JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	Philip John Urquhart, Coroner
HEARD	:	10 - 11 MAY 2022
DELIVERED	:	9 JUNE 2022
FILE NO/S	:	CORC 421 of 2019
DECEASED	:	JACK, DESMOND EDWARD

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Mr Will Stops assisted the coroner.
Mr Joshua Berson (State Solicitor's Office) appeared on behalf of the Western Australia Police Force and the WA Country Health Services

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Desmond Edward JACK*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 10 – 11 May 2022, find that the identity of the deceased person was* ***Desmond Edward JACK*** *and that death occurred on 28 March 2019 at St John of God Hospital, 1 Clayton Street, Midland, from a gunshot injury to the anterior trunk in the following circumstances:*

Contents

SUPPRESSION ORDER
There be no reporting or publication of any document or evidence that would reveal police policies and standard operating procedures, tactics, or training methods in relation to the use of force, including, but not limited to, firearms

INTRODUCTION

1 The deceased (Mr Jack) died on 28 March 2019 at St John of God Hospital, Midland (SJGHM), after he had been shot by a police officer on his parent's property at Mooliabeenee. Mr Jack was armed with a knife at the time. He was 33 years old.

2 Mr Jack's death was a reportable death within the meaning of section 3 of the *Coroners Act 1996* (WA) (the Act) because it resulted from injury. By reason of section 19(1) of the Act, I have jurisdiction to investigate Mr Jack's death.

3 As the death occurred following the discharge of a firearm by an on-duty police officer, an inquest into Mr Jack's death was mandatory pursuant to section 22(1)(b) of the Act because it "*appears the death was caused, or contributed to, by any action of a member of the Police Force*".

4 Section 22(1)(b) of the Act is enlivened whenever the issue of causation or contribution in relation to the person's death arises as a question of fact, irrespective of whether there is fault or error on the part of the police officer(s) involved.

5 On the basis that it would be contrary to public interest, I made a suppression order in respect to any reporting or publication of matters relating to the Western

Australian Police Force (WAPF) policies, procedures, tactics or training methods in relation to the use of force by its officers (the order). The terms of the order are set out on the previous page. The redacted portions in this finding have been made to comply with the order.

6 I held an inquest at Perth into the death of Mr Jack over two days on 10 and 11 May 2022. The following seven witnesses gave oral evidence:[1]

i. Edwin Ruzayi, Clinical Nurse Specialist with the Wheatbelt Mental Health Service;

ii. Senior Constable Mark Harrison, one of the two police officers who attended the Mooliabeenee property on 28 March 2019;

iii. Constable Cameron Johnson, the other police officer who attended the Mooliabeenee property on 28 March 2019;

iv. Detective Sergeant Chris Boudewyns, author of the WAPF Internal Affairs Unit (IAU) Report;

v. Chris Markham, Capability Advisor – Use of Force, Operational Skills Faculty at the WA Police Academy;

vi. Inspector Louise Ball, Assistant Divisional Officer of the Custodial Services and Mental Health Division of the WAPF;

vii. Dr Florence Van Schie, Clinical Director/Consultant Psychiatrist with the Wheatbelt Mental Health Service.

7 The documentary evidence at the inquest comprised of one volume of the brief that was tendered as exhibit 1 at the commencement of the inquest and a further four exhibits (exhibits 2A, 2B, 3 and 4) that were tendered during the inquest.

8 My primary function has been to investigate the death of Mr Jack. It is a fact-finding function. Pursuant to section 25(1)(b)(c) of the Act, I must find, if possible, how the death of Mr Jack occurred, and the cause of his death. Given the known circumstances in this matter, those findings can be made without difficulty.

[1] I have used the ranks of the police officers as of 28 March 2019

9 Pursuant to section 25(2) of the Act, I may comment on any matter connected to the death of Mr Jack, including public health or safety, or the administration of justice. This is an ancillary function of a coroner.

10 Section 25(5) of the Act prohibits me from framing a finding or comment in such a way as to appear to determine any civil liability or suggest a 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.

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

12 I am also mindful not to insert hindsight bias into my assessment of the actions taken by police in their dealings with Mr Jack on 28 March 2019. Hindsight bias is the tendency, after the events, to assume the events are more predictable or foreseeable than they actually were at the time.[2] The need to adhere to that principle is particularly relevant in this matter as police officers who are interacting with a highly agitated person, who is armed with a weapon, are often required to make quick decisions in a highly adrenalised environment.

13 The primary focus of the inquest was whether the discharge of his firearm by Senior Constable Mark Harrison (Officer Harrison) that fatally wounded Mr Jack was appropriate and justified in the circumstances that existed at the time.

14 As Mr Jack had long-standing mental health issues, the inquest also focused on (i) the level of care provided to him by the Wheatbelt Mental Health Service (WMHS) and (ii) his mental state in the period leading up to, and at the time of, his interactions with police on 28 March 2019.

[2] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10

DESMOND EDWARD JACK

15 Mr Jack was the youngest of four children and he had two brothers and a sister. Growing up, he was a shy child, who was good at sport. Mr Jack attended school at Bindoon until he was 15 years old. He then worked as a concreter with his father and one of his brothers. Mr Jack remained single, and he did not have any children.

16 At the time of his death, he was living in a single storey dwelling (the granny flat) that was separate from the main house on his parent's semi-rural property in Mooliabeene. Mooliabeene is about 85 km north-east of Perth, and about 18 km east of Gingin. It is located in the Shire of Chittering.

Mr Jack's interaction with WMHS and other mental health service providers [3]

17 Prior to Mr Jack's first referral to WMHS, he had been admitted to the Frankland Centre at Graylands Hospital on a Hospital Order from the Magistrates Court, after he was charged with two counts of assault occasioning bodily harm and one count of property damage. There were concerns regarding his mental state at the time of his offending as he claimed to be a messenger of God and that the devil was putting ideas into his head. On 25 May 2010, Mr Jack was sentenced to a 12-month Intensive Supervision Order for the two assaults and a 6-month Community Based Order for the property damage.

18 Mr Jack's mental state whilst in the Frankland Centre was described as overfamiliar, restless, pressured in speech with gross thought disorders and loosening of association. He described devils and angels that "*controlled his mind and get us to do things*". He was prescribed the mood stabiliser, lithium, for a short time; however, this was ceased after he had settled.

[3] Exhibit 1, Volume 1, Tab 22, Report of Dr Victoria Pascu dated 5 September 2020; Exhibit 1, Volume 1, Tab 23.1, Report of Dr Florence Van Schie dated 22 April 2022; History for Court - Criminal and Traffic for Desmond Jack

19 Mr Jack's initial diagnosis was paranoid schizophrenia, and he was discharged from the Frankland Centre on a Community Treatment Order (CTO). At the time of his discharge, Mr Jack was on a nightly dosage of 20 mg of olanzapine. Information from Mr Jack's family at the time was that he had been experiencing psychotic symptoms for four years following extensive methylamphetamine use. It was also reported he used alcohol and cannabis.

20 When transferred to WMHS on 1 June 2010, Mr Jack described graphic images of violence, stating that he believed these thoughts were separate from his own. He admitted to significant cannabis use since he was a teenager, as well as methylamphetamine and lysergic acid diethylamide (LSD); although he denied recent use of cannabis. He stated that he had reduced his medication due to the side effects. He was also angry and "*argumentative about the need for medication*".

21 Mr Jack was maintained on the CTO, with some improvement following the change of oral medication from one antipsychotic medication (olanzapine) to another (risperidone). However, once his CTO expired, Mr Jack stopped attending his appointments with WMHS. His mother, who was very involved with Mr Jack's treatment from the beginning, had been unhappy with a plan to start depot injections[4] after doubts emerged regarding his compliance with oral medication. She did not believe there was enough "*personal development*" for Mr Jack, and she supported changes to his medication doses following his complaints about the side effects.

22 By letter dated 18 January 2012, Mr Jack's consultant psychiatrist advised that Mr Jack had ceased his involvement with WMHS. That letter stated:

[4] A depot injection releases a medication slowly over time, requiring less frequent administrations. It is designed to increase medication adherence and consistency.

> In conclusion, it has been evident that since Mr Jack's discharge from Graylands Hospital the management of his illness has been impossible as he has not been compliant with treatment when not in a supervised environment. This has, unfortunately, been compounded by the difficulties in engaging his carers to participate in his treatment. In light of the circumstances, his Community Treatment Order was allowed to lapse about a year ago. I am also discharging him from follow up with our service for the same reason.

23 In September 2012, Mr Jack moved to Queensland – possibly to avoid mental health treatment in Western Australia. He led an itinerant lifestyle in Queensland, living in backpacker hostels. He obtained occasional work as a labourer.

24 On 17 December 2012, Mr Jack was involuntarily admitted to the mental health unit at Cairns Base Hospital in Queensland. He was noted to be talking "*in riddles without making sense*" and to being thought disordered. He denied any psychiatric history. He was diagnosed with Bipolar Affective Disorder with psychotic features. Mr Jack was restarted on oral antipsychotic and mood stabilising medications. He was discharged on 24 December 2012 when his mental state began to improve.

25 On 6 June 2013, Mr Jack was readmitted to the mental health unit at Cairns Base Hospital. He had been arrested following an attempt to board a flight with pepper spray. At the time, Mr Jack was noted to have elevated mood with extreme thought disorder that had him asserting he could talk to animals. He was described as lacking insight and with poor judgment. He was diagnosed as experiencing a severe relapse of mania with psychotic symptoms, arising from his Bipolar Affective Disorder. After a 10-week admission, Mr Jack was eventually discharged on 22 August 2013 with lithium, sodium valproate (another mood stabiliser) and the antipsychotic, asenapine, to treat his condition. After his hospital discharge, Mr Jack returned to Western Australia to live with his parents.

26 The next period of care from WMHS began in September 2013 after Mr Jack began residing with his parents. Dr Florence Van Schie, a consultant psychiatrist

with WMHS, first saw Mr Jack on 20 September 2013. At that time, his medication compliance remained poor, and he still presented with extreme thought disorder. He was educated about his diagnosis and his acceptance of his mental health issues improved, however it remained poor overall. Mr Jack maintained his concerns about side effects from his prescribed medications.

27 On 31 March 2014, Mr Jack was admitted to Swan Districts Hospital with a relapse of his Bipolar Affective Disorder due to medication non-compliance and a manic episode with psychotic features. On this occasion he had grandiose beliefs regarding his ability to singlehandedly save animal species from extinction. He was admitted as a voluntary patient and agreed to commence monthly depot injections for the administration of one of his medications. Mr Jack was subsequently given a paliperidone (an antipsychotic) depot before he was discharged on 23 April 2014. He was also recommenced on oral doses of lithium and olanzapine.

28 In June 2014, Dr Van Schie noted an improvement, and it was decided to replace the olanzapine medication with quetiapine. Lithium and the paliperidone depots were continued. In September 2014, Mr Jack's father contacted WMHS with concern regarding Mr Jack's mental state and his behaviour. He also expressed frustration that the medications were not controlling Mr Jack's symptoms.

29 In October 2014, Mr Jack's care was transferred to Dr Sam Restifo, another consultant psychiatrist from WMHS. Although he denied cannabis and methylamphetamine use, Mr Jack said that he was still using synthetic "*designer smokes*" and alcohol. As a result of the side effects with paliperidone, Mr Jack's depot injections from his general practitioner were reduced from 100 mg to 50 mg monthly.

30 Subsequent reviews with the consultant psychiatrist at WMHS noted Mr Jack improved after continued compliance with his medication, provided he abstained from using synthetic cannabis.

31 In March 2015, Mr Jack began exhibiting agitation, pressured speech and thought disorder as a result of using synthetic cannabis. As his symptoms settled after he had ceased using synthetic cannabis, Dr Restifo formed the view that these episodes may have been drug-induced, rather than due to Mr Jack's Bipolar Affective Disorder.

32 In November 2015, after a period of stability, Mr Jack was transferred to the care of his general practitioner with the recommendation that the monitoring of lithium levels and renal and thyroid functions occurred every three months, and psychiatric reviews every six to 12 months as necessary. On 8 December 2015, Mr Jack was deactivated from WMHS. At the time of his deactivation, Mr Jack was subject to a combination of 50 mg monthly paliperidone depot injections, and nightly doses of 1,350 mg of lithium and 500 mg of quetiapine

33 On 26 September 2017, Mr Jack self-referred to WMHS for a medication review due to the side effects from his medications and he was subsequently re-engaged by WMHS.

34 At his psychiatric review with Dr Restifo on 31 October 2017, Mr Jack said he had increased tremors and was oversleeping which he attributed to his medications. Although he remained stable on the combination of drugs outlined above; in view of the side effects, it was planned that there be a gradual reduction of quetiapine with a monitoring for a potential relapse.

35 On 7 December 2017, Mr Jack was involved in a car accident, and he was taken to the emergency department at Joondalup Health Campus. Hospital testing found acute lithium toxicity in Mr Jack's system. On 11 December 2017, Mr Jack's

general practitioner tested his lithium level which was found to be within a therapeutic range. Nevertheless, as a result of the earlier lithium toxicity, Mr Jack's nightly dosage of lithium was reduced to 900 mg every two nights and 1,350 mg every third night.

36 On 22 January 2018, Mr Jack requested a transfer of care to a private psychiatrist and declined any further follow up from WMHS. Support from his mother for that decision was confirmed during a home visit by WMHS on 23 January 2018. As a result, Mr Jack was deactivated from WMHS on 30 January 2018.

37 On 20 March 2018, a referral from Mr Jack's general practitioner was received by Midland Community Mental Health Service. However, as Mr Jack was outside that service's catchment area, the referral was declined, and it was sent to WMHS. When contacted by WMHS, Mr Jack was adamant he did not want further treatment from WMHS and stated he was prepared to pay for private psychiatric care.

38 On 18 April 2018, another referral from Mr Jack's general practitioner was received by City East Community Mental Health Service, which also declined to see Mr Jack as he was outside its catchment area. As a result, Mr Jack was contacted by WMHS and provided with the details of a bulk billing private psychiatrist who provided a Telehealth service. Mr Jack was also reminded that he could access WMHS at any time. This was the last direct contact WMHS had with Mr Jack.

39 In May 2018, Mr Jack's general practitioner provided him with referrals to a number of private psychiatrists. However, it does not appear that Mr Jack engaged the services of a private psychiatrist before his death.

40 On 1 October 2018, Mr Jack received a paliperidone depot injection at his general practitioner's practice. This was the last time a depot antipsychotic was

administered to Mr Jack at the practice. On 6 November 2018, Mr Jack attended a consultation with a one of the general practitioners at the practice and reported that he had stopped taking some of his antipsychotic medications, including the paliperidone depot injections. He was agitated and verbally aggressive during the consultation and he was advised he could follow up with another doctor. During several further consultations with different general practitioners at the practice between 27 November 2018 and 11 February 2019, Mr Jack requested prescriptions for chlorpromazine (an antipsychotic), quetiapine and panadeine forte.

THE EVENTS LEADING UP TO 28 MARCH 2019 [5]

41 On 18 February 2019, Mr Edwin Ruzayi, a clinical nurse with WMHS, received a telephone call from Rurallink.[6] Mr Ruzayi was advised that Rurallink had received an anonymous telephone call the day before regarding Mr Jack. The caller said that a family member of Mr Jack may be contacting WMHS.[7]

42 Mr Jack's last consultation with a general practitioner was on 23 March 2019. He requested repeat prescriptions for chlorpromazine and quetiapine, stating he had misplaced his previous prescriptions. He was somewhat agitated with pressured speech, stating he was "*spaced out*". He was reported to be not overtly aggressive.

43 At about 12:50 pm on 27 March 2019, WMHS received a telephone call from Louisa Arkins, Mr Jack's sister. Ms Arkins expressed concern about Mr Jack. She reported that one of her brothers had received a call from Mr Jack stating that he

[5] Exhibit 1, Volume 1, Tab 24, Statement of Edwin Ruzayi dated 2 May 2022; Exhibit 1, Volume 1, Tab 23.1, Report of Dr Florence Van Schie dated 22 April 2022; Exhibit 2A, Notes of conversation with Mr Jack's sister by Mr Ruzayi on 27 March 2019

[6] Rurallink is an after-hours telephone service for people in rural and regional Western Australia experiencing a mental health crisis.

[7] The timing of this telephone call is consistent with the statement of Demond Jack's mother which said that, prior to his death, Mr Jack "*had suffered some agitation over the past six weeks*": Exhibit 3, Statement of Dolores Jack dated 25 July 2019

planned to take his own life, or the life of someone else, on 1 April 2019. Mr Jack had also bought gifts for his nieces and nephews, which caused concern for his family as it suggested an intention to carry out his stated plan.

44 Ms Arkins called WMHS again on the same day at 2:00 pm. On that occasion she spoke to Mr Ruzayi. During this conversation she said that as the day progressed, Mr Jack had presented as manic and talking "*gibberish*". Ms Arkins advised that he was sedating himself with painkillers and she felt he was abusing that medication to control his mental health symptoms. She was unsure whether he was compliant with his prescribed medication, which she believed was quetiapine and lithium. Ms Arkins advised that her mother did not currently see an issue with Mr Jack's presentation, although her father was worried Mr Jack might harm him and he therefore wanted him off the property.

45 Mr Ruzayi discussed with Ms Arkins the options available to the family to get Mr Jack the support he required. Ms Arkins said she would have a discussion with the family, including her mother, regarding what needed to be done, and that the family would contact WMHS if they needed further assistance. WMHS did not receive any further calls from Mr Jack's family on 27 March 2019.

THE EVENTS OF 28 MARCH 2019

Telephone call to WMHS [8]

46 At about 10.00 am on 28 March 2019, Mr Jack's mother telephoned WMHS and spoke to Mr Ruzayi. Her concern for Mr Jack's mental health had escalated and she asked if he could get a referral that would allow him to be directly admitted to SJGHM.

[8] Exhibit 1, Volume 1, Tab 24.1, Statement of Edwin Ruzayi dated 2 May 2022; Exhibit 1, Volume 1, Tab 25.2, Incident Report dated 28 March 2019; Recording of triple zero calls on 28 March 2019; Exhibit 1, Volume 1, Tab 10, Statement of Russell Jack dated 5 April 2019; Exhibit 3, Statement of Delores Jack dated 25 July 2019

47 Mr Ruzayi advised Mr Jack's mother that admissions to SJGHM must be through the hospital's emergency department and that included admissions under the *Mental Health Act 2014* (WA).

48 Mr Ruzayi then had a discussion with Mr Jack's mother regarding the options available for a hospital admission. Those options included a voluntary admission or an involuntary admission under the *Mental Health Act 2014* (WA). An assessment from a mental health clinician was also discussed, with support from WAPF if required. The option of calling triple zero for police assistance if there was an imminent risk was also raised.

49 Mr Jack's mother stated that although Mr Jack was "*unstable*", he was asleep at the time and she was going to wait until he woke up to see if he agreed to be admitted to hospital voluntarily. The agreed plan was that Mr Jack's mother would decide if Mr Jack required hospital admission when he woke up and, if required, she would contact WMHS for support.

Mr Jack wakes up [9]

50 At about 1.00 pm, Mr Jack entered his parent's house and had lunch. When his mother told him of her plans to make an appointment for him to see his general practitioner and for him to be admitted to SJGHM, Mr Jack said that he did not want to do that. After he had eaten his lunch, he went back to the granny flat and locked himself in.

51 Mr Jack's mother then rang her other two sons (Russell Jack and Phillip Jack) and asked them to come over and assist with getting their brother into hospital. Russell Jack attended his parent's property with his licensed rifle, as he was concerned Mr Jack might attempt to hurt someone.

[9] Exhibit 3, Statement of Delores Jack dated 25 July 2019

52 With the assistance of her two eldest sons, Mr Jack's mother made another attempt to persuade Mr Jack to voluntarily admit himself to SJGHM. However, he refused to do so and after briefly coming out of the granny flat, he went back inside and relocked the door. A decision was then made by Mr Jack's family to contact the WAPF.

The first triple zero call [10]

53 Just before 1.14 pm, Mr Jack's mother called triple zero. She spoke to the operator for about two minutes and advised that Mr Jack was having a "*psychotic episode*" and was "*speaking gibberish and is delusional*". She said that he had been diagnosed with schizophrenia and that he had locked himself in the granny flat at her property. Mr Jack's mother said that she wanted to get Mr Jack to hospital for treatment. The conversation ended with the operator advising her that arrangements would be made for police to attend and provide assistance.

54 At 1.17 pm, the operator entered the contact details for Mr Jack's mother and then added the following information on the Computer-Aided Dispatch System (CAD)[11]:

> Son Desmond Jack is having a mental health breakdown. Desmond has diagnosed schizophrenia. He locked himself in the granny flat at the back of the property and caller unable to get in to him. He is speaking gibberish and is delusional, so caller was trying to get him to hospital for help before he locked himself in.

The response by police [12]

55 The police station nearest to Mooliabeenee was in Gingin and it was allocated the job for police to respond to the call from Mr Jack's mother. The only on-duty

[10] Exhibit 1, Volume 1, Tab 25.2, Incident Report dated 28 March 2019; Recording of triple zero calls on 28 March 2019; Exhibit 3, Statement of Delores Jack dated 25 July 2019
[11] CAD is the central system used by the WAPF where all tasking is recorded, allocated, managed and monitored.
[12] Recording of triple zero calls on 28 March 2019; Exhibit 1, Volume 1, Tab 14.1, Statement of Senior Constable Mark Harrison dated 11 April 2019

police officer at the station on the afternoon of 28 March 2019 was Officer Harrison.[13]

56 At 2.08 pm, Officer Harrison refreshed CAD on his police desktop computer. It was only then he noticed the CAD job that had been entered regarding the triple zero call made by Mr Jack's mother. This job was categorised as a "Priority 3", which meant that it was regarded as non-urgent, although still requiring police attendance.

57 As Officer Harrison was checking the names of the two persons listed on the CAD job on the WAPF Incident Management System (IMS), he called the Regional Desk at the WAPF Perth Operations Centre (POC). He advised that he was the only officer at the police station, and it would not be suitable to attend the CAD job by himself. The dispatcher at POC said he would check the status of the CAD job by speaking to Mr Jack's mother and then provide Officer Harrison with an update.

58 The dispatcher called Mr Jack's mother just after 2.12 pm and spoke to her for about two and a half minutes. Mr Jack's mother confirmed that Mr Jack was still in the granny flat and would not come out. She said he was still "*acting irrationally*" and had previously threatened his father and had said he wanted to kill himself by 1 April. Although Mr Jack's mother said that Mr Jack had not threatened self-harm that day, he had nevertheless "*gone psychotic*". When the dispatcher advised that he would have to call in a police officer to the Gingin police station, Mr Jack's mother reiterated that the family "*do need some assistance*". The call ended with the dispatcher stating he will make arrangements and "*hopefully get someone to you soon*".

[13] The other police officer rostered for duty was undertaking a training course.

59 The dispatcher subsequently called Officer Harrison and advised that Mr Jack was still "*going off*", Officer Harrison then made arrangements for Constable Cameron Johnson (Officer Johnson) to commence his shift earlier that day. Officer Johnson arrived at the Gingin police station at about 2.30 pm. He and Officer Harrison left to attend the job shortly after that.

The attempt by Russell Jack to speak to Mr Jack and the second triple zero call [14]

60 At about 2.40 pm, Russell Jack made another attempt to speak with Mr Jack, this time through a window at the rear of the granny flat that was slightly open. However, as he spoke, he could hear Mr Jack shouting and becoming agitated from inside. Mr Jack threatened to "*slash*" his brother, and that he was going to come outside. Russell Jack took those threats very seriously and genuinely believed Mr Jack was going to attack him with a knife. As a result, he armed himself with the rifle that he had brought with him. He then called triple zero at 2.46 pm.

61 That conversation lasted for just over two minutes. Russell Jack told the operator that the incident had already been called in by his mother. He repeated that Mr Jack was having a "*psychotic episode*" and that he had threatened to kill him. Russell Jack said he had his firearm for his own protection and that he was "*in fear of my life*". He said although he, his other brother and his mother had backed off, they still needed police to get there as soon as they could as Mr Jack was "*in a bad way*". The operator advised him to keep his distance from Mr Jack and that police should be there soon. The CAD entry for this conversation was made at 2.50 pm.

[14] Exhibit 1, Volume 1, Tab 11, Statement of Russell Jack dated 28 March 2019; Exhibit 1, Volume 1, Tab 25.2, Incident Report dated 28 March 2019; Recording of triple zero calls on 28 March 2019

Attendance by Officers Harrison and Johnson [15]

62 Officers Harrison and Johnson arrived at the Mooliabeenee property shortly after Russell Jack had called triple zero. Both were in police uniform and each had their police-issued accoutrements, which included handcuffs, capsicum spray, extendable baton, taser and a Glock firearm. They drove up the driveway and parked their marked police vehicle at the rear of the main house, which was about 15 metres from the rear of the granny flat.

63 The police officers spoke to Mr Jack's mother and her two sons, and it was confirmed that Mr Jack had been making threats to his brothers and to self-harm. Although Mr Jack's mother advised that Mr Jack had no access to any of the property's firearms, she said there were some knives missing from the kitchen of the main house.

64 The police officers could not ascertain exactly where Mr Jack was inside the granny flat. They noted it had two sets of sliding windows at the rear or eastern side that had the curtains drawn closed. There was a glass sliding door on the western side, which appeared to be the only entrance to the granny flat.

65 Officer Harrison, after positioning himself so that he could see the sliding door, called out, "*Desmond, it's the Gingin police come out and talk to us*". There was no response and no movement from within the granny flat. Officer Harrison then walked back to the rear of the granny flat where Officer Johnson was positioned with Mr Jack's brothers.

[15] Exhibit 1, Volume 1, Tab 13.1, Statement of Constable Paul Johnson dated 11 April 2019; Exhibit 1, Volume 1, Tab 14.1, Statement of Senior Constable Mark Harrison dated 11 April 2019

Mr Jack leaves the granny flat armed with a knife [16]

66 When the two police officers and Mr Jack's brothers were at the rear of the granny flat, Mr Jack's mother was standing where she could see the sliding door. She then saw Mr Jack leave the granny flat, holding a small knife.[17] He ran towards a large water tank that was on the northern side of the granny flat (the water tank). She called out that "*he*" was now outside and that he had "*a knife*".

67 Officer Harrison ran to where Mr Jack's mother was and told her to "*stay put*". He then began to run after Mr Jack from the western side of the granny flat.

Mr Jack's interaction with Officer Harrison [18]

68 Officer Harrison correctly assumed that the person he saw running away from the granny flat was Mr Jack. He also saw that Mr Jack was holding a knife in his right hand and that the blade was about the same length as the width of his hand. Although Officer Harrison called out for Mr Jack to stop, he continued running around the northern end of the granny flat and out of the police officer's sight.

69 As he ran after Mr Jack, Officer Harrison briefly sighted him running through a narrow section between a shed and the water tank.

70 As Officer Harrison reached the spot where he had last seen Mr Jack, he saw Mr Jack had stopped running and was now standing in front of him, about 10-12 metres away. Mr Jack then turned around so that he was facing Officer Harrison. He did not say anything and raised the knife in his right hand to about the same height as his head. Officer Harrison said, "*Desmond, don't*", or words to that effect.

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[16] Exhibit 1, Volume 1, Tab 14.1, Statement of Senior Constable Mark Harrison dated 11 April 2019; Exhibit 3, Statement of Delores Jack dated 25 July 2019

[17] It was a foldable knife that was 18 cm in length when the knife was unfolded, with a blade approximately 7.5 cm long with a pointed end: Exhibit 1, Volume 1, Tab 28, Compilation of Scene Photographs

[18] Exhibit 1, Volume 1, Tab 14.1, Statement of Senior Constable Mark Harrison dated 11 April 2019

71 Mr Jack then began making a stabbing motion with the knife by moving it up and down from above his head to a point in line with his chest. This stabbing motion was done quickly and repeatedly. Concerned that Mr Jack might try and stab him, Officer Harrison drew his firearm. Mr Jack began moving towards him, still making stabbing-type motions with the knife.

72 As Officer Harrison pointed his firearm at Mr Jack, he took a step backwards and yelled at Mr Jack to stop. Officer Harrison repeated this several times. Mr Jack did not respond and kept moving towards Officer Harrison. He continued to make the stabbing motions with the knife.

73 When Mr Jack was about two or three metres away from Officer Harrison, the officer discharged his firearm once. Mr Jack doubled over immediately and released the knife from his hand.

Medical attention provided to Mr Jack [19]

74 Officer Johnson and the three members of Mr Jack's family arrived at the scene shortly after Mr Jack had been shot. By this stage, Officer Harrison was applying pressure to the gunshot wound to Mr Jack's stomach with a field dressing he was carrying.

75 At 2.58 pm, Officer Harrison activated the portable radio he was carrying by pushing the emergency button. This enabled Officer Johnson to communicate with POC to request a Priority 1 attendance of an ambulance. That call for an ambulance was then made by POC at 3.02 pm.

76 At one point, Mr Jack began to resist the first aid Officer Harrison was providing. He was then put into the recovery position by the two police officers, and Officer

[19] Exhibit 1, Volume 1, Tab 13.1, Statement of Constable Paul Johnson dated 11 April 2019; Exhibit 1, Volume 1, Tab 14.1, Statement of Senior Constable Mark Harrison dated 11 April 2019; Exhibit 1, Volume 1, Tabs 15-16, St John Ambulance Patient Care Records; Exhibit 1, Volume 1, Tab 25.2, Incident Report dated 28 March 2019

Johnson placed his handcuffs on Mr Jack, behind his back. When he was told to stop moving his legs by Officer Harrison, Mr Jack responded, "*No, it's the bull shark.*" This was the only time Mr Jack spoke to Officer Harrison.

77 As the police officers continued to provide first aid to Mr Jack, Russell Jack was directed to retrieve the trauma kit from the police vehicle. When he came back with the trauma kit, Officer Harrison's field dressing was replaced with gauze from the trauma kit. Mr Jack's mother, a volunteer ambulance officer, was able to assist with the first aid.

78 Officer Johnson maintained communications with an ambulance operator, who advised that as much pressure as possible should be applied to the wound. At the operator's suggestion, Mr Jack's mother placed her knee over the wound. The handcuffs were also removed from Mr Jack once he had stopped struggling.

79 Volunteer ambulance officers arrived at 3.18 pm. By this stage, Mr Jack was unconscious. Ambulance officers placed an oxygen mask on Mr Jack, as well as defibrillator pads. Cardiopulmonary resuscitation (CPR) was then commenced, and Mr Jack was placed into the ambulance, with his mother. It left the property at 3.28 pm under Priority 1 conditions.

80 At 3.43 pm, by arrangement, another ambulance with paramedics intercepted the ambulance conveying Mr Jack on Great Northern Highway in Chittering. Traffic on the highway was stopped at the location, which allowed Mr Jack to be transferred to the other ambulance without delay. The paramedics' initial examination noted that Mr Jack was unresponsive and not breathing.

81 Urgent resuscitative efforts were continued by the paramedics; however, it was clear that Mr Jack was in an extremely critical condition. The ambulance departed the scene on Great Northern Highway at 3.57 pm and Mr Jack was taken to the emergency department at SJGHM under Priority 1 conditions, arriving at

4.30 pm. Despite the extensive efforts to revive him, Mr Jack was declared life extinct at 4.45 pm by a doctor at SJGHM.

CAUSE AND MANNER OF DEATH [20]

Cause of death

82 Dr Jodi White, a forensic pathologist, conducted a post mortem examination on Mr Jack's body on 1 April 2019. A computerised tomography (CT) scan was also undertaken. Unsurprisingly, the most significant finding from the post mortem examination was the single gunshot injury to Mr Jack's lower anterior chest wall/upper anterior abdominal wall. There were associated internal injuries to Mr Jack's liver and his right lung with connected blood loss. The bullet was found within the back of the right chest. Mr Jack's lungs were congested with aspiration.

83 A macroscopic examination of Mr Jack's brain by a neuropathologist found no significant abnormalities.

84 A toxicological analysis of Mr Jack's blood samples detected several prescribed medications, including mirtazapine and quetiapine. A small amount of methylamphetamine was also detected, as was tetrahydrocannabinol, which was consistent with recent use of cannabis. Alcohol was not detected.

85 At the conclusion of her investigations, Dr White expressed the opinion that the cause of death was a gunshot injury to the anterior trunk.

86 I accept and adopt the conclusion expressed by Dr White as to the cause of Mr Jack's death.

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[20] Exhibit 1, Volume 1, Tabs 3A-C, Interim Post Mortem Report to the Coroner, Post Mortem Report to the Coroner and Supplementary Post Mortem Report to the Coroner dated 1 April 2019; Exhibit 1, Volume 1, Tab 4, Neuropathology Report by Dr Vicki Fabian dated 23 April 2019; Exhibit 1, Volume 1, Tab 5.1, Final Toxicology Report dated 22 May 2019

Manner of death

87 I find that the manner of Mr Jack's death was homicide by way of self-defence. This occurred when Officer Harrison discharged his firearm and shot Mr Jack as he approached the police officer while brandishing a knife in a threatening manner. Based on all the available evidence, and for the reasons I have outlined below, I find that Officer Harrison was justified in discharging his firearm as it was reasonable for him to conclude that Mr Jack's actions at the time had placed his life in imminent danger.

MATTERS RAISED BY THE EVIDENCE

Actions of WMHS on 27-28 March 2019

88 The actions taken by WMHS following the two telephone calls it received from Mr Jack's sister on 27 March 2019 and the telephone call it received from Mr Jack's mother on 28 March 2019 were the subject of an investigation by the WA Country Health Service (WACHS) (the WACHS investigation).[21]

89 The WACHS investigation found that the triage assessment of Mr Jack suggested that he was at risk, however the care plan did not describe any intervention or follow-up action by WMHS to ensure Mr Jack's safety. In each instance when WMHS was contacted, the documented outcome was for the family to take further action and to contact WMHS if its support was required.[22]

90 The WACHS investigation also found that the normal work flow process within WMHS was for clinicians to table cases that had been triaged at the service's clinical risk meeting. This process was informal and not documented and relied upon clinician attendance to nominate cases that had been triaged for clinical risk review. Furthermore, the staff member normally providing triage was occupied

[21] Exhibit 1, Volume 1, Tab 21, SAC1 Clinical Incident Investigation Report CIMS221331
[22] Exhibit 1, Volume 1, Tab 21, SAC1 Clinical Incident Investigation Report CIMS221331, p.5

with additional meetings at the time of contact, and the clinician who triaged Mr Jack on the first occasion was not working the following day when the risk review meeting occurred. As a consequence, Mr Jack was not reviewed at this meeting.[23]

91 When asked at the inquest whether WMHS should have adopted a more active role following the telephone calls by Mr Jack's sister on 27 March 2019, Mr Ruzayi stated that although Mr Jack's sister was concerned regarding her brother's behaviour, she had advised that Mr Jack's mother did not have the same concern.[24] Mr Ruzayi also said that he was conscious of the need to build up the rapport that WMHS needed to have with Mr Jack's family. As Mr Ruzayi said at the inquest:[25]

> So, to me the view I had was it was really important to be working with Desmond's mother and having everyone on the same page doing this, if we had a chance of actually continuing to support the family in the future.

92 As to the agreed plan with Mr Jack's mother, following her call on the morning of 28 March 2019, Mr Ruzayi said that, "*there wasn't anything that was communicated that was sort of – indicated to me that from the previous day that he* [Mr Jack] *had deteriorated.*"[26] When asked whether he should have made a note for WMHS to contact Mr Jack's family after a certain period of time, Mr Ruzayi said that his plan was to check the next morning whether Mr Jack's mother had had the discussion with him and what was Mr Jack's views in terms of engaging with mental health service providers.[27]

93 Although Mr Ruzayi did not document that course of action,[28] I accept his evidence that this is what he intended to do.

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[23] Exhibit 1, Volume 1, Tab 21, SAC1 Clinical Incident Investigation Report CIMS221331, p.5
[24] ts 10.5.22 (Ruzayi), p.12
[25] ts 10.5.22 (Ruzayi), p.12
[26] ts 10.5.22 (Ruzayi), p.15
[27] ts 10.5.22 (Ruzayi), p.15
[28] See Exhibit 2B, Notes made by Mr Ruzayi of the conversation with Mr Jack's mother on 28 March 2019

94 I am prepared to find that the planned actions by Mr Ruzayi with Mr Jack's sister and then with Mr Jack's mother the next day were appropriate. In so finding, I note that the previous relationship between WMHS and Mr Jack and his family had been somewhat fractious. I also accept Mr Ruzayi's explanations that he was of the opinion the risk was only likely to escalate on 1 April and that the *Mental Health Act 2014* (WA) provides for the use of the least restrictive option which, in this case, would have been Mr Jack's voluntary admission to a hospital.[29] From what Mr Jack's mother had told him, I find it was reasonable for Mr Ruzayi to conclude that this was still a viable option.

95 I can therefore understand the approach taken by Mr Ruzayi, and to now criticise that approach would be inserting hindsight bias in my assessment, something which I am mindful not to do.

96 Nevertheless, it was unfortunate that Mr Jack was not reviewed at the WMHS risk review meeting for the reasons that have been outlined above. However, I am satisfied that the improvements made in this area since Mr Jack's death should reduce the likelihood of such an outcome from happening again. Those improvements are outlined later in this finding.

Officer Harrison's actions in following Mr Jack

97 Before Officer Harrison left the Gingin police station, he made the decision to take a police vehicle with a secure pod, rather than one with no secure compartment.[30] He made that decision as he thought it might be necessary to convey Mr Jack to Perth for a mental health assessment and that it would be better if he was conveyed in a secure pod, rather than in an unsecured police sedan.[31]

[29] Exhibit 1, Volume 1, Tab 24.1, Statement of Edwin Ruzayi dated 2 May 2022, p.3
[30] Exhibit 1, Volume 1, Tab 14.1, Statement of Senior Constable Mark Harrison dated 11 April 2019, p.8
[31] Exhibit 1, Volume 1, Tab 14.1, Statement of Senior Constable Mark Harrison dated 11 April 2019, p.8

98 Once the two police officers were provided with the additional information regarding Mr Jack's mental state after they arrived at the Mooliabeenee property, I am satisfied that Officers Harrison and Johnson were authorised to apprehend Mr Jack for a mental health assessment pursuant to section 156(1) of the *Mental Health Act 2014* (WA).[32] Section 172 of the *Mental Health Act 2014* (WA) authorises police to use "*reasonable force*" in exercising their power under section 156(1).

99 I am also satisfied that Officer Harrison had attempted to establish a dialogue with Mr Jack by asking him to come outside and talk to him. That amicable approach was unsuccessful.

100 As they drove to Mooliabeenee, Officers Harrison and Johnson had also arranged for other police to attend as backup.[33] However, Mr Jack left the granny flat before that backup could arrive. As Chris Markham (Mr Markham) noted:[34]

> Before SC Harrison and PC Johnson had time to discuss options and to determine a plan and a course of action which would be appropriate in the circumstances, the situation suddenly escalated again and became dynamic. This is because Desmond suddenly exited the front of the granny flat, armed with a knife in his right hand.

101 Given his agitated state, the threats he had made earlier and that he was now armed with a knife, I find that once Mr Jack had left the granny flat the attending police had to follow him. This was because his mental illness required him, "*to be apprehended to protect the health or safety of the person or the safety of another person*".[35]

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[32] Section 156 (1) of the *Mental Health Act 2014* (WA) states:
A police officer may apprehend a person if the officer reasonably suspects that the person –
(a) has a mental illness; and
(b) because of the mental illness, needs to be apprehended to –
(i) protect the health or safety of the person or the safety of another person; or
(ii) prevent the person causing, or continuing to cause, serious damage to property.

[33] Exhibit 1, Volume 1, Tab 14.1, Statement of Senior Constable Mark Harrison dated 11 April 2019, p.9

[34] Exhibit 1, Volume 1, Tab 27.1, Report of Chris Markham dated 7 May 2022, p.46

[35] Section 156(1)(b)(i) of the *Mental Health Act 2014* (WA)

102 I therefore find Officer Harrison was justified in pursuing Mr Jack as he ran out of the granny flat.

Officer Harrison's discharge of his firearm

103 As with every fatal police shooting, the death of Mr Jack was investigated by the WAPF Homicide Squad and the IAU. The Homicide Squad investigation found that the actions of Officer Harrison "*did not constitute any form of criminality*".[36] The managerial investigation undertaken by IAU concluded that Officer Harrison's actions during the course of the incident did not breach any WAPF policy or procedure.[37]

104 Notwithstanding the conclusions of the Homicide Squad and the IAU, I am required to undertake my own investigations to determine if I should make a report under section 27(5)(a) or (b) of the Act.[38] I am also required to undertake my own analysis as to whether WAPF policy and procedures have been complied with. In undertaking these inquiries, I was assisted by the Homicide Squad memorandum prepared by Detective Senior Constable Matt Bower,[39] the IAU report prepared by Detective Sergeant Chris Boudewyns (Detective Boudewyns)[40] and the comprehensive report prepared by Mr Markham in his capacity as Capability Advisor – Use of Force at the WA Police Academy's Occupational Skills Training Faculty.[41] One part of Mr Markham's role is the responsibility for management and oversight of "Use of Force" reporting in the

[36] Exhibit 1, Volume 1, Tab 8, Letter from Acting Detective Superintendent Craig Collins dated 5 August 2020
[37] Exhibit 1, Volume 1, Tab 8, IAU Report of Detective Sergeant Chris Boudewyns dated 15 June 2020
[38] Section 27(5) of the *Coroners Act 1996* (WA) provides:

A coroner may report to –

(a) The Director of Public Prosecutions if the coroner believes that an indictable offence has been committed in connection with a death which the coroner investigated; or

(b) The Commissioner of Police if the coroner believes that a simple offence has been committed in connection with a death which the coroner investigated.

[39] Exhibit 1, Volume 1, Tab 6, Memorandum of Detective Senior Constable Matt Bower dated 24 April 2019
[40] Exhibit 1, Volume 1, Tab 8, IAU Report of Detective Sergeant Chris Boudewyns dated 15 June 2020
[41] Exhibit 1, Volume 1, Tab 27.1, Report of Chris Markham dated 7 May 2022

WAPF, which includes the review and quality assurance of "Use of Force" reports submitted by WAPF officers.[42]

105 Unsurprisingly, WAPF has a detailed policy governing the use of force by its officers.[43] This policy covers the use of police-issue accoutrements and provides officers with direction and guidance when responding to operational policing tasks. As described by Mr Markham:[44]

> Specifically, the policy provides guidance in regard to the justification for officers to use reasonable force in the management of conflict situations, where there is a need to reduce a threat and gain control of a subject.

106 In addition, police officers are trained to follow a particular decision-making process when responding to policing tasks. Part of this process requires a police officer to always undertake an ongoing risk assessment.[45]

107 The WAPF Use of Force Policy has a section regarding the use of firearms.[46]

108 This part of the policy sets out when it is justified for a police officer to draw their firearm: [redacted][47]

109 The pointing of firearm in the direction of a person is permitted [redacted][48]

110 The circumstances for when a firearm can be discharged at a person is defined as: [redacted]

[42] Exhibit 1, Volume 1, Tab 27.1, Report of Chris Markham dated 7 May 2022, p.4
[43] Police Manual Policy FR-01.01 – Use of Force
[44] Exhibit 1, Volume 1, Tab 27.1, Report of Chris Markham dated 7 May 2022, p.21
[45] WAPF Situational Tactical Options Model (STOM)
[46] Policy Manual Policy FR-01.02 – Use of Firearms
[47] Exhibit 1, Volume 1, Tab 27.1, Report of Chris Markham dated 7 May 2022, p.24
[48] Exhibit 1, Volume 1, Tab 27.1, Report of Chris Markham dated 7 May 2022, p.25

[redacted][49]

111 When using a firearm, police officers must ensure they not only comply with the relevant policy, but also with their training and the relevant legislation regarding the use of force that applies to the general community.

112 In addition to the training course undertaken by police recruits, police officers must also undertake annual critical skills training with the WAPF Operational Safety and Tactics Training Unit (OSTTU).

113 The Critical Skills 3 (CS3) training program comprises of a mandatory In-Service Weapons Training and Requalification Program approved by OSTTU. The validity period for the CS3 requalification is one year.[50] Officer Harrison had completed his annual CS3 training on 14 January 2019.[51]

114 What Officer Harrison did as he pursued Mr Jack has already been summarised in this finding under the sub-heading "***Mr Jack's interaction with Officer Harrison***". With more detail, Officer Harrison described what he did as Mr Jack came towards him:[52]

> I took a step backwards and contemplated tactically disengaging from Desmond. I was standing between a small shed and a big concrete water tank. There is also a tree in this space which narrows the gap further between the shed and water tank. These items stopped me from being able to move to the left or right.
>
> The only option for me was to go back the way I had come. However, I quickly assessed that Desmond was gaining so much ground on me, that if I turned and ran, he would be able to stab me in the back.
>
> I yelled at him several times "*Desmond, stop*" or "*Don't*". I'm pretty sure I also yelled something like "*Drop it*".
>
> As Desmond came in line with the tree between the shed and the concrete tank, he was only now about 2-3 metres away from me.

[49] Exhibit 1, Volume 1, Tab 27.1, Report of Chris Markham dated 7 May 2022, p.25
[50] Exhibit 1, Volume 1, Tab 27.1, Report of Chris Markham dated 7 May 2022, p.31
[51] Exhibit 1, Volume 1, Tab 27.1, Report of Chris Markham dated 7 May 2022, p.33
[52] Exhibit 1, Volume 1, Tab 14, Statement of Senior Constable Mark Harrison dated 11 April 2019, pp.27-28

> He was still stabbing the knife into the air towards me frantically.
>
> I thought Desmond was going to stab me and try to kill me. I believe Desmond was imminently going to stab me and that I was at serious risk of receiving grievous bodily harm or death.
>
> I fired my firearm once.

115 I am satisfied that there were sufficient grounds for Officer Harrison to reasonably suspect there was a risk of grievous bodily harm or death to him once Mr Jack stopped and turned around to face him, and then began making stabbing motions with the knife he was holding. I therefore find that Officer Harrison was entitled to draw his firearm at that point [redacted] I am also satisfied that once Mr Jack started moving towards Officer Harrison, whilst continuing the stabbing motion with the knife and ignoring the police officer's demands that he stop, there were clearly sufficient grounds for Officer Harrison to reasonably believe there was an imminent risk of grievous bodily harm or death to himself. I therefore find that Officer Harrison was justified in discharging his firearm once at Mr [redacted].

116 The risk assessments made by Officer Harrison were supported by the accounts of the other persons who were in close proximity. Russell Jack described what he saw as follows:[53]

> Des ran between a small shed that has a water tank behind it and a large garage area, which has a red car in it.
>
> Des ran towards the back of the garage when he suddenly stopped.
>
> At that point I knew the first officer was following him and Des had a knife.
>
> I heard the first officer shouting continuously *"Des drop the knife, put the knife down"*.
>
> Des stopped next to a tree stump and turned to face the first officer's voice.
>
> ...
>
> I could see that Des was psyched.
>
> Des had murder in his eyes.

[53] Exhibit 1, Volume 1, Tab 11, Statement of Russell Jack dated 28 March 2019, pp.8-12

Des raised his right hand close to his head as if he was holding a spear at shoulder level.

At that point I could see a silver blade protruding from his clenched fist which was holding the handle.

The blade was approximately 5" long. It was about 1" wide.

...

The first officer continued to shout at Des.

Everyone started to shout at Des. I told him to put the knife down.

Des started to bounce on his feet. It looked like he was trying to pump himself up.

Des also started to pump his right hand in a stabbing motion.

...

Des looked erratic. He was all over the place looking around.

Des started to bounce towards the first officer. I couldn't see the officer, but Des was looking intently at where I thought he was.

Des suddenly lunged forward. He went out of my view.

I could hear the first officer. His voice had a sense of urgency. He sped up saying *"Drop the knife. Drop the knife"*.

Almost immediately after Des lunged at him I heard a gunshot.

117 Phillip Jack stated what he saw:[54]

Des looked straight at me, he was holding his right hand over his shoulder, holding a knife in an overhand grip with the blade out.

He turned north, took a step, and then turned back; it was as if he had seen something.

He looked at me again and then started violently stabbing the air with the knife in his right hand.

I heard *"Put the knife down, put the knife down"* and *"Don't do it"*. More than one person was yelling.

Des had started sprinting from the large shed towards the water tank and gap with a smaller shed.

I knew it was very confined in there, I sprinted towards Des, I feared for the police.

I was running as fast as I could, for a brief second I lost visual of him as he passed behind the small shed.

I heard the officer's voice as he shouted at Des, change from a controlled dominant direction, to an almost fear for your life tone shouting *"Put the knife down"*.

I then heard a gunshot and a thud.

[54] Exhibit 1, Volume 1, Tab 12, Statement of Phillip Jack dated 28 March 2019, pp.5-7

118 Officer Johnson described what he saw (at a distance of about 30 metres) as follows:[55]

> Desmond was bouncing up and down like he wanted to fight anyone who came near him.
>
> He was in a fighting stance with both fists clenched.
>
> I could not see a knife or any other weapons on him, but I shouted out to him telling him to drop the knife.
>
> Even though I could not see a knife, I believed he did have a knife in his possession because of what I had been told.
>
> When I shouted at him to drop the knife, he just looked at me.
>
> ...
>
> I looked to see where Russell was because I was concerned Russell might come at me.
>
> I immediately looked back towards Desmond and he ran back behind the shed out of my view.
>
> As he did this, he held his right hand up and motioned as though he was stabbing something.
>
> I could not see a knife at that stage, but he was motioning as though he was stabbing something in the air.
>
> Desmond ran out of my view behind the shed.
>
> I would have been still about 30 metres away from Desmond so there was distance between us.
>
> ...
>
> I moved towards the rear of the shed where Desmond had run to.
>
> I heard Senior Constable Harrison yell out "*Stop drop the knife*". This happened within a second of Desmond going out of my view.
>
> ...
>
> As a result of Senior Constable Harrison's command to Desmond I pulled my Glock pistol from my holster.
>
> I believed that as a result of Senior Constable Harrison's command, that Desmond was in possession of a knife and Senior Constable Harrison's or another person's life may have been at risk.
>
> As I drew my Glock pistol, I heard the sound of a pistol firing once.

119 Mr Jack's mother, unlike the others, did not immediately follow Mr Jack. She described what she heard and observed: "*As the policeman and my sons were*

[55] Exhibit 1, Volume 1, Tab 13.1, Statement of Senior Constable Cameron Johnson dated 11 April 2019, pp.14-17

running towards Desmond, I heard them screaming at him to put the knife down. I was at the back of the granny flat when I heard the gunshot."[56]

120 I am satisfied, based on the evidence before me, that Mr Jack was undergoing a severe psychotic episode on 28 March 2019. Members of his family had recognised that, and they are to be commended for the efforts they made to have Mr Jack obtain the medical attention he so desperately needed. Tragically, his psychotic state prevented him from understanding that his family and the two attending police officers were acting in his best interests. As Russell Jack described:[57]

> Des had worked himself up to what happened. I knew when the police arrived that there was a very real chance he would be hurt or hurt someone else.
>
> Des had ample opportunity to run away through the bush.
>
> The first officer was boxed into a confined space at the point Des ran at him with a knife.
>
> I can't see that the first officer had any other option but to defend himself.
>
> Des would have seriously hurt the first officer, intending to evoke what eventually happened to him.

121 I accept these observations made by Russell Jack. I also agree with the analysis made by the IAU investigation as to the actions by Officer Harrison:[58]

> In this particular case, he thought through his force options and possible scenarios if Desmond were to get past him and possibly seriously injure family members that he had threatened to kill earlier. He fired a single round when Desmond [was about to] attack him which disabled him, no further shots were required.

122 Accordingly, I am satisfied that the risk assessments made by Officer Harrison complied at all times with his training. I am also satisfied that he only shot Mr Jack in self-defence when there was no other viable option open to him to avoid the very real risk of grievous bodily harm or death to himself.

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[56] Exhibit 3, Statement of Delores Jack dated 25 July 2019, p.2
[57] Exhibit 1, Volume 1, Tab 11, Statement of Russell Jack dated 28 March 2019, p.15
[58] Exhibit 1, Volume 1, Tab 8, IAU Report of Detective Sergeant Chris Boudewyns dated 15 June 2020, p.33

The viability of Officer Harrison using less-lethal options

123 As to the effectiveness of Officer Harrison undertaking a less-lethal option instead of discharging his firearm at Mr Jack, Mr Markham addressed those in his report and/or his evidence at the inquest. Three questions arose with respect to this matter.

124 One question was whether police officers are trained to fire "a warning shot". Mr Markham testified that there is certainly no training regarding that option as:[59]

> It would be considered very unsafe for police officers to discharge a round from their firearm as a warning shot in terms of what is a safe direction, where do you discharge that round? Now, the fact that the officer has got the firearm drawn and he's challenging the subject and giving them clear verbal commands and directions to drop the knife, stop, get back, get down on the ground, whatever it is they're saying, that should be sufficient for the subject to understand, as opposed to a warning shot being discharged.

125 The second question was whether police officers are trained to shoot at a part of the body that is less likely to be fatal. Mr Markham testified that officers are trained [redacted].[60] He went onto explain:[61]

> [redacted]
>
> ...
>
> [redacted] So, it's an incredibly stressful life-threatening situation that they're in and we cannot expect this is achievable for an officer to be able to discharge their firearm and maybe hit an arm that's holding a knife or hit a leg. Legs and arms are moving very, very quickly.
>
> ...
>
> What happens is police officers' discharging a firearm at that range, it's instinctive reaction shooting. They're not getting what's called a sight picture. So, it's not about

[59] ts 11.5.21 (Markham), p.112
[60] ts 11.5.21 (Markham), p.110
[61] ts 11.5.21 (Markham), pp.110-111

> marksmanship. It's about reacting and stopping the threat as quickly as they can and as effectively as they can [redacted]

126 The third question was whether Officer Harrison ought to have deployed his taser instead of his firearm. Officer Harrison explained at the inquest that he could not use his taser as a viable force option at the time he saw Mr Jack making the threatening stabbing motions with the knife, because Mr Jack was beyond the effective range for a taser.[62]

127 Mr Markham confirmed in his evidence at the inquest that the optimum range for the two probes from a taser to be effective is three to four metres. Mr Markham then added:[63]

> Other things that have to be taken into consideration is the fact that we have a subject that's moving towards you. So, you've then got to get two probes into moving parts of the body. So, you've got movement on the part of the officer, movement on the part of the subject. Very difficult to get two probes to make contact with the subject in those circumstances. [redacted]

128 Mr Markham continued:[64]

> And in terms of taser and effectiveness, we know from our statistical analysis of use of tasers going back over the years, it's about 67 per cent effective in those circumstances and that's specifically when somebody is coming at you with a or they're – you're – an officer is confronted by somebody armed with an edged weapon. So that's another factor that Senior Constable Harrison has got to take into consideration is, *"I'm here on my own. I don't know where PC Johnson is. I have no backup officer. I have no one to provide me with lethal cover. Therefore, in the circumstances as Desmond is running towards me, I want to make sure that I can effectively stop the threat safely and – and quickly."* So that's why he drew his firearm.

129 I am satisfied with the explanations given by Mr Markham as to why none of these three options was viable in the circumstances that existed in this case.

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[62] ts 10.5.21 (Harrison), p.51
[63] ts 11.5.21 (Markham), pp.102-103
[64] ts 11.5.21 (Markham), p.103

The placing of handcuffs on Mr Jack

130 As already noted above, Officer Johnson placed his pair of handcuffs on Mr Jack after he had been shot. His explanation was that when Mr Jack started to kick and resist the first aid treatment, it was necessary to place handcuffs on him, "*to stop him assaulting us or anyone else, whilst we were applying first aid*".[65]

131 Officer Harrison's evidence at the inquest was that as Mr Jack was still struggling, "*we secured handcuffs on him, just to prevent him from attempting to hurt himself or others*".[66]

132 The accounts by the two officers of Mr Jack's behaviour after he had been shot are supported by Russell Jack who described his brother as, "*struggling with the first officer and acting violently*".[67]

133 Detective Boudewyns was asked whether it would be common practice to handcuff someone after they had been shot. He answered:[68]

> Sometimes, because we don't know what else they are carrying. So, they could have another weapon. Until that's clear, yes. Obviously there has been a propensity to go at police with a knife. We don't know whether he was carrying one, two, three knives or anything else.

134 Mr Markham testified that it was appropriate for Officer Johnson to use his handcuffs even though Mr Jack had just been shot. He was satisfied that it complied with police training and noted the possibility that there were "*other knives secreted on his person that we can't see*".[69] Mr Markham also noted that Mr Jack was "*physically struggling*" and that police officers must prevent their own weapons being grabbed.[70] In addition, Mr Markham observed:[71]

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[65] Exhibit 1, Volume 1, Tab 13.1, Statement of Constable Cameron Johnson dated 11 April 2019, p.20
[66] ts 10.5.21 (Harrison), p.55
[67] Exhibit 1, Volume 1, Tab 11, Statement of Russell Jack dated 28 March 2019, p.13
[68] ts 10.5.21 (Boudewyns), p.92
[69] ts 10.5.21 (Markham), p.106
[70] ts 10.5.21 (Markham), p.107
[71] ts 10.5.21 (Markham), p.107

> And then, of course, in terms of bodily injury to Desmond himself by applying the handcuffs, they were actually restraining him and stopping him from, as was described, thrashing around, or bracing himself, pushing himself up off his arms which was causing him to lose more blood. So, my take on that is that the use of handcuffs was entirely appropriate and proportionate in the circumstances.

135 In light of the circumstances that existed and the evidence before me, I am satisfied that Officer Johnson was justified in placing his handcuffs on Mr Jack when he did. It was also the case that the handcuffs were removed as soon as Mr Jack stopped struggling.[72]

Officer Harrison's encounter with another armed man on 21 March 2019

136 I should also note that the IAU report in this matter referred to an incident exactly one week earlier involving Officer Harrison and a man who was affected by alcohol, armed with a knife, had mental health issues, and was expressing thoughts of self-harm (the man).[73] The man had also verbally goaded Officer Harrison to shoot him. It is evident from this brief description that there were some obvious similarities with the incident involving Mr Jack.

137 This earlier incident was captured on a private body-worn camera belonging to Officer Harrison's partner on the day (who was not Officer Johnson). At my request, the WAPF provided a copy of the body-worn camera footage and it became exhibit 4 at the inquest.

138 I have viewed the footage and it is clear that the "Use of Force" options adopted by Officer Harrison and his partner during this incident complied with WAPF policy and procedure at all times. After multiple requests from police who were only a short distance away, the man eventually placed the knife on the ground in front of him. But he then refused a request to kick it further away so that it was out of his reach. Officer Harrison had his firearm pointed at the man at various

[72] Exhibit 1, Volume 1, Tab 13.1, Statement of Constable Cameron Johnson dated 11 April 2019, p.24
[73] Exhibit 1, Volume 1, Tab 8, IAU Report of Detective Sergeant Chris Boudewyns dated 15 June 2020, pp.27-28

times and he exercised commendable restraint in not discharging his drawn firearm as the man began to pick up the knife and the initial tasering attempt by his partner failed.

139 The incident was resolved a short time later when the man was tasered by another police officer. However, the resolution of this incident contrasted sharply with the one involving Officer Harrison and Mr Jack. Four police officers were in close proximity when the man was tasered and the incident was considerably less dynamic than the one confronting Officer Harrison when he first sighted Mr Jack.

IMPROVEMENTS SINCE MR JACK'S DEATH

Changes at WMHS

140 The WACHS investigation made two recommendations. First, that a template for WMHS clinicians describing support options and management plans be developed and implemented in triage management practice.[74] Second, that WMHS formalise and document its patient risk meeting agenda and work flow process, including triage processes.[75]

141 With respect to these recommendations, Dr Van Schie reported:[76]

> Triage function is now held by the ACCESS team (Advice, Consultation, Collaboration, Entry, Support Service). Previously it had been up to the triage officer ... to use their own judgment to decide to escalate clinical matters, either immediately through coordinators or psychiatry teams, or at the following morning whole of service meeting.
>
> Following this SAC1 recommendation, a meeting is now scheduled daily at 15:45 hours for the triage officer of the day to present ALL referrals and contacts for the day to the rest of the ACCESS team, to share decision-making and provide handover of any developing situations for the following day. The meeting is chaired by the ACCESS Team Coordinator (which is a new position) and is attended by a Psychiatrist or Senior Medical Officer. These conversations are recorded at the time in the PSOLIS[77]

[74] Exhibit 1, Volume 1, Tab 21, SAC1 Clinical Incident Investigation Report CIMS221331, p.2
[75] Exhibit 1, Volume 1, Tab 21, SAC1 Clinical Incident Investigation Report CIMS221331, p.2
[76] Exhibit 1, Volume 1, Tab 23.1, Report of Dr Florence Van Schie dated 22 April 2022, p.5
[77] Psychiatric Services Online Information System

> electronic record which is available after hours should the patient attend an Emergency Department.

142 I am satisfied that this new process addresses the issues that arose in the handling of Mr Jack's case on 27 and 28 March 2019.

143 Dr Van Schie also reported that the recommendation for a template for WMHS mental health clinicians has been implemented in the triage management practice.[78] This document is titled "ACCESS Orientation Safety Plan Template" and subsequent revisions have led to further improvements.

144 At the time of Mr Jack's death, WMHS was only funded to operate during business hours, Monday to Friday. However, funding has now been provided for an expansion into business hours on weekends and public holidays. Unfortunately, there has been a difficulty in recruiting staff and hence, there is still no WMHS service seven days a week.[79] Nevertheless, Dr Van Schie hoped that will take place, "*in the next couple of months, but it's really up to getting some stable staff.*"[80]

The expansion of the Mental Health Co-Response model

145 The Mental Health Co-Response model (MHCR) is a collaborative partnership between the WAPF, the Western Australian Mental Health Commission and the Department of Health. It is designed to improve the responses for police attendance to tasks where members of the public are experiencing a mental health crisis.[81] It began as a two-year trial that covered the Perth metropolitan area from January 2016 to January 2018.

146 The MHCR has four components, one of which are mobile teams which comprise of police officers with specific training in mental health and an authorised mental

[78] Exhibit 1, Volume 1, Tab 23.1, Report of Dr Florence Van Schie dated 22 April 2022, p.5
[79] Exhibit 1, Volume 1, Tab 23.1, Report of Dr Florence Van Schie dated 22 April 2022, p.6
[80] ts 11.5.21 (Dr Van Schie), p.141
[81] Exhibit 1, Volume 1, Tab 25.1, Report of Inspector Louise Ball dated 4 May 2022, p.1

health practitioner (AMHP). These teams provide the first response to police-initiated incidents where a person is experiencing a mental health crisis.

147 In November 2018, the WAPF Corporate Board ratified the MHCR as being a permanent service model across the metropolitan area and granted approval for it to be expanded from two teams to four teams. This enabled MHCR services to cover all metropolitan police districts for six days a week and increase the availability of its services from eight hours to ten hours per day.[82]

148 In 2020, the Western Australian government announced a $20.2 million election commitment to expand the number of MHCR mobile teams in the metropolitan area and to expand the MHCR into Bunbury and Geraldton. The MHCR commenced in Geraldton on 8 September 2021. Since late January 2022, it provides mobile teams coverage every Monday to Saturday, from 1.00 pm to 11.00 pm.[83] The MHCR mobile teams are scheduled to commence operating in Bunbury from 1 July 2022.[84]

149 Unfortunately, MHCR does not currently operate anywhere else in regional Western Australia. As Inspector Louise Ball, Assistant Divisional Officer of the Custodial Services and Mental Health Division of the WAPF, noted in her report:[85]

> From a WA Police Force perspective, the limitation in extending the model to the outer areas of Perth, such as Mooliabeenee are largely resource driven, with current demands for mobile team attendance outstripping resources.
>
> The most constrained resource is the limited AMHPs that are available, along with the large geographical areas covered by the mobile teams. AMHPs are employees of the various health services, who in addition to their regular employment, nominate to perform the role of an AMHP with a mobile team.
>
> Extending the current metropolitan MHCR model to the outer areas of Perth that are outside the metropolitan Police Districts would increase the demands on the mobile

[82] Exhibit 1, Volume 1, Tab 25.1, Report of Inspector Louise Ball dated 4 May 2022, p.2
[83] Exhibit 1, Volume 1, Tab 25.1, Report of Inspector Louise Ball dated 4 May 2022, p.3
[84] Exhibit 1, Volume 1, Tab 25.1, Report of Inspector Louise Ball dated 4 May 2022, p.4
[85] Exhibit 1, Volume 1, Tab 25.1, Report of Inspector Louise Ball dated 4 May 2022, p.7

> teams, and the AMHPs in those mobile teams, where those services are already oversubscribed.
>
> For every job that a mobile team attends in the metropolitan area, there are three or four other jobs which would otherwise fall within the remit of the mobile teams that are not attended. As a result, there is a large amount of unmet demand within the metropolitan area, requiring general duties patrol staff to attend the task without the benefit of an AMHP.
>
> ...
>
> From an operational perspective, it is theoretically possible to deploy a mobile team from Midland to a job in an area such as Mooliabeenee. However, in deploying that resource to Mooliabeenee, it would likely mean that the mobile team is unable to respond to other incidents.

150 Understandably, MHCR mobile teams do not attend mental health tasks that may pose a risk to the AMHP. The MHCR Operational Guidelines makes it clear that a MHCR mobile team will not attend an incident where, "*based on known factors, the imminent safety and security of the mental health practitioner is likely to be compromised*".[86] I therefore agree with Inspector Ball's assessment that it was unlikely a MHCR mobile team, had it been available, would have been involved in Mr Jack's matter, given the potential risk posed to the AMHP.[87]

151 I endorse the continuing expansion of the MHCR, not only within the metropolitan area, but also to the regional areas. I regard it as a vital component in an improved procedure by the WAPF when dealing with people afflicted with mental illness.

Additional mental health training for operational police officers

152 Commencing in January 2021, WAPF introduced a one-day course into its In-Service Critical Skills Program which trains police officers in how to deal with people who are experiencing a mental health crisis. This training involves establishing better communicative skills that are designed to embed empathy and

[86] Exhibit 1, Volume 1, Tab 25.1, Report of Inspector Louise Ball dated 4 May 2022, p.3
[87] Exhibit 1, Volume 1, Tab 25.1, Report of Inspector Louise Ball dated 4 May 2022, p.7

rapport with the person.[88] This training program (known as CS5) also involves scenario-based training. The CS5 program is a bi-annual qualification.[89]

153 In addition to the above course, police officers are also able to access a guide produced in 2019 by the Australia and New Zealand Police Advisory Agency (ANZPAA). This guide assists police officers dealing with incidents involving mental health issues.[90] Although all WAPF officers have access to this training guide, it is up to the individual officer to use or refer to it.

154 There is also a mental health first aid training course that police officers can elect to do at the Police Academy.[91]

155 I commend the WAPF for the introduction of the above courses. Given the high proportion of incidents involving mental health issues that operational police officers attend (which, I fear, will only increase), it is vitally important that those police officers are equipped to deal with such incidents; particularly if a MHCR mobile team is unable to attend.

Body-worn cameras

156 In the same month that Mr Jack died, the Minister for Police announced the first stage of a State-wide rollout of body-worn cameras to operational police officers, with the delivery of such cameras to all operational officers scheduled to be completed by June 2021.[92]

157 The benefit of body-worn camera footage (that also has sound) is obvious. It provides independent evidence of an incident and will become an integral part of any investigation into actions by police. It also has the potential to be used in

[88] ts 11.5.22 (Markham), p.119
[89] ts 11.5.22 (Markham), p.120
[90] ts 11.5.22 (Markham), p.119
[91] ts 11.5.22 (Markham), pp.119-120
[92] https://www.mediastatements.wa.gov.au/pages/mcgowan/2019/03/body-worn-cameras-to-be-deployed-to-frontline-officers.aspx

police training, providing a real case scenario of what police ought to do (or ought not to do). In addition, such footage will always be available whenever a police officer draws their firearm. As explained by Mr Markham:[93]

> So, when a firearm is drawn there's what's called a signal sensor sidearm – sidearm sensor. So, it breaks the contact in the holster. As soon as the firearm is drawn from the holster, it sends out a Bluetooth sign. Any police officer within a 10-metre radius – so not just the officer drawing the firearm, but any other officer within a 10-metre radius, it will activate their body-worn camera.

CONCLUSION

158 All too frequently, the Coroner's Court encounters cases in which a person's life and the lives of their loved ones are devastated by the scourge of a serious mental health illness. Sadly, Mr Jack's death is now added to that lengthy list.

159 Mr Jack was undoubtedly experiencing a major psychotic episode when he approached Officer Harrison in a very threatening manner, armed with a knife. Despite repeated calls from Officer Harrison and others to stop, Mr Jack did not. In doing so, he left Officer Harrison with no viable option other than discharging his firearm once at him and he died from the gunshot wound a short time later. As Russell Jack so poignantly observed, only hours after his brother's death: "*The man I saw today wasn't my brother.*"[94]

160 Regretfully, it would appear Mr Jack was intent on carrying out an earlier threat he had made to his other brother: "*If the police ever come here to try and take me, I'd come out with a knife and they will have to shoot me.*"[95] (I note there was no evidence before me that WAPF were aware of this threat before Mr Jack was shot.)

161 I have found that Mr Jack died from a gunshot injury to his anterior trunk after Officer Harrison discharged his firearm at him once. I have also found that the

[93] ts 11.5.22 (Markham), p.121
[94] Exhibit 1, Volume 1, Tab 11, Statement of Russell Jack dated 28 March 2019, p.15
[95] Exhibit 1, Volume 1, Tab 12, Statement of Phillip Jack dated 28 March 2019, p.1

circumstances facing Officer Harrison meant it was appropriate for him to take the action that he did in order to defend himself. If Officer Harrison did not discharge his firearm, I am satisfied Mr Jack would have attacked him with the knife he was brandishing.

162 Although the impact of Mr Jack's death will never be as profound for the two police officers involved as it was for his family, it was obvious from the manner in which the officers gave evidence at the inquest that they were affected by it. Fittingly, Officer Johnson conveyed the following to Mr Jack's family at the completion of his evidence:[96]

> I just want to offer to the family of Desmond my condolences to yourselves. I know there's nothing I can say or do to help heal or to mend any wound, but again, my condolences always, and if you ever need anything at any time, please do not hesitate to contact us.

163 It is inevitable that police will continue to encounter people experiencing psychotic episodes. It is important that the WAPF, the Western Australian Mental Health Commission and the Department of Health continue to broaden their collaborative approach through the MHCR model.

164 I also commend the WAPF for increasing the opportunities for operational police officers to be better equipped in dealing with people experiencing mental health issues. Every effort must be made to lessen the prospect of a person with mental health issues becoming a danger to themselves or to other members of the community. By offering courses to operational police officers that will educate them to better manage a situation involving people experiencing a mental health crisis will only enhance the prospect of achieving that objective.

165 I do not see the utility in making recommendations that the MHCR be expanded further in the Perth metropolitan area, or that it be extended to other regional areas. Those recommendations have already been made in a number of recent

[96] ts 10.5.22 (Johnson), p.85

inquests by several coroners and need not be repeated again.[97] The WAPF, and by a necessary extension the State Government, are already aware of the benefits the MHCR has provided and will continue to provide should it be introduced to other regions outside of the Perth metropolitan area, Geraldton, and Bunbury.

166 I am also satisfied with the improvements that WMHS have made to its practices and procedures. These improvements have meant it is not necessary for me to make any recommendations for changes in those areas.

167 Mr Jack's immediate family attended the inquest and their continuing grief at the loss of Mr Jack was palpable. I particularly commend Mr Jack's mother for extending her gratitude to Dr Van Schie (through Counsel Assisting) for the assistance the Doctor had provided to her son.[98]

168 It is very clear to me that the family of Mr Jack loved him dearly and were making every effort to protect him from harming himself or a member of his family on 28 March 2019. It was no doubt heartbreaking for Mr Jack's family that their attempts to help him ended so tragically.

169 I extend my sincere condolences to the family of Mr Jack.

PJ Urquhart
Coroner
9 June 2022

[97] For example: Inquest into the death of ***Andrew John Key*** [2020] WACOR 36; Inquest into the death of ***Scott William Martin*** [2021] WACOR 23; Inquest into the death of ***Chad Riley*** [2021] WACOR 24
[98] ts 11.5.22, p.145