seems that like many teenagers, Ashley occasionally abused alcohol in his youth. However, I accept his brother's evidence that as he matured he became more interested in surf sports and his desire for physical fitness led to his avoiding alcohol. I accept his wife's evidence that when he joined the police force Ashley was mostly a non-drinker.

18. Like most experienced police officers, Ashley's police work involved exposure to numerous tragic, traumatic and stressful experiences. In his case, these included dealing with violent and threatening situations, and attending at road fatalities, drownings, suicides and murders.

19. Evidence of Mr Byrant's problematic response to these stressors appears to date back to at least 1995, when according to his wife he was abusing alcohol "more regularly". According to Deborah, Ashley's drinking became worse after a tragic incident at Crescent Head on 9 July 1995, when two of his colleagues were shot dead when responding to an incident.

20. It seems from this period onwards, Mr Bryant had periodic problems with alcohol. He would cycle into stages of heavy drinking when workplace stressors were particularly oppressive while at other times his commitment to physical activity and fitness would help him moderate his consumption of alcohol.

21. As is frequently the case, it is likely Ashley did not always disclose his true level of alcohol usage to his employer. On 19 January 1995, in a declaration for assessment for attendance at training camps, he disclosed drinking 5 to 10 standard drinks per week. On 16 March 1995, in a Medical Examination for the State Protection Support Unit, he disclosed an alcohol intake of "max 80g/week" (ie about 8 standard drinks). On 28 September 1995, he disclosed 10 standard drinks per week. On 9 October 1995, in a Medical Examination, he disclosed 5-10 standard drinks per week. On 7 November 1995, in a Medical Assessment for SPSU, he disclosed ½ drink per day. And, on 18 September 1996, he reported in a Medical Examination that his alcohol intake was "20g/day ie 2 middies".

22. The family submits that the disclosures cited above should be accepted as accurate because they reflect that Mr Bryant refrained from drinking when he was preparing for training camps. However, they relate to a period over 18 months from early 1995 to late 1996 when Mrs Bryant acknowledges Ashley was drinking heavily regularly. I conclude that like most people, Ashley underestimated his alcohol consumption when asked about them by officials and medical practitioners.

23. However, Mr Bryant's excessive alcohol consumption did come to the attention of his employer in August 1999, when concerns were raised by his Local Area Command about his being abusive when intoxicated in a telephone call to staff at his Police Station (City of Sydney), and due to his sick leave record.

24. As a result, on 30 August 1999, Ashley was assessed by a Drug and Alcohol Counsellor in the NSWPF's Healthy Lifestyles Unit. During this assessment, Ashley agreed that alcohol was a "major problem" for him, that he had experienced

blackouts virtually every time he drank in the past 6 months, and had at times been drunk at work, and had driven while drunk. He also disclosed the following:-

- That he was aged 13 or 14 when he had his first experience with alcohol;
- Commenced drinking on regular basis when joined police aged about 19;
- "*Drunk at work not since Royal Commission*";
- Experiencing 6 blackouts in last 6 months;
- Drinking had affected his partner/family;
- Longest alcohol-free period since began drinking regularly – 3/7 to 1/12;
- Drinking 10-12 schooners 1 to 2 times per week;
- Suicidal ideation – "In past 6-12/12 ago";
- *"Definitely have a problem with drinking";*
- Had blackouts virtually every time he drinks for past 6/12;
- Had been drunk at work; and
- Had driven drunk

25. During this assessment, Ashley agreed with the counsellor that he would remain abstinent for 2 weeks, but stated that he did not feel he could remain abstinent forever. Although it was agreed that he would see the counsellor again on 13 September 1999, Ashley cancelled this appointment, stating that he is "OK", did not need more help, and would make contact in the future if necessary.

26. It seems that Mr Bryant's psychological state was next examined as part of an annual review in May 2004, when he was attached to Unsolved Homicide. On that occasion, Ashley answered "*no*" to the question "*Would you like an opportunity to speak with a psychologist about any issues?"*

27. Mr Bryant participated in the "WellCheck" program (which was delivered by external psychologists) in 2005 and 2006. This program was a monitoring process to assess an officer's continuing fitness for the particular type of duty he or she was undertaking. It consisted of an interview and psychometric testing.

28. In early 2006, Mr Bryant's drinking led to his wife Deborah suggesting that he needed help. On this occasion Ashley told Deborah that he had often thought about shooting himself, and that when he had been assessed by police psychologists, he had not disclosed his true feelings, being fearful that this might result in him losing his job.

29. It is likely that this conversation occurred around the time of a WellCheck appointment on 7 April 2006. Between April and June 2006, Ashley consulted a number of times with a psychologist Mr Kenny Glassman.

30. That was also the year in which Mr Bryant was likely experiencing distress due to family circumstances. His father died on Mothers' Day after a long illness with dementia. And about 2 months later, Deborah had a miscarriage.

31. In August 2006, Mr Bryant attended some social drinks with work colleagues from which he did not return home until about 4am, when he appeared with lacerations to his head. He called in sick and did not attend his 7 am shift. He was unable to recall how he was injured when asked by his Commander the following day.

32. In September 2006, Ashley was referred to the NSWPF Safety Directorate after an off-duty incident in Brisbane where, after drinking, he became aggressive and wanted to fight a colleague. That assessment by the Safety Directorate concluded that Mr Bryant consumed alcohol at harmful levels. He was advised to abstain from alcohol.

33. As part of the assessment, on 19 September, Ashley was seen by police psychologist Renata Cimino for a fitness for duty assessment as per the PMO referral. Ashley acknowledged that he was an alcoholic, although he had been in denial for some time. Ashley reported that his drinking had been a problem for a while, he was a regular binge drinker, his alcohol intake had significantly increased over the past six months and over the last six weeks he had been drinking a six pack of beer and three glasses of wine every night. He stated he had been dry from alcohol for ten days, since the incident at work. Ashley believed his depressed mood was associated with his drinking behaviour. Ashley's MMPI-2[1] results recorded elevations on the social isolation scale and social discomfort scale.

34. Ms Cimino concluded that Ashley's symptoms were "consistent with alcohol abuse, compounded by depressive and anxious symptomology" and were chronic, having had some impact on his social and occupational functioning. She determined that Ashley was currently "unfit for full duties". She noted he was in the process of addressing treatment through EAP contact (the sessions with Mr Glassman). She recommended Ashley make contact with a psychiatrist for further assessment or diagnosis, as well as maintain contact with his psychologist.

35. Ashley reported that he was due to take one month long service leave from the following day. Ms Cimino noted that Ashley was to be reviewed upon his return from leave to monitor his progress and recorded that she had advised PMO Dr Kirby of the above.

36. On 9 October 2006, Ms Cimino emailed Dr Kirby as she had been informed that while she was on leave, Dr Kirby sought feedback about the outcome of Ashley's assessment and could not recall if they had discussed the case. Ms Cimino noted in the email that she had spoken to Dr Kirby on 19 September following her assessment of Ashley and had advised Dr Kirby of her impressions and recommendations. Ms Cimino stated that although the psychometric test results indicated no major concerns, she felt that was inconsistent with the clinical interview. Dr Kirby stated that he sought access to Ms Cimino's notes to "quantify

[1] The Minnesota Multiphasic Personality Inventory is a psychological test that assesses personality traits and psychopathology.

the strength of the opinion in the discussion around firearm access and a treating psychiatrist referral", because of an email from Ashley about the whereabouts of the PMO referral.

37. On 10 October 2006, Dr Kirby emailed Ms Cimino, stating that what he could not remember was whether they agreed about whether Ashley should have his gun back. Dr Kirby stated he did "give Ashley his gun back." In fact, as detailed below, he had made a recommendation to Mr Bryant's command that he was fit for full operational duty which was accepted and resulted in Ashley's service firearm being returned to him.

38. The following day, Ms Cimino replied that at the time they had agreed that Ashley would remain on restricted duties and be reviewed after his annual leave. Ms Cimino suggested they may review Ashley anyway to monitor his progress.

39. As part of this assessment, Ashley agreed that he had a problem with alcohol and needed to remain abstinent. Although in-hospital treatment was offered, he declined this offer, but agreed to some further sessions with psychologist Mr Glassman.

40. Mr Bryant was also assessed as to his "fitness for duty" by the Police Medical Officer (PMO) on 19 September 2006. His firearm had been taken from him prior to this assessment. Although he was assessed as fit for full operational duties, the PMO advised Ashley that he should consult with a psychiatrist for his "mood disorder" and should remain abstinent of alcohol.

41. On 4 October, the PMO reported to Ashley's commander at the Homicide Squad that he was being treated for "significant alcohol issues" and had been referred to Employee Assistance Program (EAP) counselling, and was receiving treatment for depression.

42. The PMO recommended that:

> *This officer is fit for full operational duties, should be reviewed here in 8 weeks and is to be urged to continue abstaining from alcohol and continuing to follow up with professional help for his mood disorder.*
>
> *If there are signs of relapse, deterioration in performance or other worrying signs, then he should be restricted and referred back for review.*

43. Ashley was promoted to Sergeant in January 2007 and transferred to Bourke but he began acting in the position in early December 2006. As a result he was not referred back for review as recommend by the PMO.

44. His commander at the Homicide Squad signed off that he had no outstanding health issues. Even though the form required answers in relation to the officer's medical history for the last 12 months, the commander indicated that he had not been on restricted duties of any kind or on sick leave or stress leave.

45. Shortly after this transfer, Ashley commenced drinking again and was soon back to his previous heavy use of alcohol. Deborah Bryant made contact with Mr Glassman and asked him to speak to Ashley but according to her he declined, citing patient confidentiality reasons.

46. Mr Bryant experienced some further potentially traumatic incidents in 2008, one of which involved him attempting to break up a knife fight outside his home in Bourke, and another case in which he apparently had to view thousands of images of child pornography. In about August 2009, he was required to respond to a very distressing accident where a car had reversed over the head of an 18 month old child.

47. Despite his exposure to traumatic incidents like these, and notwithstanding his drinking problems, it seems that Mr Bryant continued to perform as a very competent officer. In May 2008, a Management Team gave him rankings of 7 or 8 out of 9 in all areas of assessment. Similarly, when in around May 2009 Mr Bryant applied for transfer to Ballina, he was recommended by his superiors as being "*very passionate and hard working*" and "*highly capable and competent*".

48. In about December 2009, the Bryant family moved to Ballina. By this time, Deborah was becoming seriously concerned about Ashley's welfare. He told her on more than one occasion he did not think he could work in the police for much longer.

49. In January 2010, Ashley was exposed to another incident which apparently caused him considerable distress, involving the accidental drowning of a married couple at South Ballina beach.

50. In 2011, Ashley's drinking was "very bad" according to his wife - he was drinking even when on call, and at times engaged in risky behaviour at work, where he was (he claimed) "*hoping he would get hurt*". He spoke to his wife of thoughts of shooting himself while in the surf.

Medical discharge

51. This evidence supports a conclusion that Ashley was struggling from PTSD, depression and alcohol abuse for some years prior to it being officially recognised as a basis for his separation from the NSWPF. Having regard to his service it is easy to understand how he could suffer from PTSD.

52. The inquest obtained good insight to this aspect of Mr Bryant's condition from Detective Inspector Matthew Kehoe, an officer who had known Ashley for all of his service and who obviously respected and cared for him.

53. Detective Inspector Kehoe explained that in late 2009, he was instrumental in Ashley applying for and being appointed to a detective sergeant's position in the Ballina detectives unit. He remained in that role for the rest of his service. It involved a very high workload and resulted in Ashley being exposed to a high number of very distressing cases – violent murders, drownings, suicides and fatal motor vehicle crashes.

54. Attending the scenes of such incidents and dealing with the victims and survivors would precipitate mental anguish that only someone who had suffered similar exposure could fully appreciate. Detective Inspector Kehoe was such a person and he was vigilant in ensuring that Detective Sergeant Bryant was made aware that support was available for him.

55. On 23 January 2012, Mr Bryant consulted his general practitioner, Dr Linda Brown, due to recurrent nightmares, excessive drinking and his wife's concerns about these

problems. Ashley apparently broke down during this consultation, leading to Dr Brown prescribing medication, and referring him to Sara Goldie, a Clinical Psychologist / Psychotherapist practising in Bangalow.

56. In Mr Bryant's first consultation with Ms Goldie on 6 February 2012, he scored "extremely severe" when tested for depression/anxiety/stress. He also acknowledged significant suicidal thoughts, including thoughts of jumping from a cliff at Lennox Point or at Minyon Falls. Ms Goldie noted that alcohol was a "coping strategy", and that Ashley's thoughts of his children was a "protective factor". He saw Ms Goldie a further three times in February and March 2012.

57. On 12 March 2012, Ashley attended Dr Brown's rooms in a very distressed condition. This led to Dr Brown convincing him that he needed to take some time off work. Dr Brown also referred Ashley to a Psychiatrist, Dr Scurrah, at Bangalow, for an urgent assessment. It was on 12 March 2012, that the NSWPF was officially notified of Ashley's condition via a Workcover certificate and P902 Incident Notification Form completed by Dr Brown.

58. She assessed Ashley as "*extremely distressed, teary and agitated"* and "*Not able to work*". She prescribed Temazepam, and arranged an urgent assessment by Dr Scurrah.

59. The next day Ashley texted Detective Inspector Kehoe and told him that he was not coping and needed some time away from the job. Detective Inspector Kehoe spoke to Dr Brown and made arrangements to secure Ashley's service firearm and confirmed that he did not have access to other guns.

60. Mr Bryant saw Dr Scurrah at Bangalow on 20 March 2012. In a letter to Dr Brown dated 21 March 2012, he wrote that Ashley had developed chronic depression, chronic PTSD / alcohol dependence related to workplace traumas. Dr Scurrah also noted that Ashley was struggling with the perceived stigma of his illnesses, and recommended at least 3 months off work, with daily exercise and no alcohol.

61. Dr Scurrah discussed with Ashley the option of his being admitted to a private clinic, however he chose to undertake treatment as an outpatient. It was agreed that he would re-commence counselling with Ms Goldie.

62. Mr Bryant saw Ms Goldie again on 4 April 2012, but as she did not provide services under Workcover, it was agreed that he would continue his treatment with a psychologist who did, Timothy Loughnan.

63. Mr Bryant's condition did not improve and so on 1 May 2012, he agreed to undergo in-patient treatment in the Currumbin Clinic on the Gold Coast, where he remained until 20 May 2012.

64. Ashley was uneventfully detoxified from alcohol during his three weeks in Currumbin. He was diagnosed by psychiatrist Dr Danesi, with – 1. Alcohol dependency; 2. PTSD; 3. Major Depressive Disorder; and 4. Dysthymic Disorder.

65. On 4 June 2012, Dr Scurrah wrote to a NSWPF Senior Injury Management Adviser stating that Ashley had chronic severe PTSD, chronic depressive disorder, and alcohol dependence undergoing successful treatment. Dr Scurrah advised that Ashley was currently not capable of performing either operational or non-operational police roles, but that he would review his non-operational capacity in three months.

66. By late June 2012, Ashley had made it clear that he did not intend to return to work with the Police Force, and that he wished to be medically discharged.

67. In mid-2012, the Bryant family decided to move from Ballina to Port Macquarie (Mr Bryant's home town) after Deborah secured a job there. Shortly before this, Ashley enrolled in part-time study for a law degree by distance education through Southern Cross University at Lismore.

68. In a medico-legal report dated 7 August 2012, Byron Bay psychologist Tim Loughnan told Mr Bryant's lawyers that he suffered PTSD with depression and alcohol dependence secondary to injuries resulting from numerous traumatic experiences at work. Mr Loughnan further stated that while long term employability was very difficult to predict, Ashley may, with good long term support, be able to return to some form of work away from trauma or emotional pressure.

69. During 2012, consideration was given by the NSWPF to a Return to Work plan for Ashley, however his treating medical professionals concluded that this was not appropriate. In a letter to a NSWPF Injury Management Advisor on 10 September 2012, Dr Scurrah stated that since Ashley's discharge from Currumbin in late May, his Depression and PTSD had continued on a chronic course, although he had since then maintained abstinence from alcohol.

70. A report dated 18 October 2012 was prepared by psychiatrist Dr Greg Pearson as part of an independent medical examination for the workers compensation insurer, TMF Employers Mutual Ltd. In it Dr Pearson advised that Mr Bryant had PTSD (in partial remission), a Major Depressive Disorder (in remission) and Alcohol Dependence (in remission). Dr Pearson concluded that these disorders were due to exposure to traumatic events in the workplace and that Mr Bryant's condition prevented him at that time from participating in employment.

71. In November 2012, based on the views of both treating and independent medical practitioners, a recommendation was made for Mr Bryant's discharge from the NSWPF. On 6 December 2012, Ashley was discharged from the NSWPF on medical grounds.

72. Between Mr Bryant leaving active duty and being discharged he had frequent contact with Detective Inspector Kehoe who telephoned, texted and/or visited Ashley.

Post discharge treatment

73. After his discharge from the Police Force, Ashley continued to be treated by Dr Scurrah and by Mr Ian McCombie, a psychologist who practiced in Coffs Harbour and who Mr Bryant started seeing after the family moved to Port Macquarie.

74. Throughout 2013, despite abstinence from alcohol, Ashley continued to struggle with his mood and emotions, and in dealing with the care of his children. These problems impacted negatively on his relationship with his wife.

75. Also in 2013, Ashley commenced studying a law degree at Southern Cross University. He enjoyed his studies; they provided a distraction from his worries and emotional difficulties.

76. At this time he was awaiting a decision as to whether he would receive an early payout of his superannuation entitlements on the basis that he was "permanently unable" to participate in remunerative work.

77. In about April 2013, Mr Bryant was assessed by a psychiatrist, Dr Hong, on behalf of the administrator of the superannuation fund. That assessment was for the purpose of determining whether Ashley's cessation of employment was due to permanent physical or mental incapacity; and whether he was at the time of ceasing employment, permanently unable to be employed in any occupation in which it would be reasonable to expect him to engage.

78. As a result of that assessment, Dr Hong issued a report on 18 April 2013, in which he concluded that although Ashley's impairment was permanent, he was not permanently unable to participate in remunerative work, and was capable of re-training so as to undertake employment of a less stressful nature than being a police officer.

79. Based at least in part on Dr Hong's opinion, the State Superannuation fund determined that Mr Bryant was entitled to Partial Permanent Incapacity (PPI) benefits, but not Total Permanent Incapacity (TPI) benefits.

80. Ashley took this decision badly, and in about June or July 2013, he began do drink alcohol again.

81. On 15 July 2013, Ashley was seen by his treating psychologist, Mr McCombie, at Coffs Harbour in an extremely distressed and depressed state, apparently due to money worries associated with the State Superannuation decision to deny him TPI benefits. They discussed Ashley's resumption of alcohol, and the possibility of in-patient care at a private clinic in Coffs Harbour. Ashley declined this.

82. Deborah Bryant told the inquest that during or after his stay in the Currumbin Clinic, her husband had explained to her his discomfort at being an in-patient in a facility where many of the other patients were drug addicts from a similar social milieu as those her husband had investigated and charged when he was in the police force. He didn't feel comfortable sharing common facilities or participating in group therapy sessions with those people.

83. Near the end of July 2013, Ashley's GP, Dr Brown, referred him to Dr Debbie Kors in Port Macquarie, so that he could consult with a GP closer to home. He started consulting with Dr Kors from 29 July 2013. Ashley continued however to consult with his treating psychiatrist Dr Scurrah in Bangalow and with the psychologist Ian McCombie in Coffs Harbour.

84. Ashley's state of mind appears to have been "up and down" during 2013. In May, for instance, the family went on holiday to the Byron Bay area, where Ashley performed very well in a triathlon. And in September, treating doctors noticed some improvement in Ashley's state with a reduction in his drinking. However, this was short-lived, and Ashley was soon consuming up to 10 or more alcoholic drinks per night.

85. In a letter dated 24 October 2013, the insurer, TMF Employers Mutual Ltd informed Mr Bryant of a final decision rejecting his claim for whole person impairment and accepting only partial impairment. This was based on Dr Pearson's assessment that Mr Bryant had only suffered a whole person impairment of 7%, rather than the minimum impairment of 15% required to base a payout for a permanent impairment.

86. During October and November 2013, Ashley's condition apparently continued to fluctuate, and his drinking continued, although he did report attempts to maintain two alcohol-free days per week.

87. On 20 November 2013, the Bryants celebrated their 20th wedding anniversary with a few days in the Hunter Valley. However according to Deborah, things soon after returned to how they had been for the previous few months which seems to have been characterised by "ups and downs". For instance, on 8 December, Jason, Ashley's brother, received messages from Ashley which sounded "happy enough" in which he wrote about his surfing activities in Port Macquarie.

88. However, on 9 December, Mr and Mrs Bryant met at a café in Port Macquarie and after discussing the problems associated with Ashley's continuing alcohol usage, it was agreed that he would move out of the matrimonial home.

89. After the separation, on 11 December, Ashley consulted Dr Kors and told her he was distraught and ashamed after splitting up with his wife. He also told Dr Kors that he had been abusive towards his wife and children, and was fearful of the possibility that he could seriously harm them. He told Dr Kors he was planning to move into student accommodation at Southern Cross University in Lismore.

90. Dr Kors made contact that day with Mr McCombie to confirm Ashley's upcoming appointment, and she also wrote to Dr Scurrah and to Dr Brown, advising them of recent events. Although Dr Kors suggested contact with the local Mental Health team, Ashley declined this option.

91. Ashley moved into student accommodation at Lismore on Friday 13 December 2013. On that same day, he sent a message to his brother Jason which said – *I am not ok, but I am safe.* To which Jason replied *Call me when you feel like talking or if I can help with anything.*

92. Two of the other students living in the six bedroom, two bathroom complex said they saw Ashley on the day he moved in and over the weekend. They had little contact with him but said he appeared to be involved in routine activities – moving his possessions into his bedroom, putting groceries in the shared fridge and going surfing. They noticed nothing out of the ordinary in the limited contact they had with him.

93. On Sunday 15 December, Ashley posted Christmas cards to each of his children with inscriptions that, even in hindsight, could not be seen as indicative of an intention to end his life.

The day of the death

94. On Monday 16 December, Dr Brown who had been advised of the recent crisis by Dr Kors after her consultation with him the previous Wednesday, called Ashley, to check on his welfare. Dr Brown discussed with Ashley his situation, and also spoke about suicide risk. Mr Bryant assured Dr Brown that he had an appointment with her in two days, and that he intended to keep it, and that he would not want to see his children hurt by him harming himself.

95. Dr Brown said in evidence that she would not have described Ashley as agitated, and although he was upset, he went to some lengths to reassure her that he was safe, and would attend his appointment in two days' time.

96. At about 4 pm that day, Ashley attended an appointment with his psychologist, Mr McCombie, at Coffs Harbour which Deborah also attended. At this meeting, there was discussion about Ashley's future plans, and whether he should return home to his family.

97. There is a divergence in the evidence of Mr McCombie and Deborah Bryant in relation to parts of this conversation. Deborah's evidence was that Ashley wanted to come home but that she insisted that this could not happen until he stopped drinking. However, Mr McCombie's evidence, and his file note, was to the effect that it was Deborah who wanted Ashley to return home to share the child-care but that Ashley said he needed some time away.

98. Both Mrs Bryant and Mr McCombie agree that Ashley became upset and left the session before its scheduled conclusion.

99. Mr McCombie followed Ashley out of the room. He offered Mr Bryant a return to treatment at Currumbin Private Hospital which was not accepted. However Ashley agreed to see him the next day, and also to call once he arrived back in Lismore. Mr McCombie said that while he was concerned, he did not get the impression that Ashley had any intention to harm himself.

100. However, it is now clear that after leaving Mr McCombie's rooms, Ashley must have driven almost directly to Minyon Falls near Lismore, perhaps stopping on the way to buy beer and a bottle of whisky.

101. During that evening, Ashley spoke by telephone to a number of people, including his mother in law, and brother Jason - telling them he intended to end his life. In his call to Jason at about 8.23 pm, he gave Jason details of money in bank accounts.

102. At about 8.30 pm Ashley made a 000 call. He told the operator that he was an ex detective sergeant of police, that he was at Minyon Falls, and that intended to take his life.

103. He said:

> *I understand that this call is being recorded. I suffer post traumatic stress disorder. I can no longer live with the trauma of it and I want this to go to the coroner. There needs to be more things put in place for what happens. Listen, for partners of those that suffer because I suffer and so do the partners. And there has to be more done for them.*

104. The operator tried to keep Ashley talking and asked him to wait for police to get there. Ashley replied, *"No I will be gone before they arrive. Thank you."* He then terminated the call.

105. A few minutes after this call, Ashley called his friend Detective Inspector Kehoe and told him of his intentions. He asked Detective Kehoe to promise that he would investigate his death. Detective Kehoe told Ashley he could not make that promise because he believed that if he did Ashley would go through with his threat. Despite Detective Kehoe's efforts to reassure Ashley that together they could get through the crisis he was experiencing, Ashley remained resolute and ended the call.

106. Police were despatched to Minyon Falls immediately after the 000 call, and arrived at the car park at the top of the falls at about 9.05pm. There they found Mr Bryant's

car and some of his property. On the viewing platform, Police found more of Ashley's property, as well as some empty beer bottles and a mostly consumed bottle of Scotch whisky.

107. Police went to the base of the waterfall and located Ashley's body. He was clearly dead with injuries consistent with those to be expected from a fall from a height. Ashley's body was guarded overnight and recovered the next morning.

Expert evidence

108. Dr Yvonne Skinner, Professor Matthew Large and Professor Alexander McFarlane provided expert reports which were included in the brief of evidence. The three psychiatric experts also gave evidence concurrently at the inquest hearing on 5 May 2017. Prior to giving evidence, the experts were provided with a document covering areas of agreement and disagreement in relation to five broad topics and discussed their conclusions.

109. Dr Skinner provided a report dated 30 March 2015 at the request of the Crown Solicitor's Office on behalf of the Coroner. Dr Skinner has been a consultant psychiatrist since 1986 and is a registered medical practitioner and consultant psychiatrist in clinical private practice.

110. Professor McFarlane provided three reports dated 9 December 2015, 9 February 2016 and 30 March 2017. He was retained by the lawyers for Deborah Bryant. Professor McFarlane has been a registered medical practitioner since 1976. His position is Professor of Psychiatry and he is the Director of the University of Adelaide Centre for Traumatic Stress Studies.

111. Professor Large provided a report dated 19 January 2016 and a supplementary report dated 19 April 2017. He was retained by the solicitors for the NSW Police Force. Professor Large has been a medical practitioner since 1988 and a psychiatrist since 1995. He is a Conjoint Professor of Psychiatry at the University of New South Wales (Conjoint with South Eastern Sydney LHD). Professor Large's title at Prince of Wales Hospital is Medical Superintendent for the hospital group and he has a clinical role in the Emergency Department.

Analysis and conclusions

Officer safety - the context

112. Police officers are not the only employees who risk injury or even death doing their job. For example, each year, a significant number of truck drivers, miners and construction workers are killed or injured during the course of their employment. They work in hazardous industries in which accidents are not uncommon.

113. However, an aggravating aspect of the risk faced by police officers is that the threat to their safety frequently comes from people intentionally trying to do them harm simply because they are doing their job. At every vehicle stop and every door knock the officer cannot know whether the person he or she is about to interact with will react violently.

114. Police forces around the country seek to minimise these risks by training officers in situational awareness and use of force tactics and equipping them with an array of

weapons. The training and appointments reduce the risk of physical harm but do little to redress the psychological effects of constantly having to be on guard.

115. The corrosive effect of having to continually consider whether the member of your community you are about to engage with will seek to physically harm you is exacerbated by the requirement to so frequently interact with individuals the officer suspects have engaged in deviant behaviour and/or committed serious crimes.

116. And then there are the victims. The bashed wives; the drowned toddlers; the mangled motorists; the sexually abused adolescents; the screaming, the grief, the blood and the wreckage; the decomposed bodies and the mass disaster mayhem – the longer an officer serves, the more of these horrors he or she will be exposed to.

117. Inevitably an officer will become apprehensive about what to others might appear a routine event, suspicious of ordinary behaviour and cynical about civil society's response to aberrance, as the officer sees it.

118. The bureaucracy essential to manage a large organisation and the accountability required of police officers in modern liberal democracies confirm the jaded officer's suspicion that the "system" is loaded against law enforcement in favour of "the criminals."

119. He or she is likely to become socially isolated as it is easy for an officer to conclude that only other officers understand what's really going on in the community and avoiding social contact with civilians reduces the risk of conflict and embarrassment.

120. Even spouses might not understand why an officer would not want to talk about what had gone on at work. An officer's children will see as harsh and authoritarian the officer's attempts to protect them from evils he or she has seen but that they can't imagine. They will resent that shift work keeps their parents away from activities non police parents participate in and requires them to tip toe around the house as mum or dad sleep. Families fracture.

121. The hyper-vigilance necessary to keep an officer safe has neurological adverse effects that officers and their families may not be aware of.[2]

122. Significant improvements have been made over many decades in relation to officer physical safety. Police forces have been slower to address the psychological harm and social dislocation suffered by their sworn members.

123. An officer admitting that the stressors were weighing on him or her risked the officer being seen as weak or "not cut out for the job." Expressing concern about the impact of work on family life could lead to an officer's professional commitment being questioned.

124. Traditionally, officers were encouraged to use alcohol to wipe away memories of horrifying events, to cultivate informants and to build team bonds.

[2] Gilmartin K M, *Emotional survival for law enforcement*, E-S Press, Tucson, Arizona USA, 2002, pp33-46

125. In these circumstances, it is not surprising that some police officers and former officers suffer from PTSD, depression, anxiety or alcohol dependency or that their social and family supports fall away.

126. Addressing the risk of this harm requires police forces to:

- educate their officers about psychological injuries;
- provide ready access to screening programs that enable an officer to determine whether his or her mental health is deteriorating;
- ensure those who are deteriorating can easily access treatment; and
- drive cultural change that encourages officers to seek help free from fear that it will damage their career prospects and that recognises that for some a change of career is called for, with programs that will assist an officer transition to other jobs.

127. It is against that background that the support provided to Ashley Bryant by the NSWPF needs to be assessed.

Mr Bryant's diagnosis

128. There is consensus among Mr Bryant's treating clinicians and the experts who provided evidence to the inquest that at the time of his death he was suffering from PTSD, depression and alcohol dependence.

129. It is less clear when these conditions manifested and the degree to which each contributed to Mr Bryant's decision to end his life.

130. Some of the experts considered alcohol abuse was the more dominant negative influence while others asserted that it was primarily the repeated exposure to extremely traumatic events that undermined Mr Bryant's mental health and predisposed him to excessive drinking as a form of self-medication.

131. After his death there was found on his laptop a list of 72 traumatic incidents he had been exposed to between 1988 and 2012. This list would have been complied largely from memory so it is likely that there were many more.

132. Most suicides involve a complex interaction of numerous circumstances and conditions. It is widely accepted that suicide is often an impulsive act. It is likely that the disinhibiting effects of alcohol played a significant role in precipitating Mr Bryant's jump to his death. It is also the case that alcohol abuse would counteract the benefits of the medication Mr Bryant was taking and would exacerbate his symptoms of depression and anxiety. However, there is no doubt he suffered from PTSD and depression for a number of years and those conditions significantly increased his risk of self-destruction.

133. I am of the view that it is impossible to determine the extent to which his psychiatric disorders contributed to his alcohol dependence or *vice versa*. That is one of the reasons such comorbidities are referred to as a dual diagnosis. I conclude that it is

not possible to apportion with any precision the degree to which Mr Bryant's various disorders contributed to his decision to end his life.

134. However, I accept that Mr Bryant did not have a history of problematic alcohol abuse or any psychiatric illness before he joined the police service. In 1987, his GP of 5 years certified that he had "*no history of behavioural or psychiatric conditions including depression and anxiety"* and no "*history and/or evidence of alcohol or drug addiction."* I accept that all of his psychological disorders, including his alcohol dependence, arose during the course of his service as a police officer and that there was as causal connection between that service and his illnesses.

The adequacy of the support provided by the NSWPF

135. The primary issues to be resolved are whether the NSWPF:

- adequately responded to Mr Byrant's alcohol abuse after it became aware of it in 1999 and 2006; and
- took sufficient steps to ascertain whether he was suffering from PSTD.

Alcohol abuse

136. Ashley's wife told the inquest that he was periodically abusing alcohol from the mid-1990s onwards. It is difficult to accept that this would not have come to the attention of his immediate superiors although it could be that alcohol abuse among police officers (and the members of many other vocations) was so wide-spread at that time that Mr Bryant's imbibing was not considered abnormal.

137. An official response was not forthcoming until 1999 when an abusive interaction with other staff members while drunk prompted Mr Bryant's commanding officer to refer him to the Healthy Lifestyle Unit. There he disclosed binge drinking, drink driving, regular blackouts, and being drunk at work.

138. He had one counselling session. Another appointment was made but Ashley cancelled it. There was no follow up or any other action taken, the file was simply closed.

139. From 2004 when he was transferred to the State Crime Command Unsolved Homicide Unit, Ashley underwent quarterly WellCheck assessments. Although an annual psychological assessment identified alcohol consumption under "Critical items" in the record of that assessment, no remedial response was implemented when Ashley simply checked the box "No" when responding to a question as to whether he would like to receive counselling.

140. None of the next four WellCheck assessments identified that Mr Bryant was drinking at harmful levels but that could well be a result of his giving less than frank responses to the people undertaking those assessments.

141. He told his wife in early 2006 that if he honestly answered the psychological assessors' questions he could lose his job. This was said in the context of his disclosing suicidal ideation to his wife but it is likely that he also hid other

behaviours he anticipated would prompt a welfare intervention, such as the binge drinking that his wife reports he was engaging in during this period.

142. Following a WellCheck assessment in April 2006, Ashley availed himself of consultations with a psychologist under the Employee Assistance Program. He saw Mr Glassman on four occasions, the last being on 21 June 2006.

143. In September 2006, following further incidents in which Ashley had acted aggressively towards other officers in social situations when affected by alcohol, he was suspended from active duty and referred to the Police Medical officer (PMO) for a Fitness for Duty assessment (FFD).

144. As part of this process, he saw a police psychologist who concluded that he was unfit for full operational duty due to his chronic alcohol abuse that she adjudged to be an inappropriate coping strategy to respond to anxiety and depression.

145. That police psychologist recommended Ashley continue to seek the assistance of Mr Glassman to address his alcohol abuse and to help with his anxiety and depression. Ashley attended upon Mr Glassman on a further four occasions in September, October and November. Despite the police psychologist's recommendation, on 4 October 2006, the PMO declared Mr Bryant fit for full operational duties.

146. As detailed earlier, the PMO recommended to Ashley's commanding officer that he again be reviewed by the PMO in 8 weeks' time. This did not happen and there was no follow up by either Ashley's commanding officer, the PMO, or any other member of the NSWPF until Ashley left on sick leave never to return in March 2012. Indeed it appears that the PMO's assessment that Ashley required follow up was never communicated to any of the commands he subsequently served in. Nor were any of those commands warned that Ashley was at risk of relapse.

147. The PMO also recommended that Ashley seek treatment from a psychiatrist but as that could only be obtained at his expense, it did not occur.

Conclusions

148. The NSWPF WellCheck policies in place in 1999 were deficient in that they contained no mechanism to ensure that despite disclosing serious alcohol abuse Mr Bryant was required to undergo any treatment or further assessment.

149. In 2006, the PMO erred when he recommended Mr Bryant be considered fully fit for operational duty, probably as a result of the PMO forgetting or failing to adequately have regard to the assessment of the police psychologist who had examined Ashley.

150. The NSWPF systems then in place were deficient in that they provided no mechanism to ensure the follow up review recommended by the PMO was actually undertaken. Nor were any of the commands Ashley subsequently served in warned that he was at risk of relapse of alcohol dependence.

151. Those policies were also deficient in that they did not provide for an officer to receive psychiatric treatment unless he or she privately funded it. As the need for

that treatment in Ashley's case was almost certainly due to his police service, this was inappropriate.

PTSD

152. Mr Bryant was not formally diagnosed with PTSD until after he went on sick leave in 2012 but it seems very likely that he was suffering from it well before that. Dr Skinner, who reviewed all available medical records, concluded that he was probably suffering from it from about 1996.

153. When the PMO, Dr Kirby, saw him in 2006 he concluded Ashley was suffering from depression although he too thought it was also possible that PTSD was involved as did the police psychologist who examined Mr Bryant at that time.

154. In the years following his being declared FFD in 2006 he served in Bourke and Ballina. In both places Mr Bryant was exposed to severely distressing and traumatic incidents and in the latter posting this was exacerbated by an unreasonably high workload. In those circumstances his primary coping mechanism of physical fitness activity was not always available because of time constraints and so he again resorted to alcohol as a form of self-medication.

155. Detective Inspector Kehoe was alert to the potential risk the nature and volume of the work Ashley was undertaking as the officer in charge of the Ballina detectives. As regional Human Resources Manager, he sought to provide him with what support he could. However, he was not aware that Ashley was particularly susceptible to harm on account of his previous history of mental illness and alcohol dependence.

Conclusions

156. The likelihood that Mr Bryant was suffering from PTSD was identified in 2006 by a police psychologist and the PMO. However, apart from being given access to a private psychologist for another four sessions, the NSWPF took no steps to further investigate whether Ashley was actually suffering from PTSD, even though he subsequently served in positions that exposed him to numerous traumatic incidents that would have exacerbated the condition if it already existed or precipitated it if it did not.

157. Information about Mr Bryant's period of restricted duties and the reasons for it should have been conveyed to his subsequent commands so that it could be taken into account when assessing the officer's condition and determining what support he needed.

158. The NSWPF was or should have been aware that repeated exposure to traumatic events increased the risk and the severity of PTSD. It was aware, at least from 2006, that Mr Bryant was at serious risk of harm of that nature and failed to adequately investigate or respond to it.

159. However, that does not necessarily lead to a conclusion that any intervention by the NSWPF would have led to a different result. Mr Bryant had access to mental health care – he did not exhaust all of the funded consultations to a psychologist that were approved and he would have been aware that more could have been available had he sought them.

160. After he went off on sick leave in early 2012, Mr Bryant had extensive psychotherapy, from a number of mental health professionals including extended in-patient treatment. Like most illnesses, no treatment for mental health disorders is universally successful.

Post separation medical treatment

161. After he went off on sick leave in early 2012 and after his discharge from the NSWPF later that year, Ashley received treatment from psychiatrist Dr Scurrah, psychologists Ms Goldie, Mr Loughnan and Mr McCombie, and GPs Dr Brown and Dr Kors.

162. His friend and colleague, Detective Inspector Kehoe regularly made contact in an attempt to assist Mr Bryant cope with his illness.

163. There is no evidence suggesting that Ashley's post-discharge treatment by any of his health professionals was anything other than appropriate. There was agreement to this effect by the expert witnesses, Dr Skinner and Professors Large and McFarlane.

164. More than that, those practitioners and Detective Inspector Kehoe demonstrated dedication to helping their patient/colleague and compassion for him and his family. That Ashley died despite their conscientious care demonstrates how dangerous his conditions were.

Conclusion

165. There was no deficiency in the treatment provided to Mr Bryant by the medical practitioners he consulted after he went off on sick leave in early 2012. On the contrary, the dedicated support of his doctors and his family enabled Ashley to manfully struggle with his illness in an on-going attempt to regain his health. Even on the day of his death he spoke to two of his treating clinicians and assured them of his safety. That he died later that same day emphasises the impulsive character of the act of self-destruction that precipitated this inquest.

Support post discharge

166. After Mr Bryant was discharged from the NSWPF medically unfit, the management of his condition was governed by the NSWPF Death and Disability Scheme. That involved various insurers making determinations of entitlements based on their investigations and assessments.

167. The evidence demonstrates that these processes significantly added to the stress Ashley was already undergoing as a result of his work induced psychological injuries. It seems his willingness to undertake study was misconstrued as capacity for work and the necessity to repeatedly describe incidents that had precipitated his PTSD exacerbated it. There can be little doubt that this stress increased his risk of self- harm.

168. However, the inquest did not investigate the nature of the actions taken and decisions made by the various insurers or seek to assess the reasonableness of those actions. Those decisions could have been challenged in other proceedings and it would be beyond the scope of this inquest to speculate on what the outcome

of such proceedings may have been had they been initiated. Mr Bryant was receiving legal advice about those issues. In those circumstances it would be inappropriate for these findings to make adverse comment about them when the companies and individuals involved have not been given an opportunity to respond.

169. That does not mean that this report should not acknowledge the difficulties the administration of the scheme caused Mr Bryant and his family.

Recommendations

170. Pursuant to s 82 of the *Coroners Act 2009*, Coroners undertaking inquests may make recommendations connected with a death, particularly as to issues which may relate to public health and safety or ways in which the likelihood of similar deaths occurring may be reduced.

171. In this case, the issues that call for consideration from that perspective relate to the methods the NSWPF use to identify officers who may be suffering mental health issues – particularly PTSD, depression and alcohol dependency and how the force responds to an officer diagnosed with those ailments to support the officer and his or her family.

Screening and support

172. Most operational officers will be exposed to distressing and traumatic incidents during the course of their service. The evidence indicates that the more such incidents an officer is exposed to the greater the risk that he or she will develop an adverse reaction manifesting in PTSD, depression or anxiety.

173. These facts support the submissions that all officers involved in responding to serious crime or disasters should be regularly screened as should officers at various points in the duration of their service. Currently only about 10% of officers are regularly screened via the WellCheck program.

174. However, there are a number of factors that militate against making screening mandatory for more officers.

- Considering the stressors police officers are confronted with, only a very small proportion of officers actually suffer diagnosable mental health deterioration. Widespread screening would mean many officers not in need of it would be required to undergo it.

- To mandate that officers attend interviews with mental health assessors is invasive.

- For it to be effective the information would have to be able to be disclosed to the officers' superiors involving a significant invasion of officers' privacy in connection with highly personal information.

- There is limited evidence to support the effectiveness of mandatory screening. Officers disinclined to seek help can easily give false responses. False positives risk healthy officers being unnecessarily removed from active duty.

- Widespread screening is expensive and diverts officers from their core duties.

175. It would be more beneficial to ensure that officers are able to determine whether they may be in need of assistance and to reassure officers that seeking help will not negatively impact their careers or standing among peers. It is also important that the incidence of exposure to potentially harmful events that individual officers are exposed to is tracked so that managers can have regard to the increased risk this may precipitate. The first and third of these responses require sophisticated technologies, the second requires cultural change.

176. The NSWPF has undertaken numerous initiatives to pursue these ends.

177. Assistant Commissioner York, Superintendent Redfern, and police psychologist Jennifer Placanica gave evidence about a range of measures the NSWPF have put in place, or is in the process of developing, which are aimed at addressing the mental health of police officers.

178. Of particular note is Together for Life, a suicide prevention program adapted from a very successful Canadian initiative that is in the process of being introduced in NSW.

179. The development of the Incident and Support Database, which allows a record to be made of incidents that may have affected an officer, will give commanders access to this important information about the exposure of their officers to events that can manifest in PTSD or other mental health disorders

180. The RECON Project involves physiotherapy, exercise and physical training. It is now being extended to police with psychological injuries.

181. The hosting of an eminent international expert specialising in emotional survival for law enforcement officers – Dr Kevin Gilmartin, and the wide distribution among police and police officers' families of video of his presentations and copies of his book is another example of steps being taken to break down stigma around the adverse mental health impacts of policing and to build resilience.

182. The NSWPF has sought to collaborate with the Black Dog Institute and the Mental Health Commission to better understand how it can protect its officers from psychological harm.

183. An electronic system is being developed to track recommendations from the PMO that an officer be reviewed so that the PMO and the officer's commander can ensure these occur. Currently, the system relies on a spread sheet but Superintendent Redfern advised that would soon be replaced by a more sophisticated computerised system. The Incident and Support Database enables commanders to have regard to an officer's past exposure to traumatic incidents when rostering the officer.

Conclusion

184. The evidence persuades me that the NSWPF is actively and effectively engaging with the issues brought into focus by the death of Ashley Bryant. It is striving to address the challenges of managing the impact of the extreme stressors police officers are exposed to by exploring the best practice from around the world and

committing significant resources to numerous remedial programs. More still needs to be done but I accept the NSWPF has identified the difficulties in ensuring the psychological safety of officers and is committed to addressing them. Nothing would be achieved by the making of redundant or duplicative recommendations.

Findings required by s81(1)

185. As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

186. The person who died was Ashley Newton Bryant

Date of death

187. Mr Bryant died on 16 December 2013.

Place of death

188. He died at Minyon Falls near Lismore in New South Wales.

Cause of death

189. The medical cause of Ashley's death was multiple traumatic injuries sustained in a fall from height.

Manner of death

190. The death was intentionally self-inflicted while Mr Bryant was suffering the effects of post-traumatic stress disorder and depression and while he was under the influence of alcohol.

I close this inquest.

Magistrate M A Barnes
State Coroner