Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 02 /18

I, Sarah Helen Linton, Coroner, having investigated the death of ***Aileen Helen QUARTERMAINE*** *with an inquest held at the* ***Kalgoorlie Courthouse*** *on* ***16 January 2018*** *and at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***17 January 2018*** *find that the identity of the person was* ***Aileen Helen QUARTERMAINE*** *and that death occurred on or about* ***26 July 2014*** *at* ***Unit 1, 19E Hare Street, Mullingar*** *as a result of* ***the effects of fire in a woman with alcohol effect*** *in the following circumstances:*

Counsel Appearing:

Ms S Teoh assisting the Coroner.
Ms A Barter with Ms E Langoulant (ALS) appearing on behalf of the deceased's family and, in particular, Mr Harry Collard.
Mr B Humphris appearing on behalf of the Commissioner of Police.
Mr B Nelson (State Solicitor's Office) appearing on behalf of WA Country Health Service.

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INTRODUCTION

1. Aileen Helen Quartermaine lived in Kalgoorlie. Her body was found on 26 July 2014 after a fire at her home in Hare Street in Mullingar, a suburb of Kalgoorlie. It is believed she died as a result of the effects of that fire either that same day or sometime during the evening before.

2. Ms Quartermaine had a long history of mental illness and had been diagnosed with chronic paranoid schizophrenia. At the time of her death she was being managed as a voluntary patient by Kalgoorlie Community Mental Health Service, although she had been an involuntary patient in the past. Ms Quartermaine had been a regular inpatient at Kalgoorlie Regional Hospital in the past when her mental health issues became acute.

3. The day prior to her death Ms Quartermaine's son had been concerned about her mental state and had tried to arrange for Ms Quartermaine to go to hospital but he was unsuccessful. In the process of trying to arrange for Ms Quartermaine to be taken to hospital Ms Quartermaine's son had contact with local police officers and staff at Kalgoorlie Regional Hospital. The circumstances of Ms Quartermaine's death the following day raised concerns about whether these agencies should have done more to ensure Ms Quartermaine was properly assessed after being contacted by her son.

4. The death of Ms Quartermaine was a reportable death under the *Coroners Act 1996* (WA). On 23 December 2015 the State Coroner decided that it was desirable that an inquest be held in relation to the death of Ms Quartermaine to ascertain the circumstances attending the manner of her death. I held an inquest, which was conducted at the Kalgoorlie Courthouse on 16 January 2018 and at the Perth Coroner's Court on 17 January 2018.

5. The documentary evidence included a comprehensive report of the investigation into the death by the Western Australia Police and Ms Quartermaine's extensive medical history.[1]

6. The inquest focused primarily on the events that occurred the day preceding the discovery of her death, and the involvement of the various agencies at that time, as well as what circumstances could be ascertained about when and how Ms Quartermaine died.

BACKGROUND

7. Ms Quartermaine was born in Wagin, Western Australian on 30 January 1954.

8. Ms Quartermaine had been in more than one long term relationship and had a number of children. Her relationships had been troubled so later in life she preferred to remain single although there was evidence before me that she did have an intermittent partner at the time of her death, who was not generally a positive influence, but he had moved out because he was

[1] Exhibits 1 and 2.

concerned about her behaviour.[2] Ms Quartermaine remained close to her children and their partners and her grandchildren. In particular, she had regular contact with her youngest son, Harry Collard.

9. Ms Quartermaine was first diagnosed with a mental illness in 1986 and had suffered frequent relapses, which were often precipitated by alcohol use and social issues. She had been managed in the past by various mental health services, including Graylands Hospital, Narrogin Community Mental Health and Inner City Mental Health.[3]

10. Ms Quartermaine became a client of the Kalgoorlie Community Mental Health Service (KCMH) in 2006 with a diagnosis of schizophrenia/schizoaffective disorder. Ms Quartermaine also suffered from several other medical issues, including hypercholesterolaemia, Type 2 diabetes, seizures, alcohol abuse and hypertension. Her medications included various oral medications for her cholesterol and hypertension as well as a monthly depot of paliperidone (an antipsychotic).

11. Ms Quartermaine's medical care was managed by KCMH together with periods of treatment in Kalgoorlie Regional Hospital. From August 2006 to November 2013 she had nine admissions to Kalgoorlie Hospital due to mental health disturbance.

12. Of significance, on one occasion in April 2008 Ms Quartermaine was taken to hospital by police after she had threatened to burn her house down. She was found to have suffered a relapse of manic symptoms of her schizoaffective disorder due to poor compliance with her medication. Similarly, in October 2013 Ms Quartermaine was taken to hospital by police after she suffered a relapse of her paranoid schizophrenia and allegedly tried to set her house alight. These two hospital admissions are relevant to my consideration of the circumstances of Ms Quartermaine's death.

13. Ms Quartermaine's last admission in 2013 was on 10 November 2013. Ms Quartermaine had relapsed after being non-compliant with medication and following an alcohol binge. She was admitted to A Ward as an involuntary patient and responded well to oral medication. She changed to voluntary status quickly and was discharged home on 14 November 2013.[4]

14. At the time of her death Ms Quartermaine lived alone in a Homeswest unit in Kalgoorlie. The severity of her mental illness made her unable to find and maintain employment. She was on a Disability Support Pension and her finances were managed by the Public Trustee. Late in November 2013 Ms Quartermaine was having tenancy issues due to antisocial dealings with her neighbours and was facing eviction from her Homeswest unit. Court proceedings had been commenced. Ms Quartermaine had been homeless in the past and helping her maintain her accommodation was a priority for those involved in her ongoing mental health care. Ms Quartermaine was being assisted in the court proceedings by the Community Legal Centre.[5]

[2] Exhibit 1, Tab 14, p. 5; Exhibit 2, Tab 2, RPH Outpatient Case Notes 02 to 03.2005.
[3] Exhibit 2, Tab 2.
[4] Exhibit 2, Tab 1, Inpatient Discharge Summary 19.11.2013.
[5] Exhibit 1, Tab 22; Exhibit 2, Tab 2.

15. In February 2014 a client management plan was prepared for Ms Quartermaine by KCMH staff. The plan was for Ms Quartermaine to attend every 28 days for her depot injection and to advocate for her regarding her tenancy issues.[6]

LAST HOSPITAL ADMISSION

16. On 7 March 2014 Ms Quartermaine did not attend the KCMH Clinic for her depot injection. Ms Quartermaine was brought into Kalgoorlie Hospital by police four days later, on 11 March 2014, after she was found in her neighbours' house wearing their clothing, eating their food and taking their belongings. She had become aggressive when challenged. At the hospital Ms Quartermaine presented as dishevelled, thought disordered and with moderate paranoid ideation evident. She seemed to think her neighbours had been stealing her possessions. Ms Quartermaine agreed to a voluntary admission. As Ms Quartermaine was likely overdue for her depot medication she was given a dose of paliperidone upon admission to the ward.[7]

17. During the hospital admission a referral was completed by hospital staff to the Goldfields Aged Care Assessment Team (ACAT) as Ms Quartermaine was noted to have been non-compliant with her medications while in the community (other than her monthly depot medication) and was neglecting her diet. It was felt that she needed community support to maintain her health, especially for her physical needs, and a general assessment for possible home care was sought.[8] It was hoped that more support would reduce the frequency of further relapses.[9] Contact was made with SilverChain to assist with medication prompts.[10]

18. Ms Quartermaine's court case in relation to her Homeswest tenancy was adjourned during this time due to her hospital admission.[11]

19. On 8 April 2014 Ms Quartermaine remained labile with grossly disorganised thoughts.

20. On 10 April 2014, while still a hospital inpatient, Ms Quartermaine suffered a seizure. A Code Blue was called but Ms Quartermaine's seizure spontaneously resolved. A subsequent CT scan of her brain was reported to be normal and the seizure was felt to be drug related.[12] A review of her history established that she had experienced past seizure activity. She was commenced on a new medication for her seizures.[13]

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[6] T 7 – 8 – 17.1.2018.
[7] Exhibit 1, Tab 21; Exhibit 2, Tab 2, Mental State Examination 11.3.2014.
[8] Exhibit 2, Tab 2.
[9] Exhibit 2, Tab 1, Letter to court 20.3.2014.
[10] Exhibit 2, Tab 1 and Tab 2.
[11] Exhibit 2, Tab 1.
[12] Exhibit 2, Tab 2, Diagnostic Imaging Report 10.4.2014.
[13] Exhibit 2, Tab 2, Integrated Progress Notes.

21. While in hospital Ms Quartermaine's dose of her antipsychotic medication paliperidone was increased to control her psychotic symptoms and her other medications were altered slightly.[14]

22. By 14 April 2014 Ms Quartermaine showed no evidence of thought disorder and was considered well enough for discharge. She was aware that she needed to be more compliant with her medication regime to prevent further seizures.[15]

23. The following day (15 April 2014) Ms Quartermaine still presented as well and was keen to be discharged. She was assisted to obtain her medications prior to discharge. Ms Quartermaine was discharged home later that day with follow up arranged with KCMH.[16]

24. Her discharge oral medications, in addition to her monthly depot (that had been increased to control her psychotic symptoms), were:

- Thiamine 200 mg daily (a vitamin B supplement);
- Atorvastatin 40mg daily (for cholesterol);
- Aspirin 100 mg daily (as a preventative);
- Perindopril 10mg in the morning (for blood pressure); and
- Carbamazepine 200 mg (for seizures and potentially as a mood stabiliser).[17]

MENTAL HEALTH CARE FROM 16 APRIL 2014

25. Ms Quartermaine's KCHM case manager at the time was Sandra Campbell, a very experienced Registered Mental Health Nurse employed by KCMH. Ms Campbell had known Ms Quartermaine for many years through various services prior to becoming her KCMH case manager in late 2013 and was very familiar with her medical history.[18] At the relevant time Ms Campbell's position was Clinical Nurse Specialist for the elderly.[19] Ms Campbell had taken on Ms Quartermaine's management as Ms Quartermaine had requested a non-indigenous case worker.[20]

26. Ms Campbell described Ms Quartermaine as an interesting person who was quite difficult to engage but Ms Campbell believed she had developed a good relationship with her.[21] Ms Campbell agreed that Ms Quartermaine had periods of rapid decline in her mental health, which were precipitated by many things, including non-compliance with her medication, but also drug and alcohol use and social stressors.[22]

[14] Exhibit 1, Tab 21.
[15] Exhibit 2.
[16] Exhibit 2, Tab 1, Inpatient Discharge Summary 17.4.2014 and Tab 2, Integrated Progress Notes.
[17] T 16 – 17.1.2018; Exhibit 1, Tab 21.
[18] Exhibit 1, Tab 22.
[19] T 3 – 17.1.2018.
[20] Exhibit 1, Tab 22 [14].
[21] T 3 - 17.1.2018.
[22] T 3 - 17.1.2018.

27. A KCMH note entered on 16 April 2014 by Ms Campbell records that Ms Quartermaine was discharged from hospital the previous day, Ms Quartermaine had her Webster-paks of oral medications and SilverChain were in place for medication prompts. A phone call was made to Ms Quartermaine that day. She indicated all was well and she would let SilverChain visit daily.[23] No new client management plan was prepared by Ms Campbell for Ms Quartermaine after her discharge, despite the changes to her medication regime.[24] No new plan was actually due to be done until August 2014 although Ms Campbell agreed a new plan could have been done in the circumstances, but did not appear to consider the changes to be significant.[25] At the time Ms Campbell did not have any significant concerns about Ms Quartermaine and did not consider that her risk of suicide had changed.[26] Ms Campbell's opinion was that Ms Quartermaine was doing very well at this stage. Her tenancy issues had been resolved by this time.[27]

28. A home visit was conducted by Ms Campbell on 23 April 2014 to drop off more Webster-paks but Ms Quartermaine was not at home. Ms Campbell had a phone conversation with SilverChain staff, who indicated they were having difficulty with providing medication prompts to Ms Quartermaine as Ms Quartermaine was often not in or not answering the door. Ms Campbell made a note to attempt another home visit the following day.[28]

29. Ms Campbell did attempt a home visit the following day and Ms Quartermaine was again not at home. She left a typed noted for Ms Quartermaine telling her to collect her Webster-paks from A Ward at the hospital and made a note in her records that she would 'await contact'.[29]

30. The next entry is on 28 April 2014, at which time Ms Quartermaine had self-presented to the KCMH Clinic and participated in a review with Ms Campbell and a psychiatrist, Dr O'Daly. Ms Quartermaine was very settled and denied any social issues. The plan was to encourage her adherence to her medication regime. Ms Quartermaine was given two Webster-paks, encouraged to take her medication regularly and reminded to be ready for her depot on 8 May 2014.[30]

31. On 2 May 2014 Ms Campbell spoke to SilverChain staff who advised that Ms Quartermaine had told SilverChain that she did not want the medication service, which was why she was not answering the door, so the service was withdrawn. The KCMH was going to try to help monitor her compliance in its stead.[31] It appears Ms Quartermaine continued to take her medications, presented for her monthly depot injection and generally seemed well throughout May 2014.

[23] Exhibit 2, Tab 2, Integrated Progress Notes 16.4.2014.
[24] T 8 – 9 – 17.1.2018.
[25] T 8 - 9 – 17.1.2018.
[26] T 11. – 17.1.2018
[27] T 12 – 17.1.2018.
[28] Exhibit 2, Tab 2, Integrated Progress Notes 23.4.2014.
[29] Exhibit 1, Tab 22; Exhibit 2, Tab 2, Integrated Progress Notes 24.4.2014.
[30] Exhibit 2, Tab 2, Integrated Progress Notes 28.4.2014.
[31] Exhibit 1, Tab 22; Exhibit 2, Tab 2, Integrated Progress Notes 2.5.2014.

32. According to KCMH medical records, Ms Quartermaine was given her monthly depot medication on 6 June 2014 and she was reported to be taking her oral medications regularly at that time.[32]

33. On 11 June 2014 a home visit was performed by Ms Campbell. Ms Quartermaine was not at home so a note was left for Ms Quartermaine to collect her medication Webster-pak[33] Ms Quartermaine picked up the Webster-pak on 16 June 2014. Ms Campbell queried how compliant she was being with taking her oral medications at this stage.[34] Ms Campbell explained that patients are often on depot medication because they are unreliable with oral medication and Ms Quartermaine had been off all oral medication for a number of years but then they had been recently restarted, for her physical conditions, and the plan was to trial it for 6 to 12 months to see if they could get her onto a regular medication regime. The problem was that, at this stage, Ms Quartermaine appeared to be taking the medications too sporadically, which may have impacted on her physical health issues.[35]

34. Ms Quartermaine picked up her Webster-pak two days late again on 25 June 2014.[36]

35. Ms Campbell went on annual leave in July 2014. According to the notes, on 7 July 2014 Ms Quartermaine was given her next monthly dose of depot medication during a home visit by a registered nurse, Nurse Frank, who was assisting with some of Ms Campbell's case load while Ms Campbell was on leave. On this occasion Ms Quartermaine reportedly appeared pleasant but was distracted and worried about her son who was in prison. A phone call was organised for 10.30 am the following day to enable Ms Quartermaine to speak to her son.[37]

36. When Nurse Frank attended Ms Quartermaine's home the following day Ms Quartermaine was reported to present quite differently from the previous day. She was agitated and paranoid and would not let the nurse into her home. She also would not accept the call from her son. An odd smell was noted to be emanating from the home, which the nurse felt may be due to the psychoactive substance Kronic (a synthetic cannabinoid). The son's phone call was rebooked for the following day (9 July 2014) and the documented plan was to attempt another home visit on that day to reassess the situation.[38]

37. There is no entry in the Integrated Progress Notes to confirm that this visit took place on 9 July 2014. The only record of the visit is in the PSOLIS system, which is a health information system specifically for mental health patients. It allows documentation of findings of community mental health issues, such as home visits as well as outpatient clinic visits.[39] The PSOLIS service event entry simply recorded that Nurse Frank and Denise Ellis, an

[32] Exhibit 2, Tab 2, Integrated Progress Notes 6.6.2014.
[33] Exhibit 1, Tab 22; Exhibit 2, Tab 2, Integrated Progress Notes 11.6.2014.
[34] Exhibit 2, Tab 2, Integrated Progress Notes 16.6.2014.
[35] T 15 – 17.1.2018.
[36] Exhibit 2, Tab 1, Integrated Progress Notes 25.6.2014.
[37] Exhibit 2, Tab 1, Integrated Progress Notes 7.7.2014.
[38] Exhibit 2, Tab 1, Integrated Progress Notes 8.7.2014.
[39] T 73 – 16.1.2018.

Aboriginal Mental Health Worker employed by KCMH, attended Ms Quartermaine's house for a home visit and "Aboriginal Cultural Input" occurred.[40] Nurse Frank did not provide any additional report about what occurred at this visit to his supervisors.

38. Neither Nurse Frank, nor Ms Ellis, were still working for KCMH at the time of the inquest and there was no information available from them as to how Ms Quartermaine presented. Nurse Frank had been asked to provide a written handover of all his case matters before he left the service, but unfortunately he left early due to ill health and did not complete this task.

39. It was suggested by Ms Campbell at the inquest that the reference to "Aboriginal Cultural input" was simply a reference to the presence of the Aboriginal health worker, Ms Ellis, as that was the usual code used in those circumstances.[41] Ms Campbell indicated she would have expected there to be an entry in relation to the visit in the integrated progress notes, in addition to the PSOLIS entry, that should have been done by either Nurse Frank or Ms Ellis.[42]

40. However, Nurse Frank did provide a verbal handover to Ms Campbell when she returned from leave. According to Ms Campbell on 21 July 2014 she spoke with Nurse Frank about Ms Quartermaine and he advised that there were no concerns for Ms Quartermaine's mental state, her depot was up to date and she had picked up her Webster-paks. Nurse Frank did refer to the possibility that Ms Quartermaine had been smoking on 8 July 2014 but he advised he had visited again on 9 July 2014 with Denise Ellis and there were no further concerns.[43]

41. Ms Campbell was not concerned about what she was told as she indicated that it is not unusual for people who use drugs "to present as very well one day and like this the next day and then very well the next day."[44] Ms Campbell had met Nurse Frank and was aware that he had been working in nursing for many years so she was confident if he had been very concerned at the time he would have dealt with the issue and arranged for her to be assessed and if he had any ongoing concerns he would have passed them on to her during the handover.[45]

42. The next entry in the KCMH case notes is dated 23 July 2014. No home visit had occurred since 9 July 2014. Ms Campbell's evidence was that such a gap was not unusual as some patients can easily go 'depot to depot' (28 days) without a review in between provided they are travelling well and coping in the community.[46]

43. On 23 July 2014 Ms Campbell documented that she had been on annual leave and that Ms Quartermaine had apparently been given two Webster-paks since 7 Jul 2014. This meant she was up to date with her Webster-

[40] Exhibit 1, Tab 27.
[41] T 31.
[42] T 32.
[43] T 17 – 18 – 17.1.2018; Exhibit 1, Tab 22 [61] – [62].
[44] T 18 – 17.1.2018.
[45] T 18 - 19. – 17.1.2018.
[46] T 20 – 17.1.2018.

paks[47] but she was due for another Webster-pak. The plan was for Ms Quartermaine to start collecting her Webster-paks herself as the Bega Aboriginal Health Service would only provide the medications for free if Ms Quartermaine got regular medical checks. Ms Campbell was concerned that Bega would not continue the service, given Ms Quartermaine's non-compliance, so she was considering the need to take Ms Quartermaine to a GP for a review for consideration of whether she should cease her oral medications entirely as sporadic taking of the medications could do more harm than good.[48] The plan had not progressed further at the time of Ms Quartermaine's death a few days later.

REQUEST FOR POLICE TO ATTEND

44. Ms Quartermaine stayed with her son, Harry Collard, overnight on 24 July 2014. On the morning of 25 July 2014 Ms Quartermaine argued with her son and she left his home that morning.[49]

45. Ms Quartermaine was seen at 10.00 am that same day at the local IGA supermarket. Ms Quartermaine was a regular customer at the store and was known to behave disruptively in the store at times. On this occasion she was described by witnesses as agitated and shaking. Ms Quartermaine was also abusive to staff and she was eventually evicted from the store.[50] She saw her son, Mr Collard, outside the store and then she left in a taxi and returned home in the company of Mr Collard's dog.[51]

46. Later that afternoon Ms Quartermaine's son, Mr Collard, went to the deceased's home to check on her. He found Ms Quartermaine was acting strangely, couldn't talk properly and was shaking. Her demeanour had changed significantly from when he had seen her earlier in the day. Mr Collard told his mother that he thought she was sick and needed help but she denied that she was unwell. Knowing his mother's history Mr Collard felt that she needed review by a doctor.[52] Mr Collard attempted to convince Ms Quartermaine that she should go to hospital but he was unsuccessful.[53] He then decided that he would have to seek help to arrange for Ms Quartermaine to be taken to the 'A ward' at the hospital for assessment.[54]

47. Mr Collard was under the impression that an ambulance would not attend the house without police in attendance, so at about 4.30 pm he asked a neighbour to contact police on his behalf. The neighbour had seen Ms Quartermaine earlier that day at the IGA but had not seen her at her house that day. When Mr Collard approached the neighbour he appeared agitated, but the neighbour had seen Mr Collard appear agitated before so did not note his behaviour as anything unusual. Mr Collard told the neighbour he

[47] T 33.
[48] T 21, 29 – 17.1.2018; Exhibit 2, Tab 2, Integrated Progress Notes 23.7.2014.
[49] Exhibit 1, Tab 6.
[50] Exhibit 1, Tab 6 and Tab 9.
[51] Exhibit 1, Tab 15, pp. 31 – 32.
[52] Exhibit 1, Tab 6 and Tab 15, p. 32..
[53] Exhibit 1, Tab 6.
[54] Exhibit 1, Tab 14, p. 44.

wanted to call the police for his mother but did not say why the police were required, so the neighbour decided not to call the police.[55]

48. At around 5.30 pm Mr Collard approached a different neighbour, who was out the front of their unit watering the garden. The neighbour recalled that Mr Collard said, "Excuse me can I get you to call the police, I am not very well." She noticed at the time that he did not look well, as he was a little pale and flushed as if he had the 'flu'. He then said, "She's not well either," and used his head to motion towards Ms Quartermaine's unit. The neighbour asked Mr Collard why he didn't get an ambulance and he replied that he had to go through the police and they will call the ambulance.[56]

49. The neighbour did not know Mr Collard's name, but as she went inside to make the telephone call she heard him call out, "The name's Quartermaine and I am from flat one."[57]

50. The neighbour telephoned police and told them that, "The boy from down the road has asked me to call police as he isn't well and someone else isn't well and he needed police to call an ambulance."[58] After making the call the neighbour went back outside but Mr Collard had gone.[59]

51. Another neighbour who lived in the unit complex saw Mr Collard, who he knew, as Mr Collard left the neighbour's house. He overheard Mr Collard saying to himself, "Mum's in a bad way" and "I'm the only one here for Mum" as well as other statements in relation to concerns about his mother. The neighbour didn't want to engage with Mr Collard so he went inside his unit.[60]

52. Mr Collard recalled that he sat on a letter box facing the street and waited for the police to come. They initially drove past him, which he found frustrating, but then they turned around and pulled up to speak to him.[61]

POLICE ATTENDANCE

53. Senior Constable Kevin Guy has been a police officer since 2003, and joined the WA Police in 2008. He had been stationed at Kalgoorlie Police Station since April 2014, only a few months prior to this incident. Senior Constable Guy had not had any involvement with Ms Quartermaine or Mr Collard prior to Friday, 24 July 2014.[62]

54. Constable Mace was a probationary constable, having started with the WA Police in 2012. She had been stationed in Kalgoorlie since the end of January 2014, approximately five months prior to this incident. Similarly to

[55] Exhibit 1, Tab 9.
[56] Exhibit 1, Tab 10 [5] - [10].
[57] Exhibit 1, Tab 10 [11] – [12].
[58] Exhibit 1, Tab 10 [19].
[59] Exhibit 1, Tab 10.
[60] Exhibit 1, Tab 11.
[61] Exhibit 1, Tab 15, p. 36.
[62] T 25 – 16.1.2018.

Senior Constable Guy, Constable Mace had not had any dealing with Mr Collard or Ms Quartermaine prior to this day.[63]

55. Senior Constable Guy and Constable Mace began the afternoon shift at 3.00 pm on 24 July 2014 and were allocated front line tasking duties, which effectively meant that they were to respond to any jobs that were sent to them. They were allocated a fully marked police vehicle for that purpose, with Senior Constable Guy taking on the driving duties and Constable Mace travelling as the passenger, which meant that she generally operated the vehicle's computer. Senior Constable Guy acknowledged he was the more senior officer of the pair, so he expected he would "take the front foot on all the jobs,"[64] although he was not her supervisor. There was evidence it was a busy Friday night, so they were moving from "job to job to job"[65] and the nature of most of the jobs was pressing.[66]

56. Shortly before 5.43 pm Senior Constable Guy and Constable Mace received notification over the radio from the Kalgoorlie Operations Centre of a job to attend in Hare Street. They were already at another job at this time. Senior Constable Guy recalled that they were instructed to attend at Hare Street in regards to a male who was asking for police assistance, but the caller was unable to specify exactly what sort of attendance was required and what the police were needed to do. In effect, the two police officers were asked to attend to investigate and find out more about what was required.[67] Their evidence was that they were not told over the radio that there was someone extremely sick who required assistance.[68]

57. The CAD job, created at 5.43 pm, did record that the caller had reported they had been asked to call the police as a male person reported someone was "extremely sick" and it was believed the male came from Unit 1, 19E Hare Street (which we now know was Ms Quartermaine's address).[69] However, although a CAD job was created, Senior Constable Guy and Constable Mace did not read the CAD job prior attending Hare Street. Senior Constable Guy's evidence was that it was his usual practice to read the CAD job before attending a job, but that TADIS does not always work due to problems with the cellular network in Kalgoorlie, so it is not always possible. In this case, he recalled that TADIS wasn't operating at the time they received the radio call so the CAD job was not available on the system until after they had reached Hare Street.[70]

58. When they reached Hare Street they initially struggled to establish the address that they were to attend.[71] However, as they drove down Hare Street they were flagged down by a male. The police assumed immediately that he was the person who was the subject of the call to police, which the person

[63] T 54 – 16.1.2018.
[64] T 26 – 16.1.2018.
[65] T 49 – 16.1.2018.
[66] T 49, 55 – 16.1.2018.
[67] T 26 – 27 – 16.1.2018.
[68] T 27, 55 – 16.1.2018.
[69] T 28 – 16.1.2018; Exhibit 1, Tab 8.2.
[70] T 27, 29 – 16.1.2018.
[71] T 55 – 16.1.2018.

confirmed.[72] The evidence establishes this person was Mr Collard, although the attending police were not aware of his identity at that time and they did not ask for his name.[73] Senior Constable Guy's explanation for not asking his name was because Mr Collard was being quite loud and aggressive and if he had been asked and then refused to provide his details, it might have led to a situation where they had to arrest him for an offence under the *Criminal Investigation (Identifying People) Act 2002* (WA).[74] Senior Constable Guy conceded that in hindsight, he could have simply asked for his name without necessarily leading down that path, but at the time he was felt that it would have been an escalation of matters.[75] Constable Mace did not ask his name as Senior Constable Guy was taking the lead in questioning at that stage and she saw no reason to intervene.[76]

59. Senior Constable Guy spoke to Mr Collard to try to ascertain the reason why he wanted their attendance. Senior Constable Guy said they "got little information from him"[77] as Mr Collard was hard to understand.[78] He was described as increasingly agitated and swearing in response to questioning. Both officers recalled Mr Collard saying that he wanted a lift to the hospital, but when asked why, he did not provide any medical reason as to why it was necessary and they could not see any reason why Mr Collard needed medical help.[79] It also did not appear to either officer that Mr Collard required a mental health assessment.[80] At the time, Senior Constable Guy formed the impression that Mr Collard was intoxicated and described him as "just a drunk aggressive man."[81] He had no concerns for his welfare.[82] Constable Mace was not sure if Mr Collard was intoxicated at the time, although she agreed that he was verbally aggressive towards police.[83]

60. Mr Collard denied being intoxicated at the time he spoke to the police officers,[84] but he did acknowledge that he became frustrated when speaking to Senior Constable Guy and became aggressive as a result, although he did his best to remain polite.[85]

61. There was at least some information before the police officers, even at the time, that Mr Collard might have been seeking help for another person. Senior Constable Guy conceded in his oral evidence that Mr Collard made a reference to his mum, but he initially denied that Mr Collard went on to say that his mother needed medical help or a mental health assessment.[86] However, it was put to Senior Constable Guy that when he was interviewed by Inspector Wilde, shortly after the incident, he had acknowledged that Mr Collard had mentioned that "his mother was to get a mental health

[72] T 6 – 16.1.2018.
[73] T 31 – 16.1.2018.
[74] T 31 – 32 – 16.1.2018.
[75] T 32 – 16.1.2018.
[76] T 57 – 16.1.2018.
[77] T 30 – 16.1.2018.
[78] T 7 – 16.1.2018.
[79] T 30 – 31, 57 – 16.1.2018.
[80] T 31 – 16.1.2018.
[81] Exhibit 1, Tab 16, p. 8.
[82] T 41 - 42 – 16.1.2018; Exhibit 1, Tab 16, p. 10.
[83] T 56 – 16.1.2018; Exhibit 1, Tab 15, p. 8.
[84] Exhibit 1, Tab 14, p. 41.
[85] Exhibit 1, Tab 14, p 37, 41.
[86] T 31 - 32 – 16.1.2018.

assessment."[87] Senior Constable Guy accepted that this was correct and that his recollection at the time of the interview was to be preferred.[88] Constable Mace also said in her interview that Mr Collard "just started going on about wanting a lift or wanting a lift for someone to the hospital"[89] and she agreed in her oral evidence that she remembered he mentioned someone else, although she did not recall a specific reference by Mr Collard to his mother.[90]

62. Senior Constable Guy's evidence was that they were standing on the footpath next to the road when they spoke to Mr Collard and they did not approach Ms Quartermaine's house and he did not see a woman at the house.[91] However, he was aware that they had been told to attend the address at Unit 1, 19E Hare Street, and in his police interview Senior Constable Guy accepted that he should have attended the address.[92]

63. Unlike Senior Constable Guy, Constable Mace did recall seeing a person, probably a female as she later heard a woman's voice,[93] at the door to a house nearby. She later realised this was the address related to the call although she did not know this at the time. At the time Constable Mace thought it sounded like the woman was directing her comments to Mr Collard.[94] Constable Mace heard the woman's voice say that "she wanted to stay at home"[95] and telling Mr Collard to move along.[96] It also seemed like the woman didn't want Mr Collard in her house.[97]

64. Constable Mace also appeared to accept that it was possible Mr Collard had been implying that the woman should go to hospital.[98] Constable Mace said in her interview, conducted the day after their attendance in Hare Street, that it appeared that Mr Collard was saying that the woman in the house needed to go to hospital but she didn't want to go.[99]

65. Despite the possible involvement of this woman, and the reference by Mr Collard to another person needed to go to hospital, it did not occur to Constable Mace at the time to speak to the woman calling out. In her interview Constable Mace said that she didn't feel there was any reason to do so as the woman was speaking as a normal person and she was indicating she just wanted to be left alone by Mr Collard, which did not raise any issues for the police.[100]

66. Constable Mace accepted that in hindsight it would have assisted the police to find out more information about what the person was saying.[101] Constable

[87] Exhibit 1, Tab 16, pp. 4-5, 9.
[88] T 37 – 16.1.2018.
[89] Exhibit 1, Tab 16, p. 4.
[90] T 56 – 16.1.2018.
[91] T 33, 46 – 16.1.2018.
[92] Exhibit 1, Tab 16, p. 10.
[93] Exhibit 1, Tab 15, pp. 8 - 9.
[94] Exhibit 1, Tab 15, p. 9.
[95] T 9 – 16.1.2018.
[96] T 56 – 16.1.2018.
[97] Exhibit 1, Tab 15, p. 9.
[98] Exhibit 1, Tab 15, p. 9.
[99] Exhibit 1, Tab 15, p. 10.
[100] Exhibit 1, Tab 15, p. 9.
[101] T 58 – 16.1.2018.

Mace gave evidence that since that time she has gained experience and developed as a police officer and she would be more thorough if a similar situation presented itself now.[102]

67. Senior Constable Guy indicated that if he had been aware of Mr Collard's name and the warnings entered in association with him in the police system, it might not have changed what he did, but if he had obtained more information about Mr Collard's mother, Ms Quartermaine, that may have altered events. Senior Constable Guy accepted that he should have asked Mr Collard for his mother's name[103] and he gave evidence at the inquest that, following these events, he is now very conscious of taking everybody's details.[104] If he had obtained some information about Ms Quartermaine and ascertained that she was at the house, then that would have prompted him to make follow up inquiries with Ms Quartermaine and find out her version of events.[105]

68. Senior Constable Guy's conversation was ended by Mr Collard walking away in an agitated manner after effectively being told that the police were not a taxi service.[106] Senior Constable Guy did not feel at that time that any further investigation was warranted as he had formed the impression that Mr Collard simply wanted a lift to hospital for an unknown reason and was not in any physical or mental distress.[107]

69. Senior Constable Guy gave evidence he was concerned that the situation was deteriorating, so he decided that it would be better if the police left as that would defuse the situation.[108] Senior Constable Guy described Mr Collard as acting in a disorderly manner in a public place, that may have prompted the necessity to arrest him, but given his behaviour was directed only to Senior Constable Guy and his partner, he felt it best if the police simply removed themselves from the situation rather than arrest Mr Collard. He had explained to Mr Collard that the police were not a taxi service and their job was to deal with criminal matters. Senior Constable Guy had also told Mr Collard that he had the option of either calling a taxi, or alternatively they could request an ambulance if he felt it was medically necessary, an offer he declined.[109] Senior Constable Guy believed this was sufficient, based upon what he knew. Accordingly, he did not follow Mr Collard.[110]

70. Mr Collard agreed that he walked off in an agitated state. He was concerned that he might assault Senior Constable Guy so he walked away to try to calm down.[111] He acknowledged the police officers had suggested he call an ambulance but he declined at that stage and told them not to bother calling an ambulance for him. He said he refused the offer as he was angry at that

[102] T 61 – 16.1.2018.
[103] T 37 – 16.1.2018; Exhibit 1, Tab 16, p. 9.
[104] T 34 – 35 – 16.1.2018.
[105] T 38 – 39 – 16.1.2018.
[106] T 4 – 16.1.2018.
[107] Exhibit 1, Tab 16, p. 10.
[108] T 34 – 16.1.2018.
[109] T 43 – 44, 59 – 16.1.2018; Exhibit 1, Tab 16, pp. 5, 10.
[110] T 50 – 16.1.2018.
[111] Exhibit 1, Tab 14, p. 37.

stage that the police officers would not transport his mother themselves, as many police had done in the past.[112]

71. Senior Constable Guy was asked whether he tried to identify, and speak to, the neighbour who had made the call to police, but he indicated that was not his usual practice as people often wanted confidentiality when calling police and he also didn't think the neighbour was likely to be able to provide any additional information.[113] Constable Mace, on the other hand, was under the impression that Mr Collard was the actual caller.[114]

72. After Mr Collard walked away the two police officers returned to their vehicle. At that time the CAD job was available. It included the information that someone had been reported to be "extremely sick." Senior Constable Guy was asked whether this information had caused him to wonder whether he had all the relevant information, but he indicated that at the time he assumed the person that had been reported as sick was Mr Collard, and from speaking to Mr Collard Senior Constable Guy had not formed the impression that there was anything physically or mentally wrong with Mr Collard.[115] In regard to the latter, Senior Constable Guy indicated he had asked Mr Collard, "Are you a danger to yourself?"[116] and his question had been met by "a barrage of expletives."[117]

73. The open CAD job for this incident was closed after Constable Mace made an entry. The entry indicated that they had attended and spoken to the caller, who advised that he wanted police to give him a lift. The entry then read, "Caller was advised that police are not a taxi service and he was given the contact number for a taxi service or advised to try SJA if he would like."[118] Constable Mace's evidence was that she would have discussed her entry with Senior Constable Guy first, as being a probationer it was her practice to discuss the matter with her senior officers when writing off a job, as part of her training.[119] Senior Constable Guy agreed that the entry would have been made under his direction.[120]

74. Constable Mace estimated that their entire attendance at Hare Street lasted for approximately 15 minutes (longer than the CAD job records would suggest, as the job came in on the computer after they were there).[121]

KCMH & KALGOORLIE HOSPITAL NOTIFICATION

75. The event of Ms Quartermaine's death prompted a Sentinel Event Investigation into the circumstances surrounding her death. The

[112] Exhibit 1, Tab 14, pp. 45 – 46.
[113] T 34 – 16.1.2018; Exhibit 1, Tab 16, p. 9.
[114] T 57 – 16.1.2018.
[115] T 35 - 36 – 16.1.2018.
[116] T 35 – 16.1.2018.
[117] T 35 – 16.1.2018.
[118] T 29 – 16.1.2018; Exhibit 1, Tab 8.2.
[119] T 59 – 16.1.2018.
[120] T 30 – 16.1.2018.
[121] T 63 – 16.1.2018.

investigation found evidence that, separate to the calls for police attendance, Mr Collard also made attempts to contact Kalgoorlie Hospital by telephone for assistance with his mother.[122]

76. The first call occurred during business hours on 25 July 2014, although the specific time was uncertain. It was noted as an anonymous call to the Mental Health Inpatient Unit and recorded a claim that Ms Quartermaine was "going off."[123] The caller terminated the call before further detailed information could be obtained. The call was then communicated to the Mental Health Business Support Officer, who in turn tried to contact the case manager for Ms Quartermaine, Ms Campbell. They were unsuccessful at the time but receptionist staff later communicated the information about the call to Ms Campbell.[124]

77. Ms Campbell's recollection was that at some point during the day on 25 July 2014 she was told by one of the Clinic reception staff that someone from the Mental Health Inpatient Unit had telephoned and informed them that someone had called and said that "Aileen was going off somewhere."[125] Records suggest this information was passed on at about 2.00 pm.[126] Ms Campbell did not speak to anyone about this at the time but later in the day she discussed the call with Sidney Carruth, the Co-ordinator of the Aboriginal Mental Health Team and Ms Quartermaine's former case manager. It was a 'hallway discussion' and Ms Campbell recalls that they agreed that the information was "too inadequate to act on."[127] Ms Campbell assumed the call related to Ms Quartermaine as she was the only Aileen she knew. Ms Campbell did not think the call had been made by Ms Quartermaine's son as in her experience he usually attended the KCMH office when he had concerns about Ms Quartermaine. If she had known more details, Ms Campbell indicated that she could have returned the call and advised that the police be notified or contacted the police herself, but she did not know enough to make such calls. As well as not being sure who had made the call, and whether it definitely related to Ms Quartermaine, Ms Campbell was also uncertain from the information conveyed whether Ms Quartermaine was exhibiting mental health issues or simply antisocial behaviour, possibly alcohol or drug related.[128]

78. Ms Campbell did not make a record of what she was told about the call or her conversation with Mr Carruth, but she was able to rely on her memory.[129] Mr Carruth could not recall the conversation when interviewed about it in early February 2015.[130]

79. The second telephone call was identified as being made by Mr Collard, and was received at the Inpatient Mental Health Unit at 5.30 pm on 25 July 2014. Mr Collard spoke with an experienced Mental Health Nurse and

[122] Exhibit 1, Tab 19.1.
[123] Exhibit 1, Tab 19.1.
[124] Exhibit 1, Tab 19.1.
[125] Exhibit 1, Tab 22 [64].
[126] Exhibit 1, Tab 19.1A, p. 14.
[127] Exhibit 1, Tab 22 [67].
[128] T 25 - 26.
[129] T 23.
[130] Exhibit 1, Tab 22, Interview Transcript and Tab 24.

expressed his concerns that his mother was "acting up." Mr Collard was advised to call the police. He stated that he had already done so and that they were not helpful. Mr Collard was then advised to call an ambulance and that the ambulance would contact police if their support was needed. At this stage Mr Collard reportedly became abusive and hung up the telephone.[131]

DISCOVERY OF MS QUARTERMAINE'S BODY ON 26 JULY 2014

80. At about 9.30 pm on the evening of 25 July 2014 one of Ms Quartermaine's neighbours, who had spoken to Mr Collard that afternoon, went outside and looked at Ms Quartermaine's unit to check that everything was 'ok'. The back light was on and the unit appeared quiet so the neighbour went back inside before retiring to bed about an hour later.[132]

81. At about 2.00 am on Saturday, 26 July 2014, Ms Quartermaine's neighbour woke up. She went to the living room and looked through the blinds at Ms Quartermaine's home, again to check whether there was anything of concern. The back light was now off but the unit appeared otherwise the same. The neighbour then went back to bed.[133]

82. The following morning, at about 9.30 am the neighbour was out the front of their unit watering the garden when another neighbour in the complex approached her and mentioned that there was a broken window at Ms Quartermaine's unit and the curtains were gone. After talking for about 5 minutes they were joined by another neighbour who asked if anything had happened the previous night as she had heard the smoke alarm at Ms Quartermaine's unit.[134]

83. All three neighbours then walked down towards Ms Quartermaine's unit and confirmed that Ms Quartermaine's smoke alarm was still activated. They were concerned as they were aware that Ms Quartermaine had been involved in setting fire to her unit in the past. The neighbours tried to look inside the unit through the broken window. It was too dark to see much but it did appear that the room was badly burnt. They tried unsuccessfully to enter the unit through the backyard before deciding that they should ring emergency services for assistance.[135]

84. At 10.38 am on Saturday, 26 July 2014, one of Ms Quartermaine's neighbours contacted police to report the sound of the fire alarm emanating from the deceased's unit. Kalgoorlie Police notified the Department of Fire and Emergency Services (DFES), who arrived at the unit shortly afterwards.[136]

[131] Exhibit 1, Tab 19.1.
[132] Exhibit 1, Tab 9.
[133] Exhibit 1, Tab 9.
[134] Exhibit 1, Tab 9.
[135] Exhibit 1, Tab 9 and Tab 11 and Tab 12.
[136] Exhibit 1, Tab 6 and Tab 13.

85. On arrival, DFES staff found the premises to be secure and there was visible evidence of fire damage. A fire fighter entered the home through the broken bedroom window. No active fire was located but significant fire damage was visible in the master bedroom and significant smoke damage was observed throughout the rest of the premises.[137]

86. The fire fighter went to the front door to try to open it to allow his colleagues access but found the door was locked and blocked by a couch that was pushed against the door, preventing it from opening. It was very dark inside the house, making it difficult for the fire fighter to see. He pushed the couch out of the way and opened the main door but access was still blocked by the locked screen door, which he could not open. Eventually another firefighter forced the screen door open and once they were inside there was sufficient light for the fire fighters to discover that there was a deceased female seated in the couch that had been blocking the front door. This person was later identified as Ms Quartermaine. Kalgoorlie Police were immediately notified of the death and they attended and secured the scene.[138]

ARSON SQUAD INVESTIGATION

87. Two detectives from the WA Police Arson Squad attended the scene on the evening of 26 July 2014. Detective Senior Constable Ian Zuidema prepared a report in relation to the Arson Squad investigation and gave evidence at the inquest.[139]

88. On examining the scene police noted that Ms Quartermaine's chin was resting on her chest and she appeared to be holding two cigarette lighters and some cigarette papers in her hands. Heavy smoke staining was observed on parts of Ms Quartermaine's skin, including her hands, face and a portion of her stomach, and inside her nasal passage was visible soot accumulation. There were no obvious signs of injury. Further examination of Ms Quartermaine revealed she had in her possession three cigarette lighters, the two in her hands and another inside her bra.[140]

89. The location of Ms Quartermaine on the couch positioned behind the front door gave the impression that she had barricaded herself in, rather than an impression that she had been trying to escape the main bedroom fire through the front door. Although it could not be absolutely determined, it also appeared that she had chosen to sit in the chair while the fire was lit and burning.[141]

90. All the internal walls of the unit showed smoke staining to various degrees but there was no direct flame impingement observed in any rooms except the main bedroom. This included the chair on which Ms Quartermaine was found, and indeed, Ms Quartermaine herself. It was notable that one of the

[137] Exhibit 1, Tab 6 and Tab 13.
[138] Exhibit 1, Tab 6.
[139] Exhibit 1, Tab 7.
[140] Exhibit 1, Tab 7, p. 4 - 5.
[141] T 15 – 16.1.2018.

gas burners on the gas stove in the kitchen was found to be in the 'on' position although there was no pot or pan on the stove about the burner.[142]

91. Unlike the rest of the unit, the main bedroom showed clear effects of direct flame impingement, focused primarily on the mattress on the main bed, bedside table and drawer cabinet. A small metal ashtray was located under the mattress, which was observed to have contained remains of cigarette butts and ash. The position of the ashtray was below the point where the mattress showed the most damage.[143]

92. The exact time that the fire occurred could not be determined, but from other known events it must have occurred within a time window from approximately 6.00 pm on 25 July 2014 to 10.30 am on 26 July 2014. The evidence supported the conclusion it occurred earlier in that time period, in the late evening or early hours of the morning.[144]

93. At the conclusion of the examination of the unit Detective Senior Constable Zuidema determined the fire had ignited in the main bedroom, either on or in the immediate vicinity of the mattress. The cause of the fire was classified as 'undetermined' as there were two likely causes. The first cause was considered the most likely cause of the fire, and that was the introduction of a mobile heat source (such as cigarettes or the contents of the ashtray) to combustible materials in the immediate vicinity of the mattress in the main bedroom by the deceased. That is, that the deceased lit the fire. However, the possibility that the fire was accidentally ignited by an unattended cigarette could not be eliminated.[145]

94. Detective Senior Constable Zuidema was asked whether the fact that Ms Quartermaine was found with the cigarette lighters and papers in her hand lent more weight to either of the possibilities and he indicated that this evidence lends more weight to Ms Quartermaine having deliberately started the fire.[146]

CAUSE OF DEATH

95. On 30 July 2014 Dr A.V. Spark, a Forensic Pathologist, performed a post-mortem examination on the body of Ms Quartermaine. Dr Spark noted there was soot staining on the face, hands, soles of the feet, in the upper and lower airways and on the lining of the stomach.[147]

96. Microscopic examination of the tissues showed probable heat effect of the lining of the airways, with carbon deposition in the upper and lower airways. The presence of carbon within the upper and lower airways is a strong indication that products of the fire were inhaled; it is possible that other

[142] Exhibit 1, Tab 7.
[143] Exhibit 1, Tab 7.
[144] T 15 – 16.1.2018.
[145] T 13 – 14 – 16.1.2018; Exhibit 1, Tab 7, p. 7.
[146] T 14 – 15 – 16.1.2018.
[147] Exhibit 1, Tab 3.

irrespirable gases such as carbon dioxide and other toxic products, not detectable in post mortem toxicology screens, were also inhaled.[148]

97. Neuropathology examination reported a brain showing no significant abnormalities.[149]

98. Toxicology analysis reported the presence of carbon monoxide within the blood at approximately 30% saturation. Carbon monoxide is generally considered to be fatal at levels of approximately 40-50%. A high level of alcohol was also detected within the blood at 0.124%. The therapeutic drug carbamazepine, which was prescribed to the deceased, was also detected within the blood.[150]

99. Dr Spark indicated that the deceased's death may have resulted from inhaling other toxic products in addition to carbon monoxide. It is also possible that the level of alcohol may have caused respiratory depression and, in combination with the fire, was responsible for the death.[151]

100. In conclusion, Dr Spark expressed the opinion that the cause of death was best stated as effects of fire in a woman with alcohol effect. I accept and adopt the conclusion of Dr Spark as to the cause of death.[152]

MANNER OF DEATH

101. Detective Sergeant Christopher Page from the Kalgoorlie Detectives Office prepared the WA Police coronial investigation report into the death of Ms Quartermaine and he gave evidence at the inquest. Detective Sergeant Page concluded there were no suspicious circumstances in this case and based upon his investigation and analysis of the circumstances leading up to the fire, he believed it was probable that Ms Quartermaine deliberately started the fire in an attempt to take her life.[153]

102. Detective Senior Constable Zuidema from the Arson Squad gave his opinion that it was most likely that Ms Quartermaine lit the fire, but did not express an opinion as to her intention at that time.

103. I note that Ms Quartermaine had a known history of psychosis and had lit a fire in her unit in the recent past, which had led to her detention under the *Mental Health Act*. No charges were laid by police in relation to the incident in October 2013 due to her diminished mental state and the minimal damage that occurred.

104. Ms Quartermaine's mental health was known to deteriorate when she had been drinking alcohol, and the post mortem findings indicate that she was intoxicated at the time of her death. Ms Quartermaine's son had also been

[148] Exhibit 1, Tab 3.
[149] Exhibit 1, Tab 3 and Tab 4.
[150] Exhibit 1, Tab 3 and Tab 5.
[151] Exhibit 1, Tab 3.
[152] Exhibit 1, Tab 3.
[153] T 9 – 16.1.2018; Exhibit 1, Tab 6, p. 7.

sufficiently concerned about her deteriorating mental health on 25 July 2014 to try to get her taken to hospital for assessment.

105. On the basis of all the evidence before me I am satisfied that Ms Quartermaine deliberately lit the fire on or about 26 July 2014, but I am unable to reach the conclusion that she had an intention to take her life when she did so due to the evidence of her probable diminished mental capacity to understand the nature and consequences of her actions at the time.

106. In the circumstances, I make an open finding as to the manner of death.

INTERNAL INVESTIGATION INTO POLICE CONDUCT

107. The circumstances of Ms Quartermaine's death prompted an internal investigation by the WA Police Internal Affairs Unit into the conduct of the two police officers who spoke to Mr Collard on 25 July 2014 prior to Ms Quartermaine's death. Sergeant Roy Begg conducted the internal affairs investigation and prepared a report that was before the court. Sergeant Begg also gave oral evidence at the inquest.

108. Sergeant Begg indicated that the two police officers who had attended the address the previous evening, Senior Constable Guy and Constable Mace, were interviewed by Inspector Wilde from the Goldfields Esperance District Office. An interview was also conducted with Ms Quartermaine's son, Mr Collard, to assist in establishing what occurred and to allow him to express his concerns about what occurred, so they could be considered as part of the investigation. Copies of the transcripts of those interviews were provided to the court.[154]

109. It is apparent from the interview conducted with Mr Collard that he had found it frustrating that Senior Constable Guy would not take his mother to hospital, as his past experience was that when he rang Kalgoorlie Police they would always come and take his mother to hospital. He formed the impression that Constable Mace was willing to assist him, but was perhaps constrained in doing so by the stance taken by Senior Constable Guy. Mr Collard told the interviewing police he didn't blame the police for what occurred, but he was very disappointed that they had not helped him with his mother when he asked for help. Mr Collard genuinely believed that the police prejudged him when speaking to him on the day, and this detrimentally affected their communication with him, which does appear to have been the case to a certain degree. Mr Collard acknowledged that in hindsight he should have perhaps called for an ambulance when his other attempts to get help were not met with an appropriate response, but by that stage he was becoming increasingly upset and frustrated and was effectively unable to think straight.[155]

[154] Exhibit 1, Tab 8.
[155] Exhibit 1, Tab 14, p. 19 20.

110. Sergeant Begg noted in his report that there were a number of warnings recorded in the police system against the name of Ms Quartermaine. The purpose of the warnings is to alert police officers that may be dealing with an individual that there may be information they need to know for safety reasons and to inform their decision-making. It requires a police officer to put the person's name in the police computer system to access that information. This can be done in a police vehicle via the TADIS in-car computer system.[156] In relation to Ms Quartermaine, the warnings indicated that Ms Quartermaine suffered from depression and had a medical condition.[157] There were similar warnings in the system in relation to Mr Collard.[158]

111. However, none of the alerts were identified as the attending police did not take the name of Mr Collard, nor appreciate the involvement of Ms Quartermaine in the events, so they did not access that information. Senior Constable Begg expressed the view that he would have expected an attending police officer to have accessed the computer system and 'run up the names' in that situation.[159] He also expected the attending officers to have spoken or checked on Ms Quartermaine and to consider a mental health assessment for her, which in the circumstances of this case would have involved conveying her to Kalgoorlie Hospital for medical assessment.[160]

112. Sergeant Begg accepted that the two police officers may have initially been advised of the job by telephone, rather than on the CAD system, which provides more information, but also agreed that there is an expectation that officers will refer to the CAD text to assist them in their inquiry and should view that information before closing a job.[161]

113. The investigation found that Senior Constable Guy and Constable Mace "provided a poor response to the incident."[162] It was concluded that had the officers chosen to speak to Ms Quartermaine, they may well have deemed her in need of mental assessment, which could have prevented her taking the course of action that led to her death. Sergeant Begg acknowledged that the officers' actions did not cause Ms Quartermaine's death, but felt that "their failure to respond adequately to her son's cry for help may have contributed to her demise."[163]

114. Managerial notices for unprofessional conduct were issued to both officers.[164] The managerial notice given to the two involved police officers set out the conclusions of the investigation in relation to the failure to conduct appropriate basic inquiries and it was concluded that both officers' conduct

[156] T 17 – 16.1.2018.
[157] T 18 – 16.1.2018; Exhibit 1 Tab 8, p. 3.
[158] T 19 – 16.1.2018.
[159] T 20 – 16.1.2018.
[160] T 20 – 16.1.2018.
[161] T 24 – 16.1.2018.
[162] T 21 – 16.1.2018.
[163] T 22 – 16.1.2018.
[164] Exhibit 1, Tab 8.

had fallen below the standards of good conduct and discipline expected of a member of the WA Police.[165]

115. A managerial notice sits fourth in the hierarchy of outcomes of such an investigation, so it is considered to be a relatively severe sanction within the service. It was described by Sergeant Begg as "a form notice given to a subject police officer which demonstrates the seriousness of the unprofessional conduct he or she has engaged in and the consequences for that officer which may follow should any form of unprofessional reoccur."[166]

116. The consequence, in this case, was to put both Senior Constable Guy and Constable Mace on notice that any further deviance from expected standards will be detrimentally viewed.[167]

INTERNAL INVESTIGATION INTO KCMH

117. A Sentinel Event Investigation into the circumstances of Ms Quartermaine's death identified that Nurse Frank had been employed on a short term contract for a three month period. During the course of his contract Nurse Frank became ill and this affected his work performance. He finished his contract earlier than anticipated due to his ill health. While still employed Mr John Gregory, the Team Leader for Community Mental Health in Kalgoorlie spoke to RN Frank about concerns regarding his patient care and he requested a written handover from Nurse Frank before he finished his contract, but the written handover was not provided.[168] There was only the verbal handover to Ms Campbell.

118. Mr Gregory was interviewed after Ms Quartermaine's death and advised that Nurse Frank had not escalated any concerns about Ms Quartermaine to him as the Team Leader while he was working for the community mental health team.[169]

119. The investigation noted the two telephone calls that were received from Mr Collard on 24 July 2014 were in general dealt with according to the appropriate procedure, with the first referred to Ms Quartermaine's case manager and the second providing advice to Mr Collard to call an ambulance.

120. A difficulty with the first telephone call was that not enough information was obtained for Ms Campbell to make a proper assessment of the situation. Ms Campbell explained that she had limited options to obtain more information as she could not call Ms Quartermaine, as Ms Quartermaine did not have a telephone,[170] and Ms Campbell would not have gone out to visit Ms Quartermaine as she would have been concerned for her safety.[171] Ms

[165] Exhibit 3.
[166] T 21, 23 – 16.1.2018.
[167] Exhibit 3.
[168] Exhibit 1, Tab 26.
[169] Exhibit 1, Tab 26.
[170] T 23 – 17.1.2018.
[171] T 24– 17.1.2018.

Campbell's options were also limited by her heavy caseload at the time.[172] Her main option would have been to call the police to conduct a welfare check, with an acknowledgement that in the country the mental health staff rely heavily on the police given the limited other resources available. However, based upon what was known, Ms Campbell did not feel there was enough information to justify involving the police.[173]

121. The options available to the staff taking the second call were limited as the call was taken after-hours and the after-hours staff do not have anyone available to conduct welfare checks. Suggesting an ambulance be called was really the only option available.

122. Some of the recommendations of the Sentinel Event Investigation were:

- To develop and implement a communication process for Mental Health Inpatient Service staff to escalate concerns about community based clients of the Community Mental Health Service; and
- All at risk patients who are known to decompensate quickly are to have a Crisis Management Plan developed and discussed with key stakeholders including the relatives.

123. In relation to the first recommendation, Dr Billinghurst, the Director of Medical Services for WACHS – Goldfields, advised that since the death of Ms Quartermaine there are now better processes for taking calls, with an effort by staff to collect as much patient details as possible, and record the information on a specific form. This information is then communicated through to the next available mental health team meeting to assist in making decisions whether to fast track an outpatient appointment or arrange a site visit.[174]

124. The second recommendation was linked to a general concern expressed by Dr Neil Cock, a Consultant Psychiatrist who reviewed this case, that perhaps those dealing with Ms Quartermaine did not fully appreciate the risk Ms Quartermaine presented to herself when acutely unwell and potentially intoxicated.[175] Dr Roland Main, the WACHS Area Director, Clinical Services – Adult/Older Mental Health, agreed with Dr Cock's comments in this regard. Dr Main noted that it is unusual not to have a crisis plan in place for a patient like Ms Quartermaine.[176] Dr Billinghurst noted that the crisis plans are often geared towards the emergency department presentations, and Ms Campbell also expressed a view that they are more helpful for patients who are more itinerant.

125. Dr Billinghurst gave evidence at the inquest that all of the recommendations made in the Sentinel Event Investigation Report have been entered and signed off.[177]

[172] T 24 - 25– 17.1.2018.
[173] T 23, 25– 17.1.2018.
[174] Exhibit 1, Tab 19.1 and Tab 26, p. 4.
[175] Exhibit 1, Tab 19.1B.
[176] Exhibit 1, Tab 26, p. 7.
[177] T 82.

OTHER ISSUES ARISING FROM THE EVIDENCE

126. Under s 25(2) of the *Coroners Act 1996*, where a death is investigated by a coroner, a coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

127. As is apparent from the discussion above, the internal investigation into the police conduct found failings in relation to the response of both attending police officers that have been addressed by way of internal disciplinary proceedings. Both police officers acknowledged in their evidence that they have reflected upon their conduct since this time, and have made changes to the way they go about their duties. I agree with the findings generally of the internal investigation. The failure of the police officers to make further enquiries with Mr Collard or Ms Quartermaine was a missed opportunity to help them to obtain appropriate medical treatment for Ms Quartermaine, which might have saved her life.

128. As to the role of the KCMH and the Hospital staff, I am satisfied that the internal investigation has identified failings in communication between staff, that have now been addressed with new procedures to strengthen handover procedures and ensure that any concerns about mental health patients are considered by appropriately qualified staff.

129. There were also two other issues raised in relation to the police computer system, which might have provided relevant information about Mr Collard and Ms Quartermaine that could have assisted the police to assess the situation, as well as mental health training for regional WA Police staff.

130. When Senior Constable Guy and Constable Mace were questioned about why they did not access TADIS before they spoke to Mr Collard, both police officers referred to problems with the reliability of TADIS in the country and noted that it can also "freeze on quite a regular basis."[178]

131. Following the inquest, information was provided to the court by the WA Police in relation to how TADIS operates in regional areas. I was informed that TARDIS is reliant on a Telstra signal, that can be intermittent due to weather, distance or reception and there can also be congestion or fault conditions that can interfere with the signal. The service in regional WA is totally reliance on the service provider, so there is little that the WA Police can do to resolve these issues.[179]

132. In addition to problems with the signal, the WA Police advised that TADIS may also "freeze,"[180] as described by Senior Constable Guy and Constable Mace, because TADIS is a complex platform relying on many servers and databases to deliver its functionality. I am advised that there is a multi-

[178] T 55.
[179] Email correspondence Mr Humphris to Counsel Assisting dated 9 February 2018; Ex 1, Tab 29.
[180] T 55.

disciplinary team within the WA Police that is currently looking at ways to improve the TADIS performance in this regard.

133. Another issue raised was whether police officers based in regional areas might benefit from mental health training. Information was provided by the WA Police that police recruits are given approximately ten hours of mental health training during their 26 week recruit course. In addition, WA Police Academy offers a two day Mental Health First Aid course to sworn police officers and unsworn police staff, and to date over 16% of WA Police employees have undergone this training. There is also a three day training course for police officers who are part of the Mental Health Co-Response project within WAPol, but there are no plans at this time to extend that to regional Western Australia.[181]

134. The Mental Health First Aid course is probably the best option for frontline police officers, such as Senior Constable Guy and Constable Mace, to equip them with more skills to deal with members of the public who have mental health issues. It is not apparent from the information provided whether it is proposed that this course be rolled out to the other 84% of WAPOL employees, including those based in regional areas. If it is not, then I encourage the WA Police to endeavour to do so, as it is apparent from the evidence in this inquest that in regional areas the local mental health staff rely heavily upon the police to assist them, given the limited resources available. In those circumstances, it is important that the local police officers have as much mental health training as possible to equip them to perform that role.

CONCLUSION

135. Ms Quartermaine had a long history of schizophrenia/schizoaffective disorder with frequent relapses. She was under the care of a community mental health service at the time of her death and was on regular antipsychotic medication. She was last seen by her mental health team during a home visit on 9 July 2014.

136. On the day prior to her death Ms Quartermaine was showing signs of a deterioration in her mental health, that were recognised by her son, Harry Collard. Mr Collard took appropriate steps to alert both the police and Ms Quartermaine's KCMH team to her deteriorating mental state, but sadly his calls for help were not successful in obtaining the help that he sought. Some of this was due to Mr Collard becoming increasingly frustrated with what he felt was the obstructive attitude of the police and hospital staff. The communication failures meant that the opportunity to get medical treatment for Ms Quartermaine was missed.

137. I am satisfied that the WA Police and the WACHS have responded appropriately to the death of Ms Quartermaine, and investigated thoroughly the roles the agencies played on the day prior to her death. Both agencies have instituted actions in response to address individual staff failings and

[181] Exhibit 1, Tab 27.

considered changes to systems and procedures. In the circumstances, I do not make any recommendations.

138. However, I do make the observation that this sad case should be a reminder to police officers and hospital staff, particularly in regional areas, that all efforts should be made to communicate effectively with people seeking their help, without prejudgment, so that they fully understand the situation and what assistance is being sought.

S H Linton
Coroner
22 March 2018