JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Rosalinda Vincenza Clorinda Fogliani, State Coroner
HEARD	**:**	18-19 SEPTEMBER 2019
DELIVERED	**:**	4 NOVEMBER 2020
FILE NO/S	**:**	CORC 977 of 2015
DECEASED	**:**	KEY, ANDREW JOHN

Catchwords:

Nil

Legislation:

Nil

Case(s) referred to in decision(s):

Nil

Counsel Appearing:

Mr D Jones assisted the State Coroner.
Mr B Nelson, with Mr L Geddes (State Solicitor's Office) appeared for the Western Australia Police Force and the South Metropolitan Health Service.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of ***Andrew John KEY*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 17 - 18 September 2019, find that the identity of the deceased person was* ***Andrew John KEY*** *and that death occurred on 11 August 2015 at Rockingham General Hospital from incised injury to the neck, in the following circumstances:*

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INTRODUCTION

1. Andrew John KEY (Mr Key) died at Rockingham General Hospital on 11 August 2015, as a result of a self-inflicted injury to his neck that occurred while police officers were in the course of restraining him. He was 49 years old.

2. Mr Key had a longstanding diagnosis of Bipolar Affective Disorder and in the week leading up to his death the condition had relapsed and he had displayed increasingly erratic and aggressive behaviour. He lived with his parents and in the days leading up to the date of his death, they had made a number of attempts to inform his clinicians and the police of their concerns about his escalating behaviour. On such occasions, following either reviews or discussions, no action was taken to apprehend Mr Key, nor to initiate the processes for detaining him as an involuntary patient under the *Mental Health Act 2014*.

3. On 11 August 2015 Mr Key attended the house of an acquaintance, where an argument ensued. Attempts were made to keep him calm, however, he left abruptly. It appeared that Mr Key was in a stolen vehicle and that he may be possession of a shotgun. His behaviour was highly erratic. The acquaintance informed Mr Key's mother and also contacted the police. Police were also contacted by Mr Key's mother, who further advised that Mr Key had disclosed an intention to take his life.

4. Police began to search for Mr Key, and they located him in the vicinity of Point Peron Caravan Park. When Mr Key saw the police he was still some distance away from them, and he fled on foot and entered an area of bushland. Police followed him into the bushland and located him crouched under a bush. They did not know if he was carrying a weapon.

5. Mr Key did not show his hands when instructed to do so by police, and two officers moved towards Mr Key in an attempt to restrain him. A struggle ensued and it became apparent that Mr Key had a knife in one hand. Attempts to disarm Mr Key were unsuccessful, and as Mr Key momentarily broke free of police, he stabbed himself in his neck. One police officer deployed his Taser, causing Mr Key's arm to drop away from his neck. Police then restrained Mr Key and applied first aid, but

unfortunately, Mr Key remained resistant to their efforts, expressing the wish for his life to end.

6. Paramedics attended and conveyed Mr Key to Rockingham General Hospital where unfortunately, despite all resuscitation efforts, he could not be revived and he tragically died on 11 August 2015.

THE INQUEST

7. Mr Key's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (WA) (the Act) and it was reported to the coroner as required by the Act.

8. By reason of s 19(1) of the Act I have jurisdiction to investigate Mr Key's death. The holding of an inquest, as part of the investigation into his death, is mandated by reason of s 22(1)(a) of the Act. This is because immediately before death, Mr Key was a person held in care by reason of being under the control, care or custody of members of the Police Force, while they were in the process of restraining him, and after they restrained him.

9. By reason of the circumstances, an inquest was also mandated to scrutinise the actions of the police officers for the purposes of ascertaining whether any action by a member of the Police Force caused or contributed to Mr Key's death (s 22(1)(b)).

10. My primary function has been to investigate Mr Key's death. It is a fact-finding function. Pursuant to s 25(1)(b) and (c) of the Act, I must find if possible, how Mr Key's death occurred and the cause of his death.

11. Pursuant to s 25(2) of the Act, in this finding I may comment on any matter connected with Mr Key's death, including public health, safety or the administration of justice. This is the ancillary function.

12. Pursuant to s 25(3) of the Act, as Mr Key was a person held in care, in this finding I must comment on the quality of his supervision, treatment and care. This obligation reflects the community's concern about the treatment of those who are deprived of their liberty.

13. Section 25(5) of the Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence. It is not my role to assess

the evidence for civil or criminal liability, and I am not bound by the rules of evidence.

14. Pursuant to s 44(2) of the Act, before I make any finding adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding. I heard submissions on this aspect at the inquest.

15. In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361 - 362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.

16. I held an inquest into Mr Key's death on 17 and 18 September 2019. I heard from eight witnesses and received the following exhibits into evidence:

    a) Exhibit 1, containing 28 tabs;
    b) Exhibit 2, containing 14 tabs;
    c) Exhibit 3, containing two tabs; and
    d) Exhibits 4.1 and 4.2.

17. After the inquest on 10 October 2019 I received Exhibit 5 into evidence, and on 2 December 2019 I received Exhibits 6 and 7 into evidence.

18. My findings appear below.

BACKGROUND AND MEDICAL HISTORY

19. Mr Key was born in Southampton in the United Kingdom and lived there until his adult years. As a child, mainstream schooling was challenging for him, and after the age of 13 years he was home tutored and then enrolled in a special needs boarding school. From an early age he displayed some psychological difficulties and his parents sought appropriate clinical support for him.[1]

20. Very sadly in the setting of his schooling, Mr Key experienced events that led to understandable and ongoing trauma for him, during his youth and

[1] Exhibit 1, tabs 2, 3, 8 and 9; Exhibit 2, tab 7.

into his adult years. These events were the subject of ongoing investigations at the time of his death.[2]

21. In the United Kingdom Mr Key married and he and his wife welcomed a son together. Sadly, he and his wife later divorced and after this event, still experiencing the ongoing trauma, at the age of 21 years Mr Key took an overdose and was admitted to a psychiatric ward in the United Kingdom. He was diagnosed with depression and treated with antidepressant medication.[3]

22. Mr Key subsequently travelled to Australia, to be with his parents who had moved here. He married again and from this new marriage he and his wife welcomed a son together. A few years afterwards, they separated and Mr Key returned to live with his parents. At the time of his death he had been separated from his wife for some years.[4]

23. Unfortunately, Mr Key experienced a range of stressors and on occasions when unwell, he was unable to manage his behaviour, which became intermittently disruptive. His stressors were exacerbated by his intermittent abuse of alcohol and drugs (including synthetic cannabis). When not unwell, Mr Key was generous and polite towards family and friends.[5]

24. Between June and July 2013, Mr Key was admitted as an involuntary patient to the Rockingham General Hospital after an incident outside his former wife's home, and there he received a diagnosis of manic episode with psychotic features and Bipolar Affective Disorder.[6]

25. Mr Key continued to be treated with a range of medications for his mental health conditions, and his medications included the mood stabiliser sodium valproate and the antipsychotic olanzapine. After discharge from Rockingham General Hospital he received follow up treatment in the community, with regular medical reviews mainly through Rockingham Kwinana Mental Health Service, though he declined counselling referrals. His medications were reviewed and changed to sodium valproate and another antipsychotic, namely quetiapine.[7]

[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Ibid.

26. Mr Key was discharged from Rockingham Kwinana Mental Health Service on 8 April 2015. Throughout this time he lived with his parents, who continued to remain supportive of him.

27. During his life Mr Key had worked assiduously. He had been employed for a decade as a senior manager of an electronics company, with a high level of responsibility which he discharged diligently. He was latterly employed as an electronics technician. He had a particular and high level aptitude for electronics, which he had demonstrated from a young age. He was a loving son and his death came as a shock to his loved ones. He leaves behind family members who continue to mourn his loss.[8]

28. Mr Key's parents have expressed concern about aspects of his medical treatment and care. They question whether he ought to have been admitted to hospital for treatment of his mental health condition. They also raised questions related to actions of police when seeking to apprehend persons with mental health conditions. These matters were explored at the inquest.

IMMEDIATE PAST PSYCHIATRIC HISTORY

29. On 5 August 2015 Mr Key was taken to Rockingham General Hospital's emergency department by his parents after exhibiting inappropriate behaviours at home (he was markedly unsettled and appeared to be responding to unseen stimuli). He attended the emergency department with them voluntarily. There, Mr Key was seen by the emergency department doctors and then he was assessed by Psychiatry Registrar Dr Radha Balan (Dr Balan) and Psychiatrist Dr Abayomi Adeniyi (Dr Adeniyi). The doctors were aware of Mr Key's medical history, including his prior admission to a psychiatric inpatient unit in 2013, and his prior diagnosis of Bipolar Affective Disorder.[9]

30. The medical history obtained on 5 August 2015 reflected that Mr Key had ceased his daily dosage of quetiapine a few days prior to the onset of his psychiatric symptoms. Intermittently he displayed an elevated mood with grandiose ideas. He had also been sleeping poorly, and had persecutory delusions. However, he denied suicidal ideation, or visual or auditory hallucinations.[10]

[8] ts 212 to 213.
[9] Exhibit 2, tabs 7 and 12; Exhibits 6 and 7.
[10] Ibid.

31. Dr Adeniyi and Dr Balan spoke with Mr Key in the company of his parents, and afterwards they took him into the patient interview room within the emergency department to assess him individually. Dr Adeniyi performed the risk assessment, and it was noted that Mr Key had made a previous suicide attempt. Following this assessment, it was concluded that Mr Key was at low risk of suicide, self-harm, violence or aggression, vulnerability or absconding. A provisional diagnosis was made of Bipolar Affective Disorder with manic and psychotic symptoms, in the context of erratic compliance with medication.[11]

32. Dr Adeniyi did not consider that Mr Key was thought disordered. He formed the view that Mr Key had partial insight into his illness, and that he appeared capable of making decisions about his mental health treatment. Mr Key expressed a willingness to accept oral medications and to engage in voluntary outpatient based care in the community by the Rockingham Kwinana Mental Health Service.[12]

33. Dr Adeniyi offered Mr Key voluntary admission to Rockingham General Hospital but Mr Key declined the offer. After this, Dr Adeniyi and Dr Balan accompanied Mr Key back to the bed cubicle within the emergency department, where his parents were waiting. Dr Adeniyi discussed the outcome of Mr Key's risk assessment with his parents and informed them that Mr Key had declined a voluntary admission.[13]

34. Dr Adeniyi and Dr Balan had formed the view that Mr Key's parents were content to take their son home, or at least that they were agreeable. Medical notes contain the statement: "*Family are happy to take him home*." At the inquest Mr Key's mother testified that she had initially been informed by Dr Adeniyi that Mr Key was to be admitted to hospital by reason of a relapse of his Bipolar Affective Disorder, and that he was manic. She did not recall any mention of it being an involuntary admission. She recalled being informed that there was a bed available for Mr Key. Mr Key's mother had expressed agreement with that. Consequently, her expectation was that he would be admitted.[14]

35. The sequence of events is that after this interaction, Mr Key's parents were asked to wait while Dr Adeniyi and Dr Balan spoke with her son. As previously indicated, they proceeded to assess him individually. Upon their return, Mr Key's mother was informed by Dr Adeniyi that her son

[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Exhibit 1, tabs 8 and 9; Exhibit 3, tab 1; Exhibits 6 and 7; ts 183; ts 206; ts 215 to 217; ts 219 to 220.

had agreed to take his medications and that he would be returning home with her. Mr Key's mother was not expecting that.[15]

36. At the inquest Mr Key's mother testified that she did not expressly inform Dr Adeniyi or Dr Balan that she did not want to take Mr Key home, and that in hindsight she believed she should have put her foot down and refused to take him home. She believed Mr Key needed to be hospitalised, and felt shocked by this outcome. Mr Key's behaviour was unpredictable at home, he would not sleep or settle at night time, he appeared disturbed and he would leave the house unexpectedly. All of this was understandably troubling and exhausting for Mr Key's parents.[16]

37. Dr Adeniyi reported that he informed Mr Key's parents that the relapse of his Bipolar Affective Disorder was most likely due to his non-compliance with his quetiapine medication. Mr Key's medication was reviewed and he was provided with a three day supply of medication, that included an increase in his dosage of quetiapine to control his symptoms, and recommencement of sodium valproate to stabilise his elevated mood and prevent a full relapse of his bipolar disorder.[17]

38. As part of the follow up plan for Mr Key, the following arrangements were made by the clinicians:

    a) referral to the brief intervention team (being the acute treatment team) of the Rockingham Kwinana Community Mental Health Service, for psychiatric follow-up, monitoring and ongoing risk assessment to facilitate clinical recovery in the community, or admission to a mental health hospital in the event of clinical deterioration; and

    b) referral to Mr Key's GP to manage some medical conditions, and assist with repeat scripts of his prescribed medications.[18]

39. Dr Adeniyi did consider admitting Mr Key for involuntary treatment on 5 August 2015 and reported the following reasons for concluding that Mr Key did not meet the criteria for an involuntary treatment order, based upon their risk assessment and review:

[15] ts 214 to 217.
[16] Ibid.
[17] Exhibit 2, tab 12.
[18] Ibid.

a) Mr Key had a low risk of harm to himself or other persons, and he had no such obvious significant risk;

b) Mr Key was able to make an informed decision about provision of treatment;

c) Mr Key was willing to engage with the treatment plans in the community;

d) there was available treatment in the community to manage Mr Key's mental illness;

e) Mr Key preferred the outpatient treatment option, and from Dr Adeniyi's perspective the parents agreed with this; and

f) The outpatient treatment plan was the less restrictive alternative to his freedom of choice and movement.[19]

Clinical decisions made on 5 August 2015

40. At the inquest I considered the question of whether Mr Key ought to have been admitted as an involuntary patient under the *Mental Health Act 2014*, when he presented at Rockingham General Hospital on 5 August 2015 as described above. I am assisted in my inquiry by the information provided by the independent expert Dr Alexandra Welborn (Dr Welborn), who is employed at Royal Perth Hospital in Clinical Services and Consultation-Liaison Psychiatry. Dr Welborn prepared a report for the coroner and she gave evidence at the inquest.[20]

41. A decision by a psychiatrist to make an involuntary treatment order must be in compliance with the *Mental Health Act 2014*. Section 25 sets out the criteria for making an inpatient treatment order. The psychiatrist must consider a range of matters including the person's need for treatment, whether there is a significant risk to the health or safety of the person, the person's capacity to make treatment decisions, and in making such an order, must be satisfied of the following: "*that the person cannot be adequately provided with treatment in a way that would involve less restriction on the person's freedom of choice and movement than making an inpatient treatment order*."

[19] Ibid.
[20] Exhibit 2, tab 7; ts 159 to 176.

42. In her report to the coroner, Dr Welborn noted that when Mr Key was brought into the emergency department of Rockingham General Hospital by his parents on 5 August 2015, he was experiencing an undisputed relapse of his Bipolar Affective Disorder with classic symptoms. Dr Welborn opined that the clinician's decision made on 5 August 2015, not to admit Mr Key as an involuntary patient, was justified in the documentation:

> "*With the benefit of hindsight, it would have been wise to admit [Mr Key] from ED as an involuntary patient. Psychotic symptoms were evident. However the Mental Health Act specifically addresses the rights of the mentally ill patient to be treated in the least restrictive setting. In this case after a comprehensive assessment the decision was made that Mr Key could be treated in the community with an increase to his medications and review by the community team. This decision is justified in the documentation.*"[21]

43. Some of the differences in the perspectives, as between Mr Key's parents and his clinicians, may be accounted for when regard is had to the individual clinical assessment of Mr Key by Dr Adeniyi (that was documented by Dr Balan) while his parents awaited the outcome in the emergency department area. Mr Key's parents were not present when he was assessed by Dr Adeniyi, with Dr Balan, and it was appropriate for the clinicians to make the individual assessment.

44. On all of the information before me, I have no reason to doubt that Mr Key expressed to his clinicians a willingness and desire to go home. Mr Key's clinicians properly had regard to his wishes, in the context of their overall risk assessment, and balanced against the least restrictive setting for him.

45. It is to be borne in mind that what may appear to be obvious in hindsight is often not so clear at the time. Care must be taken not to assess the clinical decisions on 5 August 2015 by reference to Mr Key's subsequent and tragic death.

46. It is understandable that Mr Key's parents question the decision not to admit him as a patient on 5 August 2015. However, this could only have been done by commencing the process for the making an involuntary treatment order, because Mr Key wished to go home.

[21] Exhibit 2, tab 7; ts 162 to 163; ts 170 to 171.

47. At the inquest I had foreshadowed that I would not be finding that an order ought to have been made for the involuntary detention of Mr Key under the *Mental Health Act 2014*. For the reasons outlined above, and having regard to Dr Welborn's opinion, I am satisfied that overall, appropriate clinical decisions were made about Mr Key's treatment and care on 5 August 2015.[22]

48. In coming to the above conclusion I have also taken into account the supply of medications to Mr Key on 5 August 2015. Dr Welborn noted that the purpose of giving Mr Key only three days' worth of medication when he was reviewed in the emergency department on Wednesday 5 August 2015, was to stimulate another medical review of the patient to determine whether the medication was having the desired effect. The medication would have run out on the weekend of 8 and 9 August 2015. This view was supported by Dr Gordon Shymko, Acting Director of Clinical Services of the Rockingham Peel Group, who had reviewed the clinical notes, and explained at the inquest that the emergency department is governing the patient's care over a very short period.[23]

49. Records reflect that later on 5 August 2015, after further review by clinicians, it was decided that Mr Key would be requiring more follow up than the short term follow up associated with the brief intervention team (being the acute treatment team). It was considered he would require appropriate follow up over the weekend.[24]

Clinical decisions made on 6 August 2015

50. The next day, arrangements were made to provide Mr Key's mother with the ongoing prescriptions for quetiapine and sodium valproate. Records completed at 9.23 am on 6 August 2015 reflect that Mr Key's mother presented on that date to collect his prescriptions and that she expressed anxiety about her ability to maintain control over her son, and anxiety about the medication not having the desired effect. She reported that Mr Key was highly reactive and kept taking off from home. He was ignoring advice not to drive. An appointment had been scheduled for 19 August 2015 with the doctor who had previously treated Mr Key (and who had written up the repeat prescriptions). However, understandably Mr Key's mother was under the impression following the hospital visit the day before, that this would have occurred much sooner. Her expressed

[22] ts 230.
[23] Exhibit 2, tab 7; ts 193.
[24] Exhibit 3, tab 1.

concerns generated arrangements for follow up for Mr Key as soon as possible.[25]

51. In the meantime, the situation became even more urgent. Records reflect that at 2.15 pm on 6 August 2015, the Clinical Nurse Specialist spoke with Mr Key's father by telephone. Mr Key's father also expressed his escalating concerns about Mr Key's manic behaviour, raising the question of whether it was safe for Mr Key to drive, and whether Mr Key may be a danger to himself and the community. It is clear that both parents were doing their best to manage Mr Key's outbursts and departures from the home, but at this stage, there was little they could reasonably achieve by themselves. They were understandably exhausted. Mr Key required urgent medical treatment for his deteriorating mental health. The Clinical Nurse Specialist informed the emergency department doctor and made a note, in respect of Mr Key, that "*they have enough information to admit*."[26]

52. From the above telephone conversation with Mr Key's father, the Clinical Nurse Specialist formed the view that Mr Key would be brought into the emergency department by his father. At 7.00 pm on 6 August 2015, it was noted that Mr Key had not yet been seen in the emergency department and accordingly a Community Home Visit was initiated with an urgency level of "*rapid*", meaning within two hours.[27]

53. The Psychiatric Services Online Information System (PSOLIS) records of the Client Triage Detail reflect that a home visit to Mr Key occurred on 6 August 2015 at 7.15 pm, with two nurses attending from the Community Mental Health Team. This visit does not appear to have been separately documented in the medical record from the Peel and Rockingham Kwinana Mental Health Service. Mr Key's parents dispute that this visit occurred.[28]

54. I turn first to the medical records of this meeting. The PSOLIS records of the Client Triage Detail reflect that on 6 August 2015 at 7.15 pm, two nurses from the Community Mental Health Team attended Mr Key's home and initially spoke with Mr Key's father, who advised that Mr Key had since settled, was taking his medication and it was felt that Mr Key no longer needed to go to hospital. Mr Key presented shortly afterwards, and based upon the nurses' observations of him, whilst he was smiling expansively and appeared in an elevated mood, overall no immediate risks

[25] Exhibit 2, tabs 7 and 8; Exhibit 3, tab 1.
[26] Ibid.
[27] Ibid.
[28] Exhibit 2, tabs 7 and 8; Exhibit 3, tab 1; Exhibits 4.1 and 4.2; ts 199 to 200; ts 204 to 205.

were identified. It was recorded that Mr Key and his father declined further assistance from the Community Mental Health Team and they were advised to call the Mental Health Emergency Response Line (MHERL) if required.[29]

55. Dr Shymko reviewed the medical records, and at the inquest he testified that the Clinical Nurse Specialist who attended this home visit is the most qualified nurse they have in the community. This nurse is the lead clinician for their after-hours team. The other attending nurse was a Clinical Nurse.[30]

56. I turn now to Mrs Key's disputation about this visit ever having taken place, as she testified that she had left the home at 10 minutes to 7.00 pm on the night of 6 August 2015, and received no subsequent advice from her family about a visit from the Community Mental Health Team shortly after her departure from the home. She would have wished to be there if she had known about it. Mrs Key also produced the home diary, where careful records were kept of the days' events, to show there is no record of a home visit on 6 August 2015.[31]

57. Mr Key's mother also disputes that there was a telephone conversation at 2.15 pm on 6 August 2015 between the Clinical Nurse Specialist and Mr Key's father. In this regard, an extract of outgoing telephone calls is produced.[32]

58. Through its counsel the South Metropolitan Health Service submits that:

    a) the contemporaneous record of the telephone conversation at 2.15 pm on 6 August 2015 contained within the Integrated Progress Notes should be preferred over the extract from the family's outgoing telephone calls, that do not reflect a telephone call being made by the family to the Rockingham General Hospital; the South Metropolitan Health Service also submits that it should be inferred that the call was made to Mr Key, following on from the immediately prior documented decision about follow-up and assessment as soon as possible; and

    b) the contemporaneous record of the home visit at 7.15 pm on 6 August 2015 within the Client Triage Detail should be

[29] Ibid.
[30] Ibid.
[31] ts 220 to 221; Exhibits 4.2.
[32] Exhibit 4.1.

preferred over the extract from the family's home diary, on the basis that such diary is not established to be a complete record of all events on 6 August 2015.

59. I have considered the contemporaneous records and all of the evidence before me on these points. I have no reason to find that there is an error on the face of the PSOLIS records (specifically the Client Triage Detail), whether inadvertent or otherwise. I am satisfied that the hand written entries for 6 August 2015 and the PSOLIS record of the Client Triage Detail accurately portray the events, and that they are reliable.

60. I turn now to the clinical decision making on 6 August 2015. Independent expert Dr Welborn reviewed this and reported to the coroner. Dr Welborn opined that perhaps a medical review at this point may have revealed clinical features of concern. However, Dr Welborn specifically noted the home visit by the two nurses from Community Mental Health Team, referring to it as good clinical practice that was undertaken promptly.[33]

61. Dr Welborn noted that home visits require clinicians with the right skills, knowledge and attitudes. It is clear that earlier in the day there was thought to be enough information to admit Mr Key as a patient, but that when he was assessed by the nurses in his home setting he appeared sufficiently settled. That coupled with the expressed desire to stay at home, led to Mr Key being left in the care of his family, being considered the least restrictive setting.[34]

62. I have had regard to Dr Welborn's opinion, and it is apposite that I make some comment about fluctuating mental states. It appears that in the earlier part of the day, Mr Key's mental state was deteriorating, but that towards the end of the day, he had settled. Such an outcome is not necessarily uncommon. Unfortunately it is difficult, if not impossible, to predict a future deterioration. Mr Key had not at this stage expressed any suicidal ideation and the nurses needed to be guided by their observations of him. I am satisfied that overall, appropriate clinical decisions were made about Mr Key's treatment and care on 6 August 2015.

[33] Exhibit 2, tab 7.
[34] Ibid.

Clinical decisions made on 7 August 2015

63. Records reflect that by telephone, at 12.50 pm on 7 August 2015, a clinician from the Rockingham Kwinana Mental Health Service contacted Mr Key's mother, who was still concerned about Mr Key's erratic behaviour, and worried that he was still out driving, being a danger to himself and others. From this conversation, the clinician recorded that Mr Key remained insightless, brittle and irritable. This prompted a telephone call from the clinician to Mr Key, who denied any issues of concern. Mr Key claimed to be sleeping OK, explained that his mother ensured he took his medication and indicated his willingness to attend the next medical appointment. Mr Key was informed by the clinician that the weekend staff would be contacting his mother (obviously to check on how he was going) and he was accepting of this.[35]

64. Independent expert Dr Welborn reviewed the clinical decision making on 7 August 2015 and reported to the coroner. Dr Welborn opined that with the benefit of hindsight at this juncture this information may have been sufficient to trigger the process for having Mr Key assessed for detention as an involuntary patient under the *Mental Health Act 2014*.[36]

65. Dr Welborn explained that this is because less than 48 hours had elapsed since his assessments and additional clinical information had come to light which indicated that Mr Key was at risk and that he could be putting others at risk. Specifically he was known to have a relapse of his mental illness impacting upon his judgement, and clinicians were aware that he was driving, contrary to advice given. Prior history showed that he had crashed cars in the past when unwell. Had this process been triggered, it would have mandated the police to collect Mr Key and bring him in to hospital for further examination.[37]

66. At the inquest Dr Shymko informed the court that the clinician making the assessment during the telephone conversation with Mr Key on 7 August 2015 was another Clinical Nurse Specialist, and one of the most senior clinicians in the Rockingham Kwinana Mental Health Service, whose clinical skillset was regarded as a cornerstone of the service.[38]

67. Dr Shymko opined that the reason for this contact was to try and determine the relative stability of Mr Key at that time, given the concerns expressed

[35] Exhibit 3, tab 1.
[36] Exhibit 2, tab 7.
[37] Ibid.
[38] ts 204.

by his mother. When the Clinical Nurse Specialist contacted Mr Key directly, she determined that he remained suitable for treatment in the community.[39]

68. For the reasons I have expressed previously in respect of the decision-making of the previous two days, I am satisfied that overall, the clinical decision that was made about Mr Key's treatment and care on 7 August 2015 was justifiable.

69. I again express the caution previously alluded to, namely that a retrospective assessment of clinical decision-making needs to be undertaken with care. It is vital to ascertain the facts. It is equally vital to avoid the assumption that Mr Key's subsequent deterioration was more predictable than it appeared at the material time.

70. This is not to derogate from the genuine concern that Mr Key's parents had for their son in the days leading to him going missing. As it transpired, their fears were well founded and the unfolding events must have been harrowing for them.

MR KEY GOES MISSING

71. The observations proffered by Mr Key's parents to the various clinicians between 5 and 7 August 2015 reflect upon what was subsequently better understood to be a serious relapse of Mr Key's Bipolar Affective Disorder. However, up until approximately midday of 7 August 2015, when clinicians interacted with Mr Key, he presented as sufficiently settled, and was assessed generally as being of a low risk to himself and others. Assessments can only be made at a point in time, and it is unfortunate that Mr Key's demeanour was changeable and unpredictable.

72. In the late afternoon of 7 August 2015, Mr Key's mother noted a marked deterioration in his mental state and she reported that she contacted the Rockingham Kwinana Mental Health Service, whereupon she was advised to bring Mr Key in to the hospital. That evening as the family were getting ready to leave for the hospital, Mr Key suddenly and unexpectedly left the home in his vehicle, leaving his parents very concerned. They drove around looking for him but could not find him. They resolved to renew their efforts to find him the next morning.[40]

[39] ts 205.
[40] Exhibit 1, tabs 8 and 9.

73. Records reflect that at 9.30 am on Saturday 8 August 2015, the Clinical Nurse Specialist contacted Mr Key's mother by telephone, who informed the nurse that her son's whereabouts were unknown, though he had indicated to a sibling that he would be staying in Wanneroo.[41]

74. Mr Key's mother recounted the circumstances of his sudden departure in his vehicle the evening of 7 August 2015 to the Clinical Nurse Specialist. He had not come home since that departure. In that telephone conversation, the Clinical Nurse Specialist advised Mr Key's mother to contact the police with the vehicle registration number so that they would be aware of the current circumstances, and it was also noted that Mr Key's mother would contact the MHERL with any updates.[42]

75. Independent expert Dr Welborn reviewed the above interaction. The doctor opined that by this stage one would like to have seen vigorous efforts made to locate Mr Key, and that in an ideal world, the Rockingham Kwinana Mental Health Service would also have contacted police directly on the Saturday, as well as providing the advice to his family to contact the police. This would have allowed additional relevant details to be passed on to the police.[43]

76. I accept and adopt Dr Welborn's opinion on this interaction and note that it is qualified by what ought to occur in an ideal world. The reality is that clinical staff must balance a range of competing tasks. On this occasion the Clinical Nurse Specialist appeared to be satisfied that Mrs Key would make the contact with police. Nonetheless it is important to learn from these events, and regard ought to be had to the desirability of clinicians directly passing their concerns onto police, where possible, as the additional relevant details regarding a patient's mental state, coming from a clinician, may operate to elevate the urgency attached to a task.

77. Throughout the day on 8 August 2015, Mr Key's parents continued to look for him. They observed him drive by in his vehicle on one occasion, but he did not stop and they were unable to make contact with him. It is clear Mr Key did not at this stage wish to be located by his parents, nor interact with them. Mr Key's mother therefore contacted police, who attended at her home, and she explained her concerns to them.[44]

[41] Exhibit 1, tab 3.
[42] Ibid.
[43] Exhibit 2, tab 7.
[44] Exhibit 1, tabs 2 and 8.

78. Police conducted a search and they later located Mr Key and spoke with him. Mr Key informed police he had attended at Fiona Stanley Hospital that morning for a check-up and been released. He told the police officers that he would contact his parents to inform them that he was ok. He expressed the desire not to presently interact with his parents. The attending police officers did not hold any concerns for Mr Key, having regard to his behaviour and demeanour, and they allowed him to leave.[45]

79. Records from Fiona Stanley Hospital reflect that Mr Key had indeed presented to the hospital's emergency department at 6.53 am on 8 August 2015, reporting left leg pain, and that he was discharged with a follow up recommended with his GP for pain management. It was noted that Mr Key appeared verbose, overly inclusive and mildly elevated in mood, that he had a background potentially of Bipolar Affective Disorder and was due for review by his clinician within a few days. The examination noted: "*no florid delusions at present*."[46]

80. Senior Constable James McKee was one of the police officers who conducted the welfare check on Mr Key, and spoke with him on 8 August 2015. The Computer Aided Despatch (CAD) Task for this welfare check referred to a history of Mr Key's Bipolar condition and that he was considered a high mental health risk. The currently expressed concern came from Mr Key's parents, as he was not taking his medications. It was recorded that there were no threats of self-harm, or previous attempts.[47]

81. At the inquest, Constable McKee testified that when he spoke to him, Mr Key indicated that he assumed his parents had contacted police, and that his parents were panicking about him. Constable McKee was aware that Mr Key's mother had contacted police due to her concerns about his mental health, and it was a matter that he took into account. Mr Key indicated to Constable McKee that he had been to hospital, checked over, and everything was all good.[48]

82. Constable McKee recalled that Mr Key appeared to be sober, reasonable and rational. He gave answers relevant to the questions being asked of him and did not appear to be under the influence of anything. He was not sweating, his eyes were not glazed over, nor was he fidgety, nervous, angry or crying. Constable McKee's role was to consider whether he

[45] Exhibit 1, tab 2.
[46] Exhibit 1, tab 24.1.
[47] Exhibit 2, tab 11; ts 28.
[48] Exhibit 2, tab 11; ts 19 to 20.

needed to take Mr Key to hospital for assessment, and he testified that he held no concerns whatsoever about Mr Key.[49]

83. Constable McKee also testified that he has been with the Police Force for 34 years, and that he conducts welfare checks on a daily basis. He is not a trained psychologist and needs to make a decision based upon his interaction. He was aware that he needed to form a view as to whether Mr Key was at some type of risk to himself or others, before deciding to take him to hospital against his will, otherwise he had no authority.[50]

84. It is clear that Mr Key was not agreeing to be taken into hospital by police for a mental health assessment. It is not always possible, nor necessarily appropriate, for police to seek to persuade a person to voluntarily attend hospital for a mental health assessment under such circumstances. Police officers are required to act in accord with the apprehension powers under the *Mental Health Act 2014*. In order to apprehend a person, for the purpose of arranging for an assessment (for the purpose of a decision as to whether a person is to be referred for an examination to be conducted by a psychiatrist), a police officer must form a reasonable suspicion that:

a) the person has a mental illness; and

b) because of the mental illness, the person needs to be apprehended to protect their health and safety or that of another person, or to prevent the person causing or continuing to cause serious damage to property.

85. At the inquest, Inspector Stuart Mearns of the State Custody Coordination and Transformation Division commented on the exercise of the apprehension powers under the *Mental Health Act 2014* generally. He drew attention to the challenges faced by police officers in this area because people's moods may change over short periods of time. On this occasion Mr Key's mother contacted police, and Mr Key represented that his parents were panicking about him. Inspector Mearns acknowledged that where a health service makes the request of police, that factor would form part of the police officers' decision making. For this reason it is desirable that clinicians consider directly passing their concerns onto police, as opposed to requesting family members to contact police.[51]

[49] Exhibit 2, tab 11; ts 20 to 22; ts 37.
[50] Exhibit 2, tab 11; ts 20 to 23.
[51] ts 146.

86. Due to Mr Key's fluctuating mental state, and the need for Constable McKee to assess Mr Key based upon his presentation, as well as the background information that he had, I am satisfied that there was no apparent basis for the exercise of any compulsive powers in respect of Mr Key on that occasion.

87. Unfortunately, Mr Key was upset about his parents having contacted police to look for him, and in his deteriorating mental state he did not realise that they were trying to help him. At approximately 10.00 pm on 9 August 2015, Mr Key telephoned his mother to express his displeasure. In that conversation, Mr Key was accusatory and made unpleasant remarks. Alarmingly, Mr Key expressed an intention to take his life, something his mother had not heard him express previously. He then switched his telephone off.[52]

88. Mr Key's parents were understandably distressed and they continued their endeavours to make contact with their son. The next day, 10 August 2015, in the late afternoon Mr Key's mother contacted Mr Key's previous treating doctor at the Rockingham Kwinana Mental Health Service (being the same doctor who had written the repeat prescriptions for him, and who was a medical officer within psychiatry). The plan had been for Mr Key to see this doctor on 19 April 2015. He is referred to in this finding as the "treating doctor". Mr Key's mother informed the treating doctor of Mr Key's expressed intention to take his life.[53]

89. The treating doctor advised Mr Key's mother to call the police and inform them that Mr Key was suicidal with a relapse of Bipolar Affective Disorder. He advised her to tell police that when they locate Mr Key, he is to be taken to the emergency department for psychiatric review and not to let him go. It was noted that Mr Key's mother agreed to do this due to her significant safety concerns.[54]

90. The treating doctor reported to the coroner that in his view the family are best placed to raise their concerns with police, as they can provide information that staff are not aware of, such as details of the vehicle Mr Key was driving, his last known whereabouts, his friends, and his state of mind. The treating doctor explained that it would not be usual practice for him to make the call to the police unless he had been directly involved in Mr Key's current care, and knew about the relevant circumstances. He

[52] Exhibit 1, tabs 2, 8 and 9; Exhibit 2, tab 7.
[53] Exhibit 1, tabs 2 and 8; Exhibit 2, tabs 7 and 8; Exhibit 3, tab 1; ts 194.
[54] Ibid.

had not seen Mr Key since he last attended his clinic on 5 December 2014 (and he was due to next see him on 19 August 2015).[55]

91. Independent expert Dr Welborn opined that by this stage it would appear crucial to bring Mr Key in for further psychiatric assessment and appropriate care. By this stage it was known that he had expressed suicidal ideation.[56]

92. At the inquest, Dr Gordon Shymko, who had reviewed the clinical notes, provided his views on the telephone contact between Mr Key's mother and his treating doctor on 10 August 2015. Dr Shymko drew attention to the fact that Mr Key had been examined on 5 and 6 August 2015, and there had been telephone contact with him on 7 August 2015. On his review, these assessments had been fairly consistent and the determination (by the treating doctor) of Mr Key requiring further assessment was probably right. However, Dr Shymko opined that it would have been difficult at that point to, in effect, consider the enforcement of the involuntary patient provisions of the *Mental Health Act 2014* (by starting with, in effect, an involuntary assessment).[57]

93. This interaction again raised the question of whether is it desirable for clinicians to make direct contact with police. At the inquest, Dr Shymko informed the court that the question of whether the clinician directly contacts the police, or leaves it up to the family member to contact police is a question of clinical judgement, and he referred to the possibility of the family being able to provide police with contemporaneous information.[58]

94. When Mr Key's mother, as requested by the treating doctor, telephoned the police on 10 August 2015 at approximately 4.40 pm, alerting them to concerns she had about Mr Key's safety, unfortunately the call taker at the Police Assistance Centre advised that there was nothing the police could do. It is clear from this telephone call that the call taker did not apprehend the seriousness of the situation, and relied upon the fact that Mr Key had recently been released from hospital, and he had recently been seen by police and let go.[59]

95. Further, the call taker did not appreciate the import of new information, namely that the previous night, Mr Key had expressed the intention to end

[55] Exhibit 2, tab 8.
[56] Exhibit 2, tab 7; Exhibit 3, tab 1.
[57] ts 190.
[58] ts 192.
[59] Exhibit 1, tabs 8 and 25; Exhibit 2, tabs 11 and 13; Exhibit 5; ts 107.

his life. It is also clear from this telephone conversation that had a clinician, or someone from the Rockingham Kwinana Mental Health Service called the Police Assistance Centre, the call taker would have treated the call differently, and would likely have initiated a Computer Aided Despatch (CAD) Task for police to locate Mr Key. A clinician would have been in a better position to clearly convey the nature of Mr Key's mental state, the risk to himself and others, and it is likely such interaction would have garnered an urgent response.[60]

96. Regrettably, Mr Key's mother was told by the call taker from the Police Assistance Centre that Mr Key was an adult and that she and her husband should get on with their own lives. Whilst the comment was expressed from a well-intentioned perspective, it was not appropriate. This represents a missed opportunity to initiate a CAD Task, to locate Mr Key and possibly to arrange for urgent medical attention.[61]

97. On the question of whether, in similar circumstances, a call taker would be more inclined to act upon a telephone call from a clinician as opposed to a family member, various views were posed. However, I take account of the evidence of police, referred to immediately below, that essentially a CAD Task ought to have been created upon the call from Mr Key's mother of 10 August 2015. Therefore the question of whether a clinician ought to have made the telephone call is of lesser relevance.[62]

98. Superintendent Ricky Chadwick, formerly of the State Communications Unit, reviewed the telephone call between Mr Key's mother and the Police Assistance Centre Call taker of 10 August 2015, and he provided a report to the coroner. Superintendent Chadwick reported that the advice given by the call taker to Mr Key's mother was not appropriate and the service did not meet the Western Australia Police Force Service Delivery Standards. There was no CAD Task to initiate police attendance or record reference to this call.[63]

99. Superintendent Chadwick reported that the call taker was polite and courteous, but it was not her role to provide Mr Key's mother with an opinion on how to manage her son and lead her life. Despite the call taker's good intentions, she failed to properly question the caller, did not identify the risk factors or the welfare concerns, and did not initiate a CAD Task. The call taker was placed on a development action plan, and has

[60] Ibid.
[61] Ibid.
[62] ts 191 to 192.
[63] Exhibit 3, tab 13; ts 103 to 104.

since expressed her sorrow at sounding seemingly unconcerned at the time.[64]

100. At the inquest, Superintendent Chadwick explained that the call taker missed the key indicators and appeared to have developed a position, namely she was trying to provide reassurance that police did not need to attend. The Superintendent testified that it was evident it was disclosed to the call taker that someone intended to kill themselves, and also that the person had made a threat against Mrs Key. Therefore the call taker should have placed a task on CAD.[65]

101. Superintendent Chadwick testified that, had a CAD Task been placed by the call taker, it could have generated an alert to the supervisor, who could have assisted with further questioning of the caller. If it had been entered as a Priority 1 or 2 task (a life-threatening incident) it would have flashed up automatically on the screen of the dispatcher, and a police vehicle could have been dispatched straight away. If it had been entered as a Priority 3 or 4 task (falling below a life-threatening incident) it would have gone to the task vetting unit, for assessment, which may have included a return call to the caller for further information, or contact with the relevant hospital.[66]

102. Whilst the system is now different, in that the various arms of this process are in the one location, obviously allowing for easier communications, Sergeant Chadwick confirmed that as at 2015, there was nonetheless a vetting process, through the District Control Centre (as it then was). His expectation, if a CAD Task had been put on, was that the District Control Centre would have called the Rockingham General Hospital, and also called Mr Key's mother for further information, and if appropriate, they would have put out an alert for Mr Key.[67]

103. The main difference now (as opposed to 2015) is that there is access to a clinician from the Mental Health Co-Response team, which Superintendent Chadwick described in very positive terms. He outlined the benefits of having a clinician available to advise the call taker, and/or assess the risk. The clinician would also have been able, hypothetically, to have accessed the PSOLIS records for Mr Key, and would likely have been alerted to his mental health condition, factoring this into the risk

[64] Exhibit 2, tab 13; Exhibit 5.
[65] ts 91 to 96; ts 101.
[66] ts 97; ts 108.
[67] ts 97 to 98; ts 101 to 102.

assessment. This aspect is dealt with in more detail below under the heading: *Improvements*.[68]

104. Through its lawyer the SSO, the Western Australia Police Service accepts the outcome of the internal audit by Superintendent Chadwick, namely that there were missed opportunities to follow up on the call from Mr Key's mother of 10 August 2015 and that it did not meet the Western Australia Police Force Service Delivery Standards. Warning signs and key trigger words that were missed by the call taker included: "*Bipolar, had previously attempted suicide, not taking his Meds, threatened to commit suicide on this occasion, Hospital advised caller to contact police for attention as he is a danger to himself and others, we barricaded ourselves into our home last night*."[69]

105. I am satisfied that the response to Mr Key's mother's call of 10 August 2015 fell below the standards that ought reasonably be expected under the circumstances.

106. I note that after Mr Key's tragic death, there was a rigorous analysis of this interaction undertaken by police at the material time, and that appropriate steps were taken to seek to ensure that the outcome would not be repeated in similar circumstances.

107. It cannot now be known whether the initiation of a CAD Task by the call taker on 10 August 2015 to locate Mr Key would have resulted in his apprehension and treatment. Whilst it does represent a missed opportunity, any further comment about possible outcomes would be speculative.

EVENTS LEADING UP TO DEATH

108. In the early hours of the morning of 11 August 2015, at approximately 3.40 am, Mr Key's parents heard noises and saw their son driving a white LandCruiser Ute on their front lawn. His manner of driving and operating the high beam appeared aggressive and unsafe. Understandably, they were fearful and did not go outside. They observed Mr Key slowly drive off. Later they barricaded the house from the inside.[70]

[68] ts 99; ts 108 to 109.
[69] Exhibit 1, tab 13; ts 109; ts 229.
[70] Exhibit 1, tabs 8 and 9.

109. Mr Key's mental state continued to deteriorate, and his behaviour became increasingly bizarre, aggressive and threatening. At approximately 4.00 am on 11 August 2015, Mr Key arrived at the residence of a male friend, unexpectedly, attired in a high visibility vest, very animated, and claiming that police were following him. The LandCruiser was parked close by with the high beam on, and Mr Key said he had stolen it.[71]

110. Mr Key asked his friend for ammunition (which his friend did not have) and for the keys to his friend's dirt bike, which his friend gave to him. Mr Key appeared to be hiding something behind his back, and upon leaving warned his friend, in aggressive tones, not to call police.[72]

111. At approximately 8.45 am on 11 August 2015, Mr Key's male friend drove to the residence of his former wife, and as he had cause to believe Mr Key may be there and he was concerned for her safety. Shortly after he arrived at her residence, as he had feared, Mr Key also arrived, behaving bizarrely and aggressively. They tried to calm Mr Key and offered him food, while contact was made with his family members. Mr Key remained volatile, he felt he was being followed and he soon left the residence, running out the door. Mr Key's mother was personally informed of this event by the friend's former wife who attended at her home, and told her that Mr Key had a shotgun, and was seeking ammunition.[73]

112. Records reflect that shortly after 9.00 am on 11 August 2015, Mr Key's mother promptly telephoned the Police Operations Centre and recounted the above events, as told to her. She informed police that Mr Key had a Bipolar disorder, he had a loaded shotgun, he had run away, he did not have his medications and he had expressed the intention to end his life. Police also received a telephone call from the friend's former wife, to similar effect.[74]

113. In the meantime, as Mr Key was leaving that residence in the LandCruiser, he had an altercation with another man in a parked vehicle outside, who had stopped there to take a telephone call. Mr Key was suddenly and unexpectedly aggressive towards him, and wanted him to go away. It appears Mr Key may have thought this man was following him, which was not the case. As Mr Key drove off, he damaged the man's vehicle.[75]

[71] Exhibit 1, tabs 2 and 6.
[72] Ibid.
[73] Exhibit 1, tabs 6 to 9.
[74] Exhibit 1, tabs 7, 8 and 25; Exhibit 2, tab 11.
[75] Exhibit 1, tab 10.

POLICE INVOLVEMENT

114. As a result of information received on 11 August 2015 concerning a stolen LandCruiser and a person with a shotgun, Rockingham Police, Regional Operations Group South and the Rockingham Response Team attended in the vicinity of the Point Peron Caravan Park on Point Peron Road, Peron, to locate and apprehend Mr Key. Some of the police officers had placed on ballistic vests. A request was made for negotiators to be made aware, and for the canine squad to be available. When police arrived, they were informed that Mr Key was close by and had gone towards the beach.[76]

115. The police's earlier Incident Report for 8 August 2015, that is, the print out of the CAD Task, contained information that would have given rise to mental health concerns for Mr Key, if it had been viewed by the police officers who were deployed to search for Mr Key on 11 August 2015. The notations included the following: "*Bipolar High Mental Health Risk has been missing from A/A since 17:00hrs. Was in angry manic state yesterday and has not been admitted to hospital. Andrew has missed two lots of medication*."[77]

116. The Western Australia Police Force through its lawyer the SSO, informs the court that it did not capture data at that time which could establish whether the incident details of 8 August 2015, stored in the Police Computer Aided Despatch System (PCAD), was subsequently viewed by attending police on 11 August 2015. It is confirmed that hypothetically, the details would have been available for viewing on 11 August 2015.[78]

117. However, the PCAD system that was operational in 2015 did not permit searches for terms within the body of an Incident Report. Accordingly, if attending police had searched for "*Andrew Key*" or similar in PCAD on 11 August 2015, the above details recorded on 8 August 2015 would not have been returned. The new CAD system introduced in 2016 has a greater search function, that allows more effective linkage with a summary list of previous related incidents.

118. It is noteworthy that the Incident Report for 11 August 2015, that is the print out of the CAD Task, records the following relevant details:

    a) at 9.13.07 am the call from the former wife of Mr Key's friend is recorded advising that Mr Key was at her place approximately

[76] Exhibit 1, tabs 2, 3 and 12; ts 74; ts 115.
[77] Exhibit 2, tab 11.
[78] Ibid.

30 minutes ago, inside a stolen white ute wearing a high vis vest and armed with a loaded shotgun; there is also reference to Mr Key previously visiting his friend with a loaded shotgun, acting strange, asking for shells for the gun, then leaving;

b) at 9.13.07/8 am the call from Mr Key's mother is recorded noting the earlier calls advising of white land cruisier ute coming into the driveway of her house with the high beams on;

c) at 9.16.53 am the following is recorded: "*caller also advises that police are looking for her son. He also called yesterday and threatened to kill himself, caller phoned police but advises that no job was put on*?"[79]

119. The above CAD Task reflects that police were dispatched promptly (9.15.30 am). At the inquest Inspector Stuart Mearns confirmed that these 11 August 2015 CAD Task details would have been available to police at the material time on the TADIS computer system in the police vehicle.[80]

120. Police were despatched just before the call from Mr Key's mother was entered onto the CAD Task records. On all of the information before me, I am not satisfied that the attending police officers were aware of the relevant mental health issues in respect of Mr Key prior to their attendance. The improvements in respect of the assessments of relevant mental health information, after Mr Key's death, are addressed later in this finding, in the context of the Mental Health Co-Response Team.

121. After they were despatched, police quickly sighted Mr Key on the beach, walking between the beach and vegetation adjacent to Point Peron Road. From a distance, Mr Key did not appear to have anything in his hands. Mr Key appears to have become aware of the presence of police, and he continued walking in a westerly direction along the beach away from them. Police lost sight of Mr Key when he went down a track that leads out to the road along the boundary of a boat yard.[81]

122. The police officers established a perimeter cordon and commenced searching along the track. One of the police officers, Senior Constable Liam Grieg, located Mr Key's high visibility vest, wallet, keys and a mobile telephone partially buried at the base of a tree in the bush area.

[79] Exhibit 2, tab 11; ts 217 to 218.
[80] Exhibit 2, tab 11; ts 150.
[81] Exhibit 1, tabs 2, 3 and 12; ts 74; ts 115.

Police continued their search for Mr Key, calling out on a number of occasions announcing their presence and that they would not harm him if he followed instructions. Mr Key did not respond.[82]

123. Shortly afterwards, another one of the police officers, Senior Constable Matthew Gaze, located Mr Key crouched down with his arms tucked under his chest, and his forearms on the ground in the bushes not far from where his possessions had been found. He was wearing a black jumper with a hood over his head, and was faced downwards. Due to the information that had been provided about Mr Key being in possession of a shotgun, Constable Gaze drew his firearm, pointed it at Mr Key and instructed him to show his hands on a number of occasions. Constable Gaze was approximately five metres away from Mr Key. Mr Key did not respond to him. He appears to have remained primarily motionless and not to have looked up.[83]

124. In the meantime First Class Constable Hayden Brown and First Class Constable Rory Hughes arrived upon the scene, and Constable Gaze stepped back, holstering his firearm to allow the officers access to Mr Key. They intended to handcuff him. It had been ascertained that Mr Key was not directly in possession of a shotgun. Constable Hughes made a risk assessment and decided to interact with Mr Key. However, when Constable Hughes walked towards Mr Key and touched him on the shoulder, Mr Key looked up at him shouting that he would "*do it*" and he appeared "*psyched up*." It was clear that Mr Key was resistant to their efforts. Constables Brown and Hughes both proceeded to attempt to roll Mr Key onto his back and to physically restrain him. Mr Key resisted them by kicking out his legs and yelling at them to let go.[84]

125. Constable Hughes grabbed Mr Key's left wrist and observed he had a knife in his left hand. The blade portion that he was able to see appeared to be approximately three centimetres long. The portion that Constable Gaze observed appeared to be approximately eight centimetres long. When Constable Brown saw the knife, he estimated the blade to be approximately 10 centimetres long. The situation quickly escalated. Constable Hughes thought that Mr Key was going to stab him, stab himself or stab a colleague. Constable Gaze saw Constable Hughes holding Mr Key's wrist and attempting to prevent him from thrusting the knife towards himself. In the meantime, Constable Brown grabbed

[82] Exhibit 1, tabs 2, 3, 12, 13 and 14; ts 45 to 51; ts 69 to 70.
[83] Ibid.
[84] Exhibit 1, tabs 2, 3, 12, 13 and 14; ts 59 to 60.

Mr Key's right forearm, struggling with him. Constable Brown was endeavouring to pin Mr Key's right forearm to his chest.[85]

126. Constable Hughes attempted to disarm Mr Key by hitting his left hand, containing the knife, on the ground. Constable Hughes knocked his left hand as hard as he could on the ground four or five times. His intention was to get the knife out of Mr Key's left hand and secure it. At one point, Constable Gaze, who was standing to the side, thought he heard Constable Hughes state that he had the knife under control. Constable Brown heard words to a similar effect.[86]

127. However, Constable Hughes did not recall saying words to that effect, and did not think he would have said that he (Constable Hughes) had got the knife. It is to be borne in mind that the situation had quickly become dangerous by reason of the knife, and events were unfolding rapidly and police were acting under considerable pressure.[87]

128. Mr Key initially relaxed his left hand, releasing the knife, that fell onto the ground. Constable Hughes then relaxed his grip on Mr Key's left hand, though he was still holding onto it. Then Mr Key suddenly broke free of Constable Hughes' grip and grabbing the knife with his left hand, alarmingly he stabbed himself in the middle of his neck, and continued to use the knife on his neck in a sawing motion. Police tried to stop him.[88]

129. At the inquest Constable Hughes' recollection was that Mr Key held the knife in his left hand when he stabbed himself in his neck. Upon questioning, he also agreed that it would be awkward for a right handed person to cut the left side of their throat with their left hand, as opposed to the right side of their throat with their left hand.[89]

130. However, at the inquest Constable Brown recalled seeing Mr Key move his right hand at his neck in a back and forth motion (though he did not observe a knife in the right hand), and recalled seeing blood starting to come from behind that right hand. Constable Brown therefore assumed Mr Key cut himself with his right hand. It was noted that at one point, Mr Key had both hands clenched and close to his neck, and I bear in mind

[85] Exhibit 1, tabs 2, 3, 12, 13 and 14; ts 45 to 51; ts 64 to 65; ts 75.
[86] Exhibit 1, tabs 2, 3, 12, 13 and 14; ts 54 to 55; ts 78; ts 88.
[87] Ibid.
[88] Exhibit 1, tabs 2, 3 and 13; ts 52 to 53.
[89] ts 52 to 53; ts 78 to 82; ts 87.

Constable Brown's evidence to the effect that he was not looking at Mr Key's right hand over the whole time.[90]

131. This issue concerning the hand by which Mr Key held the knife was raised at the inquest with Detective Senior Sergeant Sean Bell, who was in charge of the Internal Affairs Unit investigation of the incident. Detective Senior Sergeant Bell testified that on his review he believed on the evidentiary standard, that the knife was in Mr Key's left hand, and that he had broken Constable Hughes' grip, when he inflicted the injuries onto his neck.[91]

132. At the inquest Constable Hughes was asked about the passage of time between him seeing the knife on the ground, and Mr Key picking it up again. Constable Hughes described it as being almost instantaneous, and a second or two at most. Given that he was still involved in restraining Mr Key, possibly pushing him back with his hand on Mr Key's chest, Constable Hughes testified that he did not have the time or ability to kick the knife away when it fell onto the ground.[92]

133. Constable Gaze heard Constable Brown state, with some urgency, that Mr Key was cutting himself, and in effect that he should be Tasered. At the inquest Constable Brown confirmed that interaction, and explained that the purpose of the deployment of the Taser was to make Mr Key stop cutting himself. Constable Gaze deployed his Taser (single cycle) and gained some neuromuscular incapacitation. This caused Mr Key's arm to drop away from his neck. Police officers removed the knife and restrained Mr Key, applying handcuffs behind his back. It was at this stage that Constable Gaze saw that Mr Key was bleeding heavily from a wound to the throat.[93]

134. At the inquest the police officers were questioned in some detail in connection with their recollections of the event. To the extent that there were some discrepancies as to what words Constable Hughes said in connection with the knife, and in what hand Mr Key held the knife when he inflicted the injuries to his neck, it is to be borne in mind that the events happened quickly, under duress, with elevated risks to safety and with a tragic and traumatic outcome. On all of the evidence before me, I am satisfied that Mr Key acted deliberately and with determination to inflict

[90] Ibid.
[91] ts 112.
[92] Exhibit 1, tabs 2, 3 and 13; ts 52 to 53.
[93] Exhibit 1, tabs 2, 3, 12, 13 and 14; ts 83.

the fatal injuries to his neck, most likely with the knife held in his left hand, while the police were endeavouring to prevent him from doing so.

135. The relevant Incident Report reflects that a silver pocket knife was seized from the scene, and it was subsequently found to have a six centimetre blade. I am satisfied this was the knife that My Key used to inflict his neck injury.[94]

FIRST AID

136. Constable Brown advised the other police officers that Mr Key had cut his neck open, and he called for an ambulance on the police radio. The police officers acted promptly to get Mr Key out from under the thick scrub and into open ground in order to administer first aid. Throughout, Mr Key continued to struggle and resist, throwing his head back and forward as officers attempted to steady him to apply first aid to the wound on his neck. He yelled at them to let him die. As his struggling subsided, police removed the handcuffs, and continued to endeavour to apply first aid, applying pressure to his neck wound, and with Mr Key endeavouring to refute their efforts.[95]

137. Records reflect that at 10.37 am on 11 August 2015 St John Ambulance received a call and they departed under Priority 1 conditions arriving at the scene at 10.51 am. On arrival Mr Key had severe bleeding from a neck wound and police were continuing to provide first aid with pressure over the wound. Mr Key was initially breathing, had a weak pulse and was responsive to painful stimuli. The paramedics took over. A cannula was inserted and intravenous fluids were rapidly infused.[96]

138. During transfer to the stretcher Mr Key's breathing ceased. An oropharyngeal airway was inserted by the paramedics and ventilation provided. Mr Key went into cardiac arrest. CPR was commenced and he was transferred into the ambulance. An endotracheal tube was placed and CPR was continued. Cardiac rhythm during transfer alternated between Pulseless Electrical Activity and asystole. Adrenalin and a total of three litres of normal saline were administered intravenously.[97]

139. Mr Key was conveyed to Rockingham General Hospital with the ambulance departing the scene at 11.21 am and arriving at the hospital at

[94] Exhibit 1, tab 27.
[95] Exhibit 1, tabs 2, 3 and 13; ts 54 to 55; ts 83.
[96] Exhibit 2, tab 1.
[97] Ibid.

11.32 am. Paramedics with the assistance of police officers, continued their resuscitation efforts throughout. Upon arrival at Rockingham General Hospital resuscitation was continued. Intravenous fluids, blood and blood products were given. A total of eight units of packed cells and two units of fresh frozen plasma were given.[98]

140. Attempts were made in the emergency department with assistance from a Surgical Consultant to control the bleeding from Mr Key's neck wound using diathermy and clamping. At 11.50 am there was a return of circulation that lasted for three to four minutes. CPR was recommenced at 11.55 am and continued until 12.18 pm on 11 August 2015, when a decision was made to terminate resuscitation efforts, and tragically Mr Key was pronounced to have died.[99]

CAUSE AND MANNER OF DEATH

141. On 14 August 2015 the forensic pathologist Dr C. T. Cooke (Dr Cooke) made a post mortem examination at the State Mortuary on the body of Mr Key. Dr Cooke's examination showed an incised injury to the right side and front of the neck, comprising at least four cuts to the skin, three of which came together and formed a single cut which extended across the front of the right internal jugular vein.[100]

142. Minor injuries were noted at examination, namely a possible Taser injury to the left side of the abdomen (loin) and possible restraint marking to the left wrist. There was evidence of early coronary and aortic arteriosclerosis, and congestion of the lungs with some aspiration of vomit into the airways.[101]

143. At the conclusion of the examination Dr Cooke formed the opinion that the cause of death was incised injury to the neck. Toxicological analysis was ordered and became available on 28 October 2015. The quetiapine metabolite was detected, but valproic acid was not detected. Tetrahydrocannabinol was detected at a level of less than 1 ug/L. Testing for alcohol, amphetamines, opiates and benzodiazepines was negative.[102]

144. I accept and adopt Dr Cooke's opinion. **I find that the cause of Mr Key's death was incised injury to the neck.**

[98] Exhibit 1, tab 24; Exhibit 2, tab 1.
[99] Exhibit 1, tabs 5 and 24.
[100] Exhibit 2, tab 4.
[101] Ibid.
[102] Exhibit 2, tab 5.

145. By reason of the events outlined above under the heading *Police Involvement*, I am satisfied that Mr Key inflicted the incised injury to his neck himself, while he was in the process of being restrained, and that he did so deliberately and with the intention to end his life.

146. The police officers who were involved in locating and restraining Mr Key did not cause or contribute to his death. This is a finding that I foreshadowed at the inquest hearing. The police were in the process of carrying out their legitimate policing functions. No doubt it was upsetting for Mr Key to be located by the police and it is clear he did not wish to be restrained by the police. However, Mr Key's act of inflicting the incised injury to his own neck was a completely disproportionate response to the police actions.[103]

147. I have taken account of the relapse of Mr Key's Bipolar Affective Disorder, and the likely effect on his mental state. I am satisfied that Mr Key knew that the foreseeable consequence of inflicting the injury to his neck was death, and that he was able to form the intention to take his life, having regard to the deliberate nature of his actions, his statements about wanting to die to the police, and his prior and recent statement about wanting to take his life made to his mother.

148. **I find that the manner of Mr Key's death is by way of suicide.**

COMMENT ON SUPERVISION, TREATMENT AND CARE

149. Immediately before death, Mr Key was a person held in care and under s 25(3) of the Act I must comment on the quality of his supervision, treatment and care while in that care. Specifically, immediately before death, Mr Key was under, or escaping from, the control, care or custody of a member of the Police Force.

150. Major Crime Squad investigators attended the scene and commenced an investigation due to Mr Key being in police custody at the time of his death.[104]

151. Investigators from the Internal Affairs Unit also attended the scene, and conducted their own investigation, which included reviewing the Major

[103] ts 230.
[104] Ibid.

Crime Squad investigation. Drug tests on all of the involved police officers yielded negative results.[105]

152. The Internal Affairs Unit Investigation concluded that the police officers used various options under the relevant policy, in an effort to resolve the situation, referring to matters that included the setting up of a cordon, the attempt to obtain a negotiator, the use of ballistic vests and tactical communications (such as announcing their presence and advising they would not harm Mr Key). At the inquest Detective Senior Sergeant Bell, in charge of the Internal Affairs Unit Investigation testified that he was satisfied that attending police officers complied with their training and their obligations.[106]

153. The Internal Affairs Investigation also noted that the police officers did not become aware that Mr Key had the knife until they had already attempted to restrain him, at which point it was too late to safely withdraw due to the confined environment.[107]

154. At the inquest Detective Senior Sergeant Bell explained that when police tried to interact with My Key (Constable Hughes touched his shoulder) they did not have any indication that he was going to try and commit suicide. Police were trying to arrest him for the stolen motor vehicle, and to make further inquiries. At that stage, he opined, police had sufficient evidence to arrest.[108]

155. I am satisfied that it was appropriate for police to endeavour to interact with Mr Key, and that his subsequent reaction could not reasonably have been predicted. Constable Hughes' act of touching Mr Key on his shoulder was not aggressive nor inappropriate. Mr Key had not been responding to police, nor appearing to heed their instructions to show his hands. He was crouched on the ground looking downwards. His hands were out of view and it was not known that he held a knife in his left hand. There had been reports of Mr Key carrying a shotgun. Whilst no shotgun was visible to police (nor subsequently found), Mr Key was crouched in the bushes and it could not be known whether such a weapon was close by or to hand.

156. Unfortunately, once Constable Hughes touched Mr Key's shoulder, Mr Key reacted suddenly and unpredictably with the knife. I accept the

[105] Exhibit 1, tab 3; ts 111.
[106] Exhibit 1, tab 3; ts 114.
[107] Ibid.
[108] ts 114 to 115.

above assessment by the Internal Affairs Investigation to the effect that by that stage, it was too late for police to withdraw.

157. I am satisfied that attending police did endeavour to stop Mr Key from inflicting the injury to his neck, but unfortunately he was resistant to their efforts.

158. I have considered the appropriateness of the discharge of the Taser by Constable Gaze. The relevant policy provides that: "*A Taser can be discharged to reduce the threat and gain control of a subject where the member reasonably believes there is an imminent risk of serious injury to any person*."[109]

159. The use of the Taser was found to be justified by the Major Crime Squad and by the Internal Affairs Unit, that noted that as Mr Key was struggling with the police officers, and had a knife, there was a risk of serious injury when Constable Gaze discharged his Taser. I accept those assessments.[110]

160. I have considered the evidence concerning the police's endeavours to apply first aid measures to Mr Key's neck wound, and I am satisfied that appropriate first aid measures were used. I have considered the application and then removal of the handcuffs, and am satisfied that they were removed at the first reasonable opportunity in order to better render first aid.

161. An ambulance was promptly called for, and appropriate information was conveyed to generate a Priority 1 response. Police continued to assist the paramedics on the way to the Rockingham General Hospital, continuing with CPR and holding direct pressure to Mr Key's wound on the way to the hospital.[111]

IMPROVEMENTS

162. Inspector Stuart Mearns informed the court of the development of the Mental Health Co-Response Trial, and its subsequent integration into the Western Australia Police Force business model, after evaluation. The Inspector produced a report for the coroner, and he gave evidence at the inquest.[112]

[109] Exhibit 1, tab 3; ts 113.
[110] Ibid.
[111] Exhibit 2, tab 1.
[112] Exhibit 2, tab 14; ts 124 to 125.

163. The Mental Health Co-Response Trial involved police and mental health practitioners working together and co-responding to calls to the Western Australia Police Force for assistance with mental health related incidents. It operated as a partnership between the Western Australia Police Force, the Western Australia Mental Health Commission and the Western Australia Department of Health.[113]

164. The initiative was based upon developing trends identified in the mental health area, and police decided to look at how they attended their ever increasing mental health related tasks. They looked at programs in other jurisdictions and around the world, and they commenced a two year trial from January 2016 to January 2018.[114]

165. The two year trial aimed to divert persons experiencing mental health distress away from the criminal justice system, and provide more effective outcomes. The operating hours were 2.00 pm to 10.00 pm Monday to Saturday, inclusive. The trial included the placement of a mental health practitioner in the Police Operations Centre (who could be consulted on issues arising across the State), and the creation of mobile teams comprising police and mental health practitioners for the South East (Cannington) and North West (Warwick) Districts. The mobile teams were allocated to a police vehicle, they had mobile access to PSOLIS records and access to advice from on call psychiatrists.[115]

166. The aims of the trial included the enhanced access to mental health assessment, treatment and support for people with a mental illness involved in incidents attended by police, and the reduction of a risk of injury to police and people with a mental illness during a mental health crisis. It was to provide a greater opportunity for early diversion away from the criminal justice system and into the health system (or support networks) and reduced recidivism and police contact with people with a mental illness.[116]

167. The trial was independently evaluated by the Edith Cowan University – The Sellenger Centre for Research in Law, Justice and Social Change, that produced an evaluation report. The report noted a 296% increase in demand over eight years, for police to attend and manage incidents involving a mental health element (from 4,766 incidents in 2007 to 18,902 incidents in 2015). The evaluation demonstrated the value of the Mental

[113] Exhibit 2, tab 14; ts 124 to 141; ts 156; ts 158.
[114] Ibid.
[115] Ibid.
[116] Ibid.

Health Co-Response, showing benefits in resource allocation, the safety and wellbeing of officers and consumers, and integrated interagency collaboration at each stage of the model.[117]

168. In October 2018 the Mental Health Co-Response was expanded and integrated into business as usual within the Western Australia Police Force. The expansion included an additional two mobile teams, for the South (Cockburn) and the East (Midland). The hours of service were extended, including an additional two hours, ending at midnight.[118]

169. Under appropriate conditions, based upon risk to life or safety, the mental health practitioners in the Mental Health Co-Response are able to access the PSOLIS records and obtain relevant mental health information to assist in assessing the risk to community members and to police in a given incident.[119]

170. At the inquest I explored the question of what might have been the benefits of the Mental Health Co-Response if it had been in place at the time of Mr Key's death in 2015. For the reasons outlined below, I am satisfied that it would likely have had benefits when the call taker took the call from Mr Key's mother on 10 August 2015, but that it would have been unlikely to materially change the actions of the attending police on 11 August 2015.

171. In 2015, Police Assistance Centre call takers were not trained in relation to identifying and understanding mental health conditions. They were trained to not provide mental health counselling. Their role was to focus on the immediacy of the task at hand and instigate a CAD Task for police attendance where necessary. This remains the situation at present.[120]

172. Then and now, call takers receive contact from the public, that will include requests for assistance from police in relation to a person's welfare, including incidents involving self-harm and suicide. These are to be managed in an urgent manner, and there is guidance as to the queries to be made by the call taker to assist with garnering the relevant information. The call taker does not analyse the information; the analysis is carried out at several levels following the submission of the CAD Task.[121]

[117] Ibid.
[118] Ibid.
[119] ts 131 to 132.
[120] Exhibit 3, tab 13.
[121] Ibid.

173. However, in January 2016 the Mental Health Co-Response Trial commenced, and it resulted in the placement of an on-duty mental health clinician at the Police Operations Centre between 2.00 pm and 10.00 pm Monday to Saturday, inclusive. This enabled call takers, upon advice, to offer immediate assistance to those in need. The mental health clinician can assist the call taker with adding valuable content to the CAD Tasks for the information of attending police.[122]

174. At the inquest Inspector Mearns explained that Mrs Key's telephone call of 10 August 2015, if it had been loaded onto the system (by means of a CAD Task), would likely be the kind of job that the mental health clinician at the Police Assistance Centre would have been asked to look at. Hypothetically speaking, such a clinician may have accessed Mr Key's PSOLIS records (or equivalent) and added some mental health information to assist the police officers, for when they located Mr Key. Again hypothetically such information may have become available to the police officers through the CAD system, when they were dispatched on 11 August 2015.[123]

175. However, in relation to the events on 11 August 2015, it is noted first that the incident occurred outside the operating hours of the Mental Health Co-Response. Also, I take into account Inspector Mearns' views, to the effect that this was a high priority and high risk incident, possibly involving a firearm and criminal behaviour. This category of task is not suitable for Mental Health Co-Response to attend. If it were operating at this time, the mobile team could only have attended to conduct an assessment of Mr Key after he had been located, secured, and the scene made safe. At the inquest Inspector Mearns explained that a high priority risk incident involving a firearm and potentially some criminality, would not be allocated to a mobile Mental Health Co-Response team, and it would not have automatically come up for a mental health practitioner to look at.[124]

176. Nonetheless, hypothetically it is likely that the Mental Health Co-Response would have resulted in more detailed and focused information being entered onto the CAD Task system on 10 August 2015, so as to alert police to the risk of suicidality, and unpredictable behaviour. It might have resulted in earlier attempts to locate and apprehend Mr Key, before 11 August 2015, by which stage he was reported to be carrying a shotgun.

[122] Ibid.
[123] ts 143 to 144; ts 146 to 148.
[124] Exhibit 2, tab 14; ts 134; ts 141; ts 152 to 153.

177. For this reason, and with the aim of avoiding deaths in similar circumstances, I make a number of recommendations concerning the Mental Health Co-Response, immediately below.

RECOMMENDATIONS

178. At the inquest, Inspector Mearns informed the court that the Mental Health Co-Response Coordinating Unit are looking at developing options for expansion into regional Western Australia. There are some unique features to be considered, due to the size of the State, the differences in workloads, the distances involved, and availability of mental health clinicians in regional areas.[125]

179. The evidence of Inspector Mearns was that, to his knowledge, there is no indication that either the Western Australia Police Force or the Western Australia Mental Health Commission intend to cease their respective funding of the different aspects of the Mental Health Co-Response.

180. Following the inquest the SSO sought and obtained instructions from both the Western Australia Police Force and the Western Australia Mental Health Commission, and informs the court that neither agency has any reason to doubt the Mental Health Co-Response would continue to be funded in its current form. Both agencies inform the court that they are fully committed to continuing the Mental Health Co-Response in its current form, with both agencies funding it from internal sources.[126]

181. Both agencies confirm that if there were to be an extension of the Mental Health Co-Response in terms of the existing metropolitan service, or an introduction of a rural and remote service, they would require external funding.

182. Whilst there were no plans to expand the existing metropolitan service, the agencies would be supportive of this if additional funding were allocated. Further the court is informed that the Western Australia Police Force, the Western Australia Mental Health Commission and the Western Australia Country Health Service formed a steering group in order to consider options for expanding the Mental Health Co-Response to regional areas. The steering group has commenced planning, with a focus on implementing an enhanced response for critical areas of need in regional areas.

[125] ts 140 to 141.
[126] Exhibit 2, tab 14.2.

183. In support of the continuation of the Mental Health Co-Response, and the consideration of its expansion, I make the following recommendations:

Recommendation No.1

That the Mental Health Co-Response continue to be funded, and that consideration be given to providing the Western Australia Police Force and the Western Australia Mental Health Commission with additional, external funding in order to support expansion of the programme in a way that meets demand.

Recommendation No.2

That consideration be given to providing the Western Australia Police Force and the Western Australia Mental Health Commission with additional, external funding in order to support the expansion of the Mental Health Co-Response in metropolitan areas of Perth.

Recommendation No.3

That work continue on the planning of the Mental Health Co-Response in regional areas of the State, and consideration be given to providing the Western Australia Police Force and the Western Australia Mental Health Commission with additional, external funding in order to support the expansion of the Mental Health Co-Response into regional areas.

CONCLUSION

184. Mr Key had sadly endured traumatic events at one of his schools in his younger years. This had an ongoing and destabilising impact upon him, that continued into his adult years and up to the time of his death. Over time he had also been diagnosed with Bipolar Affective Disorder, for which he was treated.

185. At the time of his death, he was experiencing a relapse of Bipolar Affective Disorder, with a significant adverse impact upon his mental state. His mood was intermittently elevated, he was also experiencing persecutory delusions and was generally very unsettled. On occasions, this manifested as aggression and in the lead up to his death his behaviour became increasingly erratic and unpredictable.

186. Unfortunately, the events of 11 August 2015 escalated rapidly to level that could not have been predicted. By the time that police were seeking to restrain Mr Key, he had formed the intention to take his life and under shocking circumstances, inflicted the incised injury to his neck. Tragically and despite all efforts, he was not able to be revived.

187. Mr Key had a warm and loving relationship with his parents, who remained supportive of him and strove to bring their concerns about him to the notice of clinicians and police. Mr Key had a brilliant mind when it came to electronics, and had made a successful career in this area, discharging high level responsibilities. He had warm and supportive friends, and with his family they mourn his loss. The community has lost the contributions he would have undoubtedly continued to make had he lived.

R V C FOGLIANI
STATE CORONER

4 November 2020