Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 41/17

I, Barry Paul King, Coroner, having investigated the death of ***Moses Sokiri*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***7 November 2017****, find that the identity of the deceased person was* ***Moses Sokiri*** *and that death occurred on* ***26 October 2014*** *at* ***Sir Charles Gairdner Hospital*** *from* ***bronchopneumonia and hypoxic brain injury following ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Mr J T Bishop assisted the Coroner
Mr J Rivalland appeared for the Western Australia Police
Ms S J Keighery (State Solicitors Office) appeared for the East Metropolitan Health Service and the Public Transport Authority

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INTRODUCTION

1. Moses Sokiri (the deceased) died on 26 October 2014 at Sir Charles Gairdner Hospital (SCGH) from complications of ligature compression of the neck after he hanged himself at the Greenwood train station in the early morning on 12 October 2014.

2. An hour or so before hanging himself, the deceased had been in the custody of Public Transport Authority (PTA) security guards (transit officers) and had been questioned by police officers.

3. Minutes before hanging himself, the deceased had called '000' from a public phone at the train station. The call-taker at the Police Operations Centre told him that she would arrange for police officers to attend to see him, but she did not do so.

2. The deceased's death was a 'reportable death' under section 3 of the *Coroners Act 1996* (the Act) because it 'appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury'.

3. Under section 19 of the Act, I had the jurisdiction to investigate the deceased's death because it appeared to me that the death was, or may have been, a reportable death.

8. I held an inquest into the deceased's death on 7 November 2017 at the Perth Coroner's Court.

9. The focus of the inquest was on the response by the transit officers and the attending police officers to threats of self-harm made by the deceased.

10. The documentary evidence adduced at the inquest comprised:

a. a brief of evidence comprising three volumes,[1] including a report prepared on 8 April 2016 by Senior Constable F Thorp of the Coronial Investigation Unit of the Western Australia Police (WAPOL);[2]

b. a statement dated 7 November 2017 by Joanne Pearson, a learning and development officer at the PTA;[3] and

c. a bundle of documents relating to a trial rollout of a program known as the mental health co-response.[4]

11. Oral evidence was provided by:

a. Mark Pomponio, a PTA transit officer;[5]

b. Griffin Lumbers, a police constable at the time of the deceased's death;[6]

c. Paul Sprigg, a PTA shift commander for transit officers;[7]

d. Ms Pearson;[8]

e. Superintendent Noreen O'Rourke of WAPOL Communications Division;[9] and

f. Inspector Stuart Mearns of WAPOL in the mental health division of Custodial Services.[10]

12. I have found that the cause of death was bronchopneumonia and hypoxic brain injury following ligature compression of the neck (hanging).

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[1] Exhibit 1
[2] Exhibit 1, Volume 1, Tab 7
[3] Exhibit 2
[4] Exhibit 3
[5] ts 4-16 per Hutchinson, S
[6] ts 16-25 per Capell, M
[7] ts 26-33 per Shurman, K G
[8] ts 59-64 per Pearson, J M
[9] ts 64-75 per O'Rourke, N
[10] ts 75-93 per Mearns, S

13. I have found that the actions of the transit guards and the police officers who attended Greenwood train station were reasonable and appropriate.

14. I have found that the failure by the call-taker to arrange for police officers to attend the Greenwood train station to see the deceased was not appropriate, but that the failure would not have affected the deceased's actions.

THE DECEASED

15. The deceased was born in southern Sudan on 19 September 1983, making him 31 years old at the time of his death.[11] He was the middle child of seven children. He had been in Australia for 9 years.[12]

16. The deceased was a normal, healthy intelligent child who grew up well and went to school in Uganda,[13] but he and his sister Peace Pita became refugees during the war in the Sudan. By the time he was eleven, they were looking after themselves. Their father died when he was seven and their mother died when he was 14.[14] He and Ms Pita saw their aunt killed and they saw people killed by aircraft in their town. They became refugees in Uganda and were separated.[15]

17. In 2005 the deceased arrived in Darwin. In November that year, Ms Pita arrived in Perth, so he came here to join her.[16]

18. It appears that the deceased suffered from depression and anxiety when he arrived in Australia,[17] though Ms Pita believes that he developed depression in about 2011.[18]

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[11] Exhibit 1, Volume 1, Tab 7
[12] Exhibit 1, Volume 3, Tab 3
[13] Exhibit 1, Volume 3, Tab 3
[14] Exhibit 1, Volume 3, Tab 3; *cf.* Exhibit 1, Volume 1, Tab 10, para. 49
[15] Exhibit 1, Volume 1, Tab 10
[16] Exhibit 1, Volume 1, Tab 10
[17] Exhibit 1,Volume 3, Tabs 3 and 4
[18] Exhibit 1, Volume 1, Tab 10

19. It seems that the deceased completed a bridging course at Tuart College and then attended Charles Darwin University in Darwin briefly, but he could not continue his studies when he became unwell with depression and anxiety.[19] There is evidence indicating that he completed a course in laboratory management.[20]

20. In 2008 or 2009 the deceased became involved with a woman from New Zealand with whom he had two children.[21]

21. The deceased and his partner had a volatile relationship. His partner left the deceased and went to live with her family, taking the children with her. The deceased attempted to visit the children, but his partner obtained restraining orders against him.[22]

22. In about 2010 the deceased's partner left Australia and went to New Zealand with the children, so the deceased was unable to see them. He was contacted by an agency in New Zealand requesting that he pay child support, which he apparently did.[23] However, he was unable to get work, partly due to an inability to obtain a police clearance because of breaches of the restraining orders.[24]

23. At the time of his death, the deceased was living in a rental apartment in East Victoria Park, which he shared with other people. He did not see much of his house-mates and did not often talk with them.[25] His uncle, Sworo Alfred Sekwat, lived in Balga.[26]

24. On 25 September 2014 the deceased was admitted as a voluntary patient in a psychiatric ward at the Armadale Mental Health Service (AMHS) after he had been brought in by ambulance to the emergency department.

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[19] Exhibit 1, Volume 1, Tab 10; Exhibit 1,Volume 3, Tabs 3 and 4
[20] Exhibit 1, Volume 3, Tabs 3 and 4
[21] Exhibit 1, Volume 1, Tab 10
[22] Exhibit 1, Volume 1, Tab 10
[23] Exhibit 1, Volume 3, Tabs 3 and 4
[24] Exhibit 1, Volume 1, Tab 10
[25] Exhibit 1,Volume 3, Tab 4
[26] Exhibit 1, Volume 1, Tab 9

He had overdosed venlafaxine tablets with suicidal intent in the context of cannabis and alcohol use. His blood alcohol level was 0.233%. He reported suicidal ideation when he was intoxicated, but afterwards he expressed regret and stated that he wanted help.[27]

25. The deceased remained in AMHS until 30 September 2014. He was commenced on duloxetine and by the fourth day of admission he was much improved. He requested discharge but agreed to three days of leave instead.[28]

26. When the deceased returned after those three days leave, he reported that his mood was improved and that he had no problems. He denied thoughts of self-harm or harm to others. He demonstrated improved and congruent affect, good insight and judgement, with no acute risks identified. He was discharged on 30 September 2014 and referred to the Bentley Health Service outpatient clinic for follow-up, with interim follow-up by the community adult treatment team from AMHS.[29]

27. On 5 October 2014 the deceased told Ms Pita about his depression. He said that he could not sleep and would see things in his bedroom. He said that at one stage he left his bedroom and knocked on his house-mates' bedroom doors and asked for help, but they locked him out of the house instead of taking him to hospital.[30]

28. The deceased attended Bentley Health Service outpatient clinic on 7 October 2014. He reported a low mood, loss of appetite and insomnia. He felt isolated, with no contact with his ex-partner and his children. He was not suicidal and had no acute risks. A psychiatrist increased the dose of duloxetine and added quetiapine to help his mood. A further

[27] Exhibit 1, Volume 3, Tab 3
[28] Exhibit 1, Volume 3, Tab 3
[29] Exhibit 1, Volume 3, Tab 3
[30] Exhibit 1, Volume 1, Tab 10

appointment was arranged at Bentley Health Service for 14 October 2014.[31]

11 OCTOBER 2014

29. At around 1.00 pm on 11 October 2014 the deceased was dropped off, presumably by a friend, at Mr Sekwat's house in Balga. He was intoxicated with alcohol when he arrived. He called Ms Pita and spoke to her at about 1.45 pm. She spoke to Mr Sekwat and told him that the deceased was not well and was on medication. She said that the deceased needed to be supervised.[32]

30. The deceased told Mr Sekwat about his problems with his children. Mr Sekwat tried to convince the deceased to stay overnight, but the deceased left after 6.00 pm with a friend to be dropped off at the Warwick train station. He left his children's passports with Mr Sekwat.[33]

31. At 00.19 on 12 October 2014 the deceased showed up on CCTV at the Greenwood train station. It is not clear how he arrived there.[34]

GREENWOOD TRAIN STATION

32. At about 1.10 am on 12 October 2014 the deceased was seen by John Paraskos, a PTA employee at the central monitoring room in the PTA building in East Perth who was monitoring CCTV screens showing train stations. He saw the deceased apparently chasing after three teenage girls on the Perth-bound platform at the Greenwood train station. Mr Paraskos or another PTA employee at the monitoring room used a public address system to direct the deceased to leave the girls alone.

[31] Exhibit 1, Volume 3, Tab 3
[32] Exhibit 1, Volume 1, Tab 9
[33] Exhibit 1, Volume 1, Tab 9
[34] Exhibit 1, Volume 1, Tabs 11 and 12

The deceased then appeared to settle down as he sat on a bench on the station platform.[35]

33. Mr Paraskos notified his shift commander, Mr Sprigg, of the incident. Mr Sprigg called one of the two-member teams of uniformed transit officers, the Delta 5 team, comprising Officer Pomponio and Officer Cosmo Vasiasi, and instructed them to attend the Greenwood train station.

34. At about 1.25 am on 12 October 2014 Officer Pomponio and Officer Vasiasi arrived at the Greenwood station and approached the deceased. The deceased appeared intoxicated and animated but was coherent and in control of his actions. He told the transit officers that he wanted to catch a train to Perth, but when asked to show them a valid ticket, he produced an invalid one.[36]

35. When Officer Pomponio told the deceased that the ticket was invalid, the deceased became aggressive and threatened the officers. He stepped toward Officer Vasiasi and motioned to punch him, so Officer Pomponio grabbed the deceased and took him to the ground. Officer Vasiasi placed handcuffs on the deceased's wrists behind his back and moved him to a seating area on the platform.

36. The three girls approached the officers and alleged that the deceased had chased them and that one of them had dropped a $50 note,[37] which he picked up and would not return. As a result of that allegation, Officer Pomponio called Mr Sprigg and requested that police officers attend. Mr Sprigg contacted WAPOL and passed that request along to police.[38]

37. While the deceased was seated, Officer Vasiasi obtained information about him from the IMS via Mr Sprigg. The IMS showed that the deceased suffered from

[35] Exhibit 1, Volume 1, Tab 12
[36] Exhibit 1, Volume 1, Tabs 13 and 15
[37] ts 8 per Pomponio, M; Exhibit 1, Volume 1, Tab 23.2
[38] Exhibit 1, Volume 1, Tabs 11 and 15

depression, self-harm and a mental condition, and that he was very anti-police, would assault when intoxicated and was very unpredictable. It showed that he had convictions for breach of restraining order, trespass, obstructing a public officer, common assault and, possibly aggravated assault. He was subject to a suspended sentence.[39]

38. While seated, the deceased said that he just wanted to die and that he would jump in front of a train. Officer Pomponio contacted Mr Sprigg to inform him of those threats of self-harm and to request that WAPOL also be informed about them.[40]

POLICE ATTEND

39. Senior Constable Steve Corden and Constable Griffin Lumbers were on duty at the Warwick police station when they saw a computer-assisted dispatch (CAD) request for police attendance at Greenwood train station. They drove a police vehicle from the station to the Greenwood station, arriving at about 2.10 am. Before leaving the police station, Senior Constable Corden did an IMS check on the deceased and noted that he was very anti-police, would assault when intoxicated and was unpredictable.[41]

40. At the train station, Senior Constable Corden spoke to the three girls while Constable Lumbers spoke to the deceased.

41. The girls told Senior Constable Corden that they were 12, 15 and 15 years old. At that point, Officer Pomponio handed him a mobile phone with which to speak to Mr Sprigg. Mr Sprigg told Senior Constable Corden about the CCTV recording of the deceased chasing the girls at the train station, so Senior Constable Corden arranged to attend the PTA building

[39] Exhibit 1, Volume 1, Tab 23.3
[40] Exhibit 1, Volume 1, Tab 15
[41] Exhibit 1, Volume 1, Tab 20

in East Perth to view the recording.[42] He had reached the view that the girls' story was inconsistent, and Mr Sprigg was not able to say from the CCTV recording who owned the $50 note.

42. Meanwhile, Constable Lumbers spoke to the deceased, who told him that the $50 note was given to him by a friend, Jamie Adam, earlier that evening, and he denied having picked it up that night.[43]

43. Mr Pomponio then informed the police officers about the deceased's threat to self-harm.[44] As a result of that information, Constable Lumbers assessed the deceased's mental state. He asked him if he had any mental health conditions. The deceased said that he had depression and anxiety for which he took medication. He said that he had taken his medication for that day and that he was feeling fine.[45]

44. Throughout his conversation with Constable Lumbers, the deceased appeared calm, compliant and respectful.[46] He was slightly intoxicated and a bit glassy-eyed, but was not slurring his words.[47]

45. Constable Lumbers concluded that the deceased was not a threat to himself, to another person or to property, so he did not come within section 195 of the *Mental Health Act 1996*. That section gave a police officer the power to apprehend a person for examination by a medical practitioner where the officer reasonably suspected that the person had a mental illness and needed to be apprehended to protect the health or safety of the person or any other person or to prevent serious damage to property.

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[42] Exhibit 1, Volume 1, Tab 20
[43] Exhibit 1, Volume 1, Tab 19
[44] Exhibit 1, Volume 1, Tab 19
[45] Exhibit 1, Volume 1, Tab 19
[46] ts 38 per Lumbers, G
[47] ts 27 per Lumbers, G

46. Constable Lumbers told Senior Constable Corden of his questioning of the deceased and his conclusion, and Senior Constable Corden was content with the assessment of the deceased's mental state.[48]

47. The police officers decided to seize the $50 note because of the dispute about who owned it. They told the deceased that it would be returned to him if they determined that it belonged to him. They asked him how he felt and he said that he was OK.[49]

48. The transit officers decided to release the deceased and to charge him by summons for disorderly behaviour. Officer Pomponio told him that it was not a serious charge. By this time he was apologetic.[50]

49. The police officers then left the deceased in the custody of the transit officers and drove the three girls to their relative's home in North Fremantle. The officers then went to the PTA building in East Perth.[51]

THE '000' CALL AND HANGING

50. After the police officers and the girls had left, the transit officers removed the handcuffs from the deceased's wrists and walked with him to the drop-off area of the station where their vehicle was parked. He asked for a ride home, but they considered that they had to refuse his request in accordance with PTA policy. They then drove off at about 2.30 am to continue with their duties. The last train for the night left the station at about that time.[52]

51. It is not clear whether the deceased then left the station area entirely, but he was no longer seen on the CCTV until 3.12 am. Mr Paraskos had continued to monitor

[48] Exhibit 1, Volume 1, Tabs 19 and 20
[49] Exhibit 1, Volume 1, Tabs 19 and 20
[50] ts 9 per Pomponio, M
[51] Exhibit 1, Volume 1, Tabs 19 and 20
[52] Exhibit 1, Volume 1, Tabs 13 and 15

Greenwood station and saw him at that time smoking a cigarette near the public phone.[53]

52. At 3.13 am the deceased called '000' and spoke to a call-taker. He was vague and not entirely coherent, but he eventually told the call-taker that he was alone at Greenwood railway station and could not go home because police had taken his money. He said that he needed to go home to get his medication.[54]

53. The call-taker said that the police would not have taken his money and that he would be able to catch a train home soon. She asked if there were transit officers at the station. The deceased said that he could not catch a train because he needed his money back. He said that there were no transit officers or anyone else at the station.[55]

54. The call-taker then said, 'Okay. You stay there at the station. I will get some police to come and see you there.'[56]

55. For reasons that are unclear, the call-taker failed to place a job in the CAD system to instruct available police officers to attend Greenwood train station.[57]

56. In any event, about three minutes after the deceased made the '000' call, Mr Paraskos saw him apparently trying to hang himself with the telephone cord. Mr Paraskos immediately advised Mr Sprigg, who called '000' to contact the Police Operations Centre and St John Ambulance.[58]

57. Ambulance paramedics and police officers attended within about 10 minutes and found the deceased hanging in cardiac arrest with the telephone cord wrapped around his neck. They administered CPR and

[53] Exhibit 1, Volume 1, Tab 12
[54] Exhibit 1, Volume 1, Tab 25
[55] Exhibit 1, Volume 1, Tab 25
[56] Exhibit 1, Volume 1, Tab 25
[57] Exhibit 1, Volume 2 , Tab 3
[58] Exhibit 1, Volume 1, Tab 12

adrenaline, intubated him and took him to the emergency department at SCGH. By the time they arrived at the hospital, his spontaneous circulation had returned.[59]

58. The deceased was admitted into the intensive care unit with the diagnosis of hypoxic brain injury. He did not regain consciousness. From about 17 October 2014 he was provided with palliative care until he died on 26 October 2014 at about 1.00 am.

CAUSE OF DEATH AND HOW DEATH OCCURRED

59. On 29 October 2014 Chief Forensic Pathologist Dr C T Cooke conducted a post mortem examination of the deceased's body and found changes of medical treatment, congestion of the lungs and possible early pneumonia. There was no obvious marking to the skin of the neck and no evident neck injury. The body organs were otherwise normally developed and healthy.[60]

60. Further investigations were undertaken. Microscopic examination confirmed bronchopneumonia and hypoxic changes in the brain. Microbiology testing showed the presence of *Staphylococcus aureus* bacteria, associated with bronchopneumonia. Toxicological analysis showed medications consistent with terminal medical care.[61]

61. Dr Cooke formed the opinion, which I adopt as my finding, that the cause of death was bronchopneumonia and hypoxic brain injury following ligature compression of the neck (hanging).

62. I find that death occurred by way of suicide.

[59] Exhibit 1, Volume 1, Tab 6
[60] Exhibit 1, Volume 1, Tab 4
[61] Exhibit 1, Volume 1, Tab 4

COMMENT ON THE ACTIONS OF TRANSIT OFFICERS AND POLICE OFFICERS AT GREENWOOD TRAIN STATION

63. I am satisfied that the transit officers and the police officers acted appropriately in all of their dealings with the deceased.

64. The transit officers were clearly justified in taking the deceased to ground and in restraining him until the police officers attended. Apart from those actions, it appears that they treated him humanely and with respect.

65. In accordance with PTA policy,[62] the transit officers called their shift commander to alert him to the deceased's statement that he wanted to kill himself and they made doubly sure that the police officers were aware of that.

66. The police officers, particularly Senior Constable Corden, treated the deceased fairly in obtaining his side of the story and in not accepting without question the accounts of the girls in relation to the $50 note.

67. Constable Lumbers' assessment of the deceased's mental state and his conclusion, confirmed by Senior Constable Corden, that he could not lawfully detain him under the MHA appears to have been entirely reasonable.

68. In my view, Constable Lumbers' approach to the deceased's potential mental health issues was a credit to himself, to his training and to WAPOL. I must also commend him for his exemplary oral evidence.

[62] Exhibit 2

COMMENT ON FAILURE BY CALL-TAKER TO ARRANGE FOR POLICE ATTENDANCE

69. Superintendent O'Rourke is with the Communications division of WAPOL. The Police Operations Centre is part of her division.[63]

70. Superintendent O'Rourke provided a letter to the Court dated 26 April 2017 in which she stated that an analysis of all available recordings within WAPOL's databases concluded that the call-taker did not task police officers to attend the public phone at Greenwood train station to check on the deceased. She noted that the deceased had not threatened self-harm in the phone call, but that his vulnerability required police attendance.[64]

71. However, in oral evidence Superintendent O'Rourke said that the call-taker was very experienced and very professional.[65] She also said that that, if the call-taker had made the decision that the deceased's call did not warrant police attendance, she would not have been critical.[66]

72. Superintendent O'Rourke said that the call-taker would have been entitled to transfer the deceased's call from the '000' line to the general queue because he did not indicate a life-threatening situation. She said that there was nothing in the content of the phone call that would have warranted a response by police of anything higher than a priority 3, in which officers would have had up to an hour to attend.[67]

73. In my view, given that the deceased began to hang himself within a few minutes after the phone call, it is

[63] ts 64 per O'Rourke, N
[64] Exhibit 1, Volume 2, Tab 3
[65] ts 72 per O'Rourke, N
[66] ts 74 per O'Rourke, N
[67] ts 67 per O'Rourke, N

clear that any failure by the call-taker to task police officers to attend would not have made any difference to the deceased's actions or to the result.

CHANGES SINCE THE DECEASED'S DEATH

PTA

74. Ms Pearson provided a statement describing the training provided to transit officers by the PTA. New transit officers undergo 12 weeks of training in all aspects of their duties, including at least one day of training on how to engage with customers who are disoriented, intellectually disabled, ill, mentally impaired, suffering from a mental illness or suicidal. The officers then undergo annual refresher training.

75. From 2015 transit officers have been provided with a training module specifically related to suicide awareness. Ms Pearson and the PTA's manager of Administration and Revenue identified the need for that training after statistics for fatalities and threats of self-harm on the PTA train network from 2014 to 2017 reflected an increase of self-harm and suicide reported by transit officers. The module, which includes practical training, is provided both in the initial training and in refresher training.

WAPOL

76. Between 2012 and 2014 WAPOL implemented a compulsory training program that was dedicated to re-educating all of its front-line officers on its statutory responsibilities in relation to mental health. It seems certain that Senior Constable Corden and Constable Lumbers would have undergone that training before they met the deceased on 12 October 2014,[68] and I am satisfied that they applied that training appropriately then.

[68] ts 76 per Mearns, S

77. Inspector Mearns is the project manager of a project known as 'the mental health co-response trial', which is a two-year trial which commenced in January 2016 and which will continue past the two year time-frame in order to allow for an evaluation process to be completed.[69]

78. The co-response trial involves specially trained police officers and mental health practitioners in two metropolitan police districts working together by attending mental health-related and welfare-related incidents. There is also a mental health practitioner at the Police Communications Centre to assist with incidents as they come in, and there is a mental health practitioner at the Perth watch-house to assist custody staff with people who have been arrested and held overnight.[70]

79. The co-response teams are available Monday to Saturday from 2.00 pm to 10.00 pm.

80. In a situation such as the deceased's, where a person makes a threat of suicide, a co-response team would attend if his threats had been made known to police, or if the initially attending police officers identified a potential mental health component. The advantage of having a mental health practitioner attend with police officers is that the practitioner can conduct a medically-based mental health assessment,[71] which police officers are not trained to do.[72]

81. According to Inspector Mearns, the uptake from police officers in the field of the mental health co-response is quite good and the trial is working well. Although the evaluation process has not been completed, WAPOL and its partners in the trial, the Mental Health Commission

[69] ts 86 per Mearns, S; Exhibit 3(a)
[70] ts 84 per Mearns, S
[71] ts 91 per Mearns, S
[72] ts 81 per Mearns, S

and the Department of Health, are recommending that it continue and be expanded to other districts.[73] Interim progress evaluation reports by Edith Cowan University have been 'very positive'.[74]

82. Since 2014, police officers have also been provided with mobile phones, which gives them the ability to call the Mental Health Emergency Response Line directly if they suspect that there was a mental health element in an incident.[75]

CONCLUSION

83. The deceased died in tragic circumstances in the context of mental illness, alcohol and despair.

84. Statistics obtained from the PTA indicate that the number of fatalities, which I understand to mean suicides, on the PTA train network from 2014 to 10 October 2017 was six to eight per year. In 2015 there were 107 attempted suicides or threats of self-harm and in 2016 there were 96 such attempts or threats.[76]

85. WAPOL statistics of police responses to incidents involving mental health from 2007 are especially illuminating. While those statistics are not 'scientific' since they are based on counts of keywords in the CAD system, they show a frightening trend. They show 4766 incidents in 2007, 12,552 in 2012, 18,902 in 2015 and over 22,000 in 2016.[77]

86. Anecdotal evidence heard in this Court consistently suggests that police officers face mental health-related incidents daily. For example, Mr Lumbers said that incidents involving self-harm, which I take to included suicide, and threats of self-harm comprise a large

[73] ts 81 per Mearns, S
[74] ts 91-92 per Mearns, S
[75] ts 87-88 per Mearns, S
[76] Exhibit 2
[77] ts 84 and 89 per Mearns, S

proportion of what police face, and mental health issues are faced daily.[78]

87. In these circumstances, and while it may be little comfort to the deceased's family now, it is encouraging to learn that the PTA and WAPOL are taking steps to equip their officers with the ability to help people afflicted by mental illness.

B P King
Coroner
8 March 2018

[78] ts 30 per Lumbers, G