



Western

Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 04/13

*I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of **Tracy Margaret MARSHALL**, with an Inquest held at Perth Coroners Court, CLC Building, 501 Hay Street, Perth, on 22 January 2015 find the identity of the deceased was **Tracy Margaret MARSHALL** and that death occurred on 21 February 2011 at Power Line Structure 65-A, near Karratha/Tom Price Access Road, Cooya Pooya, approximately 47km's south of Karratha, as a result of Ligature Compression of the Neck in the following circumstances:*

Counsel Appearing :

Ms K Ellson assisted the Deputy State Coroner

Mr D Anderson (instructed by State Solicitors Office) appeared on behalf of the WA Country Health Services.

Table of Contents

Introduction	2
Background	2
Location of the Deceased.....	5
Identification of the Deceased's Remains	8
Post Mortem Examination	9
Land Search 2011.....	11
Conclusion as to the Death of the Deceased	14
APPENDIX 1	16

INTRODUCTION

On 18 May 2014, skeletal remains, later identified as belonging to Tracy Margaret Marshall (the deceased) were located at the base of a power line structure (pylon 65-A) approximately 900m from the Karratha/Tom Price Road, Cooya Pooya.

BACKGROUND

The deceased had been the subject of a land search in February 2011 when she disappeared from the Nickol Bay Hospital, Karratha, after being admitted as a voluntary patient due to her deteriorating state of mind.¹

A search had been initiated for the deceased on 21 February 2011 when it was understood she had left the hospital, returned home, taken possession of her vehicle, a Toyota Corolla, and disappeared.

Karratha went on Cyclone Alert during the afternoon of 21 February 2011. This hampered the search for the deceased which had focused on areas in and around Karratha, the deceased was likely to visit. The cyclone, Cyclone Carlos, passed through Karratha in the early hours of 22 February 2011 during which time the search for the deceased was suspended.

¹ Ex A

The search continued on 23 February 2011 and a witness came forward with a description of the deceased's vehicle which he had observed on the morning of 21 February 2011 on the Karratha/Tom Price access road.

On location of the vehicle the search continued using the vehicle as the basis of the last known position of the deceased. Triangulation of the deceased's mobile phone produced information from the nearest tower but was unsuccessful in locating a defined position for the mobile phone.

The area in which the vehicle had been abandoned was in the Millstream National Park. It had been flooded during the course of the cyclone, making access from the road into the surrounding country side very difficult, and obliterating possible tracks or movements in the vicinity of the abandoned vehicle. Nevertheless the search was continued by both land and air but failed to find any trace of the deceased.

There was serious concern for the safety of the deceased. She had been in Nickol Bay Hospital as a result of a deteriorating state of mind and apparent suicidal ideation. She had been a voluntary patient due to her compliance with treatment suggestions and her self-reporting she felt safe in the hospital environment.

The search was continued until 28 February 2011 but no trace of the deceased was found.²

As a result of the deceased not being located she was declared a missing person. Pursuant to section 23 of the *Coroners Act 1996*, the then State Coroner reasonably suspected the disappearance of the deceased was as a result of a reportable death and held an inquest to determine, as far as possible in the circumstances, the events surrounding her death.³

On 14 February 2013 Mr Hope stated he was satisfied beyond all reasonable doubt as to the death of the deceased, on or about 21 February 2012, at an unknown location, as a result of unascertainable causes in the circumstances he described in that finding.⁴ Mr Hope made an Open Finding as to how the deceased's death arose.

Following the discovery and identification of the deceased's remains in May 2014 and further investigations concerning the likely cause and manner of her death, the current inquest was held to finalise issues surrounding the death of the deceased.

² Ex A

³ Inquest 04/2013 held 5-6 September 2013 Ex F tab 1

⁴ Inquest 04/2013 appendix 1 of this finding Ex F tab 1

LOCATION OF THE DECEASED

On 18 May 2014, shortly before noon, two Rio Tinto employees were conducting maintenance inspections of pylons in the Millstream area when they observed a rope hanging from pylon 65-A. On investigation they discovered human skeletal remains at the base of the pylon and reported the matter to police. They did not interfere with either the rope or remains.⁵

Inquiries indicate that although inspections are expected to be conducted annually, pylon 65-A had not been inspected for the previous five years, and consequently the remains not discovered earlier.⁶

Sergeant Stephen Stingemore of the West Pilbara District Forensic Office (WPDFO) provided evidence to the inquest as to the Forensic Officers' assessment of the site of the location of the deceased's remains on 18 May 2014.

Access to the site was not direct but via a track off the Tom Price access road approximately 6kms north of tower (pylon) 65-A, only accessible via four wheel drive access.⁷

The pylon was approximately 900m from the access road but not visible from the road due to a high ridge between

⁵ Ex F, tab 6 & 7

⁶ t 22.01.15, p20

⁷ Ex F, tab 20

the road, where the deceased's car had been located, and pylon. Once on the ridge the pylon was clearly visible and Sergeant Stingemore was confident the position of the deceased, while suspended, would have been visible from the ridge.⁸ The area around the pylon was flat with little vegetation and rocks.

The skeletal remains were located below the rope ligature in an east west orientation, mostly in their anatomically correct positions, barring the skull which was directly below the ligature and next to the feet, and a few missing bones which appear to have been subject to animal disruption. One of the missing bones was the hyoid arch in the neck configuration.

The remains were skeletonised, bleached and cracked with no damage to the bones. Parts, such as the hands were mummified, and some fingerprint ridges could be observed along with dentition in the mandibles. There was some clothing remains on the body and shoes were still attached to the feet.

The deceased's mobile phone was located in the pocket of the shorts, along with keys and other items which did not possess identifying features. The left ring finger still held a wedding and engagement ring, while a faded hospital admission band was present on the wrist.

⁸ t 22.01.15, p23

Sergeant Stingemore described the scene, the ligature, and the remains and was quite confident the evidence was entirely consistent with a person being capable of climbing the pylon and attaching the ligature; and then being able to suspend themselves from the upper loop of the ligature, approximately 180cm from the ground. That loop was stained along 1.5m of its length and was consistent with purging from a body decomposing in that position before that process caused the remains to fall from the ligature into the described position.⁹

The location of the pylon was approximately 900m from the access road upon which the deceased's vehicle had been located on 23 February 2011. It had been observed abandoned on 21 February 2011 at approximately 11:15am, before Cyclone Carlos moved through the area over night, and probably obliterated any traces of the deceased's movements away from the vehicle before it was examined on 23 February 2011.

Sergeant Stingemore described the damage to the vehicle's radiator which appeared to have been caused by the vehicle driving off road at some point, and then ceasing to be drivable sometime afterwards, where it was abandoned. There was a user's manual on the front seat of the vehicle indicating it was likely the deceased had attempted to

⁹ t 22.01.15, p19

assess the damage before abandoning the car and heading off over the ridge.¹⁰

The deceased's father informed the court the rope used as a ligature had been present in the vehicle, opportunistically, as the result of an incident a week before 21 February 2011. The deceased had attempted to self-harm and bogged the vehicle, which others had then pulled out of the sand using rope she was then able to use as a ligature on 21 February 2011.¹¹

IDENTIFICATION OF THE DECEASED'S REMAINS

On location of the human remains and their proximity to the location of the vehicle presumed to be abandoned by the deceased on 21 February 2011, it was suspected the remains belonged to the deceased.

Items located at the site of the skeletal remains were identified by the deceased's husband as the wedding and engagement rings he had bought for the deceased. Mr Marshall also identified the car keys as belonging to the deceased's Toyota vehicle which had been abandoned, approximately 900m from the skeletonised remains, as found in 2014.¹²

¹⁰ t 22.01.15, p24

¹¹ t 22.01.15, p25

¹² Ex F, tab 4

In addition the skeletal remains were subjected to a post mortem examination and as part of that examination, the odontologist identified the deceased as Tracy Margaret Marshall from her dental records, and the mandibles located as part of the complete skull.¹³

POST MORTEM EXAMINATION

The post mortem examination¹⁴ of the skeletal remains was undertaken by Dr Clive Cooke, Chief Forensic Pathologist at the PathWest Laboratory in conjunction with Dr Alana Buck the Forensic Paleontologist at PathWest.

The skeletal remains were those of a female of the deceased's approximate age and were consistent with having been exposed to the elements for a number of years.

There was no evidence of any traumatic skeletal injury and Dr Cooke was of the view that, although he could not determine a cause of death for the deceased, everything he and Dr Buck examined, including the ligature, were consistent with a death by way of hanging.¹⁵

Any hesitation in being able to conclusively determine the deceased had died by way of ligature compression of the

¹³ Ex F, tabs 14 & 17

¹⁴ Ex F, tab 16

¹⁵ Ex F, tab 16

neck was due to the lack of the presence of the hyoid bone in the neck configuration.

Dr Cooke advised the court that with hanging there may (but not necessarily) be damage to the hyoid bone in the neck, subject to the extent of force present during the compression. Had the hyoid bone been present it may have been possible to determine more about the circumstances of the death, but not necessarily. It may have confirmed ligature compression of the neck but not have been conclusive as to the method of that compression.

LAND SEARCH 2011



Exhibit F, Tab 4, Page 2
Google Map of road, creek, tower and the
deceased's abandoned vehicle in 2011

One of the issues of concern for the family of the deceased was that despite an extensive land search between 21-28 February 2011 the deceased's remains had not been discovered. This has caused ongoing angst for everyone who knew and loved the deceased.

As a result of the information obtained in 2014 it is evident the deceased abandoned her vehicle sometime before 11:15am on 21 February 2011. The location of her vehicle was not known to police at that time who, although they conducted a search during the afternoon of 21 February 2011, were looking closer to the environs of Karratha itself. By the time the deceased's car was reported in its location on 21 February, 2011 Cyclone Carlos had swept through the Millstream National Park and deposited a significant amount of water in the area. By the time the police were able to search the deceased's vehicle and its surrounds any trace of the deceased's movements around the vehicle would have been obliterated.

Nevertheless on climbing to the top of the ridge the location of the pylon is clearly visible from the top of the ridge, and Sergeant Stingemore was of the opinion the deceased hanging in the position later identified would have been obvious from the top of the ridge.¹⁶

I am satisfied from the extent of staining on the ligature and the position in which the remains were located, the deceased would still have been hanging, in position, on 23 February 2011.

Pylon 65-A, while not visible from the access road at all, was in the grid searched by Land Search and Rescue (LanSaR)

¹⁶ † 22.01.15, p23

between 21-28 February 2011. This included an aerial search by trained spotters from an aeroplane hired by the deceased's husband for the purposes of the search.

It is not clear how the search failed to locate the deceased, who I am satisfied was already deceased by 23 February 2011.

A report by Crime Inspector Martin Voyez¹⁷ concludes with a finding *“That, based on all available evidence, the body of Mrs. Marshall, ought, ordinarily, to have been found during the February 2011 land search”*.

He goes on to explain that the reason the deceased may not have been located was due to the tropical cyclone passing through the Millstream area, with significant rain fall, which rendered the terrain in and around the abandoned vehicle inaccessible by searchers on foot or vehicle. The localised flooding made comprehensive search by foot or four wheel access extremely difficult. In addition aerial searches looking down on the terrain, are notoriously difficult even for trained observers.

I am satisfied there was a search for the deceased in February 2011, however it is a matter of fact the deceased's body was not located. The search was severely hampered by the event of Cyclone Carlos and its aftermath.

¹⁷ Ex F, tab 2

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased left Nickol Bay Hospital in the early hours of 21 February 2011 as outlined by Mr Hope in his findings from inquest in 2013.¹⁸

I am satisfied the deceased returned home and located her car keys which she then used to drive her Toyota vehicle along the Karratha/Tom Price access road through Millstream National Park. Her destination is unknown although I note the Karratha/Tom Price access road can be used to access the Great Northern Highway towards the south of the state where the deceased had family (Dalwallinu).

It is clear the deceased was in an unstable frame of mind during that period and it was as a result of her bizarre behaviours she had been in the Nickol Bay Hospital.

I am satisfied that at some point in her journey, without money or sustenance, the deceased damaged her motor vehicle off road, and on returning to the road, the car eventually stopped operating.¹⁹ When located by police on 23 February 2011 it started easily but was un-drivable due to the damaged radiator.

¹⁸ Appendix 1

¹⁹ † 22.01.15, p24

I am satisfied the deceased attempted to determine what was wrong with the vehicle by use of the user's manual but at some time, and probably in frustration, decided everything was too much for her and decided to complete her attempts of the previous week.

The deceased located the rope in her vehicle and set off up the ridge to find a suitable hanging point. There before her was pylon 65-A.

I am satisfied the deceased was fit enough physically for her to be able to both climb the pylon, tie the rope and suspend herself, sometime on 21 February 2011. At that point the search was located around Karratha and by the time there was a need to widen the search Cyclone Carlos had obliterated easy access to her chosen location.

I am satisfied the deceased climbed pylon 65-A with her rope on 21 February 2011 and suspended herself with the intention of taking her life.

I find death arose by way of Suicide.

E F Vicker
Deputy State Coroner
26 February 2015

APPENDIX 1

Coroners Act, 1996
[Section 26(1)]



Western

Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: /2013

*I, Alastair Neil Hope, State Coroner, having investigated the suspected death of **Tracy Margaret MARSHALL**, with an Inquest held at Perth Coroners Court on 5-6 February 2013 find that the death has been established beyond all reasonable doubt, that the identity of the deceased person was **Tracy Margaret MARSHALL** and that death occurred on or about 21 February 2011 at an unknown location as a result of unascertainable causes in the following circumstances -*

Counsel Appearing :

Emily Winborne assisting the State Coroner
David Anderson (State Solicitor's Office) appearing on behalf of the Nickol Bay Hospital and the WA Country Health Service.

Table of Contents

Introduction.....	2
Background Information.....	3
The Search for Mrs Marshall.....	10
Additional Enquiries.....	14
Conclusion in Respect of the Suspected Death.....	15
Conclusion in Relation to How the Death Occurred and the Cause of Death.....	15



INTRODUCTION

Tracy Margaret Marshall (Mrs Marshall) was an inpatient at Nickol Bay Hospital in Karratha when she left the hospital at about 6.19am on Monday 21 February 2011, after which she was never seen again.

Mrs Marshall had been admitted to the hospital at about 4pm on the day before, Sunday 20 February 2011. She had told an Emergency Triage Nurse that she had “black thoughts” of self harm.

She was seen at about 4pm that day by Emergency Department Doctor, Coert Kruger, and she told him that she had made three suicide attempts the previous day.

Mrs Marshall was admitted as a voluntary patient. She left the hospital through a rear staff entrance without being discharged.

This inquest was held to investigate the suspected death of Mrs Marshall and in the event that the death of Mrs Marshall has been established beyond all reasonable doubt, into how the death occurred and the cause of the death.



BACKGROUND INFORMATION

At the time of her disappearance Mrs Marshall was 35 years of age and she lived with her husband at 7b Fishwick Court, Millars Well, in Karratha. The house was located across the Dampier Highway from the Nickol Bay Hospital.

Mr and Mrs Marshall were married on New Year's Eve 2007 and after their marriage they had moved from Dalwallinu, where Mrs Marshall had been working as a teacher, to Karratha.

At Karratha Mrs Marshall had initially worked as a teacher at Karratha Senior High School but had left that employment after about six months. In Mr Marshall's view she had suffered a "breakdown" as a result of the stress associated with her work.

At the time of her disappearance she was working on a casual basis as a relief teacher.

Mrs Marshall had suffered from feelings of anxiety and depression since 2000.

Mrs Marshall was a patient of Kinetic Health, a medical practice in Karratha, from 7 July 2009 until her last visit on 15 February 2011.



As a patient of the practice she regularly consulted with Dr Mark Lawry who gave evidence at the inquest.

Her final visit with Dr Lawry was on 15 February 2011. The issues raised during this consultation were very similar to issues which had been raised on a number of occasions previously. She continued to have issues with self confidence, anxiety and concentration. She was unclear as to how to conduct her life in the future and stated that she did not particularly enjoy her job, but was unable to think of an alternative job which she would find more satisfying.

On the day before her final visit to Dr Lawry, 14 February 2011, Mrs Marshall self presented to the Pilbara Mental Health and Drug Services (PMHDS). She complained of mild anxiety and wanted to know what the service offered. She described her mood as 2/10 and reported reduced memory and concentration but good energy and motivation. She advised that she was seeing a counsellor, but only had two sessions remaining.

On 15 February 2011 her case was discussed at the PMHDS clinical intake meeting and it was decided that no further action was required.

On 18 February 2011 Mrs Marshall's close friend, Leanne Barrett, contacted Mr Marshall to inform him that



his wife could not put a sentence together and had been behaving strangely, wanting an exorcism.

Ms Barrett had contacted the Mental Health Advice Line in Perth and had been advised that Mrs Marshall should be taken to hospital.

Mr Marshall took his wife to PMHDS where she was assessed by a locum Clinical Nurse Specialist, Nurse Pugh. Ms Pugh made comprehensive notes of the visit in the hospital's Integrated Progress Notes and she recorded that while Mrs Marshall was denying auditory hallucinations and self harm, she had claimed to have seen a "cleft foot" and the devil. Nurse Pugh assessed her as having poor insight into her current situation.

Nurse Pugh discussed the situation with psychiatrist Dr David Cutts by telephone.

Dr Cutts, who was not in Karratha, was not formally rostered on but took telephone questions as part of an informal agreement to provide advice for local clinicians if it was necessary.

Dr Cutts suggested that a full physical check-up be conducted, due to a history of rapid onset of symptoms, and suggested a prescription of Valium (he possibly used the generic word "diazepam"). He did not order an anti-



psychotic so that any psychotic phenomena would not be masked. Arrangements were made for Mrs Marshall to be seen by the visiting psychiatrist on 28 February 2011. It appears that this was the earliest occasion on which a psychiatrist would be available to see Mrs Marshall at the hospital.

Nurse Pugh attempted to contact the medical staff at the hospital to see Mrs Marshall but was advised that they were busy. Mr Marshall stated that he wished to take his wife away for the night to Point Samson where he believed she would be more settled.

Mr Marshall took his wife to Point Samson camping that night.

Nurse Pugh phoned Mr Marshall at around 1.15pm to check on Mrs Marshall. Mr Marshall described his wife as appearing a lot better after some sleep but stated that he would still be taking his wife to the Emergency Department on the next day.

On the next morning, Saturday 19 February 2011, Mrs Marshall again started acting strangely. She pulled a tube out of the ground and called it "Excalibur". She waved the tube around and pretended to play fight with it. She then started tap dancing with it.



Mrs Marshall was also reciting the Lord's Prayer, which was out of character for her.

She told Mr Marshall that she had been up through the night.

Mr Marshall took Mrs Marshall directly to the hospital and arrived there at about 9am. The doctor was not on duty until 10am so they waited at the hospital.

Mrs Marshall was seen by Dr Kruger who wrote an entry timed at 10.10 in the Emergency Department Progress Notes.

He noted that Mrs Marshall had "an aggressive outburst this morning towards rocks" but did not record any information relating to incident described by Mr Marshall relating to her calling the tube "Excalibur" etc.

Dr Kruger noted that the advice of Dr Cutts was to start Mrs Marshall on Valium 2.5mg in the morning and 5mg at night. She was given the prescription and allowed to go home.

That night Mrs Marshall had a tablet and went to bed early at about 8pm.



On the next day Mrs Marshall told her husband of a number of suicide attempts which included:

- She said that she had tried to electrocute herself at the caravan site;
- she said that she had previously bogged the car and had been looking for a hose to gas herself; and
- she said that when she was at the beach at Point Samson she had intended knocking herself out in the water with the tubing, but had been knocked over by a wave which had interrupted her.

Mr Marshall took Mrs Marshall back to the Nickol Bay Hospital at about 3pm that afternoon. Mrs Marshall was reviewed by Dr Kruger again at the Emergency Department.

Dr Kruger noted that this was the third presentation of Mrs Marshall since the previous Friday. He also noted that she had expressed suicidal thoughts to her husband and claimed to have made three attempts, but expressed the view that he did not believe these were serious attempts.

Dr Kruger recorded that one of the described attempts related to cutting her wrists but noted that there were no scars or any other evidence of any such attempt.

Dr Kruger did not conduct a physical examination as suggested by Dr Cutts. He stated that she was being treated by the Mental Health Team (PMHDS) and he was only seeing her by chance. He said that he was not even



sure what would be required for a physical examination in such a setting, although he understood that the purpose of such an examination would be to exclude treatable general medical conditions which might be masquerading as psychiatric illness.

He stated that he would have expected that any such examination would be conducted by the Mental Health Team on the following Monday.

In evidence Dr Kruger stated that the Emergency Department was not an ideal environment for such medical examinations to take place or to follow through with any detected abnormalities.

Nursing notes contained in the Integrated Progress Notes for 20 February 2011 timed at 5.50pm and 8.55pm record Mrs Marshall having contracted with a nurse not to self-harm and stating that she felt safe at the hospital.

At 5am on 21 February 2011 a nursing note recorded that Mrs Marshall came to the desk asking trivial questions.

The next nursing note recorded that at 6.20am Mrs Marshall was not in her room and had not been located in the hospital.



The CCTV was viewed and it was noted that Mrs Marshall had left the hospital through the back staff entrance at about 6.19am.

Mr Marshall was contacted and he began looking for her.

In evidence Mr Marshall expressed surprise that his wife had gone missing. He stated that he had been concerned that she was suicidal and did not understand that she was not an involuntary patient at the hospital. He said that he trusted the hospital to look after his wife.

THE SEARCH FOR MRS MARSHALL

At about 8.30am on 21 February 2011 Mr Marshall called police and reported Mrs Marshall missing. A police “look-out to be kept for” broadcast was made in the Karratha area. It was noted that Mrs Marshall had not taken her wallet or other personal items with her from the hospital.

Police patrols were conducted in the area, including the Karratha townsite, the local tip, the Shell truck stop on the North West Coastal Highway, the back beach area and throughout the light industrial area.



At 12pm the Karratha area went into blue alert for Cyclone Carlos. Searches continued, but their extent was limited after the Karratha area went on yellow alert at 3pm.

The Karratha district went on red alert at 2.51am on 22 February at which time searches stopped.

On 23 February 2011 searching continued. Police initiated a medical release asking the public for information and a media broadcast was conducted on local radio at 11am. Following the broadcast a telephone call was received from a member of the public who said that he had seen Mrs Marshall's vehicle on Millstream Road, about 47 kilometres south of the Karratha townsite. He advised that he had seen the vehicle on Monday 21 February 2011 at about 11.30am parked on the side of the road. There was no-one in or around the vehicle at that time.

Police attended the scene and located the vehicle. The vehicle was parked facing away from Karratha on the left hand side of the road on the gravel shoulder.

The vehicle had overheated and was not capable of being driven. It appeared to have sustained some minor damage.

Inside the vehicle police located an empty blister pack of the deceased's Valium medication (Valpam 5mg).



This was possibly significant, particularly as Mr Marshall believed that there were two such blister packs missing from his home when he checked following the disappearance of Mrs Marshall.

The area surrounding the location of the vehicle was the Millstream-Chichester National Park. This park is dominated by the Fortescue River which had flooded in the weeks prior to the disappearance, cutting off vehicular tracks.

Eight police officers and five State Emergency Services staff were deployed to commence a land search. Mr Marshall had hired an aircraft to assist with the search and that aircraft was landed at the site where the vehicle was located. Three aerial observers from the SES were placed onboard the aircraft and an aerial search was conducted along the Millstream Road.

The vehicle was subsequently examined and it was found that the lower left side of the radiator was dislodged, caused by an impact to the lower radiator support. The engine was severely overheated and the cooling system was found almost devoid of coolant. It appeared clear that the vehicle had broken down and could not be driven.



Information from Telstra relating to Mrs Marshall's mobile telephone indicated that activity on the telephone had been located at the Dixon cell tower. That cell tower is located north of Roebourne, to the east of Karratha.

Previous activity for the mobile telephone was recorded at the Nickol Karratha tower, at Karratha.

In respect of this information, it is possible that the activity detected at the Dixon tower resulted from Mrs Marshall's mobile telephone accessing automatic downloads through internet roaming and its being at a location relatively close to the location where the vehicle was found. Unfortunately the mobile telephone information did not assist with location of Mrs Marshall or her mobile telephone.

Ongoing searches were conducted until 28 February 2011.

Some additional searches were conducted following information relating to the mobile telephone being received on 5 March 2011. Following that advice a 90 minute helicopter search was conducted by a Heliwest helicopter and pilot.



ADDITIONAL ENQUIRIES

Police conducted investigations with Medicare, Centrelink, the Department of Immigration and Citizenship and the Department of Births, Deaths and Marriages. There was no indication that Mrs Marshall was alive after 21 February 2011.

Enquiries were made with local taxi companies, the Greyhound and Integrity bus services, Australian Hotels Association and interstate police. No information was provided which would indicate that Mrs Marshall was alive after 21 February 2011.

Mrs Marshall's disappearance received media coverage and was included on the National Missing Persons Co-Ordination Centre website. Her father also participated in a radio interview broadcast on the ABC. Mrs Marshall has not contacted any family members or friends and no reliable sightings of her have been reported since her disappearance.

Mrs Marshall's bank accounts have not been accessed since her disappearance.

Investigation of her accounts did, however, reveal that on 18 February 2011, three days prior to her disappearance, Mrs Marshall had transferred \$20,000 and



\$5,000 from one of her accounts to her Lite Transaction Account with the detail “for Kathryn”. Kathryn is Mrs Marshall’s sister. Whether or not this was significant in the context of the disappearance cannot now be determined.

CONCLUSION IN RESPECT OF THE SUSPECTED DEATH

Based on the above information in my view the death of Mrs Marshall has been established beyond reasonable doubt.

Mrs Marshall has not contacted family members or friends since 21 February 2011 and although extensive enquiries have been conducted, none of these have revealed any activity by her since that time.

I am satisfied that Mrs Marshall died on or about 21 February 2011.

As her body has not been located it is not now possible to determine where she died.

CONCLUSION IN RELATION TO HOW THE DEATH OCCURRED AND THE CAUSE OF THE DEATH

Mrs Marshall left the Nickol Bay Hospital on the early morning of 21 February 2011, leaving her wallet with bank cards and cash as well as other personal items at the hospital.



Shortly after she left the hospital her husband and Ms Barrett gave the District Medical Officer, Dr Tavener, a detailed history of her bizarre behaviour and expressed their fear that she might self-harm or suicide. A decision was made at that time that if found she would be an involuntary patient and would be subject to psychiatric review.

It was clearly accepted then that it was likely she was suffering from a severe mental illness.

Based on all of the information available it appears that at the time she left the hospital Mrs Marshall was suffering from signs of a psychotic illness. She had been behaving in a bizarre manner, expressing religious ideation and had suffered strange visual phenomena on a background of poor sleep, agitation and restlessness. Her condition had appeared to be worsening and included thoughts of self-harm and suicide.

Although Mrs Marshall had been seen on a number of occasions at the Nickol Bay Hospital she had never been prescribed any antipsychotic medication. This is because it was considered important to ensure that psychotic phenomena were not masked in order to enable a definitive diagnosis to be made as to her condition. She was prescribed valium which clearly did not reduce the onset of her psychotic symptoms.



While it is not now possible to make any positive diagnosis or to determine why it was that Mrs Marshall's condition was deteriorating as described, it is obvious that she was displaying signs of psychotic illness, however these were being produced and her illness was not being effectively treated.

At the time when Mrs Marshall left the hospital and drove away from Karratha in her vehicle I am satisfied that she was continuing to show signs of a psychotic illness. In other words, I consider it likely that she was behaving in a bizarre manner.

It is now unclear why it was that Mrs Marshall appears to have driven her vehicle down to the Millstream-Chichester National Park from Karratha or how it was that her vehicle appears to have been damaged.

It is also unclear as to why Mrs Marshall and her vehicle became separated and whether or not this was intentional on the part of Mrs Marshall.

If Mrs Marshall voluntarily left her vehicle at the side of the road and walked into the park, it is difficult to understand why it was she was not located and, assuming that she died shortly afterwards, why her body was not found.



The fact that cyclone Carlos struck Karratha shortly after Mrs Marshall went missing had an unfortunate effect on the search for her in that it limited the extent of the search shortly after she went missing and may have removed traces of Mrs Marshall's movements.

While Mrs Marshall had definitely expressed suicidal thoughts in the period shortly before she went missing, it is not now possible to determine whether she intentionally acted to take her own life or whether, affected by mental illness, she lost her way and died as a result of dehydration or exposure. Other possible explanations for her being missing present themselves, but in the absence of any evidence these would be pure speculation and no conclusions can be drawn.

In the above circumstances I make an open finding as to how the death arose.

A N HOPE
STATE CORONER
14 February 2013

