Coroners Act, 1996
[Section 26(1)]

Western ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 05/16

I, Rosalinda Vincenza Clorinda FOGLIANI, State Coroner, having investigated the death of ***Ewan Louis WILLIAMSON****, with an Inquest held at Perth Coroners Court, Court 51, CLC Building, 501 Hay Street between 9 and 11 February 2016 find that the identity of the deceased person was* ***Ewan Louis WILLIAMSON*** *and that death occurred on 21 December 2012 at Exmouth District Hospital, Exmouth as a result of severe heatstroke complicating a recent viral illness with focal myocarditis in the following circumstances -*

Counsel Appearing :

Mr T Bishop assisted the State Coroner

Ms R Hartley appeared on behalf of the Western Australian Country Health Service, Dr Hannay, the Department of Parks and Wildlife and Mr Campbell.

Mr B Humphris with Mr G Huggins appeared on behalf of the Commissioner of Police

Mr M Nazareth and Ms Robinson appeared on behalf of St John Ambulance, Ms Roche, Mr Sigley, Ms Sexton and Mr Smith

Mr Slattery appeared on behalf of Senior Constable J Diviney

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INTRODUCTION

Ewan Louis Williamson was 14 years old when he died in the late afternoon on 21 December 2012 at Exmouth District Hospital, having been conveyed there by ambulance after suffering severe heatstroke. He had collapsed earlier that day whilst he was hiking with his father along the Badjirrajirra Walk. This is a walking trail in the Cape Range National Park, on the west side of the North West Cape, approximately 25 kilometres south of Exmouth, in the Gascoyne Region.

By the time Ewan arrived at the hospital, his chances of survival were minimal. The doctors attempted all possible means of resuscitation but they were unable to prevent him from succumbing to the effects of the heatstroke. The tragedy of Ewan's death is magnified by the immeasurable grief of his parents. His father had intended to take Ewan out on a bushwalk, spend time with him, perhaps see some animals and explore the surrounds.

It was summertime and Ewan's father miscalculated the effect that the heat would have on his son, who had recently arrived from Scotland to visit him, following his separation from his wife. This was compounded by Mr Williamson at one point unfortunately taking a wrong turn on the trail. The result was that Ewan, who was not acclimatised to the heat, spent far more time than his father had intended

walking along a rocky trail in a remote location on an extremely hot day.

When Ewan collapsed, his father tried all possible means to rescue him. So did the attending personnel, eight of them in total, responding at different stages. Tragically, despite the courageous and sustained efforts of the emergency personnel, who were operating in a completely inhospitable environment, Ewan was unable to be saved.

The inquest

Ewan's death was a reportable death within the meaning of section 3 of the *Coroners Act* 1996 (the Coroners Act) and it was reported to the coroner as required by section 17 of the Act.

Pursuant to section 19(1) of the Coroners Act I have jurisdiction to investigate Ewan's death. The holding of an inquest was mandated by sub section 22(1)(b) of the Coroners Act in order to publicly investigate the actions of the police who took the first call for assistance from Ewan's father. The circumstances of the police response raised the question of whether or not it appeared that Ewan's death was caused, or contributed to, by any action of a member of the police force.

Between 9 and 11 February 2016 I held an inquest into Ewan's death at the Coroner's Court at Perth. The inquest focussed on the difficulties experienced by Ewan's father in seeking emergency assistance, and the difficulties experienced by the emergency services in rendering that assistance.

A number of witnesses gave evidence at the inquest and they are, in order of their appearance: Mr Gordon Williamson, Ewan's father; Mr Richard Du Cloux, formerly First Class Constable Du Cloux, one of the two police officers who first located Ewan; Mr Craig Sigley and Ms Nicola Sexton, volunteer ambulance officers; Dr Peter Hannay, District Medical Officer of the Exmouth Hospital and Health Service; Ms Raquel Roche, the ambulance dispatcher; Professor Ian Rogers, expert witness and professor of emergency medicine at St John of God Murdoch Hospital and the University of Notre Dame; First Class Constable Paul Bott, the other police officer who first located Ewan; Mr Jamie Campbell, education and interpretive officer with the Department of Environment and Conservation (DEC, as it then was); Dr Jodi White, forensic pathologist; Senior Constable Ian Thompson, supervisor for regional Western Australia at the police communications centre at Midland; Detective Sergeant Brian Thomas, in charge of the internal affairs unit's investigation into the circumstances; Mr Julian Smith, general manager of the St John Ambulance country service; Senior Constable John

Diviney, who took the first call from Ewan's father; and Inspector Gary Cunningham, in charge of the police operations centre after these events.

The evidence tendered at the commencement of the inquest comprised three lever arch files, marked as follows:

1. Exhibit 1, Tabs 1 to 35;
2. Exhibit 2, Tabs 1 to 23; and
3. Exhibit 3, Tabs 1 to 6.

During the inquest the following exhibits were tendered:

1. Exhibit 4, map of the Badjirrajirra Walk marked by Mr Williamson;
2. Exhibit 5, map of the Badjirrajirra Walk marked by Mr Campbell and three photographs depicting DEC signage on the Walk;
3. Exhibit 6.1, volunteer ambulance officer on-line training module which includes information on hyperthermia and heatstroke;
4. Exhibit 6.2, volunteer ambulance officer training guide which includes the training program for hyperthermia.

After the inquest I received submissions from the various counsel in accordance with the orders made. I am assisted by submissions from counsel assisting Mr Bishop dated 10 March 2016; submissions from the Commissioner of Police's counsel Mr Humphris dated 6 April 2016; and

submissions from Senior Constable Diviney's counsel Mr Slattery dated 8 April 2016.

THE DECEASED

Ewan was born on 3 March 1998 in Alexandria, Scotland to Janet Butler and Gordon Williamson. As a child residing in the United Kingdom he was well looked after and well developed. He was quite tall and large for his age, reasonably fit and healthy. He enjoyed playing sport at school and he had not had any significant childhood illnesses.

Mr Williamson is a civil engineer and in March 2009, the family moved to Geraldton, Western Australia. However, Ewan's parents separated and in October 2009, Ms Butler and Ewan returned to live in Scotland. Mr Williamson remained in Geraldton.

Whilst Ewan lived overseas with his mother, his parents ensured that he continued to have contact with his father. Ewan had come to Western Australia to visit his father in July 2012. He returned to visit his father again in December 2012, arriving in Perth on 16 December 2012, and planning to stay for one week.

It was wintertime in Scotland and shortly before his departure for Australia Ewan had been mildly unwell. On or about 7 December 2012 Ewan's mother had observed

him to show signs of having a head cold, with a runny nose, headache, lethargy and possibly a temperature. Knowing he was due to depart for Australia, she kept him home from school for four days to give him an opportunity to recover. Ms Butler gave Ewan some paracetamol. There was no need to consult a doctor, Ewan improved and was able to attend the last day of school before the Christmas break. The next day, Saturday 15 December 2012 Ms Butler drove Ewan to Glasgow Airport for his flight to Australia.[1]

Mr Williamson collected Ewan from Perth Airport on Sunday 16 December 2012 and after spending the night in Perth, they travelled to Geraldton on 17 December 2012. Ewan did not appear to be unwell to him. Two days later on 19 December 2012 they travelled north to Exmouth for a holiday. Mr Williamson had recently acquired a new LandCruiser and father and son discussed taking it off-road. They stayed at a caravan park and on 20 December 2012 they went snorkelling together at Turquoise Bay.[2]

Mr Williamson attended at the Exmouth Visitors' Centre and collected some pamphlets on things to do in the surrounding area. Over breakfast on 21 December 2009, they both looked at the reference material and decided to go to the Badjirrajirra Walk trail. They left Exmouth at 9.00am

[1] Exhibit 1, Tabs 5 and 6
[2] Exhibit 1, Tab 6

and over a period of approximately one hour, after stopping at a few lookouts, they arrived at their destination.[3]

THE BADJIRRAJIRRA WALK

The start of the walk

At the end of one of the tracks where they went driving, after coming off Charles Knife Road, Ewan and his father arrived at the Thomas Carter Lookout car park, which is also the commencement of the Badjirrajirra Walk. It was approximately 10.00am. They decided to walk the trail in the hope of spotting some animals, such as rock-wallabies. They had not intended to walk the entire trail given that they had seen a DEC sign with some warnings concerning the temperatures. Mr Williamson had intended that they would walk for a while and then turn back.[4]

The DEC sign positioned at the commencement of the Badjirrajirra Walk clearly stipulated that it is an eight-kilometre walk, and that hikers should allow themselves three hours to complete it. The walk was described as a "*moderately difficult loop trail traversing the top of Cape Range*." Under the heading "*Safe Walking Tips*" the sign provided three cautionary advices, one of which stated:

> "*Extreme heat can be experienced when walking Cape Range. Temperatures can regularly exceed 50°C during the months of*

[3] T 9; Exhibit 1, Tab 6; Exhibit 4
[4] T 9; Exhibit 1, Tab 6

November to March. It is recommended you walk in cooler months or during cooler times of the day."[5]

I am satisfied that the warning could not have been clearer, particularly as it gave a guide as to the temperatures that ought to be anticipated at that time of the year. Out on the trail, temperatures will regularly exceed the daily recorded temperature for the more built up areas.

Ewan and his father were carrying two litres of water each, and when they left their car to commence the walk, Mr Williamson recalled the temperature was recorded as 36 degrees Celsius on the gauge.

They left a five litre bladder of water and another one and a half litre container of water in the car. Ewan was wearing shorts, a T-Shirt, a wide brimmed hat and sandshoes. He had recently arrived from a very cold climate. This clothing is not suitable when exposure to extremely hot temperatures is anticipated.

Ewan becomes unwell but recovers quickly

Initially Mr Williamson found the terrain to be rocky, but he did not consider it to be overly difficult. Ewan and his father walked for approximately 800 metres when they came to a signpost splitting the trail. The signpost gave the option of taking a direct walk or a circuit walk. It was

[5] Exhibit 5

approximately 10.40am. They opted for the circuit walk in an easterly direction, and at this stage Ewan appeared to be quite well. However, some 30 minutes later, Ewan told his father he felt faint. They left the trail to find some shade.[6]

After approximately 20 minutes they found a small cave and Ewan, who had become silent, sat inside, on the ground, and drank most of their water. By now it was between 11.30 and 11.45am. Shortly afterwards Mr Williamson observed Ewan to have considerably improved, to the point that he appeared to be his usual self.[7]

Whilst Mr Williamson could not have known it at the time, this was an early manifestation of Ewan's heatstroke. He responded quite quickly because he was out of the sun and in a cooler environment in the cave.[8]

After Ewan improved, Mr Williamson left him in the cave with the intention of locating the original walking trail. The cave was at a point between the direct walk and the circuit walk. When Mr Williamson left the cave, he did not go the way he had come to find the cave. Instead he walked up and over a ravine and located the trail in a different section to where they had left it.[9]

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[6] T 12 – 14, Exhibit 1, Tab 6
[7] T 12 – 14; Exhibit 1, Tab 6; Exhibits 4 and 5
[8] T 124
[9] Exhibit 1, Tabs 2 and 6;

This was likely a factor that contributed to his confusion when he later took the wrong turn, because he was looking at a different part of the trail.

Ewan and his father walk in the wrong direction

Mr Williamson returned to the cave to fetch Ewan. By now it was the middle of the day. Mr Williamson, believing that the hottest part of the day would be around 2.00pm, explained to Ewan that they should leave immediately, or wait until 5.00pm. Ewan stated that he felt better and appeared keen to go on walking. They both left the cave and went to that part of the trail that Mr Williamson had found while Ewan was in the cave. By the time they left the cave it was approximately 12.30pm.[10]

Unfortunately at this point, Mr Williamson became disoriented. This is always a risk in extremely hot and remote areas. Instead of heading southwards back towards the car park as he had intended to do with Ewan, he mistakenly headed in a northerly direction, further away from the car park. Some 20 to 30 minutes later they found another signpost splitting the trail. It was approximately 1.00pm. They assumed that it was the original signpost, and they were under the misapprehension that they were close to the car park.[11]

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[10] T 14; Exhibit 1, Tabs 2 and 6
[11] Exhibit 1, Tabs 2 and 6

With this in mind, Ewan walked at a good pace. However, after walking a further 1700 metres, they found the original signpost and realised their mistake. It was approximately 1.30pm. Ewan became very distressed, because he realised that after all this time, there was still some considerable distance to go.[12]

Ewan collapses

In reality they were still approximately 800 metres from the car park. They finished their water and walked about another 400 metres before Ewan told his father he could not go on. This was at a point between 1.30 and 2.00pm. By this stage, they were approximately 390 metres from the car park. The heat was extreme and there was no shade. Mr Williamson sat Ewan down in a shallow culvert on the trail, which was the best option as it appeared to provide a modicum of stability and shade because it was "V shaped".[13]

Mr Williamson observed Ewan to be disoriented but completely conscious at this point. He was speaking and his breathing was normal. Due to these observations, he was not at this stage concerned for Ewan's life. After a couple of minutes, Mr Williamson left Ewan in the culvert and headed back towards their car to get some water and something with which he could shade Ewan. Whilst

[12] T 14 – 16; Exhibit 1, Tabs 2 and 5; Exhibits 4 and 5
[13] T 16 – 18, Exhibit 1, Tab 2

Mr Williamson was not aware of it, Ewan was now manifesting signs of established heatstroke.[14]

Ewan weighed approximately 84 kilograms and Mr Williamson knew he would not be able to convey him to the car park on his own. When Mr Williamson arrived at the car park, he called the police for assistance with extricating Ewan from the trail and getting him to the car park.

Mr Williamson makes the first emergency call to police

By the time Mr Williamson arrived at the car park it was approximately 2.00pm and by this stage he observed the temperature was recorded as 42 degrees Celsius on the gauge. He promptly dialled the emergency number 000 and asked for the police, because at this stage he did not consider the situation to be life-threatening, given that Ewan was conscious when he left him. His purpose was to seek police assistance to convey Ewan to the car. At the end of the conversation, his expectation was that police would arrive with a stretcher that could be used to carry Ewan out.[15]

Senior Constable Diviney took the call at 2.03pm on 21 December 2012 and he experienced difficulty understanding Mr Williamson's Scottish accent, a factor

[14] T 16 – 18; T 127; Exhibit 1 Tabs 2 and 6; Exhibits 4 and 5.
[15] T 17 – 19; T 51 - 52

that he said was exacerbated by ambient noise at the police communications centre. The call was of seven minutes' duration. He did not ask anyone to assist him when he could not make out what Mr Williamson was saying.[16]

On numerous occasions over the course of the telephone call, Senior Constable Diviney asked Mr Williamson to repeat himself, and Mr Williamson did so. Mr Williamson has expressed his dismay and disappointment at the length of time it took to get his point across to Senior Constable Diviney. He would have expected a reaction within a couple of minutes and he did not think Senior Constable Diviney took him seriously.[17]

At the inquest I explored the circumstances of the call from Mr Williamson, taken by Senior Constable Diviney. The audio recording was tendered into evidence. It is clear from the outset that Mr Williamson is labouring and out of breath. After being asked to repeat himself, he states: "… *We're out in the bush walking and my son has collapsed….I think of heat exhaustion.*" This critical information is conveyed within the first moments of the call, straight after 2.03pm.[18]

Mr Williamson thought he was talking to a local police officer in Exmouth. However, in accordance with police

[16] Exhibit 2, Tab 13
[17] T 18 – 19; 65; Exhibit 2, Tab 13
[18] T 18 – 20; Exhibit 2, Tab 13

operations for regional 000 calls, Senior Constable Diviney was stationed at the police communications centre in Midland. Senior Constable Diviney did not know of the Badjirrajirra Walk and Mr Williamson had to spell it out practically one letter at a time. He also had to repeat "*Charles Knife Road*" on several occasions.[19]

It is clear that approximately three minutes into the call Senior Constable Diviney had understood that Ewan, being 14 years old, had collapsed, he could not walk, his breathing was shallow, he was on his own on a rock on a walk approximately 20 kilometres south of Exmouth, he had been walking approximately three hours, and his father had come back to the car to get more water and was going to head back to his son.[20]

At this point Senior Constable Diviney asked Mr Williamson whether he needed an ambulance or just some water. In response Mr Williamson asked for a helicopter. In response to further questioning he said Ewan had no other injuries, but that he truly was completely exhausted. Over the next four minutes, with quite some repetition, Mr Williamson conveyed their GPS coordinates to Senior Constable Diviney. At the end of the call, at 2.10pm, Senior Constable Diviney took a note of Mr Williamson's mobile number, told him he will "*put a job on*" and finished by telling him he would

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[19] T 20; T 249 – 250; Exhibit 1, Tabs 6 and 7
[20] Exhibit 2, Tab 13

organise something for him. He did not specify what he would organise.[21]

Mr Williamson was hot, tired, worried and anxious to get back to Ewan. He responded to all of Senior Constable Diviney's questions, and he was clearly frustrated with the time and effort that it was taking to convey all of the information being sought.

Mr Williamson calls for an ambulance

As soon as he completed the call with Senior Constable Diviney, Mr Williamson made to return to Ewan, with the five litre water bladder and the car windshield sun shade. It took him under 20 minutes and unfortunately by the time he reached Ewan he found him to have deteriorated significantly.

Ewan was in the culvert where Mr Williamson had left him. Shockingly, by now Ewan was semi-conscious. His breathing was laboured, his eyes were open but he was unable to speak. Mr Williamson soaked Ewan in water to try and reduce his skin temperature and covered him with the sun shade. He attempted to place a hat over Ewan's face for further shielding from the heat, but Ewan pushed it away. He realised that Ewan's life was at risk. He dialled

[21] Exhibit 2, Tab 13

the 000 emergency number and called for an ambulance. It was now approximately 2.30pm.[22]

The St John Ambulance call taker, Ms Samuel, took Mr Williamson's call and immediately referred it to Ms Roche, the St John Ambulance volunteer dispatcher rostered at the Exmouth sub-centre. The information conveyed to Ms Roche was that a father had called stating his son had collapsed one kilometre down a track starting with "J" near Charles Knife Road, and his mobile number was provided.

Due to her local knowledge, Ms Roche made the connection and understood it must be the Badjirrajirra Walk. The call taker indicated to Ms Roche that she had experienced difficulty in understanding Mr Williamson's accent. Her call with Mr Williamson was of approximately two minutes' duration during which time she grasped the severity of the situation.[23]

Out on the track Mr Williamson placed Ewan in the recovery position, listened for his breathing and used all possible measures available to him to endeavour to reduce Ewan's body temperature and shield him from the heat. At this stage, Ewan's breathing remained laboured. Mr Williamson stayed with his son and awaited the arrival of the emergency services. From the time he called for an

[22] T 18 – 21; T 52 – 54; Exhibit 1, Tabs 2 and 6
[23] T 87 – 88; Exhibit 1, Tab 12

ambulance another half hour elapsed before the local police arrived, and a half hour after that, the ambulance arrived.

RESPONSE BY SENIOR CONSTABLE DIVINEY TO MR WILLIAMSON'S CALL FOR ASSISTANCE

When Mr Williamson contacted the St John Ambulance service at 2.30pm, it was the first they knew of this incident. The police had not yet alerted the ambulance services. Mr Williamson's earlier call to Senior Constable Diviney was completed by 2.10pm. At the inquest I explored the actions of the police to ascertain whether there was delay in responding to Mr Williamson's call for assistance and if so, whether any such delay caused or contributed to Ewan's death.

Senior Constable Diviney's role and training

On 21 December 2012, Senior Constable Diviney was rostered on day shift at the police operations centre in Midland in the Call Centre. He was performing the duties of 000 call taker. He performed this role on a four day shift cycle, of which two days were night shift and two days were day shift. He was on the third day of his shift. As a call taker his function was to receive the 000 calls from the public, assess the urgency of the situation and if necessary dispatch police to attend.

The dispatch was achieved by him recording the salient details of the call on the Computer Assisted Dispatch system (CAD), by populating the fields with relevant typewritten information. The CAD is accessible State-wide. In regional centres, such as Exmouth, the CAD consoles are staffed on a 24 hour, seven day a week basis. When a policing task is initiated on the CAD at the Call Centre at Midland, it becomes immediately accessible to police in Exmouth. It is therefore important that accurate details be efficiently entered into the CAD.[24]

Senior Constable Diviney had performed the function of call taker since June 2010 and had been a sworn member of the Western Australia police for 26 years. He successfully completed Dispatcher Training in October of 2010. He did not undertake a formal "*000 Call Taker*" course, because at that time it was considered that the initial training of sworn members at the Police Academy, together with subsequent operational experience sufficed. After completion of a familiarisation course and assessment in November 2011, he was deemed competent.[25]

Senior Constable Diviney's shift had commenced at 7.00am on 21 December 2012, and was due to end at 7.00pm. He took the call from Mr Williamson at 2.03pm that day, and it was of seven minutes' duration.[26]

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[24] T 249; Exhibit 2, Tab 2
[25] T 205 – 207; T 289; Exhibit 3, Tab 6
[26] T 249; Exhibit 1, Tabs 7 and 35; Exhibit 2, Tab 13

The difficulty in hearing or understanding Mr Williamson

At the inquest Senior Constable Diviney's evidence was that he had difficulty understanding Mr Williamson because he found him to have a strong Scottish accent and he was puffing. He said there were other call takers around him, there were personnel from the communications centre stationed in front of him, and the headphones he had been issued with did not cut out the ambient noise.

Senior Constable Diviney focussed on trying to hear and understand Mr Williamson and trying to obtain his GPS coordinates. Despite his clear difficulty, he did not seek assistance from any colleague during the call. There were no medical or fatigue issues that would have operated to impair his functions at work that day.[27]

I am satisfied that Senior Constable Diviney was genuinely endeavouring to identify the relevant information from Mr Williamson as quickly as he was able to do so. However, in a situation such as this the preferable course is to seek the assistance of a colleague. It is self-evident that 000 calls are likely to be time-critical and persistence in the face of such difficulty risks compromising the police response. Another call taker might have been able to better hear or understand him.

[27] T 266 – 268; Exhibit 2, Tab 2; Exhibit 3, Tab 6, sub-tab 1

Updating the CAD system

Whilst he was on the call, Senior Constable Diviney took handwritten notes of the details provided by Mr Williamson, instead of contemporaneously entering the information in typewritten form onto the CAD. As a result he did not immediately initiate a CAD task for police in Exmouth. At the inquest he explained that rather than entering information directly on the CAD, his preference was to take notes on a piece of paper to ensure that when he typed in the information, it would be correct, appropriately sequenced and able to be easily deciphered by others.[28]

As a result of this practice, the first six entries on the CAD printout tendered into evidence were made by Senior Constable Diviney at 2.15pm, five minutes after the completion of his call with Mr Williamson. The Internal Affairs Unit investigated his conduct. Detective Sergeant Brian Thomas was in charge of that investigation and he gave evidence at the inquest. In his view the call taker was required to enter the relevant information onto the CAD as it came to hand. He was critical of Senior Constable Diviney's practice of first making handwritten notes on paper. He said it would not happen on a team that he was supervising, though he conceded that clearly it does happen. He explained:

[28] T 251 - 254

> *"If that's my main job and I spend 12 hours a day doing that job, I should be very proficient at working that computer system".*[29]

The Western Australia Police Call Taker Training materials clearly stipulate the immediate submission of a CAD incident in connection with Priority 1 to 3 tasks, with the call taker then continuing to update the CAD task as the further information is gathered. This was also the expected practice at the material time.[30]

The Internal Affairs Unit investigation concluded that within the first three minutes of the call (that is, by 2.06pm) Senior Constable Diviney had sufficient information to commence a CAD incident as prescribed by standard operating procedures, but that he failed to do so. Further, there was a two-minute period where Mr Williamson was trying to obtain his GPS coordinates and during this time, the investigation posited that Senior Constable Diviney had the opportunity to commence a CAD incident, which could then be updated, but he did not do so.[31]

At the inquest Senior Constable Diviney accepted that in hindsight it would have been preferable to input the information onto the CAD as he was hearing it, and on the same basis through his counsel he accepts that it ought to have been placed at 2.06pm. If he were now in the same

[29] T 211
[30] Exhibit 2, Tab 7
[31] T 201 – 202; Exhibit 2, Tab 2

position, he said he would update the information immediately onto the CAD.[32]

Whilst Senior Constable Diviney maintained he had a lack of proficiency in typing, it is clear from the CAD entries made at 2.15pm that he is capable of making typewritten entries within an adequate time frame.[33]

Unfortunately, as a result of Senior Constable Diviney's somewhat anomalous practice, critical information concerning Ewan's state of health and location were not immediately input into the CAD. The initiation of a CAD incident has the ability to warn local police of an impending incident so that they may commence the coordination of resources. The CAD system can be continually updated as further information comes to hand and the GPS coordinates, which were important, could have been added, as they became known.[34]

I am satisfied that Senior Constable Diviney did not update the CAD in a timely and efficient manner and that he ought to have done so. This was not as a result of a failure of training. In the circumstances, for reasons outlined below concerning Ewan's poor prognosis this particular time lapse did not have an identifiably detrimental impact upon his prospects of survival.

[32] T 287; T 291; Exhibit 2, Tab 4
[33] T 287; T 291; Exhibit 2, Tab 4
[34] Exhibit 2, Tab 2

However, this does not derogate from the importance of proficiently updating the CAD in accordance with the standard operating procedures at all times as it is a singularly effective mode of communication in a time-critical emergency. There would undoubtedly be instances where an unacceptable time lapse would have clear and dire consequences for a person's health or safety.

Allocating a job code

When Senior Constable Diviney entered the data onto the CAD, he was required to allocate a job code or incident type, which denotes the urgency. Each job is allocated a unique three digit number where the first number denotes the priority. Priority numbers ranged from 1 to 4, with 1 being the most urgent. The priority dictates the grade of service expected from the police officers to whom the job is dispatched, and reflects upon the expected timeliness. When a job is submitted on CAD with a priority 1 or 2 rating, it will appear on the recipient's console with an associated audible alert to gain the attention of the console operator.[35]

At 2.15pm, Senior Constable Diviney entered a priority rating of "3", and coded it as a "*welfare check*". At the time there was a code number for "*collapsed person*" but he did not know it. He decided that to go searching for it would

[35] Exhibit 2, Tab 2

have taken up more time. He entered the closest code that in his view suited the situation. He believed the descriptive information he subsequently input was more important than the code number.[36]

However, at the end of the call, which he described as not being "*typical*" Senior Constable Diviney was unsure of whether he had allocated the correct priority, and he went to discuss it with Senior Constable Ian Thompson, his supervisor. As it transpires, this was an important step on his part because his supervisor ensured the matter was more effectively progressed. The need to check with supervisors when there is uncertainty or confusion cannot be over-emphasised.

Senior Constable Thompson had seen the job when it came up on his own screen at 2.15pm. As country supervisor, he was able to see multiple CAD entries for the regional areas. He gave evidence at the inquest and he recalled Senior Constable Diviney coming to discuss the job with him, shortly after he saw it on his own screen.[37]

From his conversation with Senior Constable Diviney, Senior Constable Thompson did not gain the impression that it was a life-threatening situation:

> *"….I do remember the conversation with [John] when he came up, and it sounded more like Ewan had just sort of gone, "You know, I don't want to go any further." And there wasn't a life-*

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[36] T 269
[37] T 162

> *threatening tinge to it at that time. I didn't believe it was, you know, urgent, urgent."*[38]

Senior Constable Diviney's was questioned on this issue. His evidence was that he did not form the view that Ewan was being uncooperative and did not want to walk any further. Rather, he formed the impression that Ewan had been walking for three hours in the sun and possibly needed a rest.[39]

Neither of them realised that at this point Ewan was suffering from heatstroke, but Senior Constable Thompson suspected it might be the problem.

Part of Senior Constable Thompson's role was to notify regional areas of jobs called in that area. Despite being of the view that it was not highly urgent, Senior Constable Thompson decided to elevate its priority rating. At 2.18pm he rang the customer service operator at Exmouth police station to draw her attention to the CAD task initiated by Senior Constable Diviney and informed her that its priority rating should be upgraded to "*maybe a 2*". The operator found the job and promptly informed the officer on duty. Senior Constable Thompson also indicated to the operator that it involved "*heat exhaustion*" and/or "*heatstroke*".[40]

[38] T 164
[39] T 285
[40] Exhibit 2, Tabs 4 and 13

This telephone call drew local police attention to Ewan's circumstances and put the gravity of the situation into sharper focus. The CAD records also reflect that at 2.30pm, Senior Constable Thompson entered the words "*Charles Knife Road and 1 km north*", which further assisted with identifying the location. Mr Williamson had given Senior Constable Diviney the name of this road within two minutes of the call (that is by 2.05pm).[41]

Senior Constable Thompson was questioned in connection with Senior Constable Diviney allocating the job code as a "*welfare check*" rather than "*collapsed person*". Senior Constable Thompson considered this to be appropriate in light of Ewan being with his father, who had water. The welfare check directs police attendance, whereas collapsed person results in an immediate referral to the ambulance service. Given that Exmouth did not have a permanent ambulance service, he would still have referred "*collapsed person*" to the Exmouth police.[42]

At the material time the 000 call takers were not comprehensively trained in the application of job codes and they were not uniformly required to utilise them. The responding police officers in Exmouth relied on the descriptive text of the CAD task, which referred to a collapsed 14 year old person. They therefore treated it as urgent despite the job code. In these circumstances, the

[41] Exhibit 2, Tabs 4 and 13
[42] T 169

allocation of the job code for "*welfare check*" did not have an identifiably detrimental impact upon Ewan's prospects of survival. The responding police officers in Exmouth could not have dealt with it any more expeditiously than they did.

Senior Constable Diviney should have called for an ambulance

Senior Constable Diviney did not initiate a call for an ambulance. Before speaking with his supervisor, at 2.15pm Senior Constable Diviney had entered descriptive information conveyed to him by Mr Williamson onto the CAD. For the purpose of addressing whether he ought to have made arrangements to call for an ambulance, it is necessary to consider what he understood of the information conveyed to him. That is reflected in the telephone call record, Senior Constable Diviney's CAD entries and his evidence at the inquest.

The information entered by Senior Constable Diviney onto the CAD included the following: "*caller has called re his 14 yr old son has collapsed with exhaustion*", the GPS coordinates and "*25km south of Exmouth no shade little water caller requesting airlift*". He also included a reference to the "*Badjirrajirra Walk 25 km south of Exmouth*" in the address field.[43]

On the basis of the information provided to him by Mr Williamson, Senior Constable Diviney formed the opinion

[43] Exhibit 2, Tab 4

that an ambulance was not required. Instead of entering information on the CAD system to the effect that Ewan had collapsed "*with heat exhaustion*", his entry was to the effect that Ewan had collapsed "*with exhaustion.*" This put a less serious complexion on the situation.[44]

Mr Williamson had twice stated that he thought Ewan had "*heat exhaustion*" but Senior Constable Diviney did not hear him on the first occasion. Under cross examination Senior Constable Diviney agreed that he most likely heard Mr Williamson say "*heat exhaustion*" on the second occasion. Senior Constable Diviney conceded that with the benefit of hindsight, a reference to "*heat exhaustion*" (as opposed to "*exhaustion*") would have been a critical piece of information to include in the CAD.[45]

Senior Constable Diviney knew that the North West of this State tends to experience very hot temperatures in December, but he did not know the exact temperature around the Exmouth area for that day. He formed the view that Ewan was out of breath and needed water, shade, rest and recuperation. He was aware Mr Williamson had gone to fetch water. Upon inquiry, he had ascertained that Ewan did not have injuries. To his mind that made the situation less serious, and impacted upon his view of whether an ambulance was required.[46]

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[44] Exhibit 2, Tab 4
[45] T 292 - 303; Exhibit 2, Tabs 4 and 13
[46] T 274 – 275; T 283 – 284; T 297

Senior Constable Diviney considered that it was important to have the GPS coordinates before calling an ambulance in any event. This was disputed by some of the other witnesses. Inspector Gary Cunningham, the inspector in charge of the police operations centre since April 2013 gave evidence at the inquest. His view was that the incident related to a collapsed person and Senior Constable Diviney should have called an ambulance immediately. Inspector Cunningham described the GPS coordinates as additional information that could be used to update the CAD. [47]

In their report the Internal Affairs Unit concluded:

> "*There is no doubt, given the circumstances provided by Mr Williamson, that SJA ambulance services should have been contacted by police. Senior Constable Diviney should have alerted another member to assist during the call to Mr Williamson.*"[48]

Detective Sergeant Thomas, on behalf of the Internal Affairs Unit, informed the court that there is no policy that sates when an ambulance should be called. Rather it was the circumstances that defined that an ambulance should have been called.[49]

At the inquest Senior Constable Diviney agreed that with the benefit of hindsight, it was a medical emergency and it would have been appropriate to call for an ambulance. If the same job came through again, he would make those

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[47] T 208; T 221; T 260; Exhibit 2, Tab 2
[48] Exhibit 2, Tab 2
[49] T 234

arrangements for an ambulance while he continued with the call. From his perspective, in practical terms, this would be achieved by getting someone else to call the ambulance while he continues to take the call. This is consistent with the expected practice outlined in the Internal Affairs Unit's report.[50]

However, Senior Constable Diviney remained of the view that the GPS coordinates were required, otherwise the ambulance officers would not attend. In hindsight he believed that at the end of the call he had enough information to call an ambulance, because he had the GPS coordinates, the name of the trail and the approximate location.[51]

His supervisor Senior Constable Thompson also accepted that in hindsight it was a situation where an ambulance should have been contacted, but he also emphasised the importance of having a location to give to St John Ambulance officers. He explained that he would still have referred it to Exmouth police because he was aware that there is no permanent ambulance service at Exmouth. He accepted that if the original CAD task had referred to "*heat exhaustion*" rather than "*exhaustion*" this would have elevated his concerns.[52]

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[50] T 260; T 274-275; Exhibit 2, Tab 2
[51] T 260; T 274 – 275; Exhibit 2, Tab 2
[52] T 169 – 171; T 175 - 176; T 184

Counsel Assisting submits that Senior Constable Diviney had sufficient information to have called an ambulance by 2.06pm or, if I accept the GPS coordinates were vital, then by 2.10pm.

I take into account the fact that First Class Constables Du Cloux and Bott left Exmouth police station without having the GPS coordinates plotted. They had the name of the Badjirrajirra Walk and Charles Knife Road. The plotting task was being undertaken for them whilst they made their way to the scene. I also take into account that the St John Ambulance service dispatched the ambulance without any knowledge of the GPS coordinates.

However, it was through the plotting of the GPS coordinates gathered by Senior Constable Diviney and the conveyance of that information to the police officers whilst they were on their way, that they were able to be correctly directed to the Badjirrajirra Walk trailhead (they had taken a short wrong turn, which is easy to do on those tracks, and it was quickly rectified).

Through his counsel Senior Constable Diviney submits that whilst an ambulance should have been called at the first opportunity, the call was of a confusing nature, evidenced by his concluding remarks to Mr Williamson: "*I'll organise something for you*" and the fact that he sought to clarify it with his supervisor.

The fact that Mr Williamson did not himself at that stage consider it to be a life-threatening emergency does not operate to dilute Senior Constable Diviney's 000 call taker responsibilities once he had sufficient information to call for an ambulance. Nor can that responsibility be passed onto the supervisor Senior Constable Thompson, who did not himself hear the call.

I am satisfied that in his telephone call Mr Williamson by words and manner of speech (including his puffing and clear exhaustion) conveyed to Senior Constable Diviney the severity of the situation and provided him with sufficient information to have caused him to have made arrangements to call for an ambulance preferably by 2.06pm, and certainly by 2.10pm.

The critical information conveyed by Mr Williamson comprised the fact that Ewan was 14 years old, had collapsed with heat exhaustion (whether or not Senior Constable Diviney heard with word "*heat*" does not alter my conclusion), his breathing was shallow and they were on the Badjirrajirra Walk south of Exmouth. He was also made aware they had been walking for about three hours in the bush and Mr Williamson had gone to fetch water.

Senior Constable Diviney through his counsel also submits that he did not realise the severity of the situation and that

his mind was focussed on extricating Ewan. I have no doubt that had Senior Constable Diviney realised the severity he would have made arrangements for an ambulance to be called. It is clear to me that he did not realise the severity. It was not as a result of a failure of training. He ought to have realised the severity.

RESPONSE BY EXMOUTH POLICE, DEC and SJA AMBULANCE SERVICES

Exmouth Police are notified and depart

The responses by Exmouth Police, DEC and the St John Ambulance services were prompt, proper and appropriate in the circumstances. They are addressed below as part of the circumstances attending Ewan's tragic death.

When Senior Constable Thompson called Exmouth Police customer service officer Ms Lake at 2.18pm to inform her of the incident and upgrade its priority, she placed him on hold whilst she immediately informed the only Exmouth police officer on duty, First Class Constable Paul Bott. He checked his screen, saw the CAD incident created by Senior Constable Diviney and began to access the relevant maps to endeavour to plot the GPS coordinates. He recalled First Class Constable Du Cloux to immediate duty for an urgent job. He endeavoured to contact Mr Williamson, leaving messages.[53]

[53] T 45; T 131 – 133

First Class Constable Bott also contacted Mr Hogstrom of the DEC in Exmouth to arrange for him to plot the coordinates whilst he was driving to the location. First Class Constable Du Cloux arrived at the station by 2.26pm and by approximately 2.30pm, both police officers had left the station, with water supplies, to attend the incident. They both understood that there was a risk of heat exhaustion. As they were leaving or on their way, First Class Bott instructed Ms Lake to call for an ambulance, in case the St John Ambulance service did not already know about the incident.[54]

An ambulance is dispatched

At the same time that First Class Constables Du Cloux and Bott were preparing to leave the station, Mr Williamson made his first 000 emergency call for an ambulance. This was at 2.29pm. He told the St John Ambulance call taker that they were stuck out on the walk 21 kilometres south of Exmouth and said: "*My son's gone down, his breathing's laboured, it's a bad sign*". He again asked for a helicopter. The telephone line cut out but the ambulance was dispatched as a result of this call.[55]

Due to the telephone line having cut out, Mr Williamson made another 000 emergency call for an ambulance at

[54] T 45; T 131 – 133; Exhibit 1, Tabs 10, 11 and 25
[55] Exhibit 1, Tab 25

2.33pm. On this occasion Mr Williamson explained that Ewan was not conscious and his breathing was shallow. The call taker informed him the ambulance was already on its way and instructed him to place Ewan in the recovery position and monitor his breathing. She informed him that he would need to call back for instructions on performing cardiopulmonary resuscitation (CPR) if Ewan stopped breathing.[56]

By 2.36pm, Ms Roche (the Exmouth sub-centre ambulance dispatcher) was informed that Ewan was no longer conscious. When Ms Roche was first contacted by the call taker at 2.32pm, she initially endeavoured to contact the State Emergency Service (SES) because she was familiar with the terrain in the Cape Range National Park and she formed the view, correctly as it transpired, that any St John Ambulance officers that she sent out would require assistance to extricate Ewan.[57]

Ms Roche was unable to make contact with the SES. She made a number of telephone calls to arrange for the dispatch of the St John Ambulance volunteer officers on roster. By approximately 2.42pm, Ms Roche made contact with Ms Nicole Sexton and by 2.46pm, with Mr Craig Sigley. At her instruction Ms Sexton and Mr Sigley went to the sub-centre, prepared the ambulance, and departed by 2.55pm. Mr Sigley drove the ambulance and on the way, he was

[56] Exhibit 1, Tabs 10, 11 and 25
[57] T 88 – 92; Exhibit 1, Tabs 2, 12 – 14

made aware that Ewan had become unconscious. He therefore treated the job as a Priority 1, and whilst he was on the sealed road he drove at between 120 to 130 kilometres per hour. He was familiar with the general location of the Badjirrajirra Walk.[58]

Exmouth police arrive at Badjirrajirra Walk

First Class Constable Bott, with First Class Constable Du Cloux as his passenger, drove to the scene under Priority 2 conditions, with emergency lights and sirens, and exceeding the posted speed limit by no more than 20 kilometres per hour. They drove approximately 24 kilometres from Exmouth, and then turned right into Charles Knife Road and drove another 10 kilometres, the last five on unsealed road.

On their way, Mr Hogstrom, who had plotted the GPS coordinates onto a map, directed the police officers by telephone towards the trailhead of the Badjirrajirra Walk. He told them Ewan was approximately 700 metres along the walking trail. The GPS coordinates recorded by Senior Constable Diviney were not precise, but they proved to be of considerable assistance.[59]

As the police arrived at the unsealed section of Charles Knife Road, they received a telephone call from the station

[58] T 88 – 92; Exhibit 1, Tabs 2, 12 – 14
[59] Exhibit 1, Tabs 10 and 15

informing them that Ewan was now unconscious. Both police officers knew that the situation was extremely serious and they acted with all due haste.[60]

First Class Constables Bott and Du Cloux arrived at the car park at the commencement of the Badjirrajirra Walk at approximately 3.00pm. It had taken them some 30 minutes to get there, from the time they left the police station. As they were driving along the unsealed portion of the track that led to the car park, they were required to slow almost to a stop in order to be able to negotiate some of the large rocks and holes.[61]

At the car park First Class Constable Du Cloux filled his pockets with water bottles and got out of the police vehicle, running towards the start of the trail. First Class Constable Bott observed Mr Williamson's Toyota Prado with the engine running, windows up and no one in it. He also filled his pockets with water bottles and ran towards the trail. At this stage, their plan was to hydrate Ewan, get him into the air-conditioned police vehicle and, calculating that the ambulance would be some 20 minutes behind them, start driving back towards Exmouth to meet the ambulance.[62]

The walking trail at the start of the Badjirrajirra Walk was steep, rocky and with no shade. It was very narrow with

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[60] T 24 – 25; T 131 – 133; Exhibit 1, Tabs 10, 11 and 15
[61] Exhibit 1, Tabs 10 and 11
[62] T 25 – 27; T 133 – 135; Exhibit 1, Tabs 10 and 11

only enough room for one person to walk along. It had a rough surface with loose stones and steep drop offs to one side. Some parts were only accessible by climbing along rock faces. The weather was extremely hot and dry and the sun was reflecting off the rocks. By now the temperature was approximately 40 degrees Celsius. Both police officers ran along the trail in a northerly direction, calling out. When First Class Constable Du Cloux was approximately 300 metres along the trail, Mr Williamson responded to his calls. First Class Constable Bott was close behind. They ran a further 50 or so metres and found Mr Williamson who led them to where Ewan was lying.[63]

The police officers found Ewan in the culvert, with the sunshade over him. First Class Constable Du Cloux removed the sunshade and observed that Ewan was lying on his back. His legs were tucked under themselves, and his head was resting on a stone, towards the right. He appeared to be having a seizure. From the symptoms displayed by Ewan upon first sight, First Class Constable Du Cloux knew straight away that the situation was extremely serious.[64]

Ewan's breathing was laboured and he was not conscious. It appeared to First Class Constable Du Cloux that Ewan was suffering the effects of heatstroke. Together with First Class Constable Bott he endeavoured to lift Ewan out of the

[63] T 25 – 27; T 133 – 135; Exhibit 1, Tabs 10 and 11
[64] T 109; Exhibit 1, Tabs 10 and 11

culvert. They found this difficult in light of Ewan's height and weight. Due to the intense heat, they formed the view that it was imperative that they transport Ewan to the air conditioned police vehicle as soon as possible, to cool him down.[65]

Ewan is extricated from Badjirrajirra Walk

With assistance from First Class Constable Bott and Mr Williamson, Ewan was lifted onto First Class Constable Du Cloux's back and across his shoulders, in a fireman's carry. His airway was carefully managed whilst they did this. As First Class Constable Bott pushed from behind, First Class Constable Du Cloux began to carry Ewan along the trail towards the car park. It was a steep incline with a lot of loose rocks and stones on the surface. At this stage, First Class Constable Du Cloux was aware that Ewan was still breathing. After approximately 40 metres, First Class Constable Du Cloux had to stop and rest. With the assistance of the others, he carefully laid Ewan on the ground in the recovery position, protecting his head. They poured water over Ewan's head, arm pits, torso and groin in an effort to cool him down.[66]

At this point which was 3.10pm, First Class Constable Du Cloux saw that he had partial reception on his telephone and he rang Karratha police station, informing the officer

[65] T 109; Exhibit 1, Tabs 10 and 11
[66] T 26 – 28; T 134 – 136; Exhibit 1, Tabs 10 and 11

that the situation was dire and asking her to ensure the ambulance was coming under Priority 1 conditions. Within moments, the officer from Karratha passed this information, together with their approximate location along the trail, on to the St John Ambulance call taker who confirmed that an ambulance was coming from Exmouth as a Priority 1. This exchange of information resulted in the provision of further relevant information concerning the urgency and location to Mr Sigley, the volunteer ambulance driver, whilst he was on his way.[67]

In the meantime, shortly after First Class Constable Du Cloux made contact with Karratha police station, Ewan was again lifted onto his back and across his shoulders. With the assistance of First Class Bott pushing from behind, First Class Constable Du Cloux carried Ewan further up the trail. After another 30 to 40 metres, First Class Constable Du Cloux had to stop again to rest. Together they laid Ewan on the ground and poured more water over him. Then Ewan was lifted onto First Class Constable Du Cloux's back and the same process was repeated for another 30 metres, because he wanted to get up the next rise before he stopped again. When they stopped, they again poured water over Ewan. His breathing was still laboured and he remained unconscious.[68]

[67] Exhibit 1, Tab 11 and 25
[68] Exhibit 1, Tabs 10 and 11

At this point, the trail widened for approximately 20 metres and the three men lifted Ewan together and carried him along for the 20 metres, before placing him on the ground. Again they poured water over Ewan. At this point First Class Constable Du Cloux and Mr Williamson placed Ewan in the recovery position and endeavoured to shade him, whilst First Class Constable Bott travelled back to the top of the trail to get a telephone signal in order to see how far away help was.[69]

It took First Class Constable Bott approximately five minutes to reach the top of the trail, and he made telephone contact with the Karratha police station. It was approximately 3.25pm. He requested that Acting Sergeant Cahill and First Class Constable Kelsey be recalled to duty to attend urgently to assist in extricating Ewan from the trail. These officers responded immediately. Within two minutes First Class Constable Kelsey had rung First Class Constable Bott and arrangements were made for First Class Constable Bott to meet them at the Charles Knife Road turn off to guide them to the trail.[70]

As First Class Constable Bott was driving towards the turn off, he encountered the St John Ambulance volunteers in their ambulance, being followed by two staff members from the DEC, Mr Campbell and Ms Halkyard. It was just after 3.25pm. First Class Constable Bott stopped and briefly

[69] T 136 – 137; Exhibit 1, Tabs 10 and 11
[70] T 136 – 137; Exhibit 1, Tabs 10 and 11

spoke with the ambulance volunteers, in order to outline the gravity of the situation and direct them to the precise location.[71]

The ambulance arrived at the car park by 3.30pm and within minutes volunteer ambulance officer Mr Sigley had located Ewan on the trail. He had with him the oxy viva and scoop stretcher. Upon arrival Mr Sigley observed Ewan to be cyanotic. His pupils were dilated and he was unresponsive. Mr Sigley took Ewan's pulse and it was present but weak. He noted that Ewan's skin felt very hot. He immediately applied oxygen to Ewan.[72]

Mr Sigley took the lead on the medical treatment provided to Ewan. He had received training on the treatment of hyperthermia and heatstroke and knew that it was to be addressed by cooling the person's body. The ambulance had cool packs and cold water for this purpose.[73]

Shortly after Mr Sigley's arrival, Mr Campbell from the DEC arrived on the trail with further equipment, including the trauma bag and drug kit that Ms Sexton, the other volunteer ambulance officer, had provided to him in the car park. Mr Campbell was also a volunteer ambulance officer qualified in advanced ambulance care. Mr Campbell assisted Mr Sigley with the administration of oxygen and

[71] T 69 – 70; Exhibit 1, Tabs 2, 10 and 14
[72] T 69 – 70; Exhibit 1, Tabs 2, 10 and 14
[73] T 70 - 71

with cooling Ewan with water. Ms Sexton arrived and took over the administration of the oxygen.[74]

As First Class Constable Du Cloux, Mr Sigley and Mr Campbell lifted Ewan onto the stretcher, his breathing stopped. This was approximately five minutes after Mr Campbell's arrival. Mr Sigley and Mr Campbell immediately began to perform CPR upon Ewan. Ms Sexton returned to the ambulance to fetch the defibrillator. When she got there she also dispensed a fresh cylinder of oxygen to First Class Constable Du Cloux who had run to the car park to fetch it. They both returned to the trail where Ewan was. However, given that Ewan was now drenched in water, it was decided not to use the defibrillator.[75]

Mr Sigley formed the view that they had to get Ewan to Exmouth District Hospital as soon as possible. He instructed that they would lift and carry Ewan on the stretcher for six paces then lower him and continue CPR. He calculated that this would mean there would be less than ten seconds between each cycle of CPR. Mr Sigley, with Mr Campbell's assistance, continued to perform CPR on Ewan. First Class Constable Du Cloux assisted both of them with the compressions. They continued in this manner lifting, carrying, lowering, and performing numerous cycles of CPR each time they stopped.

[74] Exhibit 1, Tabs 2, 10, 11, 13, 14, 16 and 17
[75] T 69 – 70; T 77; T 147 – 148; Exhibit 1, Tabs 2, 10, 11, 13, 14, 16 and 17

Ms Halkyard also assisted with compressions. Ms Sexton continued to assist with cooling Ewan.[76]

First Class Constable Bott attended to Mr Williamson and assisted him to the car park. Mr Williamson was exhausted, and was at risk of a heat related illness. Earlier when First Class Constable Bott had been at the car park he had continued to liaise with First Class Constable Kelsey in order to direct him to their planned meeting place. As they got Ewan to the top of the hill before the car park, Acting Sergeant Cahill and First Class Constable Kelsey came running down the trail, to also offer their assistance.[77]

It was now approximately 3.50pm. Ewan had been moved some 310 metres from where he was initially located by First Class Constables Du Cloux and Bott in the culvert, but he was still 80 metres from the car park. First Class Constable Kelsey immediately commenced to assist with compressions and together with Acting Sergeant Cahill, he assisted Mr Sigley and Mr Campbell with carrying Ewan on the stretcher.[78]

By now the heat was intense. The effect is reflected in First Class Constable Kelsey's evidence to the effect that the rocks on the trail were so hot that he had to lift his knees off the ground whilst he was performing compressions, as he

[76] T 36; T 70; Exhibit 1, Tabs 2, 10, 11, 13, 14, 16 and 17
[77] T 148 – 149; Exhibit 1, Tabs 2, 10, 11, 13, 14, 16 and 17
[78] T 148 – 149; Exhibit 1, Tabs 2, 10, 11, 13, 14, 16 and 17

could feel them burning through his overalls. He believed it was approximately 35 degrees Celsius when he left Exmouth, and estimated that it was between 40 and 45 degrees Celsius on the trail.[79]

Together they all made progress carrying Ewan up the trail and towards the car park. It was of necessity slow and laborious due to the need to intermittently stop and perform CPR, and the physical demands involved in carrying Ewan on the stretcher along the steep and narrow trail in the intense heat. The gravity of the situation could not be, and was not, underestimated. I have no doubt that it was a harrowing experience for all involved. They could not have applied more effort to rescue Ewan.

Ewan is conveyed to hospital

They reached the car park by approximately 4.00pm, and Ewan was placed into the ambulance. It was almost two hours after Mr Williamson first made contact with police for assistance. Mr Sigley and Mr Campbell continued performing CPR on Ewan in the back of the ambulance, using the ambulance oxygen system. Ms Sexton remained with them and assisted with Ewan's observations. First Class Constable Kelsey drove the ambulance as quickly as the conditions permitted.[80]

[79] Exhibit 1, Tab 2
[80] T 148 – 150

The start of the conveyance, on the unsealed track, caused the ambulance to rock from side to side creating difficulty with the compressions. Once they were on the sealed road, they were able to make better progress. Acting Sergeant Cahill drove the police car in front of the ambulance, with emergency lights, escorting them in convoy from the track. The ambulance followed, with emergency lights. First Class Constable Bott drove the police vehicle after the ambulance, also with emergency lights. Mr Williamson and First Class Constable Du Cloux were in this vehicle.[81]

After about 10 minutes, the ambulance reached the Exmouth-Minilya Road, which is the main road into Exmouth. The ambulance was brought to a stop and Mr Sigley momentarily ceased performing CPR, in order for Mr Campbell and Ms Sexton, to apply the defibrillator. When it was activated no shockable rhythm was detected. Mr Sigley and Mr Campbell immediately recommenced CPR as the ambulance continued the urgent conveyance to Exmouth District Hospital. At this stage, Mr Sigley observed that Ewan's pupils were fully dilated, he had no pulse and he was asystole. Other than when the defibrillator was activated, CPR was continuously performed on Ewan.[82]

[81] T 148 – 150; Exhibit 1, Tabs 2, 10,11,13,14, 16 and 18
[82] T 149; Exhibit 1, Tabs 13, 14, 16 and 18

When the police were extricating Ewan from the trail, First Class Constable Bott had contacted Dr Peter Hannay, medical officer at Exmouth District Hospital, to inform him of Ewan's poor condition and that they were about to commence CPR. As they were on the way to the hospital, First Class Constable Du Cloux kept the hospital informed of their impending arrival. This enabled Dr Hannay and the trauma room nursing staff to prepare for Ewan's arrival. At approximately 4.30pm, Ewan arrived at the hospital in the ambulance, with active CPR in progress. Dr Hannay and a number of nurses were waiting at the entrance.[83]

Ewan is unable to be resuscitated

Ewan was transferred out of the ambulance to the trauma room whilst CPR and mask-bag ventilation continued. Upon arrival Ewan felt isothermic, which was consistent with the water having been poured over him to cool him down. His airway was clear but he was not breathing. He had no pulse or heart rhythm. His pupils were fixed and dilated. Ewan was intubated and resuscitation attempts continued at the hospital under the guidance of Dr Hannay.[84]

Ewan's blood test results were available within 30 minutes, and they showed he had serious metabolic acidosis with hyperkalaemia, indicting a serious cellular injury. The

[83] T 79 – 80; Exhibit 1, Tabs 2 and 22
[84] Exhibit 1, Tab 22

doctors checked for signs of snake bite, but did not find any. After approximately half an hour of resuscitation effort, Dr Hannay thought he elicited a very faint pupil response from Ewan and on this basis, he continued resuscitation for another half an hour. Further blood test results indicated a grave metabolic situation.[85]

Tragically, despite all efforts Ewan was not able to be saved. There was no spontaneous breathing or any respiratory effort. There was no spontaneous return of circulation. Resuscitation efforts were ceased at 5.33pm and Ewan was pronounced dead. I concur with Dr Hannay's opinion that in hindsight the situation was unsalvageable from at least the time of his arrival at Exmouth Hospital.[86]

Notwithstanding his dire presentation, Dr Hannay's evidence was that an extraordinary effort was made to resuscitate Ewan and he referred to their sustained and combined efforts:

> *"….it's my belief that the police and the ambulance personnel did an extraordinary job in maintaining cardiopulmonary resuscitation attempt whilst, firstly, retrieving him from the site where he was found, getting him to the ambulance and then getting him to the hospital, ….in extreme conditions, and ….put themselves at considerable risk in doing so, and ….they had gone way beyond physical effort of what could reasonably be expected of them to the point of life support manual ….and Ewan being a child, relatively, albeit of almost ….adult physical proportion in many respects, ….we felt that we had the facility that it was only right and proper that we should give this person every chance that we could possibly do, no matter what – how*

[85] T 79 – 86; Tabs 4 and 22
[86] T 79 – 86; Exhibit 1, Tabs 4 and 22

> *bleak the outcome seemed at the time when we commenced that."*[87]

It is clear to me that Dr Hannay and his team applied all possible and proper means to resuscitate Ewan, in the face of a very difficult set of circumstances and there is nothing more they could have done to save him.

Based upon Ewan's blood test results of that day, Dr Hannay's impression was that Ewan had suffered heatstroke or an exertional heat injury, or a combination of both.[88]

CAUSE AND MANNER OF DEATH

On 27 December 2012 forensic pathologist Dr J. White made a post mortem examination of the deceased at the State Mortuary. At the conclusion of the examination Dr White was unable to form an opinion on the cause of death, and further investigations were undertaken (histology, toxicology, microbiology and biochemistry). Medical information from Exmouth District Hospital was reviewed.[89]

Microscopy of the tissues showed areas of haemorrhage and possible areas of early acute ischaemia within the myocardium of the heart. In addition there were a few foci

[87] T 85
[88] T 84
[89] Exhibit 1, Tab 32

of inflammation in the heart muscle. There were no overt infective changes.

Toxicological analysis was negative for alcohol and common drugs.[90]

Microbiological studies isolated parvovirus B19 from the heart. Abundant growth of streptococcus pyogenes group A was isolated from lung tissue suggesting a possible lung infection, but Dr White was unable to confirm it histologically.

Post mortem biochemistry revealed lactate to be high in keeping with prolonged resuscitation.

On 9 May 2013 after the completion of the further investigations Dr White formed the opinion that Ewan's cause of death was consistent with severe heatstroke/exhaustion in a young boy complicating a recent viral illness with focal myocarditis.

At the inquest Dr White explained that heatstroke was based upon her excluding other causes as a result of her investigations. She described myocarditis as a condition in which the heart muscle is inflamed. It can occur at any age. Parvovirus B19, which Dr White detected from the heart muscle, has been known to cause myocarditis.[91]

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[90] Exhibit 1, Tab 33
[91] T 111; T 156 – 160

However, parvovirus B19 can also linger in tissues after a childhood infection without necessarily being the cause of the myocarditis. Other viruses may cause it. Dr White's conclusion was that Ewan's myocarditis was caused by a common cold or influenza. It is known that Ewan had a head cold shortly before he departed for Australia. He had only been in Australia for five days.[92]

Most people with myocarditis are not usually affected by it, but it is recorded as one of the causes of sudden death because it can interrupt the normal beating of the heart. The heart muscle is damaged, making the heart more vulnerable to abnormal rhythms particularly when placed under stress. Heatstroke such as was experienced by Ewan would have been a considerable stressor. In evidence Dr White opined that Ewan died of heatstroke but she could not establish with certainty the degree to which the myocarditis contributed to Ewan's death.[93]

Taking account of Ewan's history of a recent viral illness and Dr White's evidence, I am satisfied that his viral illness likely led to the subsequent focal myocarditis which made Ewan more vulnerable to the effects of heatstroke.

The cause of Ewan's death is severe heatstroke complicating a recent viral illness with focal myocarditis.

[92] T 111; T 156 – 160
[93] T 156 - 160

Mr Williamson had not intended for Ewan to be out on the Badjirrajirra Walk for three hours. Unfortunately on their way back Mr Williamson erroneously headed in the wrong direction and away from the carpark. There is always a risk of disorientation in remote areas during prolonged exposure to the intense heat. The result was that Ewan spent far more time in the heat than was ever planned.

The manner of Ewan's death is by way of accident.

EXPERT EVIDENCE ON HEATSTROKE

Professor Ian Rogers, professor of emergency medicine, St John of God Murdoch Hospital and University of Notre Dame gave evidence at the inquest in connection with the likely effect of the heatstroke upon Ewan and whether his death was preventable.

Professor Rogers qualified as a specialist emergency physician in 1992 and has had a sub-speciality in wilderness environmental medicine. He has conducted research studies and authored a number of text book chapters on heat related illnesses. He teaches medical students in this area and presently sits on the editorial board of the international journal Wilderness Environmental Medicine.[94]

[94] T 101

Prior to the inquest Professor Rogers reviewed Dr White's post mortem examination findings and the statements of witnesses in this investigation. From his review he noted that Ewan's core temperature was not taken at any stage, but that that the volunteer ambulance officer found him hot to the touch when he arrived, which is a striking feature of heatstroke. He also noted that upon arrival, the ambulance officer had found Ewan had a faint but rapid pulse and that inflammation was found in Ewan's heart muscle (myocarditis) post mortem, a factor that will have impaired his heart function.[95]

Professor Rogers informed the court that impaired heart function reduces the capacity of the body to move heat from the core to the periphery, where heat energy can be dissipated. However, given the overwhelming environmental factors, he was unable to offer an opinion as to how much the myocarditis contributed to Ewan's death, other than to say that whilst it must have contributed in some part, it would be likely to be small. Professor Rogers' evidence was that he was very certain that Ewan died from heatstroke.[96]

In Professor Rogers' experience, heatstroke is the only universally agreed heat illness, and is defined by a core body temperature greater than 41 or 41.5 degrees and dysfunction of the brain or nervous system (altered mental

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[95] T 110
[96] T 107; T 111 - 112; Exhibit 3, Tab 1

state, confusion, seizures, and/or coma). It is a time-critical medical emergency. It is to be distinguished from heat exhaustion that is a term commonly used for someone becoming ill in a hot and thermally stressful environment.[97]

The first manifestations of heatstroke are in the nervous system and include lethargy, an unwillingness to continue exerting, or an unwillingness to cooperate or converse. Untreated there will be a progressive decline in conscious state, and an eventual lapse into unconsciousness, often followed by seizures. Ewan's laboured breathing and slower breaths were likely to be a manifestation of the increasing depression of his conscious state. Ultimately there will be dysfunction of most of the organ systems in the body. The heart is likely to be affected last, being the organ most resistant to heat stress. Children's hearts are particularly resilient. Ewan's cardiac arrest was a measure of the magnitude of the heatstroke he suffered.[98]

Ewan's body took on heat from direct solar radiation and from exertion when he was walking the trail. He also took on heat from indirect radiation, namely the surfaces he was in contact with. In the culvert, he lay on the ground and was in contact with the hot rocks.

In the pre-hospital setting, the ideal treatment for heatstroke is cold water or ice water immersion, where this

[97] T 104; T 113
[98] T 104 – 105; T 125 - 126

is possible. In the hospital setting, to maintain the patient near the monitoring equipment, the room is cooled and the patient is sprayed with water and actively fanned to maximise the heat loss by evaporation. To further assist a patient in losing heat, usually ice packs are placed in the areas of the neck, armpits, and groin and behind the knees, in order to transfer the cold to those blood vessels that are close to the skin and easy to access.[99]

In Professor Rogers' opinion, the prospect of Ewan surviving became very unlikely when he went into cardiac arrest. Loss of consciousness does not portend a grave prognosis, so long as active cooling therapies can be undertaken. The reported mortality with cases of heatstroke is 10%. Had Ewan been brought into an emergency department unconscious but still breathing with a normal pulse and blood pressure, with the application of full and aggressive cooling Professor Rogers believes he would probably have survived. He would most certainly have gone into intensive care, and may have suffered long-term organ damage.[100]

Professor Rogers did not consider that Ewan's previous days of activity were likely to have affected his ability to deal with the heat, but he did point out that partial adaption to a hot environment typically takes five to seven days. Five days earlier Ewan had come from Scotland, where it was wintertime, and he travelled to the north-west of this State,

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[99] T 108 – 109; T 112 - 113
[100] T 116 – 117; T 125– 126

in summertime. For a young traveller, the temperature differences could not have been starker.[101]

It is to be borne in mind that full adaptation is not fully protective in any event. In Ewan's case, the significant contrast in temperatures meant that the adaptation he needed to undertake was greater. It was at least 40 degrees Celsius when Ewan was out on the trail. Professor Rogers described an ambient temperature of this nature, in the middle of the day, irrespective of the level of humidity, as coming within the extreme heat load category.[102]

The rocks that Ewan came into contact with when he was laid down were subsequently measured at approximately 52 to 57 degrees Celsius. I accept that analysis. The effect of that contact was manifest in Ewan's injuries, namely burns to his skin. Professor Rogers had not previously seen such injuries, because he had not seen a heatstroke patient that has been in that type of environment with very limited or absent natural vegetation. The result of lying on the rocks is that the heat gain is transferred back to the core.[103]

Professor Rogers was questioned on what would have been the best treatment for Ewan under the circumstances in which he was found. In his opinion it was important to minimise ongoing heat gain, by shading Ewan and

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[101] T 112; T 118 – 119
[102] T 112; T 118 – 119
[103] T 121 - 122

insulating him from the hot surfaces, splashing his bare skin with water and fanning him to maximise evaporative heat loss. The key determinants of outcome in heatstroke are how hot you get and how long you stay hot for.[104]

On the basis of his specialist knowledge, Professor Rogers' preference would have been to try and cool Ewan by whatever methods possible out on the trail, though he did acknowledge that clearly there was a need to get Ewan to the ambulance as well. He opined that it was a judgment call as to whether it would have been preferable to cool Ewan on site or try to move him to the ambulance. He summarised the dilemma: "*…extrication takes you away from cooling; cooling stops you from extrication.*"[105]

Professor Rogers was complimentary of the police officers' attempts, which he described as heroic, to get Ewan to the ambulance. He stressed that he would not expect them to have his specialist knowledge of heat illness. In his view, their actions were consistent with what he would expect of a lay provider and first responder with first aid training.[106]

I am satisfied that the decision by First Class Constables Du Cloux and Bott to immediately proceed with the extrication (whilst applying some cooling techniques) was appropriate in the circumstances. There is no doubt in my mind that

[104] T 115
[105] T 115
[106] T 122 - 123

they prioritised Ewan's health and safety above all other considerations, including their own health and safety.

Once Ewan went into cardiac arrest, very shortly after the arrival of the ambulance officers, resuscitating him became the priority. The officers endeavoured to get him to the ambulance as soon as possible, whilst maintaining CPR and continuing to cool him. This was the only appropriate course in the circumstances.

WAS EWAN'S DEATH PREVENTABLE?

To summarise the relevant timing considerations: the police departed by 2.30pm and arrived at the car park at 3.00pm. The ambulance departed by 2.55pm and arrived at the car park just after 3.30pm. Both vehicles drove under priority conditions and took approximately half an hour to travel to the car park. Once they reached the car park, it was a matter of minutes before they found Ewan on the trail. Ewan went into cardiac arrest shortly after 3.30pm. These times are approximate.

Had Senior Constable Diviney made arrangements to call for an ambulance by 2.10pm, it would have had to be relayed to the volunteer ambulance officers in Exmouth. Approximately one hour elapsed from the time that Mr Williamson called for an ambulance (2.30pm) to the time of its arrival (3.30pm).

Care is to be taken in inferring how long it would have taken an ambulance to arrive if it had been called for by Senior Constable Diviney at 2.10pm, as there would be a range of unknown intervening factors. To presume that an ambulance called for at 2.10pm would arrive by approximately 3.10pm or earlier, is speculation.

Ewan's condition presented a time-critical medical emergency that relied, in part, upon the arrival of the St John Ambulance volunteer officers. Whilst a reconstruction under varying scenarios is not possible, in assessing whether Ewan's death was preventable, it was necessary to take evidence about the likelihood of his prospects of survival had an ambulance arrived at an earlier point.

In his report Professor Rogers provided an opinion on Ewan's prospects of survival had police and ambulance officers been able to attend to him 10 to 15 minutes earlier. For practical purposes his opinion is referrable to the hypothetical arrival of ambulance officers by approximately 3.15pm or 3.20pm.

Professor Rogers opined that had the ambulance officers arrived 10 or 15 minutes earlier, it would be unlikely to have altered Ewan's prospects of survival. The key interventions to save Ewan would have involved aggressive cooling strategies. Having regard to the circumstances he

expressed the following view in connection with the environment and available resource:

> *".... [they] worked against effective cooling with ongoing radiant, conductive and convective heat gains, and limited capacity to provide evaporative cooling (which in this environment, in the absence of specialised equipment, is the only possible method of active cooling that could be employed)."*[107]

At the inquest Professor Rogers was asked about the likely effect on Ewan's prospects of survival had an ambulance hypothetically arrived at approximately 3.00pm, that is, half an hour earlier. He prefaced his response by noting that the ambulance officers would have more advanced skills for recognising heatstroke and applying cooling techniques, and the ambulance itself was an environment where Ewan could be protected from solar radiation, the ambient temperature could be made as low as possible and it would be easier to employ cooling strategies. It also followed, logically, that there would be some additional assistance available with extricating Ewan. On the likely effect Professor Rogers opined as follows:

> *"....any time that he could be actively treated – actively and effectively treated earlier when he wasn't in cardiac arrest, must have increased his chances of survival and must have increased his chances of survival substantially."* [108]

Professor Rogers' evidence goes to show just how time-critical Ewan's treatment needs were on that day. It is to be borne in mind that effective cooling treatment would still have required Ewan to be extricated and in the ambulance

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[107] Exhibit 3 Tab 1
[108] T 127 - 128

due to the limited capacity to provide evaporative cooling on the trail.

The difficulty is that a judgement would still need to be made about whether to prioritise the cooling on site or the extrication to the ambulance for better cooling, and how to balance the two competing imperatives.

Given the surrounding factors, namely the environmental heat load, the length of time Ewan had been exerting himself in that environment, and to a degree his myocarditis, it cannot be known for certain what the outcome would have been. Had an ambulance arrived earlier it would have increased Ewan's prospects of survival. However it cannot be said with certainty that his survivability would have been assured, or sadly, that it would even have been likely.

He could possibly have survived and it would still have been dependent on how quickly he could have been extricated. Certainly it was critical to have afforded Ewan every opportunity to be brought to safety in order to maximise his prospects of survival.

I accept Professor Rogers' opinion and I am satisfied that, in hindsight Ewan's decline in health became irreversible and not responsive to treatment at or soon before the time of his cardiac arrest at approximately 3.30pm.

DID POLICE CAUSE OR CONTRIBUTE TO EWAN'S DEATH?

The law mandates an inquest when a death **appears** to be caused, or contributed to, by any action of a member of the Police Force (sub section 22(1)(b) Coroners Act, emphasis added). It provides for the independent and public scrutiny of the actions of the police officers by the coroner in furtherance of the protection of the community, whenever a death has that appearance.

This consideration does not arise in connection with the actions of police officers in Exmouth. They acted promptly, appropriately and with all due care and concern for Ewan's safety.

The question is enlivened in connection with Senior Constable Diviney's actions during and after his call with Mr Williamson.

The Internal Affairs Unit investigation sustained a finding of poor performance against Senior Constable Diviney, concluding that the effectiveness of the police emergency response to Mr Williamson's call for assistance was hampered by the slow and non-empathetic manner in which he obtained and relayed the information.[109]

[109] Exhibit 2, Tab 2

On 28 August 2013 a Managerial Notice was issued to Senior Constable Diviney, acknowledged as received by him on 19 September 2013 that addressed the following shortcomings:

- Failure to commit vital information to the CAD as soon as practicable;
- Allocation of incorrect priority to the CAD task;
- Not informing Mr Williamson of what to expect from police at the end of the call;
- Not giving consideration to alerting the St John Ambulance Service.[110]

I am relevantly informed but not bound by the outcome of the Internal Affairs Unit investigation. The question before me is a different one, namely the investigation of the causal or contributory factors to Ewan's death.

There was a missed opportunity to call for an ambulance at the very least at a point towards the latter part of Senior Constable Diviney's telephone call with Mr Williamson. It ought to have been called.

For reasons that I have outlined above concerning the environmental heat load sustained by Ewan after exerting himself for three hours on the trail in the sun, and then lying on the hot rocks, it cannot be known what the

[110] Exhibit 1, Tab 3

outcome would have been had an ambulance been called for at that point. By the time Ewan collapsed, having regard to the magnitude of the heatstroke, the remoteness of the location and the time it would take to convey him to hospital, his chances of survival were very poor.

I am satisfied that Ewan's death was not caused or contributed to by any action of a member of the Police Force.

WAS A HELICOPTER AVAILABLE?

On more than one occasion, Mr Williamson had requested a helicopter to assist with Ewan's extrication. At the inquest I explored the availability of a helicopter for Ewan.

Records reflect that at 2.15pm Senior Constable Diviney entered Mr Williamson's request for an airlift into the CAD. At 3.57pm, it is noted on the CAD that Perth Air Wing was attempting to source a rescue helicopter in case it was needed. Very sadly, by this time it would have been too late.[111]

Senior Constable Thompson informed the court that he had not previously seen a request for airlift on a CAD task. He was aware that it would require an initial assessment by police officers "*on the ground*". He did not make inquiries about a helicopter and his evidence was to the effect that

[111] Exhibit 2, Tab 4

once the CAD task is allocated to Exmouth police, they will make the assessment and decide whether it is necessary. Both he and Senior Constable Diviney confirmed that a helicopter cannot be arranged by a 000 call taker.[112]

At the material time, First Class Constable Bott did not believe that extrication was available by means of a helicopter in the Exmouth area. He had not previously seen a request for airlift on a CAD task. He believed that in order to arrange it, he or the officer in charge of the Exmouth police station would have had to contact the Karratha police station for them to progress it with Police Air Wing. As soon as he became aware of Ewan's plight, he prioritised the police departure to Badjirrajirra Walk.[113]

First Class Constable Du Cloux had not previously made arrangements for an airlift either. He also believed that such a request needs to go through the chain of command, to be relayed to Police Air Wing, for them to locate a helicopter with winch capability.[114]

On his way to the car park, the officer in charge of Exmouth police station, Acting Sergeant Cahill, having received an update from First Class Constable Bott, did contact the Police Air Wing, and informed them of the situation. He requested that arrangements for a helicopter be made in

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[112] T 173 - 175; T 259
[113] T 134
[114] T 48 - 49

case an airlift was required. This occurred between approximately 3.30pm and 3.50pm. Shortly after Acting Sergeant Cahill arrived at the site, they were able to complete the extrication of Ewan. The helicopter that was on standby in Perth was cancelled at approximately 5.00pm that day.[115]

St John Ambulance did not have access to a helicopter for that area and would have had to make those arrangements through police.[116]

Detective Sergeant Thomas, in charge of the Internal Affairs Unit's investigation informed the court that a helicopter would not have been dispatched until police officers had arrived at the scene to conduct an initial assessment. He confirmed that arrangements for a helicopter are made through the Police Air Wing. However, in his experience the process may be lengthy in comparison to the 30 minutes that it took for the two police officers to arrive.[117]

Inspector Cunningham informed the court that there are three helicopters available that have lift capability for winching. They are usually based in Perth and he described a fairly lengthy process for getting one to the Exmouth area, of up to some hours.[118]

[115] Exhibit 1, Tab 18
[116] T 240
[117] T 208 - 209
[118] T 312 - 313

In this case it would have been necessary for First Class Constables Bott and Du Cloux to have first assessed the requirements, as the terrain mandated a helicopter with winch capability. Clearly, a helicopter could not land at or near the culvert where Ewan lay. If the attending police officers had made that assessment shortly after arriving at 3.00pm and commenced arrangements for an airlift, it is doubtful as to whether Ewan would have been extricated any faster.

TRAINING AND LOGISTICAL SUPPORT

At the inquest I explored what other support might have assisted with the police response at the material time.

Police Training

The police are not medically trained personnel. They receive first aid training and other training that equips them to assist in an emergency situation pending the arrival of ambulance officers. The police officers were adequately trained to recognise heatstroke and apply cooling techniques. The difficulty in these circumstances arose because of the need to balance extrication as against effective cooling in a very hot and remote environment.

First Class Constable Du Cloux had received first aid training which included how to identify and respond to heat related illnesses. He received that training at the Police Academy, with subsequent refreshers. He also had more in-

depth military training in the area. When he left the station he anticipated a heat related illness and his plan was to take Ewan to their air-conditioned police vehicle, to await the ambulance. The other alternative he considered was a snake bite, which was reasonable in the circumstances. When he ran towards the trail, he filled his pockets with about eight bottles of water. He understood there was a need to reduce Ewan's body temperature. When he reached Ewan and touched him, he correctly identified the risk of heatstroke.[119]

First Class Constable Bott's training was through the Police Academy and his actions also reflected his understanding of the need to reduce Ewan's body temperature.[120]

The attending police officers prioritised extrication, and they kept cooling him with water as they did this. It was reasonable in the circumstances.

St John Ambulance volunteer officers' training

There are no paramedics in Exmouth. The St John Ambulance operates a volunteer service. The volunteers have access to a community paramedic who services five sub-centres including Exmouth. Further clinical support is provided by a paramedic at their central operations on a

[119] T 24-26; T 32, T 42-45
[120] T 135

24 hour, seven day a week basis, who also has contact with medical personnel.[121]

As at the material time, volunteer ambulance officers were required to undergo courses in primary and advanced ambulance care. One of those units contained a module on hyperthermia (including identifying and responding to it). Before commencing their roles, they were also required to complete a senior first aid certificate that also covered hyperthermia.[122]

Mr Smith, general manager of the St John Ambulance service for regional areas gave evidence at the inquest. He informed the court that every sub-centre in the north-west of this State is acutely aware of the environmental conditions, and are appropriately equipped to address them with additional supplies of water and ice packs.

The training module and development guide for St John Ambulance officers properly addressed the identification of and treatment for heatstroke, and is consistent with the evidence given by Professor Rogers on those points.[123]

I am satisfied that the regional training did, and continues to, adequately train volunteer ambulance officers to identify and respond to heatstroke.

[121] T 246
[122] Exhibits 6.1 and 6.2
[123] Exhibits 6.1 and 6.2

Logistical Support

The evidence at the inquest established that for practical purposes the only other assistance on the day would have been the availability of more persons to assist with lifting and carrying Ewan.

First Class Constable Bott stated that in hindsight, had he known the terrain he was going into, he would have arranged for more people and for the attendance of a doctor from the Exmouth District Hospital.[124]

In evidence, First Class Constable Bott maintained that had the police vehicle been equipped with a stretcher, it would only have saved them a couple of minutes. He described that portion of the trail as a "goat's track" going uphill and very slippery underfoot.[125]

First Class Constable Du Cloux, who carried Ewan, considered he would have been assisted by a stretcher, because he found it extremely challenging trying to negotiate the track whilst carrying Ewan. However he believed a stretcher may only have saved five minutes, given the state of the trail.[126]

Mr Smith of the St John Ambulance Service indicated that it is common practice in country towns for the direct phone

[124] T 139
[125] T 140
[126] T 35

call to be made to the volunteer ambulance officer, who may have connections with volunteer SES or fire fighter personnel.[127]

There are local emergency management meetings that involve police, fire, ambulance services and the officers from the local government services. Inspector Cunningham confirmed that in regional areas, reliance is placed upon local knowledge on the part of the police officers and their interaction, particularly within the forum of the emergency management meetings.[128]

Undoubtedly a better outcome would have been achieved for Ewan if there were more persons available to assist with extricating him.

However, the threshold issue concerns knowledge about the area in which the extrication is to take place. The responding police officers did not have advance knowledge of the conditions on the trail. That compounded the difficulties in the extrication.

Since that time, improvements in practices and technology, addressed below have substantially reduced this risk.

[127] T 242
[128] T 243; T 315

IMPROVEMENTS SINCE EWAN'S DEATH

Dedicated 000 Call Taker section

In order to improve the quality of the police emergency response, in November 2013 a permanent section was created within the police operations centre for 000 call taking. Twenty constables and five sergeants were transferred into that area. One of the self-evident benefits is that 000 calls are now taken by dedicated, trained and experienced police officers and qualified police assistance centre staff.[129]

Mandatory training for 000 Call Takers

Senior Constable Diviney completed his dispatcher training in October 2010 and was deemed competent on 15 October 2010 after completing the 000 Call Taker Assessment on 5 September 2010. Being a sworn member of the Western Australia Police he did not undertake a formal 000 Call Taker training course.[130]

Now, the formal 000 Call Taker training course is mandatory for all sworn and/or unsworn staff members undertaking duties as 000 call takers. It is of 40 hours duration and consists of classroom lessons, on the job training and assessment. Refresher training of seven hours duration is undertaken every 12 months. The clear

[129] Exhibit 3, Tab 6
[130] Exhibit 2, Tab 2; Exhibit 3, Tab 6

standard operating procedure is to require the prompt initiation of a CAD task with basic information so that resources can start to be arranged. The CAD task is then updated with further relevant information as it becomes available.[131]

Training in GPS co-ordinates

Senior Constable Diviney had not been trained in the use of the GPS system. It was not part of his training course. During the phone call with him, Mr Williamson was reading the co-ordinates as south/east co-ordinates in degrees, minutes and seconds. The CAD records GPS coordinates in digital format.[132]

Mr Hogstrom of the DEC was provided with the coordinates taken by Senior Constable Diviney, he converted them into digital format and entered them into the DEC's spatial support system. At approximately 2.45pm Mr Hogstrom plotted an approximate position some 800 to 900 metres south east of the Badjirrajirra Walk trailhead sign and it was not on the trail. Nonetheless, from this information Mr Hogstrom was able to direct the police to the trailhead, and once there they quickly located Mr Williamson and then Ewan.[133]

[131] T 318; Exhibit 3, Tab 6
[132] Exhibit 2, Tab 2
[133] Exhibit 1, Tab 15

First Class Constables Bott and Du Cloux both confirmed in evidence that the information from the GPS coordinates plotted by Mr Hogstrom was of material assistance to them in locating the trailhead, noting that earlier they had made a short wrong turn and they were guided back to the trail head by Mr Hogstrom.[134]

In early 2013, as a result of reviewing these circumstances, a longitude and latitude training program was developed for all 000 call takers. The Advanced Tactical Mapping course now provides skills' training in the use of GPS coordinates.[135]

Assistance with ascertaining correct job code

At the material time, a Knowledge Base existed for the coding of incidents on CAD. Senior Constable Diviney did not utilise Knowledge Base on the day because he was intent on finding out the location. [136]

Senior Constable Diviney entered the job code on the CAD system as "48", denoting "*welfare check*". Inspector Cunningham informed the court that, having regard to Knowledge Base, the job code ought to have read: "34J" – denoting "*collapsed person*" who is a "*juvenile*". This was

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[134] T 47-48; T142
[135] T 308 – 309; Exhibit 2, Tab 2; Exhibit 2, Tab 2 Exhibit 3, Tab 6
[136] T 280-282; Exhibit 3, Tab 4

supported by the outcome of the Internal Affairs Unit investigation.

For practical purposes this did not affect the police response because the Exmouth police officers dealt with it on an urgent basis, relying on the text in the CAD task.

I accept the submission from the Commissioner of Police through his counsel that at the material time the use of Knowledge Base for entering job codes was not a prescribed process. Call takers were required to assess the call and give it priority and coding based upon the information received. However, a CAD incident would also contain a summary of the details, which provided relevant information to the first responders.[137]

At the inquest Inspector Cunningham confirmed that at the material time it was not unusual for police officers not to use Knowledge Base to retrieve the job codes. This situation is now ameliorated by the creation of a dedicated call taker section, and the electronic availability of Knowledge Base on a computer screen next to the CAD task screen with a pre-emptive text function. The dedicated 000 call takers are trained in the application of Knowledge Base and are expected to utilise it. Inspector Cunningham informed the court that Knowledge Base is regularly updated as

[137] T 130 – 132; T 306 - 307

procedures develop and 000 call takers are now monitored to ensure its appropriate usage.[138]

Noise cancelling headphones

Senior Constable Diviney informed the court that the headphones he was issued with did not cut out the ambient noise, and he described it as a factor affecting his ability to hear Mr Williamson during the telephone call. It was posited that the digital recording of the telephone call, as played in court at the inquest, was clearer than what was heard by Senior Constable Diviney on the day. Various reasons were given.

At the inquest Inspector Cunningham's evidence was that he would have expected there to be ambient noise whilst Senior Constable Diviney was listening to Mr Williamson. He confirmed that since 2013, they have undertaken tests at the police operations centre to assess ambient noise. As a result 000 call takers with improved headsets that operate to better cancel out ambient noise.[139]

Mobile tower location

In September 2014, the police commenced receiving data from Telstra known as Push MoLI. It had not been previously available. It is the mobile locating information system. This automated information indicates the location

[138] T 307 - 308
[139] T 309

of a caller to 000 using the signals sent from the caller's mobile device. The GPS information is sent from the mobile handset to the tower and made available to the police operations centre.[140]

The Western Australia Police developed the software and after testing, it was launched in September 2015. This data is now able to be displayed on the 000 call taker's computer screen and on a map. It occurs instantaneously when the 000 call comes in. The geographical display on the map will indicate that a caller is in a particular area. The location will be more accurate depending on the type and age of the mobile device and location of mobile towers. If a telephone signal is available, for example it would show that a caller is in the Cape Range National Park with a shape to indicate the general area from where the signal is sent.[141]

The map is not topographical and does not have contour lines. As would be expected, reliance is still placed upon the local knowledge of the responding police officers, and their interaction with the DEC and/or the SES. The map showing the location can now be relayed to the responding police officers via the in-car computer system.[142]

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140 T 310; Exhibit 3, Tab 6
141 T 310; T 315; Exhibit 3, Tab 6
142 T 314

Emergency app.

At the inquest Inspector Cunningham informed the court that in 2013 Western Australia Police was part of a working group that released an "*emergency app.*" as a free download for smartphones. It supports speed dialling for emergency assistance and has a map and location on the bottom of the screen that displays the latitude and longitude, thereby allowing the person requesting assistance to better convey the details of their location.[143]

A new CAD system

At the inquest Inspector Cunningham informed the court that a new CAD system had recently been purchased by Western Australia Police and is currently being developed for progression towards operational usage. It contains more user-friendly functions for identifying the CAD task, the job code, address selection, and state-wide information regarding available resources and mapping. It can interface with police vehicles and they are exploring options for direct interface with other emergency services such as St John Ambulance service and the Department of Fire and Emergency services.[144]

[143] T 316 - 317
[144] T 316

Comments on improvements

There have been significant improvements in practices, procedures, resourcing and technology since the time of Ewan's tragic death, some as a result of lessons learnt from these events.

In the context of a hiker in a remote area, if there is a mobile signal the location will now be readily ascertainable. That is a significant difference because responding police will be able to identify options for accessing the location and the resources to be gathered, at an early stage. One of the primary impediments in extricating Ewan was the lack of foreknowledge regarding the terrain. This technology was not available in 2012.

All of the developments referred to above are as I would expect where a practice of continual improvement is adopted. The planned expansion of the CAD interface with other emergency services will enable swift and direct dissemination of critical information to assist first responders in undertaking their functions and coordinating their resources. I encourage its progression to implementation.

In light of the improvements outlined at the inquest, there is no need for me to make any recommendations.

COMMENTS ON RISKS ASSOCIATED WITH EXTREME TEMPERATURES IN REMOTE LOCATIONS

The Cape Range National Park environment is captivating, but it can also be inherently dangerous. The DEC sign warned of temperatures regularly exceeding 50 degrees Celsius. On 21 December 2012, the temperature on the trail was at least 40 degrees Celsius. This comes within the category of extreme heat load. Even a planned short walk along the trail presents risks, particularly for a young person who is not acclimatised to those temperatures. The risk is not only in the area of heat gain, but also of disorientation. Getting lost in a remote area during extremely hot temperatures is exceptionally dangerous.

Extricating a collapsed person from remote and inaccessible terrain is logistically complex and it cannot be assumed that all of the necessary resources will be readily available. The best way to prevent tragedy is to heed the warnings on signs. The signs in the Cape Range National Park were erected by the DEC (now the Department of Parks and Wildlife), an agency that well knows the hazards and how best to balance the risks.

CONCLUSION

Ewan and his father were hiking along the Badjirrajirra Walk for up to three hours in temperatures of up to 40 degrees Celsius. His father had planned a shorter walk,

but unfortunately took a wrong turn when he became disoriented, resulting in Ewan spending much more time in the heat than he had intended.

The police and ambulance services responded to his calls for assistance after Ewan collapsed. Due to the rugged and inaccessible terrain, extricating Ewan to get him to the hospital presented dire and unforeseen clinical and logistical difficulties. It was a harrowing experience and the attending personnel put themselves at considerable risk in getting Ewan off the trail and into the ambulance.

Tragically despite all of the efforts made to prevent his death, Ewan succumbed to the effects of severe heatstroke.

RVC FOGLIANI
STATE CORONER

22 August 2016