JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	13-17 SEPTEMBER 2021
DELIVERED	**:**	1 APRIL 2022
FILE NO/S	**:**	CORC 470 of 2019
DECEASED	**:**	WYNNE, CHERDEENA SHAYE

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:
Mr W Stops assisted the Coroner
Ms C O'Connor SC with Mr S Castan (appearing remotely) appeared on behalf of the family
Mr D Harwood and Ms J Berry (State Solicitor's Office) appeared on behalf of the Western Australia Police Force
Mr G Bourhill appeared on behalf of Joondalup Health Campus

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 ***Cherdeena Shaye WYNNE*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, Perth, on 13 - 17 September 2021, find that the death occurred on 9 April 2019 at Royal Perth Hospital, from hypoxic ischaemic encephalopathy and bronchopneumonia in a woman with methylamphetamine effect and exertion with restraint in the following circumstances:*

Contents

ABBREVIATION LIST

Abbreviation	Meaning
The Act	*Mental Health Act 2014* (WA)
ALO	Aboriginal Liaison Officer
AVL	Automated Vehicle Locator
BMI	Body Mass Index
CAD	Computer-Aided Dispatch (WAPF)
CEO	Chief Executive Officer of the Department of Communities
CT scan	Computerised Tomography scan
The Department	The Department of Communities
IAU	Internal Affairs Unit
IMS	Incident Management System (WAPF)
JHC	Joondalup Health Campus
MHCR	Mental Health Co-Response Unit (WAPF)
MHOA	Mental Health Observation Area at JHC
OSTTU	Operational Safety and Tactics Training Unit (WAPF)
PCA	Patient Care Assistant
RPH	Royal Perth Hospital
SCGH	Sir Charles Gairdner Hospital
SJA	St John Ambulance
SOCC	State Operations Command Centre (WAPF)
STOM	Situational Tactical Options Model (WAPF)
TADIS	The WAPF's former on-board computer system (now replaced by the OneForce Core mobile phone application)
The Manual	The WAPF's Handcuff Manual
VKI	Police Radio Communications
VRO	Violence Restraining Order
WAPF	Western Australian Police Force

INTRODUCTION

1 The deceased (Ms Wynne) tragically died on 9 April 2019 at Royal Perth Hospital (RPH). She was 26 years old. Five days earlier, on 4 April 2019, she had stopped breathing when being restrained by police officers from the Western Australia Police Force (WAPF) on a grass verge adjacent to Albany Highway in Bentley. Ms Wynne never regained consciousness and she died in hospital from hypoxic ischaemic encephalopathy and bronchopneumonia.

2 Ms Wynne's untimely death greatly traumatised her mother, her grandparents, her young children and other family members. Ms Wynne's family had already suffered enormous grief from the death of Ms Wynne's father who was in police custody when he took his own life 20 years earlier. He too was only 26 years old.

3 Ms Wynne's death was a reportable death within section 3 of the *Coroners Act 1996* (WA), because it was a death that "*appears to have been caused, or contributed to, by any action of a member of the Police Force*".

4 By reason of section 19(1) of the *Coroners Act 1996* (WA), I have jurisdiction to investigate Ms Wynne's death.

5 Pursuant to section 22(1)(b) of the *Coroners Act 1996* (WA), an inquest into Ms Wynne's death was mandatory because it appears her death was caused, or contributed to, by action of one or more police officers.

6 Section 22(1)(b) is enlivened when the issue of causation or contribution in relation to the death arises as a question of fact, irrespective of whether there is fault or error on the part of the police officers involved.

7 I held an in inquest into the death of Ms Wynne at Perth over the course of five days, from 13-17 September 2021. The following 16 witnesses gave oral evidence:[1]

i. Dr Stephen Paparo, the Psychiatrist Registrar at Joondalup Health Campus (JHC), who assessed Ms Wynne on 25 March 2019;

ii. Dr Martin Chapman, Deputy Director of Medical Services and Acting Head of Mental Health Services at JHC;

iii. Acting Senior Sergeant Jason Barnes, Senior Operations Officer at the State Operations Command Centre;

iv. Constable Daniel Ellis, one of the two police officers who saw Ms Wynne on Hubert Street, East Victoria Park on 4 April 2019;

v. Detective Sergeant James Stanbury, one of the police officers who attended the unit of Ms Wynne's mother on 4 April 2019;

vi. First Class Constable Luke Yakacikli, one of the police officers who attended the unit of Ms Wynne's mother on 4 April 2019;

vii. Constable Layla Boyd, one of the police officers who attended the unit of Ms Wynne's mother on 4 April 2019;[2]

viii. Jessica Bourke, one of the two ambulance officers who treated Ms Wynne on 4 April 2019;

ix. Shannan Griffiths, the other ambulance officer who treated Ms Wynne on 4 April 2019;

x. First Class Constable Shaun O'Callaghan, one of the three police officers who apprehended Ms Wynne on Albany Highway on 4 April 2019;

xi. First Class Constable Jessica Rozier, one of the police officers who was present during the apprehension of Ms Wynne on Albany Highway on 4 April 2019;

xii. Sergeant Jace Williams, one of the three police officers who apprehended Ms Wynne on Albany Highway on 4 April 2019;

xiii. Constable Emiley Regan, one of the three police officers who apprehended Ms Wynne on Albany Highway on 4 April 2019;

xiv. Professor David Joyce, Clinical Pharmacologist and Toxicologist;

[1] I have used the ranks of the police officers who testified as of April 2019. At the time of the inquest, Constable Emiley Regan had the surname of Northey. However, I will refer to her by her name as of April 2019.
[2] Constable Boyd also attended the location where Ms Wynne was initially treated by ambulance officers and the scene at Albany Highway after Ms Wynne had been apprehended and restrained.

xv. Detective Senior Constable Michael Hill, the author of the WAPF Internal Affairs Unit Report; and

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

8 The documentary evidence at the inquest comprised of three volumes of the brief that was tendered as exhibit 1 at the commencement of the inquest. A further seven exhibits (exhibits 2-6) were tendered during the inquest.[3]

9 During the course of oral closing submissions at the inquest, I granted leave to Ms O'Connor SC, counsel for the family of Ms Wynne, to provide short written submissions regarding proposed recommendations the family wanted to be made. Those written submission were emailed to the Court on 24 September 2019. I invited counsel for the other interested parties to respond to those submissions by 8 October 2021. Mr Harwood, counsel for the WAPF, emailed submissions in response in an attached letter dated 8 October 2021.

10 I have taken into consideration those submissions, in addition to the oral closing submissions from counsel at the inquest, in making my findings and considering any recommendations.

11 At the conclusion of the inquest, I requested the WAPF, through Mr Harwood, to make enquiries as to whether a screenshot was available of what First Class Constable Luke Yakacikli (Officer Yakacikli) saw from the on-board computer system (known as TADIS) in his police vehicle when he conducted the name check for Ms Wynne on 4 April 2019. By letter dated 14 October 2021, Mr Harwood advised that his instructions from WAPF were that this information was no longer available. However, that letter did contain further information from Officer Yakacikli as to his recollection of what he saw.

[3] Exhibit 4 comprised of 4A and 4B and exhibit 6 comprised of 6A and 6B.

12 My primary function has been to investigate the death of Ms Wynne. It is a fact-finding function. Pursuant to section 25(1)(b) and (c) of the *Coroners Act 1996* (WA), I must find, if possible, how the death of Ms Wynne occurred, and the cause of her death.

13 Pursuant to section 25(2) of the *Coroners Act 1996* (WA), I may comment on any matter connected to Ms Wynne's death, including public health or safety, or the administration of justice. This is an ancillary function of a coroner.

14 Section 24(5) of the *Coroners Act 1996* (WA) 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.

15 During the course of an inquest, and within the related finding, a coroner is permitted to make findings that are adverse to an "*interested person*", which includes a person who, either by act or omission, may have caused or contributed to the death being investigated. Pursuant to section 44(2) of the *Coroners Act 1996* (WA), before I make any finding adverse to the interest of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

16 During the course of the inquest, I outlined to counsel for the interested parties what particular aspects of the matter I would invite submissions to be made. They were:[4]

i. Whether adequate measures were in place to prevent Ms Wynne from absconding from the Mental Health Observation Area (MHOA) at JHC on 26 March 2019;

ii. Whether it was appropriate for Acting Senior Sergeant Barnes to manually downgrade the police alert for Ms Wynne on 30 March 2019;

[4] ts 16.9.21, pp.525-527

As to the events on 4 April 2019:

iii. Whether it was appropriate for Constable Boyd to place Ms Wynne in handcuffs at her mother's unit;

iv. Whether it was appropriate for Constable Ellis to place Ms Wynne in handcuffs on the walkway immediately outside the unit;

v. Whether there was an adequate mental health welfare check conducted by police officers upon Ms Wynne at the unit;

vi. Whether police at the unit should have formed the opinion that Ms Wynne required a mental health assessment under section 156(1) of the *Mental Health Act 2014* (WA);

vii. Whether Sergeant Williams' manner of driving was appropriate as he approached Ms Wynne running on Albany Highway;

viii. Whether the restraint of Ms Wynne, including her being placed in the prone position and being handcuffed, at Albany Highway was appropriate;

ix. Whether it was appropriate for Sergeant Williams to keep his leg across Ms Wynne's upper back after the handcuffs had been placed on her; and

x. Whether adequate monitoring was done of Ms Wynne's breathing by police officers when she was in the prone position.

17 Another matter raised by Ms O'Connor SC during her oral closing submissions was whether Constables Ellis and Fitzpatrick had reasonable grounds to approach Ms Wynne when they saw her walking on the footpath at Hubert Street on 4 April 2019.

18 In making my findings that may be adverse to the interests of an individual or entity, 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 proved on the balance of probabilities (the ***Briginshaw*** principle).

19 I am also mindful not to insert hindsight bias into my assessment of the actions taken by police in their dealings with Ms Wynne on 4 April 2019.

MS WYNNE [5]

20 Ms Wynne, a Noongar Yamatji woman, was born on 24 December 1992. She had three younger step-siblings.

21 Ms Wynne was only six years old when her father died. She had a close relationship with her father and when he died, she did not understand what had happened due to her young age. Following her partner's death, Ms Wynne's mother had difficulties coping with the loss and she had a breakdown. Ms Wynne and her step-siblings went to live with their maternal grandmother and later, with a maternal aunt.

22 Ms Wynne first came to the attention of the Department of Communities (the Department) in May 1998. She was subsequently named in 85 Interactions that included four Initial Inquiries and four Safety and Wellbeing Assessments.

23 Despite her at times turbulent and disrupted upbringing, it was to Ms Wynne's credit that her adult court appearances were mainly confined to traffic matters. Her offending was at the lower end of the scale and she was never sentenced to a term of imprisonment.

24 By the age of 20, Ms Wynne was in a relationship. She gave birth to her first son on 3 August 2013. Her second son was born on 15 November 2014. Unfortunately, Ms Wynne's relationship with her partner was marred by domestic violence. By May 2014, Ms Wynne had left her partner and she had taken out a Violence Restraining Order (VRO) on him. By this stage, it had become apparent that Ms Wynne had a polysubstance dependency which involved cannabis and methylamphetamine. In October 2014, a social worker

[5] Exhibit 1, Volume 1, Tab 10B, Statement of Shirley Wynne dated 8 September 2021; Exhibit 1, Volume 1, Tab 35; Department of Communities Report by Jackie Tang dated 10 July 2020; Exhibit 1, Volume 3, Tabs 1-4, JHC, RPH and Geraldton Hospital Medical Records; Exhibit 1, Volume 1, Tab 33, JHC Medical Records; Court Outcomes History – Criminal and Traffic for Ms Wynne

raised concerns with Ms Wynne's doctor regarding her mental health and her ability to cope with the impending birth of her second child.

25 On 25 February 2016, Ms Wynne was taken by police to St John of God Hospital, Midland, for a mental health assessment.

26 By June 2016, Ms Wynne had disclosed to staff at the Department that she was experiencing anxiety and depression, and was having difficulties coping with her two children. Unfortunately, incidents of domestic violence continued to be part of Ms Wynne's relationships.

27 On 24 November 2016, Ms Wynne attended the Department's Geraldton office, seeking accommodation for herself and her two sons. Given her erratic behaviour during this attendance police were called, and Ms Wynne was subsequently taken by police to Geraldton Hospital. It was noted she was exhibiting paranoia, behaving irrationally and experiencing visual and auditory hallucinations. Ms Wynne was discharged later that evening with a diagnosis of "*situational crisis*". Following a subsequent Safety and Wellbeing Assessment, Ms Wynne's two sons were placed into the care of the Department's Chief Executive Officer (CEO), pursuant to section 37 of the *Children and Community Services Act 2004* (WA).

28 On 23 May 2017, Ms Wynne gave birth to her daughter. By this stage, her two sons were residing with their father.

29 At the time of her death, Ms Wynne's sons were aged five years and four years. Her daughter was nearly two years old. Ms Wynne clearly loved her children and she was heartbroken from the loss of looking after her two sons. As of 24 March 2019, Ms Wynne still had custody of her daughter who meant everything to her.

THE EVENTS OF 24-26 MARCH 2019 [6]

30 At about 8.30 pm on 24 March 2019, Ms Wynne was taken by ambulance to the emergency department at JHC with her daughter. Ambulance officers had attended an address in Tapping where Ms Wynne was present. She expressed concerns to the ambulance officers that her daughter had ingested tablets from a blister packet.

31 Ms Wynne's behaviour at JHC was documented as erratic, with drug use being a possible influencing factor. Between the initial triage assessment, and prior to Ms Wynne and her daughter being seen by medical staff, Ms Wynne left the hospital with her daughter.

32 Medical staff contacted the police just after 9.00 pm, due to concerns for Ms Wynne's welfare, and the welfare of her daughter. Officers from the WAPF were tasked to attend various locations to search for Ms Wynne.

33 Several hours later, Ms Wynne and her daughter were brought to the emergency department of JHC by a member of the public. He reported Ms Wynne was not known to him and that he was awoken by her banging on his door asking for help. At about 2.15 am on 25 March 2019, police attended JHC and upon sighting Ms Wynne with her daughter, the police search for her was closed.

34 Ms Wynne told staff at JHC she was worried her daughter's heart had stopped beating and she could only be kept alive by remaining close to Ms Wynne. Ms Wynne was observed rocking and to be anxious and distressed. Her speech was quick and she had disordered thought processes, loosening of association and was hyper-aroused. Unsurprisingly, staff become concerned for

[6] Exhibit 1, Volume 1, Tab 33, JHC Medical Records; Exhibit 1, Volume 1, Tab 34A, Report by Dr Martin Chapman dated 16 February 2021 with attachments; Exhibit 1, Volume 3, Tab 5, Statement of Dr Stephen Paparo dated 9 September 2021 with attachments; Exhibit 1, Volume 3, Tab 4, Form 1A – Referral for Examination by Psychiatrist dated 25 March 2019; Exhibit 1, Volume 1, Tab 31, St John Ambulance Patient Care Record dated 24 March 2019

Ms Wynne's mental health due to her behaviour, and she was admitted to the emergency assessment unit at JHC.

35 An examination of Ms Wynne's daughter noted that she appeared well and the clinical examination was normal. Given their concerns for Ms Wynne's behaviour and mental health, hospital staff notified the Department regarding her daughter. The Department subsequently placed Ms Wynne's daughter into the provisional protection and care of its CEO[7] on 26 March 2019. I have no doubt this outcome would have been devastating for Ms Wynne.

36 Ms Wynne was seen by a social worker at about 10.00 am on 25 March 2019. During that interview, she was teary and again presented with disorganised speech and thought processes. Although she denied having any mental health issues, Ms Wynne maintained she had been a clairvoyant since she was six years old and said she regularly saw spirits and spoke to the dead. She admitted smoking cannabis daily and that she had last used methylamphetamine two weeks earlier. Ms Wynne maintained she did not use methylamphetamine regularly.

37 Dr Stephen Paparo, the on-duty Psychiatrist Registrar, assessed Ms Wynne at about 12:00 pm on 25 March 2019. Dr Paparo formed the view that Ms Wynne was experiencing drug-induced psychosis secondary to her use of cannabis and methylamphetamine. He also considered that her presentation could be a manic relapse of bipolar effective disorder or psychosis due to a medical condition.

38 After Ms Wynne declined to be admitted voluntarily, Dr Paparo decided that she required an involuntary inpatient admission with a referral to a consultant psychiatrist.

[7] Pursuant to section 37 of the *Children and Community Services Act 2004* (WA)

39 At 1.57 pm, Dr Paparo referred Ms Wynne to the mental health unit of Sir Charles Gairdner Hospital (SCGH) for assessment by a consultant psychiatrist. He did this by completing a Form 1A - Referral for Examination by Psychiatrist, where he wrote that the need for an involuntary treatment order was because of "*[e]vidence of psychosis, impaired capacity and risk to self/others*". SCGH was the referred hospital as it covered Ms Wynne's place of residence in its catchment area. Dr Paparo also completed a Form 4A - Transport Order at 2.00 pm, so that Ms Wynne would be conveyed between the hospitals by a transport officer.

40 Due to the unavailability of a bed at the SCGH mental health unit, a timely assessment at that hospital was not possible. Ms Wynne was therefore transferred to the MHOA at JHC on the evening of 25 March 2019.

41 At about 1.15 pm on 26 March 2019, a ward clerk used her swipe card to open the lockable doors at the entrance to the MHOA. Ms Wynne ran through the doors as they opened. Security and JHC staff were unable to locate her and police were advised. Dr Paparo completed a Form 7D - Apprehension and Return Order at 2.00 pm, authorising police to apprehend Ms Wynne so that she could be returned to JHC. Another doctor at JHC completed a Mental Health Missing Person Report which stated that Ms Wynne's degree of risk to herself and to others was "*high*" and that she was "*floridly psychotic*".

42 A high alert police task was created which noted that Ms Wynne was a mental health absconder and was a risk to herself and others. Police attended various locations in an attempt to find Ms Wynne without success.

43 On 30 March 2019, Acting Senior Sergeant Jason Barnes (Officer Barnes), a police officer stationed at the WAPF State Operations Command Centre (SOCC), reviewed the police task for Ms Wynne. Officer Barnes formed the view that the Form 7D - Apprehension and Return Order completed by Dr

Paparo was invalid, and accordingly, police had no authority to apprehend Ms Wynne under the order. The police task remained open, however it was downgraded by Officer Barnes to a welfare check by police to assess Ms Wynne's mental state. Police continued their search for Ms Wynne at addresses where it was thought she may be residing. As of 3 April 2019, she had not been located.

THE EVENTS OF 4 APRIL 2019 [8]

Ms Wynne's first interaction with police

44 At about 5.45 am on 4 April 2019, Constable Daniel Ellis (Officer Ellis) and Constable Enda Fitzpatrick (Officer Fitzpatrick) from Kensington Police Station were conducting patrols in a marked police vehicle in East Victoria Park. As they drove on Hubert Street, they observed a person who appeared to be in their 20s[9] walking on the footpath. This person was Ms Wynne. She was wearing a black hoodie with the hood up covering her face and dark-coloured shorts. When Ms Wynne saw the police vehicle, she ran away. Officer Ellis placed a call through the police radio communications (VKI) that a person had run away from them, and provided a description of the person and details of the location. Efforts by the two police officers to catch Ms Wynne were unsuccessful.

Ms Wynne's second interaction with police

45 At about the same time, five police officers from Cannington Detectives Office were conducting unrelated operations in the vicinity of Hubert Street. They heard the VKI call made by Officer Ellis.

46 These police officers then attended a unit at 133 Hubert Street just before 6.00 am, which was the last known address of a female person they intended to

[8] Exhibit 1, Volume 1, Tabs 19-29, various statements by attending police officers; Exhibit 1, Volume 1, Tab 16 and Tab 17, statements of the ambulance officers; Exhibit 1, Volume 1, Tab 32, St John Ambulance Patient Care Record dated 4 April 2019; Exbibit 1, Volume 2, Tab 2, RPH Medical Records; Exhibit 5, Statement of Constable Fitzpatrick dated 12 April 2019.
[9] Exhibit 5, Statement of Constable Fitzpatrick dated 12 April 2019, p.2

arrest. This unit was occupied by Ms Wynne's mother and Ms Wynne had been staying there for the past several days. Neither of them was the person that the police officers were seeking to arrest.

47 When they entered the unit, the police officers did not locate the individual they were looking for. However, they observed Ms Wynne seated in the lounge room and she appeared out of breath. As her clothing matched the description of the person who ran from Officers Ellis and Fitzpatrick, one of the police officers made a radio call advising the two officers to attend the unit.

48 By the time Officers Ellis and Fitzpatrick had arrived at the unit, Ms Wynne and her mother were arguing with each other, and with police. Ms Wynne was behaving erratically and appeared to be drug affected. The two women continued to argue with each other after Ms Wynne's mother went to her bedroom.

49 After Ms Wynne jostled with police as she attempted to enter the bedroom where her mother was, Constable Layla Boyd (Officer Boyd) made the decision to handcuff Ms Wynne to the front of her body. After that was done, Ms Wynne was taken outside where she was seated next to the front door. She remained handcuffed.

50 When she was seated, Officer Ellis asked her why she had run from police. Ms Wynne replied that she was scared and nervous. As Officer Boyd was leaving the unit, she asked Officer Ellis if she could swap over her handcuffs that were on Ms Wynne with his handcuffs. That took place and Officer Boyd and the other police from Cannington Detectives Office left the unit. Four police officers remained at the address.

51 Officer Fitzpatrick had earlier obtained the personal details of Ms Wynne from her mother. He then asked another police officer present, Officer Yakacikli, to

conduct a name check of Ms Wynne from TADIS in his police vehicle. Officer Yakacikli conducted the name check and found that Ms Wynne had no outstanding warrants or inquiries. However, there was an expired Mental Health Transport Order[10] for Ms Wynne with a note that police interacting with Ms Wynne should conduct a welfare check on her mental health. Officer Yakacikli then advised Officer Fitzpatrick that Ms Wynne did not have any outstanding matters.[11]

52 Ms Wynne was then unhandcuffed and left in the care of her mother. By this stage, she was in a calm state and police officers in attendance held no concerns regarding her mental well-being. Police left the unit at about 6.15 am.

Ms Wynne's third interaction with police

53 At about 6.45 am, a worker on a building site at Whittlesford Street in East Victoria Park saw Ms Wynne walking along the footpath holding a stick and repeatedly striking herself to the neck with it. As Ms Wynne walked past him, she asked him twice to stab her. The worker noticed that she was wheezing and appeared to have difficulty breathing. Ms Wynne then continued to walk towards Berwick Street. As the worker was reporting to emergency services what he had seen, he observed Ms Wynne walk onto the road and collapse at the corner of Berwick Street and Whittlesford Street. Passing motorists stopped and assisted her off the road.[12]

54 Two police officers from Cannington Detectives Office who had earlier attended the unit of Ms Wynne's mother went to the location. They recognised Ms Wynne and provided first aid to her. One of the officers also noticed that Ms Wynne's breathing appeared to be laboured and she was wheezing. A St Johns Ambulance with two ambulance officers then arrived at 6.55 am

[10] This was the Form 4A completed by Dr Paparo on 26 March 2019.
[11] There is a discrepancy in the evidence as to whether Officer Yakacikli also advised Officer Fitzpatrick of the need to undertake the welfare check. This matter is dealt with later in my findings.
[12] Exhibit 1, Volume 1, Tab 11, Statement of Steven James dated 11 April 2019

Ms Wynne's interaction with the ambulance officers

55 The ambulance officers saw that Ms Wynne was conscious and had abrasions to her neck; which was swollen and had some bleeding. They also noted she had stridor (noisy breathing that occurs due to an obstructed air flow to the airway). Ms Wynne told the ambulance officers she had had a fight with her mother and that she wanted to die. She also said she had taken cocaine and methylamphetamine and asked the paramedics to sedate her.

56 Ms Wynne was cooperative as she was placed on a stretcher and taken into the back of the ambulance. One of the ambulance officers then inserted a cannula to Ms Wynne's arm and applied a dressing to her neck. As they were satisfied that Ms Wynne was not a risk to either of them, the ambulance officers advised attending police that they did not need to accompany them to RPH. Police subsequently left the scene at about 7.15 am.

57 As the ambulance was about to depart, Ms Wynne became highly agitated. She unclasped her seatbelts and ignored requests to relax and sit down. In an effort to escape, Ms Wynne tried to leave the ambulance by the rear door, and then the side door. When the ambulance officer who was in the driver's seat got out to assist by going to the side door, Ms Wynne climbed into the cabin area of the ambulance and got out through the driver's side door. As she ran away, the cannula was still in her arm.

58 One of the ambulance officers advised her base that Ms Wynne had absconded and that police needed to reattend. The ambulance then slowly followed Ms Wynne as she went from Berwick Street onto Hill View Terrace. As she did that, Ms Wynne removed the cannula from her arm. However, she kept holding it in her right hand. As the ambulance followed Ms Wynne, she repeatedly yelled out to the ambulance officers that they were trying to kill her. At the intersection of Hill View Terrace and Albany Highway, Ms Wynne walked onto

Albany Highway in peak hour traffic, thereby placing herself in considerable danger.

Ms Wynne's final interaction with police

59 At about 7.35 am, First Class Constable Shaun O'Callaghan (Officer O'Callaghan) and Constable Jessica Rozier (Officer Rozier) from Kensington Police Station were the first police officers to locate Ms Wynne. They observed Ms Wynne walking south along the northbound lanes of Albany Highway in Bentley. By this stage, Ms Wynne had been walking along the highway for about 1.1 km.[13] Officer O'Callaghan drove his police vehicle past Ms Wynne and stopped a short distance in front of her. Officer Rozier then got out of the vehicle and attempted to grab Ms Wynne. However, Ms Wynne was able to avoid her and run past. Officer O'Callaghan then drove after Ms Wynne, whilst Officer Rozier followed on foot. Officer O'Callaghan then stopped his police vehicle on Albany Highway near the intersection of Tate Street and ran after Ms Wynne for a short distance along Albany Highway. He caught up to her and took hold of her right arm and shoulder as he escorted her off the highway.

60 By this stage, another police vehicle had attended from Kensington Police Station. This was driven by Sergeant Jace Williams (Officer Williams), with Constable Emiley Regan (Officer Regan) as the passenger. Officer Regan assisted Officer O'Callaghan as he led Ms Wynne from the highway onto an adjacent grass verge where they were joined by Officer Williams.

61 According to police, once she was on the grass verge, Ms Wynne began to pull away. Due to this, Officer Williams advised that she should be handcuffed. To facilitate the handcuffing and to overcome her resistance, this took place with Ms Wynne on the ground. She was initially placed on her right side before she

[13] See: https://www.google/com/maps/dir/Hill+View+Terrace+Albany+Hwy+Albany+Hwy+Tate+St

was placed in the prone position (i.e. lying on her stomach). In order to restrain Ms Wynne when she was in the prone position, Officer O'Callaghan placed one of his legs across Ms Wynne's hamstring area and Officer Williams positioned himself next to her with one leg across her upper back/shoulder blades. Officer O'Callaghan then began placing his handcuffs on Ms Wynne so that her hands were behind her back. When that was done, the police officers saw the cannula in Ms Wynne's right hand. Officer Williams told Ms Wynne to let it go and used a pressure point on her wrist to get her to release it, which she did.

62 As the restraint of Ms Wynne was taking place, the two ambulance officers had parked their ambulance on Tate Street and attended the grass verge where Ms Wynne and the police officers were. By this stage Officer Rozier was also there, as were the two police officers from Cannington Detectives Office who had provided first aid to Ms Wynne a short time earlier.

63 After handcuffing Ms Wynne and getting her to release the cannula, police lifted Ms Wynne up from the prone position.[14] However, she was limp and her head was slumped forwards. When Officer Williams tilted Ms Wynne's head back, he saw that her eyes were glazed over. Police then laid her back down on her side and the handcuffs were removed. One of the paramedics could not find a pulse on Ms Wynne's neck and CPR was commenced as Ms Wynne was lying on her back. A pulse was eventually returned after about 12 - 14 minutes. Ms Wynne was then taken by ambulance as a Priority 1 to RPH, arriving at 8.30 am.

Ms Wynne's treatment at RPH

64 Upon arriving at the emergency department of RPH, Ms Wynne had a tonic-clonic seizure[15]. A computerised tomography (CT) scan confirmed she had

[14] The time it took for police to lift Ms Wynne from the prone position after the cannula had been removed is dealt with later in these findings.
[15] A seizure involving muscle convulsions (also known as a grand mal seizure).

sustained a severe hypoxic brain injury and she was admitted to the intensive care unit. While there, Ms Wynne had a further two seizures.

65 There were initial concerns Ms Wynne had sustained a cervical spine injury, however a CT scan showed no evidence of a fracture to her cervical spine.

66 As already noted, Ms Wynne never regained consciousness. Following extensive discussions regarding her very poor prognosis between the treating medical team and Ms Wynne's family, active care was withdrawn and Ms Wynne was treated palliatively. At 11.20 am on 9 April 2019, she was declared life extinct by a doctor at RPH.[16]

CAUSE AND MANNER OF DEATH [17]

Cause of Death

67 Forensic pathologists, Dr Daniel Moss and Dr Joe Ong, conducted a post mortem examination upon Ms Wynne's body on 12 April 2019. The forensic pathologists also arranged for histology, toxicology, microbiology and neuropathology examinations to be performed.

68 The post mortem examination showed that Ms Wynne had an area of bruising to the front and left side of her neck. There was also small areas of subcutaneous bruising to Ms Wynne's arms consistent with medical intervention, such as cannulation. Ms Wynne's lungs were heavy and fluid-laden (pulmonary oedema and congestion). Neuropathology examination of Ms Wynne's brain and spine showed widespread global cerebral ischemia (insufficient blood flow to the brain) in the right and left cerebral hemispheres, cerebellum and brain stem.

[16] Exhibit 1, Volume 1, Tab 3, Death in Hospital form

[17] Exhibit 1, Volume 1, Tab 4, Letter from the forensic pathologists to the State Coroner dated 26 March2020; Exhibit 1, Volume 1, Tab 6A-C, Supplementary Post Mortem Report by Dr D.M Moss and Dr J. Ong dated 26 March 2020; Post Mortem Report by Dr D.M Moss and Dr J. Ong dated 12 April 2020; Email correspondence from Dr D.M Moss and Dr J. Ong to Counsel Assisting dated 9 September 2021; Exhibit 1, Volume 1, Tab 7, Toxicology Report dated 23 August 2019; Exhibit 1, Volume 1, Tab 8A and Tab 8B, Report of Professor D. Joyce dated 1 October 2019; Supplementary Report of Professor D. Joyce dated 18 September 2019

69 Toxicological analysis detected medications consistent with Ms Wynne's hospital treatment. Tetrahydrocannabinol was detected in a post mortem blood sample at a level of 3.9 ug/L. This indicated cannabis use prior to Ms Wynne's apprehension by police on 4 April 2019. The presence of methylamphetamine (approximately 0.06 mg/L) and amphetamine (less than 0.01 mg/L) were detected within a blood sample when Ms Wynne was admitted to RPH.

70 At the conclusion of the post mortem examination, and after considering the circumstances surrounding Ms Wynne's death and the results of the toxicological analysis and other examinations, the two forensic pathologists concluded that Ms Wynne had died from hypoxic ischaemic encephalopathy[18] and bronchopneumonia in a woman with methylamphetamine effect and exertion with restraint.

71 I accept and adopt the conclusion expressed by the forensic pathologists as to the cause of Ms Wynne's death.

72 For the reasons set out below, I find that Ms Wynne's death occurred by way of accident, which involved a number of factors.

Methylamphetamine effect and excited/agitated delirium

73 Methylamphetamine is a powerful, highly addictive stimulant that effects the central nervous system. It usually takes the form of a white, bitter tasting crystalline powder that dissolves easily in water and alcohol. It can be smoked, snorted, injected or taken in tablet form.[19]

74 Methylamphetamine intoxication can manifest in several primary forms. Acute intoxication may be characterised by agitation, increased physical activity and a propensity for aggression as well as involvement in risky, reckless or violent

[18] An incurable brain dysfunction that occurs when the brain receives insufficient oxygen and blood flow for a length of time.
[19] See: https://www.drugabuse.gov/publications/research-reports/methamphetamine/what-methamphetamine

behaviour. Paranoid beliefs about others are common and intoxicated persons can become delirious and exhibit confusion and bizarre behaviour.

75 The term agitated or excited delirium may also be applied to this condition, although there is some controversy as to what this term actually means. One definition of excited delirium is as follows:[20]

> Agitated or excited delirium is an acute, transient disturbance in consciousness and cognition that involves comparative and/or violent behaviour … This disturbance in cognition is marked by intense paranoia, aggressive behaviour towards objects and people, hallucinations, hyperthermia, altered sensorium, and lack of willingness to yield to force … The bizarre and threatening behaviour of these individuals typically leads to a police response.

76 WAPF officers receive training on the signs and symptoms of excited delirium from their Critical Skills training program. The risk factors associated with the condition are well documented throughout the training material, and the information is revisited and reinforced during annual in-service training.[21] The relevant training manual warns that:[22]

> The condition known as 'Excited Delirium' is often linked to incidents of 'Positional Asphyxia' as subjects with the condition are at greater risk of becoming involved with members and [hence being] exposed to the application of Tactical Force Options resulting in physiological stressors which can cause cardiac and respiratory distress.

77 A pharmacologist and toxicologist, Professor David Joyce, was of the view that "*methylamphetamine intoxication would have to be a strong candidate for explaining Ms Wynne's behaviour.*"[23]

78 Professor Joyce's opinion was that the observations of Ms Wynne's behaviour by witnesses on 4 April 2019 up until the point of her cardiorespiratory arrest

[20] Dukes, G D and Davis, G J, *Encyclopedia of Forensic and Legal Medicine* (2016);
See: https://www.sciencedirect.com/topics/neuroscience/excited-delirium
[21] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, p.43
[22] Exhibit 1, Volume 3, Tab 8H, Excited Delirium/Positional Asphyxia Manual, p.4
[23] Exhibit 1, Volume 1, Tab 8A, Report of Professor David Joyce dated 1 October 2019, p.9

can be sufficiently explained by methylamphetamine intoxication.[24] As Professor Joyce noted in his supplementary report:[25]

> The witnesses to Ms Wynne's behaviour on 4 April 2019 appear to be describing the same mental health disorder that Dr Paparo observed. The proposed diagnosis of drug-induced psychosis is largely substantiated by detection of methylamphetamine in post-mortem toxicology. It would have remained clinically overt while methylamphetamine use continued.

79 Professor Joyce also noted that despite the plasma concentrations of methylamphetamine and amphetamine for Ms Wynne being lower than he had usually encountered for cases involving excited delirium, a diagnosis that she was displaying excited delirium leading up to her final interaction with police was open.[26]

80 I accept these conclusions made by Professor Joyce and find that Ms Wynne was intoxicated by methylamphetamine and, based on all available evidence, that she was most likely also experiencing excited delirium during her final interaction with police.

81 Although Professor Joyce was able to say that methylamphetamine intoxication had contributed to Ms Wynne's death by causing an arrhythmia (irregular heartbeat) that was methylamphetamine-induced,[27] he stressed that the evidence was not so strong that other possible explanations should be automatically set aside. In that regard, Professor Joyce was of the view that the possibility of positional asphyxia had to be evaluated in its own right.[28]

Physical restraint and positional asphyxia

82 Positional asphyxia has been defined in various ways, including:[29]

[24] Exhibit 1, Volume 1, Tab 8A, Report of Professor David Joyce dated 1 October 2019, p.9
[25] Exhibit 1, Volume 1, Tab 8B, Supplementary Report of Professor David Joyce dated 18 December 2019, p.3
[26] Exhibit 1, Volume 1, Tab 8A, Report of Professor David Joyce dated 1 October 2019, p.11
[27] ts 16.9.21 (Professor Joyce), pp.487-488
[28] Exhibit 1, Volume 1, Tab 8A, Report of Professor David Joyce dated 1 October 2019, p.13
[29] See: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6023692/

> Positional (Postural) asphyxia is a form of mechanical asphyxia that occurs when a person is immobilised in a position which impairs adequate pulmonary ventilation and thus, results in a respiratory failure.

83 As with excited delirium, police officers with the WAPF are trained on an annual in-service basis regarding the dangers of positional asphyxia. The relevant training manual defines positional asphyxia in these terms:[30]

> Positional Asphyxia arises from circumstances where there is an increased need for oxygen and the subject is unable to source sufficient amounts to sustain life, resulting in sudden death from cardiac arrhythmia and/or respiratory arrest.
>
> While the risk of Positional Asphyxia is greatly increased by placing restrained subjects in a prone position; members are advised that the condition may occur irrespective of the position in which a restrained subject is placed. The risk of death is greatest in the period immediately following the application of Tactical Force Options and physical exertion resulting from a protracted struggle with members.

84 After Ms Wynne was escorted off Albany Highway, she was placed in the prone position for approximately one minute and 50 seconds.[31] Throughout most of that period, Ms Wynne was restrained by Officer Williams in the manner I have already outlined. The appropriateness of Officer Williams maintaining his restraint upon Ms Wynne for the length of time that he did is dealt with later in these findings.

85 The forensic pathologists who conducted Ms Wynne's post mortem examination were asked whether positional asphyxia had a causative effect on Ms Wynne's death. The forensic pathologists provided the following response:[32]

> It is very difficult to definitively either include or exclude positional asphyxia as having played a role in the death, however you will note that we include the term 'restraint' in our final COD [cause of death]. We intended this to indicate the restraint of the deceased, which may or may not have included a degree of positional asphyxia, has contributed to her death, along with the other factors noted (methylamphetamine and exertion). When multiple factors have contributed to a death, it is essentially not possible to tease out the exact contribution of each of those factors, other than to say that they have all contributed.

[30] Exhibit 1, Volume 3, Tab 8H, Excited Delirium/Positional Asphyxia Manual, p.4
[31] Exhibit 1, Volume 1, Tab 36, Disc containing CCTV footage and still images; Exhibit 3, Timeline of Events as recorded on the CCTV, Events 12 and 27
[32] Email correspondence from Dr Moss and Dr Ong to Counsel Assisting dated 9 September 2021

86 Dr Clive Cooke, a forensic pathologist, gave evidence last year at another inquest following the death of a person who had been held by police in the prone position. In that inquest, Dr Cooke noted:[33]

> One of the really important things with the prone position seems to be avoiding any weight on the back of the chest and the back of the abdomen because that will make a risk of harm such as sudden death much worse.
> …
> [The prone position] does seem to carry some risk to individuals because of the risk of cardiorespiratory impairment which may result in a cardiac arrest.

87 I am prepared to find that the restraint of Ms Wynne in the prone position was a contributing factor in her death. As to whether positional asphyxia was part of that contributing factor, based on all the evidence before me, I am only able to say that it was distinctly possible.

Physical exertion by Ms Wynne before her apprehension on Albany Highway

88 As outlined above, Ms Wynne was encountering difficulties with her breathing on 4 April 2019, even before she was placed into the ambulance. After she had alighted from the ambulance, Ms Wynne then either walked or ran the distance from the intersection of Berwick Street and Whittlesford Street to Albany Highway at the intersection of Tate Street. That distance was about 1.8 km.[34] The physical exertion required to cover this distance, coupled with the effect of the methylamphetamine in Ms Wynne's system, would have also increased the dangers of a cardiac arrest as she was being restrained by police officers on the grass verge.[35] As explained by Professor Joyce at the inquest, "*the combination of methylamphetamine intoxication and excessive exertion has a lethality that neither of them has on its own.*"[36]

[33] Inquest into the death of ***Chad Riley*** [2021] 24 delivered on 30 July 2021, pp.35-36
[34] https://www.google/com/maps/dir/Berwick+St+Hill+View+Terrace+Albany+Hwy+Tate+St
[35] ts 16.9.21 (Professor Joyce), pp.500-501
[36] ts 16.9.21 (Professor Joyce), p.501

Manner of Death

89 On the basis of all the evidence available, I am satisfied that Ms Wynne died following a cardiac arrest that occurred when she was apprehended by police. The factors contributing to this cardiac arrest included Ms Wynne's methylamphetamine intoxication, her physical exertions before her apprehension and her restraint in the prone position. I also find that Ms Wynne may have experienced positional asphyxia and excited delirium as she was being restrained by police in the prone position.

90 Accordingly, I find that death occurred by way of accident.

ISSUES RAISED BY THE EVIDENCE

The absconding by Ms Wynne from JHC on 26 March 2019

91 When Dr Paparo completed the paperwork for Ms Wynne's referral for a psychiatric assessment on 25 March 2019, he also ordered a person fulfilling the duties of a Patient Care Assistance (PCA) or a guard to monitor Ms Wynne. His reasoning for that was due to the risk of Ms Wynne absconding.[37] At the inquest, Dr Paparo gave evidence that although the MHOA had lockable doors, he was of the view that Ms Wynne still required one-to-one monitoring due to the further risk of her intruding on other patients.[38]

92 At 11.20 pm on 25 March 2019, the following entry was recorded in Ms Wynne's hospital integrated progress notes: "*transferred from EAU* [emergency assessment unit] *to MHOA, nil need to continue 1:1 PCA due to pt* [patient] *being drowsy and sedated however settled when awake and interacting. Initially on 1:1 for risk of absconding, but now contained in*

[37] Exhibit 1, Volume 3, Tab 5A, Statement of Dr Paparo dated 9 September 2021, p.6
[38] ts 13.9.21 (Dr Paparo), p.33

MHOA" (underlining added). The note continues that a reassessment of the need for a one-to-one monitoring for Ms Wynne is to be made when she is awake.[39]

93 There is no record as to whether that reassessment was carried out. It was certainly the case that there was no PCA or guard monitoring Ms Wynne when she absconded from JHC at about 1.15 pm on 26 March 2019. As there is no entry in the integrated progress notes, I find that it is most likely the reassessment was not undertaken.

94 Dr Paparo said that he was surprised that the one-to-one monitoring he had ordered had been removed shortly after Ms Wynne's admission to the MHOA.[40] He was of the view that despite its lockable doors, the MHOA did not have the security that existed in the locked ward of the mental health unit at JHC and that Ms Wynne still "*needed to be monitored closely*".[41] I agree with that assessment.

95 Dr Martin Chapman, Deputy Director of Medical Services, and Acting Head of Mental Health Services at JHC, confirmed that the MHOA was not a secure ward. However, the doors were controlled by a key-card scanner and could not be opened without a key-card. The doors are self-opening and self-closing and are programmed to close in the shortest possible time interval after having been opened.[42]

96 At his evidence before the inquest, Dr Chapman agreed that the identity of the clinical nurse that removed the one-to-one monitoring of Ms Wynne could not be ascertained. He also accepted that there were some deficiencies in the note

[39] Exhibit 1, Volume 1, Tab 33, JHC Medical Records
[40] ts 13.9.21 (Dr Paparo), p.33
[41] ts 13.9.21 (Dr Paparo), p.33
[42] Exhibit 1, Volume 1, Tab 34A, Report of Dr Chapman dated 16 February 2021, p.7

taking, as no record was made in the notes regarding the reassessment that was supposed to have been done the next morning when Ms Wynne had woken up.[43]

97 As to whether it was appropriate for the one-to-one observation of Ms Wynne to be removed, Dr Chapman said:[44]

> I would have said that the one-to-one observation you would have continued without considering stopping it in a patient who was this distressed and agitated and I certainly pick up on Dr Paparo's comments that somebody with this level of lability, it would have been much easier to keep them on a one-to-one, especially given they were awaiting transfer.

98 Dr Chapman conceded that it would have been "*much harder*" for Ms Wynne to leave in the manner that she did, had the one-to-one monitoring been continued.[45]

99 It was regrettable that Dr Paparo's sensible decision to have Ms Wynne monitored closely was only implemented for a short period of time. I agree with Dr Chapman's candid assessment that the likelihood of Ms Wynne leaving the MHOA in the manner that she did would have been significantly reduced had Dr Paparo's instructions been maintained.

100 JHC has, however, introduced measures to minimise the chance of a patient absconding in the manner that Ms Wynne did. These are addressed later in my findings.

Should Officer Barnes have downgraded the police alert for Ms Wynne?

101 As I have already referred to, Officer Barnes manually downgraded the police alert for Ms Wynne from an Apprehension and Return Order to JHC, to a police mental health welfare check for Ms Wynne. For the reasons I have outlined below, I find that it was appropriate for Officer Barnes to do this.

[43] ts 13.9.21 (Dr Chapman), p.81
[44] ts 13.9.21 (Dr Chapman), pp.82-83
[45] ts 13.9.21 (Dr Chapman), p.83

102 Following his assessment of Ms Wynne, Dr Paparo completed a Form 1A under section 26 of the *Mental Health Act 2014* (WA) (the Act) for her involuntary referral for examination by a consultant psychiatrist at SCGH. Significantly, Dr Paparo did not complete a Form 3A, which was a Detention Order under section 28 of the Act. This would have authorised the detention of Ms Wynne for up to 24 hours in order for her to be taken to SCGH.[46]

103 When Dr Paparo became aware that Ms Wynne had absconded from the MHOA, he made an order under section 98 of the Act for Ms Wynne's apprehension and return to JHC by completing a Form 7D - Apprehension and Return Order.[47]

104 Unfortunately, Dr Paparo was not authorised by the Act to make this order. That is because such an order may only be made "*in respect of a person who is absent without leave from the hospital*".[48] Section 97(1) of the Act defines a person who "*is absent without leave from a hospital*" as including "*a person who is detained under Part 6 Division 2 or 3 of the Act*". A person who is the subject of a Form 1A does not fall within this definition, even though the power to make the referral for an examination by a psychiatrist is in Part 6 Division 2 of the Act. In contrast, a person who is subject to a Form 3A is regarded as "*a person who is detained*".

105 The *Clinicians' Practice Guide to the Mental Health Act 2014* issued by the Chief Psychiatrist contains the following provisions:[49]

> 3.5.1.7 – If the person is on a referral order (Form 1A) and leaves the place, then an Apprehension and Return order (Form 7D) cannot be made. …

[46] The continuation of a Detention Order under Form 3A can be extended for up to a further 48 hours from the time that 24 hours has passed. This is done by completing a Form 3B – Continuation of Detention: see section 28 of the Act.
[47] Exhibit 1, Volume 3, Tab 5A, Statement of Dr Paparo, dated 9 September 2021; Exhibit 1, Volume 1, Tab 33, JHC Medical Records, Form 7D – Apprehension and Return Order
[48] Section 98(1) of the Act
[49] Exhibit 1, Volume 1, Tab 34D, Clinicians' Practice Guide to the *Mental Health Act 2014,* Edition 3, pp.74-75

> 3.5.1.8 – However, if the referred person is also subject to a Detention Order (Form 3A) and the option of using family members is not viable or successful, then the person in charge of the hospital or other place or a medical practitioner may make an 'Apprehension and Return Order' (s.99)(Form 7D). The Apprehension and Return Order authorises a police officer or a person prescribed in the regulations such as a staff member of the service to apprehend the person and return the person to the hospital or the other place specified in the order before the order expires (s.101)(see 4.10).

106 The Form 7D - Apprehension and Return Order completed by Dr Paparo came to the attention of the WAPF via a job entry created on the WAPF Premier One Computer-Aided Dispatch (CAD) system.[50] At 1.53 am on 27 March 2019, a CAD job entry was completed by Senior Constable Trewin (Officer Trewin) which demonstrated he had picked up the invalidity of the Form 7D. This CAD job entry detailed that Officer Trewin had rung JHC and spoken to a Dr Chuan. He advised the doctor that "*a Form 7D is not technically/legally possible when there is only a Form 1A and it* [is] *without a Form 3A*".[51]

107 In those circumstances, it was appropriate for Officer Barnes to make the following CAD job entry at 9.37 am on 30 March 2019:[52]

> SOCC CAD job reviewed. Confirmed with JHC that [Ms] Wynne is not currently an involuntary patient as she left before she was assessed. The 7D is invalid as she was not deemed an involuntary patient at the time she left (Form 3A) and now the 1A has expired we do not have the powers to exercise the 7D. Furthermore, JHC will not reissue Forms 1A or 4A. Incident changed to a welfare check and officers to assess her mental state upon sighting her. If deemed in need of care and attention, recommend she be conveyed to JHC for assessment…

108 This altering of the CAD job was one of three issues the WAPF Internal Affairs Unit (IAU) investigated regarding the death of Ms Wynne. The result of this part of the investigation was that relevant WAPF policy and procedures had been followed.[53] For the reasons I have outlined above, I agree with that outcome.

[50] Exhibit 1, Volume 3, Tab 7, Statement of Sergeant Barnes dated 10 September 2021, p.2
[51] Exhibit 1, Volume 3, Tab 7, Statement of Sergeant Barnes dated 10 September 2021, p.5
[52] Exhibit 1, Volume 3, Tab 7, Statement of Sergeant Barnes dated 10 September 2021, pp.9-10
[53] Exhibit 1, Volume 1, Tab 30, IAU Report by Detective Senior Constable Hill dated 29 June 2020, p.38

Should Dr Paparo have issued a Form 3A - Detention Order?

109 At the inquest, Dr Paparo said that he did not make a Form 3A - Detention Order for Ms Wynne because: (i) she was accepting of medication, (ii) she was to have one-to-one monitoring and (iii) it was his experience that a Form 3A was completed only if a patient was actively leaving or trying to leave.[54]

110 Dr Paparo only became aware in late 2020 that a Form 7D - Apprehension and Return Order could not be issued for a patient who had absconded when subject to a Form 1A.[55] He suspected he completed the Form 7D after a discussion with the consultant psychiatrist at JHC and the ward coordinator at the MHOA.[56]

111 Even if a Form 3A - Detention Order had been made, Ms Wynne still would have remained in the MHOA.[57] That evidence from Dr Paparo is consistent with the Tables tendered at the inquest by Mr Bourhill of the Mental Health Daily Bed Capacity for 25 and 26 March 2019. There were no locked ward beds available at JHC on either of those days. Nor were there any mental health beds available at SCGH.[58]

112 I make no criticism of Dr Paparo for issuing the Form 1A given the explanations he has provided and I would be inserting hindsight bias if I was to now find that he ought to have completed a Form 3A. I am also not surprised that Dr Paparo was unaware that a Form 7D could not be ordered with respect to a patient who had absconded under a Form 1A. A person who is subject to a Form 1A is effectively detained until they are examined by a psychiatrist at an authorised hospital or the referral period expires. However, as noted above, such a person is not defined in the Act as "*being a person who is detained*".

[54] ts 13.9.21 (Dr Paparo), p.29
[55] ts 13.9.21 (Dr Paparo), p.32
[56] ts 13.9.21 (Dr Paparo), p.32
[57] ts 13.9.21 (Dr Paparo), p.30
[58] Exhibits 6A and 6B

113 The Act (comprising of 440 pages) is a complex piece of legislation in many parts. For example, I note that the Act's drafters deemed it necessary to provide explanatory notes at the end of section 26. The *Clinicians' Practice Guide to the Mental Health Act 2014* is nearly 300 pages in length. As borne out at the inquest, even legally trained persons held different positions regarding the effect of a Form 7D - Apprehension and Return Order.[59] I can fully appreciate the following observation from Dr Chapman: "*For my team on the ground working at the coalface, it's pretty hard sometimes to interpret the Act, and they have to run on what they think is best for the patient, you know.*"[60]

114 Although a Form 3A - Detention Order can also be made for a person who is on a Form 1A, I am of the view that had a Form 3A been issued after Ms Wynne had absconded, it would have been invalid. A plain reading of section 28(1) of the Act is that the person who is to be detained under a Form 3A must be capable of being detained "*from the time when the order is made*".[61]

115 The requirement that the person must be in a position to be detained for a Form 3A to be made is also consistent with the provisions in section 28(2) of the Act regarding the extension of a person's detention under a Form 3A. Such a continuation of a person's detention cannot be made unless "*immediately before making the order, the practitioner assesses the person*".[62] An immediate assessment cannot take place if the person is not being detained and their whereabouts are unknown.

[59] For example, whether a Form 7D issued due to an absconding under a Form 3A has a life span of 14 days or whether it was confined to the duration of the Form 3A.
[60] ts 13.9.21 (Dr Chapman), p.91
[61] Section 28(1) of the Act states:

> A medical practitioner or authorised mental health practitioner may make an order authorising the person's detention for up to 24 hours from the time when the order is made if satisfied that the person needs to be detained to enable the person to be taken to the authorised hospital or other place.

[62] Section 28(4)(a) of the Act

Was it appropriate for Officers Ellis and Fitzpatrick to stop with the intention of speaking to Ms Wynne?

116 When the above officers saw Ms Wynne walking on the footpath in Hubert Street, they were intending to stop their police vehicle to talk to her. She, however, ran away before they could do that. It is clear neither officer saw Ms Wynne committing any unlawful act in the short space of time they observed her.

117 At the inquest, Officer Ellis explained his actions for wanting to speak to Ms Wynne in this way:[63]

> So East Vic Park, in particular Hubert Street, is a high crime area. Because of the time, place, circumstances, Constable Fitzpatrick and I decided to speak with the person. We decided to pull our vehicle to the side of the road to the right, and the person was approximately 10 metres in front of me at that point. I saw the – the person's sort of head move without seeing the face, and then they immediately ran.

118 Ms O'Connor SC later asked the following questions of Officer Ellis:[64]

> You hadn't heard about any report of a single person committing any crime and you weren't looking for any particular suspect? --- No, not at that time.
>
> So why do you think you had the right to ask – to pull this person over? --- Basically through training we're taught time, place and circumstances. So the time being darkness, early morning – early hours of the morning; the place, which is deemed to be a high crime area; and I guess just the – having the hood pulled down over their face gave me enough reasonable suspicion to be able to go up and – and speak with them.
>
> …
>
> Well – she's run away when it has been obvious to you that she has been sighted, is it not? --- Correct. And that then gives me – builds my suspicion as to maybe, you know, [she was] being involved in an offence.

119 The power for police to be able to stop (and potentially search) a person is regarded as an essential investigatory part of policing. It is, nevertheless, a contentious power as it clashes with the right of an individual to have their privacy respected and to be free to go about their business without

[63] ts 14.9.21 (Ellis), p.160
[64] ts 14.9.21 (Ellis), pp.173-174

interference.[65] Hence, legislation regarding this power needs to "*balance the need for an effective criminal justice system against the need to protect the individual from arbitrary invasions of his privacy and property*".[66] Parliament purports to achieve this balance by outlining the conditions for when it is permissible for police to interfere with a person's rights. Such legislation protects a person from being stopped and spoken to by police unless there are reasonable grounds for suspecting the person has committed an offence.[67]

120 The relevant legislation in this State is section 4 of the *Criminal Investigation Act 2006* (WA) which states:

> For the purposes of this Act, a person reasonably suspects something at a relevant time if he or she personally has grounds at the time for suspecting the thing and those grounds (even if they are subsequently found to be false or non-existent), when judged objectively, are reasonable.

121 A suspicion is "*more than a mere idle wondering whether* [something] *exists or not; it is a positive feeling or actual apprehension or mistrust*".[68] The element of reasonableness exists to ensure that there are facts present "*which are sufficient to induce that state of mind* [i.e. suspicion] *in the reasonable person*".[69] This requirement is designed to prevent police from stopping a person to question them based on stereotypes or demographics such as a person's race, gender, age and appearance.

122 After careful consideration, I have concluded that the two officers' suspicions fell within section 4 of the *Criminal Investigation Act 2006* (WA). As to the time, it was about 5.45 am and still dark.[70] As to the place, the evidence from Officer Ellis was that the suburb, and particularly the street his police vehicle

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[65] Croft T, "Stop and Search Without Reasonable Suspicions: Is WA Becoming a Police State?" (2010) Alternative Law Journal Vol 35 199
[66] ***George v Rockett*** (1990) 170 CLR 101, [4]
[67] Croft T, "Stop and Search Without Reasonable Suspicions: Is WA Becoming a Police State?" (2010) Alternative Law Journal Vol 35 199
[68] ***Queensland Bacon Pty Ltd v Rees*** (1966) 115 CLR 266, 303
[69] ***George v Rockett*** (1990) 170 CLR 101, [4]
[70] Sunrise at Perth on this particular day was 6.30 am: see: https://www.sunrise-and-sunset.com/evening/sun/australia/perth/

was patrolling, was "*a high crime area*". This evidence was not challenged at the inquest. As to the circumstances, given that Ms Wynne had the hood of her top pulled down over her face, it gave the impression (albeit incorrectly) that she was attempting to conceal her identity from others, particularly patrolling police vehicles.

123 Although I accept Ms Wynne's later explanation that she ran only because she was scared and nervous (and not because she was committing any offence), when she did run away from the two officers it would have only strengthened their initial suspicion that she had something to hide. Of course, the suspicions of the two officers were wrongly held. However, a suspicion that turns out to be wrong will nevertheless satisfy the provisions of section 4 of the *Criminal Investigation Act 2006* (WA) if the grounds for that suspicion are reasonable when judged objectively.

124 I do not accept the submission by Ms O'Connor SC that these police officers only stopped to speak to Ms Wynne because she was Indigenous. It was the evidence of Officer Ellis that given the poor lighting at the time, he could not determine the colour of the person's skin.[71] I am of the view that the time, place and circumstances would have justified the officers stopping to speak to any person, regardless of the colour of their skin, who appeared to be aged in their 20s, was wearing dark clothing and concealing their face; particularly if that person then fled before they could be spoken to.

125 It therefore follows that I find it was appropriate for these two officers to request Ms Wynne's name once they identified her at the unit. I accept the evidence of Officer Boyd that after Ms Wynne had fled, police had a reasonable suspicion that she may be wanted for questioning or was the subject of an arrest

[71] ts 14.9.21 (Ellis), p.172

warrant.[72] I also note that Ms Wynne did not respond to Officer Fitzpatrick's question at the unit when he asked her whether she had an arrest warrant.[73]

Were police entitled to enter the unit of Ms Wynne's mother without her consent?

126 Ms Wynne's mother has contended that she did not give informed consent for officers from Cannington Detectives Office to enter her unit on 4 April 2019.[74] Based on all the information before me regarding this matter, I have found that the relevant provisions of the *Criminal Investigation Act 2006* (WA) did not require such consent, even though it is apparent the police did not have either a search warrant or an arrest warrant.

127 Detective Senior Constable Andrew Galbraith (Detective Galbraith) and Detective Sergeant James Stanbury (Detective Stanbury) were the two police officers who initially attended the front door of the unit. It was Detective Galbraith who spoke to Ms Wynne's mother when she answered the door. His account is that he obtained her informed consent to search the unit for the female person they were seeking to arrest.[75] In contrast, Ms Wynne's mother has asserted that she did not permit the police to enter and that she only allowed them in when a threat was made that they would "*knock the door down and come in if you like it or not*".[76]

128 Detective Stanbury's account is somewhat equivocal as he did not initially hear the conversation between Detective Galbraith and Ms Wynne's mother, other than Detective Galbraith stating that they were looking for a particular woman and asked if they could enter and search the unit for her. The security door was then opened, and he and Detective Galbraith walked into the unit.[77] At the

[72] ts 15.9.21 (Boyd), p.314
[73] Exhibit 5, Statement of Constable Fitzpatrick dated 12 October 2019, p.4
[74] Exhibit 1, Volume 1, Tab 10B, Statement of Shirley Wynne dated 8 September 2021
[75] Exhibit 1, Volume 1, Tab 37, Statement of Detective Galbraith dated 18 April 2019, p.3
[76] Exhibit 1, Volume 1, Tab 10B, Statement of Shirley Wynne dated 8 September 2021, p.5
[77] Exhibit 1, Volume 1, Tab 25, Statement of Detective Stanbury dated 24 May 2019, pp.3-4

inquest, Detective Stanbury said there were no raised voices from inside the unit saying, "*No, you can't come in*" or anything to that effect.[78] He maintained that the lawful basis for him and the other police officers to enter the unit was because of the consent obtained from Ms Wynne's mother.

129 When asked by Ms O'Connor SC that if Ms Wynne's mother had refused them entry, would he and Detective Galbraith still have entered the unit, Detective Stanbury answered "*More than likely. Yes.*"[79]

130 Under the provisions of the *Criminal Investigation Act 2006* (WA), which grants arrest powers to police without an arrest warrant,[80] a person is included in the definition of an "*arrestable person*" under section 132(1)(d) if that person is reasonably suspected by police of having committed a "*serious offence*".[81] A "*serious offence*" includes any offence that carries a statutory penalty of imprisonment for 5 years or more.[82] For the purposes of arresting an arrestable person, police may enter, without the consent of the occupier,[83] "*a place where the officer reasonably suspects the person is and search it for the person*".[84]

131 Detective Stanbury gave evidence that the offences the female person was to be arrested for was burglary, stealing and stealing a motor vehicle.[85] At least one of these offences is a "*serious offence*".

132 The evidence of Ms Wynne's mother was that the person to be arrested was her cousin and she would stay at the unit sometimes; the most recent being about three months earlier.[86] That evidence alone (quite aside from other intelligence

[78] ts 14.9.21 (Stanbury), p.208
[79] ts 14.9.21 (Stanbury), p.217
[80] Part 12 Division 2 of the *Criminal Investigation Act 2006* (WA)
[81] Section 128(1) of the *Criminal Investigation Act 2006* (WA)
[82] Section 128(1)(a) of the *Criminal Investigation Act 2006* (WA)
[83] Provided the police comply with section 31 of the *Criminal Investigation Act 2006* (WA): see section 130
[84] Section 132(2)(a) of the *Criminal Investigation Act 2006* (WA)
[85] ts 14.9.21 (Stanbury), p.217
[86] Exhibit 1, Volume 1, Tab 10A, Statement of Shirley Wynne (unsigned), p.8; Exhibit 1, Volume 1, Tab 10B Statement of Shirley Wynne dated 8 September 2021, p.5

the police might have had) would support the contention that police were able to lawfully enter the unit, even if there was no informed consent from Ms Wynne's mother.

Was it appropriate for Officer Boyd to handcuff Ms Wynne at the unit?

133 The evidence of the police officers who attended the unit was that Ms Wynne was yelling at police and acting in an erratic manner.[87] She appeared to Officer Boyd to not only be very anxious, but also drug-affected.[88]

134 Ms Wynne and her mother also began shouting at each other and at one point, Ms Wynne's mother went to her bedroom. The shouting between the women continued and Ms Wynne attempted to push past police officers and enter the bedroom.[89] She continued to resist the officers when they prevented her from getting into the bedroom.[90]

135 It was at this point, and after unsuccessfully attempting to calm Ms Wynne down, that Officer Boyd decided to place Ms Wynne in handcuffs as "*the situation wasn't able to be deescalated whilst she was in the house with her mother.*"[91]

136 My Wynne was handcuffed with her hands to the front and taken to the outside area near the front door where she was seated.[92]

137 When questioned by Ms O'Connor SC as to why she placed the handcuffs on Ms Wynne, Officer Boyd answered:[93]

> Because she was being violent. She was trying to get into the bedroom where her mother was seeking retreat from the argument that they were having. She was being violent towards police. And that point, for her own safety, the safety of my officers

[87] For example, Exhibit 1, Volume 1, Tab 25, Statement of Constable Boyd, p.4; ts 14.9.21 (Ellis), p.165
[88] Exhibit 1, Volume 1, Tab 27, Statement of Constable Boyd dated 18 April 2021, p.5
[89] Exhibit 1, Volume 1, Tab 27, Statement of Constable Boyd dated 18 April 2021, p.5
[90] ts 14.9.21 (Ellis), p.162; ts 14.9.21 (Stanbury), p.220
[91] ts 14.9.21 (Boyd), p.262
[92] ts 14.9.21 (Boyd), p.262
[93] ts 15.9.21 (Boyd), pp.313-314

> that were there, and for her mother's sake, it was the most reasonable thing to do in the circumstances to ensure that we could gain control of the situation.

138 Officer Boyd maintained that it was reasonable for her to handcuff Ms Wynne in those circumstances[94] and when given the opportunity to further explain her actions, she said:[95]

> There were multiple reasons … if we take legislation aside about why we can use force, if you look at the policy, the policy is that we use handcuffs to gain control, reduce the threat, so that no one receives any bodily injury. That includes herself, that includes police, that includes her mother. She was in an erratic and volatile state, and it would have been the best way forward to make sure that she didn't receive any injuries herself, because using empty hand tactics, which is something that has been discussed when you're talking about restraining someone is more likely to cause bodily injury than putting handcuffs on them.

139 Mr Chris Markham, an expert in the use of force options available to the police, provided the Court with a comprehensive report and gave evidence at the inquest. Amongst the questions asked of Mr Markham in the preparation of his report was whether the use of handcuffs at the unit was justified, and if so, how was it justified.

140 As outlined by Mr Markham, the relevant WAPF manual is the *Police Manual Policy, Use of Force*.[96] The Purpose Statement in that manual states "*Any Use of Force MUST be reasonably necessary in the circumstances and officers will be individually accountable for such force.*"[97] (capitalisation in original)

141 Mr Markham noted that the power to carry and use handcuffs is derived from section 4 of the *Police Act 1892* (WA). However, he pointed out that there is no specific legislative provision that governs or controls the circumstances in which handcuffs may be used. Police therefore rely on sections 231, 233 and

[94] ts 15.9.21 (Boyd), p.315
[95] ts 15.9.21 (Boyd), p.317
[96] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021
[97] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, p.16

235 of the *Criminal Code* (WA) and section 16 of the *Criminal Investigation Act 2006* (WA) as the primary legislative provisions.[98]

142 Mr Markham submitted that there were a number of factors that would provide a justification for Officer Boyd to place Ms Wynne in handcuffs. These included: (i) the use of the handcuffs on the basis of self-defence or the defence of others and (ii) if Officer Boyd had reasonable grounds to believe that the handcuffs were necessary to protect herself, others or Ms Wynne from a harmful act.[99] According to Mr Markham, other relevant factors included whether Ms Wynne appeared to be drug-affected and the potential for Ms Wynne to access weapons (e.g. knives in the kitchen). If a person's behaviour is also erratic and unpredictable that could also justify the use of handcuffs.[100]

143 Another potential justification for the use of handcuffs that Mr Markham noted was if Ms Wynne was obstructing officers in the performance of their duties. Mr Markham stated that if the use of handcuffs was necessary to reduce the threat and gain control of Ms Wynne, then it would be in accordance with the relevant legislation, WAPF Use of Force Policy and the training and guidelines set out in the WAPF Operation Safety and Tactics Training Unit (OSTTU).[101]

144 It has not escaped my attention that the signed statement of Ms Wynne's mother does not refer to the erratic and physical behaviour of Ms Wynne in the unit that the police have said they witnessed. She does, however, refer to Ms Wynne screaming at police and having an "*anxiety attack*".[102] Given Ms Wynne's methylamphetamine intoxication at the time and her distrust of police, I accept the evidence of the police officers regarding Ms Wynne's behaviour when they

[98] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, p.25
[99] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, p.26
[100] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, p.27
[101] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, p.28
[102] Exhibit 1, Volume 1, Tab 10B, Statement of Shirley Wynne dated 8 September 2021, p.7

attended the unit. I also find that she was having the verbal altercation with her mother as recounted by the police. This is consistent with what Ms Wynne told the ambulance officers when they treated her at the intersection of Whittlesford Street and Berwick Street. In that conversation, Ms Wynne said that she had had a fight with her mother.[103] Even if that fight had occurred after the police had left the unit, it still demonstrated that the relationship between Ms Wynne and her mother that morning was strained.

145 I therefore find that Officer Boyd was justified in handcuffing Ms Wynne at the unit due to Ms Wynne's behaviour and for the reasons set out in Mr Markham's report, most notably the need to reduce the threat posed by Ms Wynne and to gain control of her.

Was it appropriate for Officer Ellis to handcuff Ms Wynne at the unit?

146 As outlined above, after Officer Boyd had completed her inquiries at the unit, she asked Officer Ellis to swap over her handcuffs on Ms Wynne with his own handcuffs. Officer Ellis did not have to comply with that request. He was required to make his own risk assessment as to whether it was appropriate at that time to keep Ms Wynne in handcuffs. For the reasons outlined below, I find that it was not necessary to do so.

147 In contrast to her behaviour inside the unit, once Ms Wynne was seated outside the unit and in Officer Boyd's handcuffs, Officer Ellis said in his statement she "*became calm and compliant*".[104] This is consistent with the account given by Officer Boyd in her statement:[105]

> I left the female [Ms Wynne] with the other four police officers and had no immediate concerns for her welfare at that time. They had adequate police officers present, and she was now sitting down in a non-threating [sic-threatening] position. She seemed to have calmed.

[103] Exhibit 1, Volume 1, Tab 16, Statement of Jessica Bourke dated 12 April 2019, p.4
[104] Exhibit 1, Volume 1, Tab 24, Statement of Constable Ellis dated 12 April 2019, p.6
[105] Exhibit 1, Volume 1, Tab 27, Statement of Constable Boyd dated 18 April 2019, p.6

148 Officer Boyd's evidence at the inquest differed to some degree from her account in her statement quoted above. At the time she was about to leave, Officer Boyd testified that Ms Wynne "*had calmed down but not completely*".[106]

149 Initially, the evidence of Officer Ellis at the inquest was consistent with his statement when I asked him the following questions during his examination by Counsel Assisting:[107]

> Did it surprise you that she became compliant relatively quickly? --- No, not necessarily. No.
>
> She went from one extreme to the other, it sounds like? --- From being walked outside, so I – I was under the – the, I guess, influence that getting her out of the – the apartment where it was – there was a lot going on, that could have – would have been the reason why she was escalating so much.
>
> So shortly after she was outside, she became relatively calm and compliant? --- Correct, yes, your Honour.

150 Officer Ellis testified that Ms Wynne had been complying for probably "*a few minutes before*" he placed his handcuffs on her. He could not recall saying to Ms Wynne that he would not place his handcuffs on her if she continued to remain calm.[108]

151 Officer Ellis backtracked to a degree from his evidence cited above when he was questioned by Ms O'Connor SC. When he was asked whether Ms Wynne was entirely calm at the point he placed his handcuffs on her, he responded: "*Not entirely calm but, yes, she was obviously declining down to the calm level.*"[109]

152 Officer Ellis' explanation for why he placed his handcuffs on Ms Wynne was "*[d]ue to the behaviour she was displaying earlier and that we were still unaware of who she was*".[110]

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[106] ts 15.9.21 (Boyd), p.319
[107] ts 14.9.21 (Ellis), p.167
[108] ts 14.9.21 (Ellis), pp.168-169
[109] ts 14.9.21 (Ellis), p.200
[110] Exhibit 1, Volume 1, Tab 24, Statement of Constable Ellis dated 12 April 2019, p.8

153 That account by Officer Ellis that police were still unaware of Ms Wynne's identity is not entirely accurate. His partner, Officer Fitzpatrick, had obtained that information from Ms Wynne's mother before Ms Wynne had even been handcuffed by Officer Boyd. Ms Wynne's mother provided her daughter's correct name and date of birth and, it would appear, accurately spelt out the unusual spelling of her daughter's first name to Officer Fitzpatrick.[111]

154 Once this evidence was brought to his attention, Officer Ellis agreed with Ms O'Connor SC that his statement should have read that he was still unaware of who Ms Wynne was, rather than "*we*".[112] When Ms O'Connor SC put to him that Ms Wynne was no longer a threat to injure any other person when she was sitting down after complying with his request to do that, Officer Ellis answered:[113]

> And it's to prevent – so I don't know who – who that – who she was at the time. I don't know if she had any violence – violent alerts to her name. I wanted to eliminate her from – from going back to that behaviour, and once I knew that it – that she wasn't going to – that's when I placed – that – removed the handcuffs.

155 In his report, Mr Markham offered the following opinion regarding the use of handcuffs by Officer Ellis:[114]

> Should the rationale for PC Ellis' justification for the use of handcuffs to control and effect the ongoing detention of Ms Wynne, be made on the basis of any of the examples provided in respect to the use of handcuffs by PC Boyd, then in such circumstances the use of handcuffs by PC Ellis, to continue to reduce the threat and gain control of Ms Wynne, would be in accordance with relevant legislation, WA Police Use of Force policy and the training and guidelines of OSTTU.

156 I find that the justification Officer Boyd had to handcuff Ms Wynne inside the unit did not extend to the circumstances that existed when her handcuffs were removed. I am satisfied that by this stage the threat posed by Ms Wynne no

[111] Exhibit 5, Statement of Constable Fitzpatrick dated 12 October 2019, pp.5-6; Exhibit 2, Relevant pages from Constable Fitzpatrick's notebook, p.39
[112] ts 14.9.21 (Ellis), p.196
[113] ts 14.9.21 (Ellis), p.194
[114] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, p.29

longer existed and control of her could be maintained without the further use of Officer Ellis' handcuffs. My reasons for making this finding are:

i. Police were aware of Ms Wynne's name;

ii. Ms Wynne was no longer behaving like she had inside the unit;

iii. Ms Wynne did not have ready access to any potential weapons;

iv. Ms Wynne had complied with the requests of police once she was taken outside the unit;

v. Ms Wynne had truthfully answered the questions asked of her by Officer Ellis as to why she had run away earlier;

vi. Ms Wynne had been calm and compliant for several minutes;

vii. There was no intention to arrest Ms Wynne; and

viii. There were sufficient police present (four in total) to be able to deal with any unexpected or sudden repeat of Ms Wynne's earlier behaviour in the unit.

157 Unfortunately, the handcuffing of Ms Wynne beyond what was necessary would have only increased her already high levels of stress.

158 The issue regarding the use of handcuffs on Ms Wynne at the unit was also investigated by the IAU. That investigation concluded the handcuffing of Ms Wynne "*was a reasonable action by attending police and justified by policy in reducing the threat of bodily injury and escape from detention.*"[115]

159 Unfortunately, the IAU investigation did not take into account the change in circumstances from the time Officer Boyd handcuffed Ms Wynne to when Officer Ellis placed his handcuffs on her. It ought to have done so for the reasons I have identified. There was no evidence suggesting Ms Wynne was trying to escape once she was seated outside the unit.

[115] Exhibit 1, Volume 1, Tab 30, IAU Report by Detective Senior Constable Hill dated 29 June 2020, p.39

Was an adequate mental health welfare check conducted by police at the unit?

160 At least one police officer who was at the unit was aware of Officer Barnes' CAD job entry that Ms Wynne required a mental health welfare check. It is not in dispute that Officer Yakacikli had accessed the TADIS system and saw that Ms Wynne was the subject of an expired Form 4A - Transport Order and that police were to undertake a "*welfare check only*".[116]

161 Officer Yakacikli said in his statement that he advised Officer Fitzpatrick of not just the result of the name check for Ms Wynne, but also the notes regarding the expired Transport Order.[117] Officer Yakacikli confirmed in his evidence at the inquest that he saw Officer Fitzpatrick "*and advised him there was an expired transport order*" and "*there was an alert to treat it as a welfare check; otherwise nothing else outstanding*".[118] Officer Yakacikli also confirmed that he regarded the welfare check in the context of seeing whether there were any mental health issues and to consider the provisions of section 156(1) of the Act.[119]

162 Officer Yakacikli's evidence at the inquest was that he had no welfare concerns for Ms Wynne as: "*Her demeanour had previously calmed down. She was with*

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[116] Exhibit 1, Volume 1, Tab 28, Statement of Constable Yakacikli dated 27 May 2019, p.5; see also Constable Yakacikli's instructions to Mr Harwood as outlined in Mr Harwood's letter dated 14 October 2021 to Counsel Assisting

[117] Exhibit 1, Volume 1, Tab 28, Statement of Constable Yakacikli dated 27 May 2019, p.5

[118] ts 14.9.21 (Yakacikli), p.243

[119] ts 14.9.21 (Yakacikli), p.244; 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 a cause, serious damage to property.
> …

Section 156(3) of the *Mental Health Act 2014* (WA) states:

> A police officer –
> (a) must, as soon as practicable after apprehending a person under subsection (1), arrange for the person to be assessed by a medical practitioner or authorised mental health practitioner for the purpose of deciding whether or not to refer the person under section 26(2) or (3)(a) for an examination to be conducted by a psychiatrist;

family at the time. She had made no allegations or attempts of self-harming in our presence."[120]

163 Officer Fitzpatrick, who was not called as a witness at the inquest, gave the following account in his statement regarding this matter:[121]

> I walked outside to Constable Yakacikli who advised me [Ms] Wynne did not have any outstanding matters.
>
> I walked back to the unit and I advised Constable Ellis, Constable D'Mello,[122] [Ms] Wynne and Shirley [Ms Wynne's mother] the results of the name check.
>
> Shirley indicated she was happy for [Ms] Wynne to stay with her.

164 I note that Officer Fitzpatrick's statement makes no reference to an alert for police to conduct a welfare check (mental health or otherwise) for Ms Wynne. However, a handwritten entry in his notebook stated that Ms Wynne was "*drug affected but nil welfare concerns*".[123] Based on the evidence before me, I am unable to determine if the note by Officer Fitzpatrick of "*nil welfare concerns*" was a general observation he made or if it related to a mental health welfare check he had undertaken.

165 At the inquest, Officer Ellis clarified that he did not speak to the officer who had performed the name check, and that it was Officer Fitzpatrick who had advised him of the outcome. He was then asked the following questions:[124]

> So what did Constable Fitzpatrick say? --- That there were no alerts outstanding, no warnings or anything outstanding.
>
> …
>
> And Constable Fitzpatrick didn't mention anything to you about there being an alert on the CAD system to perform a welfare check … – mental health check on Ms Wynne? --- No.

[120] ts 14.9.21 (Yakacikli), p.244
[121] Exhibit 5, Statement of Constable Fitzpatrick dated 12 April 2019, p.6
[122] Constable D'Mello was Constable Yakacikli's partner that morning
[123] Exhibit 2, Relevant pages from Constable Fitzpatrick's notebook, p.41
[124] ts 14.9.21 (Ellis), p.168

166 Clearly there is a discrepancy in the evidence as to what Officer Yakacikli told Officer Fitzpatrick. Officer Yakacikli was adamant he had told Officer Fitzpatrick that a welfare check was required.[125]

167 However, the accounts given by Officer Fitzpatrick and Officer Ellis in their statements suggest that he did not. I need not determine which version is accurate for the purpose of determining whether an adequate mental health welfare check was undertaken as I have found that it was not adequate for the following reasons.

168 There is no evidence before me that any questions were asked of Ms Wynne that were designed to assess her mental health and well-being. I accept that Officers Ellis and Yakacikli were each being genuine when they said they had no concerns for Ms Wynne's mental health and that they did not think she should be detained under section 156(1) of the Act.[126] However, they did not speak to Ms Wynne and/or her mother to confirm their conclusions. Officer Yakacikli was asked by Mr Harwood:[127]

> Do you consider that you did a welfare check? --- I guess just general interactions with her. Yes. Not me personally, but us the police – yes – in my observations.

169 Officer Ellis, like Officer Yakacikli, concluded that Ms Wynne did not need to be apprehended under section 156(1) of the Act "*based on what I knew at that point and observations.*"[128]

170 I accept that it will often be the case when police officers are interacting with someone that the person's mental health can be adequately assessed by simply making general observations as to how they are behaving and what they are saying. However, in this instance, there was a CAD job entry that required

[125] ts 14.9.21 (Yakacikli), p.255
[126] ts 14.9.21 (Ellis), p.190; ts 14.9.21 (Yakacikli), p.245
[127] ts 14.9.21 (Yakacikli), p.255
[128] ts 14.9.21 (Ellis), p.190

police to undertake a mental health welfare check upon Ms Wynne. An entry that had only been made a matter of days earlier.

171 It is my view that in those circumstances what was required was not just observations of Ms Wynne, but also having a conversation with her to ascertain her mental health. Officer Boyd explained it in this way:[129]

> In your view, was a welfare check performed at the unit during the time that you were there? --- A welfare check, I think, is encompassing of a lot of different things. Apart from just having a conversation with the person, I think that, you know, it's observations that are made. Certainly in the time I was there, there were a lot of observations made. But I wasn't present for the conversations that took place after I left, so I don't know.
>
> If you had been asked to perform a welfare check on her, say, immediately prior to you leaving, do you think that Ms Wynne would have passed that welfare check or would you – did you still have concerns for her welfare? --- She wasn't presenting with any concerns at the time in regards to her mental health. Like I said, it was more to the fact that she was evasive of police. I think that certainly if she had have communicated with me and – like, I can't – I can't – hypothetically, if I had have had then a conversation once she calmed down and she was speaking and asked how she was feeling and if she had had any thoughts of self-harm and asked about her medical history and her mental health history, these sorts of things are the things I would ask. Certainly I would get feedback from her family in relation to those sorts of things as well. That would be part of my investigation if that was the case. And depending on the answers to those questions, then I would have made a determination whether it was appropriate.

172 Officer Boyd gave evidence that she has completed a mental health first aid certificate as a police officer.[130] In his closing submissions, Mr Harwood submitted that as Officer Boyd had "*specialist training above what the normal police had*", it meant that "*there can't necessarily be criticism of other police officers who don't have the training*".[131]

173 I do not accept that submission by Mr Harwood. It is my view that "*specialist training*" is not required for a police officer who is undertaking a mental health welfare check to ask questions such as these ones cited by Officer Boyd:[132]

[129] ts 15.9.21 (Boyd), p.331
[130] ts 15.9.21 (Boyd), p.328
[131] ts 17.9.21 (closing submissions by Mr Harwood), p.673
[132] ts 15.9.21 (Boyd), p.332

- *"How are you feeling at the moment?"*
- *"Have you had any thoughts of self-harm?"*
- *"Have you tried to attempt self-harm in recent times?"*
- *"Have you got any mental health history?"*

174 In an era where there has been a well-known campaign for the general community to ask, "Are you OK?", I would expect every police officer to ask the above basic questions of a person who has been identified as requiring a mental health welfare check.[133] It was not sufficient to merely observe Ms Wynne and enquire of her mother whether she was happy for her daughter to remain with her.

175 Detective Senior Constable Michael Hill (Detective Hill), who prepared the IAU Report for this matter, agreed there was a deficiency in the mental health welfare check by not asking Ms Wynne these types of questions.[134]

176 In finding that there was an inadequate mental health welfare check conducted, the question arises as to whether the individual police officers who were responsible for that can be identified. I can exclude those police officers from the Cannington Detectives Office who attended the unit, as they were not aware of the CAD job entry that a mental health welfare check was to be undertaken for Ms Wynne. Of the remaining four police officers who attended the unit, there is no evidence before me that Officer D'Mello was aware of it. Officer Ellis has denied under oath that he was aware of it. Officer Yakacikli was aware of it. However, other than giving that information to Officer Fitzpatrick, he did not do anything else with respect to Ms Wynne and left it to Officer Fitzpatrick to do whatever he felt needed to be done.[135] Officer Fitzpatrick's account from his statement is that Officer Yakacikli only

[133] See: https://www.RUOK.org.au R U OK? is a suicide prevention charity in Australia, encouraging everyone to notice the signs of any mental health concerns in friends, family and colleagues. It revolves around the slogan "*R U OK?*" and advocates for people to have conversations with others who may have mental health issues.
[134] ts 17.9.20 (Hill), p.557
[135] ts 14.9.21 (Yakacikli), p.247

advised him that Ms Wynne did not have any outstanding matters. I also have to bear in mind that Officer Fitzpatrick and Officer D'Mello were not called as witnesses at the inquest.

177 Applying the ***Briginshaw*** principle, and given the conflicting evidence before me regarding this matter, I am not able to identify the individual officer(s) who had the responsibility of ensuring an adequate mental health welfare check for Ms Wynne was undertaken at the unit.

Should Ms Wynne have been detained at the unit under section 156(1) of the Mental Health Act 2014 (WA)?

178 This question is difficult to answer. Based on the limited information that police had who attended the unit (with the exception of Officer Yakacikli), there would be no grounds for any police officer, based only on their observations, to have reasonably suspected Ms Wynne had a mental illness that required her to be apprehended to protect her health or safety or the safety of another person or to prevent her from causing or continuing to cause serious damage to property.[136]

179 I have identified Officer Yakacikli specifically as he not only saw the expired Form 4A - Transport Order for Ms Wynne on TADIS, but he also recalled that it had expired just the month before, in March 2019. In those circumstances, he had information Ms Wynne had either recently been under some form of psychiatric care or had been referred to a psychiatrist to be assessed. Unfortunately, the significance of this potential red flag escaped Officer Yakacikli's attention, as borne out in his answers to these questions at the inquest:[137]

> [I]t's now early April, so it's not like it's an alert that might be a number of months old. It was an alert that had been made relatively recently? --- Yes, your Honour.
>
> Would you agree with that? --- Yes, your Honour.

[136] As required by section 156(1) of the Act
[137] ts 14.9.21 (Yakacikli), p.245

> So did you regard in those circumstances that your[138] welfare check might have to be a little more careful than might otherwise be the case? --- It didn't occur to me, your Honour.

180 As I have already found, the mental health welfare check of Ms Wynne was not adequate. Had the appropriate questions been asked of Ms Wynne and/or her mother, the answers could have provided police a basis to "*reasonably suspect*" that Ms Wynne had a mental illness that required her to be apprehended under section 156(1) of the Act. However, that scenario is an entirely speculative one as it is unknown how upfront Ms Wynne and/or her mother (if she was actually aware of them) would have been regarding the mental health issues that Dr Paparo had identified ten days earlier. It is also unknown whether Ms Wynne would have told police that she wanted to die (as she had told the ambulance officers about one hour later).

181 I am of the view that if the police officers at the unit had more access to information from the WAPF database regarding Ms Wynne's recent admission to JHC and her subsequent absconding, they would have had far more information to consider whether an apprehension under section 156(1) of the Act was appropriate. As Officer Ellis said at the inquest, and depending on what Ms Wynne had told police, "*had we had all the information – then, yes, I think we could have fulfilled* [section] *156 and detained her under the Mental Health Act*".[139]

182 Back in April 2019, frontline police officers only had access to certain CAD tasks on TADIS. Police officers were unable to access the Incident Management System (IMS) from their vehicles. IMS is the police database containing details of the personal profile of people that the WAPF have had contact with.[140] The IMS intelligence for Ms Wynne contained far more information about her than

[138] My use of "your" was in the context of the police having to conduct a welfare check, rather than it being the individual responsibility of Officer Yakacikli.
[139] ts 14.9.21 (Ellis), p.202
[140] ts 14.9.21 (Barnes), p.140

the CAD entries. It contained the forms completed at JHC, including the Mental Health Missing Person Report dated 26 March 2019 which stated that Ms Wynne's degree of risk to herself and to others was "*high*" and that she was "*floridly psychotic*".[141] This information would have been vital for police when determining if there were grounds to apprehend Ms Wynne under section 156(1) of the Act. Unfortunately, at the time, this information could only be accessed from office-based or desktop-based computer systems.[142] Hence, the only way a frontline police officer would have had access to this information in April 2019 is if they made a call to a deskbound police officer with access to a computer.

183 Since April 2019, the WAPF have made improvements that allow greater access to its database for its frontline officers. This is addressed in more detail later in these findings.

Was Officer Williams' manner of driving appropriate as he approached Ms Wynne running on Albany Highway?

184 Officer Williams was driving the second police vehicle that sighted Ms Wynne running on Albany Highway in Bentley. He had earlier been given a Priority 2 status to attend.[143] At this stage, Officer Rozier was following Ms Wynne on foot along the highway after her failed attempt to grab her.

185 The manner of driving of the police vehicles which approached Ms Wynne just before she was apprehended are captured by private CCTV footage from a car yard at Lot 2/1110 Albany Highway (the CCTV footage). These premises were located on the east side of Albany Highway and immediately north of the T-junction with Tate Street. The CCTV footage also depicted the apprehension of Ms Wynne, her subsequent restraint on the grass verge south of Tate Street

[141] ts 14.9.21 (Barnes), p.153
[142] ts 14.9.21 (Barnes), p.140
[143] ts 16.9.21 (Williams), pp.413,418

and the resuscitation attempts by police and ambulance officers.[144] There is no audio recording with the CCTV footage. The section of Albany Highway that appears on the CCTV footage has two lanes each for northbound and southbound traffic. There is no centre island and it does not appear that the four lanes are separated by double solid white lines.[145] The two southbound lanes are separated by a single broken white line.

186 In addition to the evidence from Officer Williams, I have relied upon the CCTV footage and the Automated Vehicle Locator (AVL) data[146] for the police vehicle driven by Officer Williams in making my finding as to his manner of driving.

187 Officer Williams had heard the VKI communications regarding Ms Wynne from the time she had been located at the corner of Berwick Street and Whittlesford Street. A later update stated Ms Wynne was near the intersection of Albany Highway and Tennant Street and was trying to jump in front of cars. As Officer Williams recounted in his statement: "*I became seriously concerned that* [Ms] *Wynne was trying to harm herself further, and may harm other persons with her actions*".[147] He then drove to that area, travelling southbound on Albany Highway. Officer Williams was asked the following questions at the inquest:[148]

> What were those concerns? --- I had serious concerns that the female, who I didn't know at that stage, was attempting self-harm and was going to get hurt – seriously hurt.
>
> And in terms of you thinking she would get seriously hurt, how did you think that? How did you think she would get hurt? --- I thought she would get hit by a car. If she was running down – down traffic or on roads, she would get hit by a car.

[144] Exhibit 1, Volume 1, Tab 36, Disc containing CCTV footage and still images
[145] This is most likely due to the fact that, as shown by the CCTV footage, the two northbound lanes had recently been resurfaced and road markings have not yet taken place. It can also be seen that there are no dividing road lines for the two northbound lanes.
[146] Exhibit 4A, AVL Data for police vehicle call-sign VK101. This data provides regular readings of the speed of the vehicle, the location of the vehicle when the reading was calculated and the date and time. It has been accepted by the WAPF at other inquests that it is generally accurate to +/- 2 km per hour.
[147] Exhibit 1, Volume 1, Tab 22, Statement of Sergeant Williams dated 11 April 2019, p.3
[148] ts 16.9.21 (Williams), p.413

188 The CCTV footage has the date and digital time of the recording identified in the top left-hand corner of the screen as the vision is played. The date for this vision is identified as 04-04-2019. The relevant vision regarding the manner of Officer Williams' driving commences at 07:37:41 and ends at 07:37:49.

189 At 07:37:32, Ms Wynne appears at the right of the screen running south on the inside northbound lane of Albany Highway. At the same time, the police vehicle driven by Officer O'Callaghan in a southerly direction passes her in the inside southbound lane (at a speed considerably slower than the driving of Officer Williams 13 seconds later). Officer Callaghan stops his police vehicle about 30 metres further along Albany Highway in the inside northbound lane. At all times, the emergency lights of the police vehicle are activated

190 At 07:37:36, Officer Rozier appears at the right of the screen running south after Ms Wynne. Officer Rozier is on the outside (i.e. kerbside) southbound lane.

191 At 07:37:40, Ms Wynne veers across from the inside northbound lane onto the inside southbound lane. It would appear she has done that to avoid Officer O'Callaghan's vehicle which is now parked ahead of her in the inside northbound lane. At this point, Ms Wynne is about 20 metres ahead of Officer Rozier.

192 At 07:37:41, Officer Williams' police vehicle appears at the right of the screen, driving south in the outside southbound lane. Its emergency lights are also activated. At this stage, Ms Wynne is running on the inside southbound lane and is close to the single broken white line dividing the two southbound lanes. She is about 40 metres ahead of Officer Williams' police vehicle.

193 At 07:37:43, Ms Wynne is still running on the inside southbound lane, however she is now virtually in the centre of the two southbound lanes. Officer O'Callaghan is out of his police vehicle and begins chasing after

Ms Wynne. He is only about 10 metres behind her and is rapidly closing the gap. Officer Williams' police vehicle is being driven in the outside southbound lane and is in the centre of the screen as it passes Officer Rozier, who has moved onto the inside southbound lane. Although it appears the brake lights on Officer Williams' police vehicle are briefly illuminated as it passes Officer Rozier, there is no indication from the CCTV footage that the vehicle has slowed down to any significant degree.

194 At 07:37:45, Officer Williams' police vehicle is about to pass Ms Wynne, who has moved slightly further within the inside southbound lane. Officer O'Callaghan is now only about five metres behind her.

195 At 07:37:47, Officer William's police vehicle drives by Ms Wynne and it is only after it has passed Ms Wynne that the vehicle's brake lights are illuminated.

196 At 07:37:49, Officer Williams stops his police vehicle in the inside southbound lane at a 45 degree angle. Also at this time, Officer O'Callaghan apprehends Ms Wynne. Officer Rozier is now at the police vehicle previously driven by Officer O'Callaghan, which she moves from the inside northbound lane to the outside southbound lane near where Ms Wynne had been restrained on the grass verge.

197 I asked Officer Williams the following questions at the inquest:[149]

> Sergeant, why were you driving quickly? --- I – I wanted to pass the lady who was running. I wanted to get in front of her so I could cut her off.
>
> Were you exceeding the speed limit in order to do that? --- I don't remember, sir.
>
> I thought you had serious concerns that she might attempt self-harm --- ? --- That's correct, I did.
>
> By being stuck by a car? --- Yes, that's correct.
>
> So you were talking about … your concern that she might deliberately jump in front of a car? --- Yes.

[149] ts 16.9.21 (Williams), p.416

> Did you take that into account with the speed that you were going as you passed her? --- I don't remember thinking that, sir.
>
> Why didn't you think that? --- I don't know. My focus was on getting down there and getting into a position where I could intercept her and get her off the road.
>
> Did you see the footage yesterday? --- I did see it. But I was at the back of the court I didn't have my glasses on yesterday so it was – I haven't seen it very well.

198 After Officer Williams was shown the CCTV footage from the better vantage point of the witness box, I asked:[150]

> Sergeant, now that you've seen the footage, are you of the view that as you drove past Ms Wynne, knowing what you knew about her, that that was a reasonable and safe way or speed at which to pass her? --- Sir, I – that's I feel that that's not for me to judge. I understand ---
>
> No, no. It certainly is for you to judge, Sergeant. You're behind the wheel? --- Well, I don't know what speed I was going, sir. I – I understand that I was going faster than her. She was running along ---
>
> Of course? --- one lane and I'm in another lane.
>
> …
>
> So you didn't take into consideration at that time the possibility of her jumping in front of your vehicle? --- I don't remember thinking that, no, sir.
>
> Right and I'm suggesting that if you were to have thought that, you would have driven a lot slower? --- Possibly. Yes, sir.

199 Officer Williams agreed that he was required to undertake an ongoing risk assessment whenever he was driving at a Priority 2 level. He was asked by Counsel Assisting what his risk assessment was at the time he approached Ms Wynne and he provided this answer:[151]

> So the risk – as you said, the risk assessment is ongoing, so as you approach each intersection you conduct split second risk assessments as you go, and that was – they were conducted – I – I don't have conscious thought or doing, but you do them as you go. You're trained to look at side streets as you pass them. You're trained to look for pedestrians if they're standing on the side of the road and take – take actions, etcetera. So the whole way during a – through a Priority 2 drive, you're conducting risk assessments. They happen in split seconds in your mind.

200 After Officer Williams said that the "*major*" risk he encountered as he drove along Albany Highway was Ms Wynne "*running down the road*", he was asked by Counsel Assisting:

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[150] ts 16.9.21 (Williams), pp.418-419
[151] ts 16.9.21 (Williams), p.419

> A benefit of hindsight is a powerful lens and, also, you'd seen it from a different angle from – as opposed to your own point of view. Having seen the footage now close-up, would you have changed your actions in the police vehicle at all, or would you maintain that that action was appropriate? --- I still think that getting past and in front of her was the best thing. Maybe not as fast as what I've just seen on the footage. (underlining added)

201 After Officer Williams had completed his evidence, the WAPF provided Mr Harwood with the AVL data for Officer Williams' police vehicle. That document subsequently became exhibit 4A. Exhibit 4B was also tendered by Mr Harwood which summarised the relevant data from exhibit 4A that established the speed of Officer Williams' vehicle as it passed Ms Wynne. I accept that portion of exhibit 4B which states the following:

> The data shows that when VK 101, the vehicle drive [sic - driven] by Sgt Williams, was on Albany Highway between 1109 – 1116 [Albany Highway] adjacent to the incident scene it was recorded at [sic - as] travelling at 50 kph at 07:37:44.[152]

202 Although the speed limit at this section of Albany Highway was 60 km per hour, I find that the speed at which Officer Williams approached and then passed Ms Wynne was very unsafe in all the circumstances. A proper risk assessment by Officer Williams ought to have made him approach Ms Wynne at a much slower speed because of the following facts.

203 First, he was already aware Ms Wynne had harmed herself to the throat a short time earlier and that she had absconded from the ambulance called to treat her.[153] Second, when driving to Albany Highway he heard a VKI communication that Ms Wynne was trying to jump in front of cars.[154] Third, he was concerned Ms Wynne would make further attempts to do precisely that before she could be apprehended by police. Fourth, part of his training as a Priority 2 driver involved looking out for pedestrians standing by the side of the road and to take appropriate action (the situation facing him as he drove towards

[152] It should be noted that although there is no evidence that this time is synchronised with the digital time appearing on the CCTV footage, they appear to be almost identical.
[153] Exhibit 1, Volume 1, Tab 22, Statement of Sergeant Williams dated 11 April 2019, p.2
[154] Exhibit 1, Volume 1, Tab 22, Statement of Sergeant Williams dated 11 April 2019, p.3

Ms Wynne was far more unpredictable and potentially dangerous than pedestrians standing by the side of a road). Fifth, by the time he sighted Ms Wynne, Officers O'Callaghan and Rozier were already at the scene, and within close proximity of her.

204 As an experienced police officer who held Priority 2 driver qualifications, Officer Williams ought to have known better than drive in the manner that he did. It was disturbing to hear his evidence that he could not recall whether his risk assessment considered the prospect of Ms Wynne deliberately placing herself in his police vehicle's path. The CCTV footage showing the speed of his vehicle and the distance between it and Ms Wynne as she was passed clearly demonstrated that he did not. Given his speed as he approached Ms Wynne, and how close she was to his police vehicle, I gravely doubt whether Officer Williams could have avoided hitting Ms Wynne if she chose to suddenly deviate to her left and run into the path of his police vehicle. Officer O'Callaghan would not have been able to prevent that happening as the CCTV footage shows he was only close enough to grab Ms Wynne after Officer Williams had driven past her.

205 For a police officer who was about to assist in the apprehension of a mentally troubled young woman who was clearly behaving erratically by putting her life in grave danger, the manner in which Officer Williams drove past Ms Wynne was only likely to add to the panic and fear she was already clearly displaying. These were two emotions Ms Wynne had been frequently demonstrating, often in the presence of police, since 5.45 am that morning.

206 Unfortunately, there were some aspects to the apprehension of Ms Wynne that followed which do not reflect well on the proposition that the police officers involved were looking after the best interests of a person they thought was

"*suffering from a severe mental health episode and needed immediate medical intervention.*"[155]

Was it appropriate for Officer O'Callaghan to handcuff Ms Wynne at Albany Highway?

207 It was obvious that Ms Wynne, for her own safety, had to be apprehended and removed by police from Albany Highway as quickly as possible. Officer O'Callaghan is to be commended for his quick-thinking and the manner in which he safely manoeuvred his police vehicle around Ms Wynne before stopping a short distance in front of her. He was able to apprehend Ms Wynne very quickly after he had alighted from his police vehicle. With the assistance of Officer Regan and then Officer Williams, he escorted Ms Wynne from Albany Highway to the relative safety of the grass verge adjacent to the highway.

208 It is evident from the CCTV footage that within a matter of seconds after reaching the grass verge, Officer Williams (the most senior officer of the three), made the decision that Ms Wynne should be handcuffed. Two questions arise from that decision. The first is whether it was appropriate to handcuff Ms Wynne and the second is whether it was appropriate to place Ms Wynne in the prone position in order to do that. I will deal with these questions separately.

209 It was Officer O'Callaghan's account that Ms Wynne was physically trying to get away from him as soon as he grabbed her by the right shoulder on Albany Highway.[156] He also said in his signed statement that after Officers Regan and Williams came to assist, and as they walked Ms Wynne off Albany Highway, Ms Wynne "*was offering significant resistance and appeared to be*

[155] Exhibit 1, Volume 1, Tab 22, Statement of Sergeant Williams dated 11 April 2019, p.4; see also Exhibit 1, Volume 1, Tab 19, Statement of 1st Class Constable O'Callaghan dated 2 May 2019, p.4 and Exhibit 1, Volume 1, Tab 21, Statement of Constable Regan dated 11 April 2019, p.4

[156] Exhibit 1, Volume 1, Tab 19, Statement of 1st Class Constable O'Callaghan dated 2 May 2019, p.6

trying to get back onto the roadway".[157] That account was the same as his evidence at the inquest.[158] In contrast, Officer Regan's version is that after she grabbed Ms Wynne, "*we walked her off the road to the verge without any resistance*".[159]

210 The CCTV footage is far more consistent with that account by Officer Regan, and I am therefore able to find that Ms Wynne was offering no resistance as she was being led from Albany Highway onto the grass verge. In so finding, I note that at 07:37:52 on the CCTV footage (which is three seconds after Officer O'Callaghan has apprehended her), Ms Wynne stops on the outside southbound lane and leans forward with her hands on her knees. She remains in that position for about two seconds. This is a common stance someone takes after physically exerting themselves and I find that was the reason why Ms Wynne did this.

211 At 07:37:57, Ms Wynne is on the grass verge with Officers O'Callaghan and Regan holding her and Officer Williams one step behind them. A viewing of the CCTV footage from 07:37:57 to 07:38:02, when Ms Wynne is lowered to the ground, does not support the following accounts by the three police officers.

212 After stating that Ms Wynne "*was offering significant resistance*", Officer O'Callaghan said:[160]

> When off the road, we sat [Ms] Wynne down on the verge, she was physically trying to get away from us and had gotten to her knees, I thought she was trying to get back onto the road.

Officer Regan's account is:[161]

> Straight after we came off the road, [Ms] Wynne started to pull away from us, she was trying to pull her arms out of our grip and forcefully trying to get away from us.

[157] Exhibit 1, Volume 1, Tab 19, Statement of 1st Class Constable O'Callaghan dated 2 May 2019, p.6
[158] ts 15.9.21 (O'Callaghan), pp.353-354
[159] Exhibit 1, Volume 1, Tab 21, Statement of Constable Regan dated 11 April 2019, p.4
[160] Exhibit 1, Volume 1, Tab 19, Statement of 1st Class Constable O'Callaghan dated 2 May 2019, p.6
[161] Exhibit 1, Volume 1, Tab 21, Statement of Constable Regan dated 11 April 2019, p.4

Similarly, Officer Williams describes:[162]

> Almost immediately after coming off the road, [Ms] Wynne began to try to pull free from us. She attempted to pull her arms free from our grip and also tried to forcefully walk or run away. We maintained our hold on her.

213 The CCTV footage shows Ms Wynne remaining in the same position during the five seconds from 07:37:57 to 07:38:02. This is the time when she is apparently offering considerable and forceful resistance. I note that for about two of those seconds, she is doubled over. As she is lowered to the ground, there is still no evidence of significant resisting (see from 07:38:02 to 07:38:05). Based on the CCTV footage, I am satisfied that if Ms Wynne was resisting during this period of time, it was not particularly significant or forceful; and whatever resistance there was, the three police officers were very much in control.

214 Once Ms Wynne was on the ground, the decision by Officer Williams to have Officer O'Callaghan handcuff her was made very quickly. At 07:38:05, Officer O'Callaghan stands upright from his crouching position over Ms Wynne and removes his handcuffs from the dark coloured vest he is wearing.[163] At 07:38:12, Officer O'Callaghan crouches down in order to apply the handcuffs to Ms Wynne. At 07:38:35, Officer O'Callaghan stands up and it is not in dispute that by this stage his handcuffs have been applied to Ms Wynne.[164]

215 As the police were detaining Ms Wynne for the purpose of a mental health assessment under section 156(1) of the Act, they were entitled to use "*reasonable force*" to detain her as permitted by section 172(2) of the Act. This provision applies as section 156 of the Act is a "*prescribed provision*" listed in the Table contained in section 171 of the Act.

[162] Exhibit 1, Volume 1, Tab 22, Statement of Sergeant Williams dated 11 April 2019, p.5
[163] ts 15.9.21 (O'Callaghan), p.367
[164] ts 15.9.21 (O'Callaghan), p.367

216 The WAPF has a Handcuff Manual as a part of its OSTTU for its recruit training (the Manual).[165] The Manual states that "*in appropriate circumstances, members can elect to use Handcuffs and other restraints as a tactical option* ***to reduce a threat and gain control*** *of a subject*"[166] (bold type in original). The Handcuff Manual further states:[167]

> Handcuffs and/or Other Restraints can be used to reduce the threat and gain control of a subject where the member reasonably suspects there is a risk of:
>
> - ***Bodily injury*** to any person *(italics and bold type in original)*
> - Escape from arrest or detention
> - Damage to property (including property of evidential value)

217 As stated by Mr Markham in his report:[168]

> The purpose of applying handcuffs to a subject is to both restrain and secure them, reducing the threat and risk of bodily injury to any person and effectively gaining control. Generally, handcuffs should not be applied until the subject has been restrained and physical control has been established. If the subject is not restrained at the time of being handcuffed then officer safety may be compromised.

218 I am satisfied the three police officers who were involved in the apprehension of Ms Wynne were entitled to be concerned that, should she break free from them, there was a very real risk she would run back onto Albany Highway, placing her at considerable risk of "*bodily injury*" (at the very least). That was an appropriate risk assessment to make and I agree with Mr Markham's observation that:[169]

> The use of Empty Hand Tactics[170] techniques and handcuffs should be reviewed in context of the entirety of the situation and how the officers used these tactical options in a combined effort to reduce the threat and gain control of Ms Wynne.

219 With respect to the decision to apply handcuffs to Ms Wynne, I also find that it was reasonable in order to reduce the very real danger of her running back onto

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[165] Exhibit 1, Volume 3, Tab 8I, WAPF Handcuff Manual – Version 1.0
[166] Exhibit 1, Volume 3, Tab 8I, WAPF Handcuff Manual – Version 1.0, p.5
[167] Exhibit 1, Volume 3, Tab 8I, WAPF Handcuff Manual – Version 1.0, p.6
[168] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, p.37
[169] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, p.36
[170] Empty Hand Tactics means any self-defence or control technique executed without the use of a weapon, it includes the use of handcuffs.

Albany Highway. I agree with the following assessment by Mr Markham as to the use of handcuffs in this instance:[171]

> In consideration of this incident, the situational factors and the significant risk of injury to Ms Wynne and other road users should she defeat the combined efforts of the officers to physically restrain her and prevent her from running back out into the traffic in Albany Highway, would support the legitimacy of their actions and the use of reasonable force in the circumstances. This is aligned to the Powers and Policy Phase of the WA Police Force STOM.[172]

220 Had the provisions in section 170 of the Act applied, and not section 172(2),[173] then my finding would have been very different. Section 170 of the Act is headed "Principles relating to detention" and, subject to section 171 of the Act, apply "*in relation to the detention of a person under this Act*".[174] Section 170(b) states that "*the degree of any force used to detain the person must be the minimum that is required to be used for that purpose*" (underlying added).

221 In the circumstances that existed after Ms Wynne had been removed from Albany Highway, the minimum degree of force to prevent her from re-entering the highway would have involved Officers O'Callaghan, Regan and Williams restraining her by hand and taking her to a location further away from the highway. One such location could have been the grassed area (or the carpark area behind it) that affronted Albany Highway at the corner of Tate Street and Albany Highway.[175]

222 In contrast, the use of force that can be regarded as "reasonable" can encompass more than one scenario with respect to a particular detaining of a person; each of which may have varying degrees of force but nevertheless fall within what is reasonable. There is no requirement to use a lesser force option before a more

[171] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, pp.36-37
[172] STOM is an abbreviation for Situational Tactical Options Model which sets out the process by which a measured and appropriate response can be made by police officers to any situation involving conflict: Exhibit 1, Volume 3, Tab 8J, Operational Safety & Tactics Training Unit - Use of Force Manual, p.7
[173] Which authorised the police to use "*reasonable force*" to detain Ms Wynne
[174] Section 170 of the Act
[175] This area is partially visible on the CCTV footage: Exhibit 1, Volume 1, Tab 36, Disc containing CCTV footage and still images

serious force option may be used (provided it is reasonable).[176] Given the circumstances, I am satisfied the decision to handcuff Ms Wynne was not an unreasonable use of force.

223 A separate question now arises as to whether it was appropriate for Ms Wynne to be placed in the prone position, with the dangers that position can cause, in order to handcuff her. It does not necessarily follow that it was appropriate to do so simply because I have found it was a reasonable use of force to handcuff Ms Wynne.

Was it appropriate for police to place Ms Wynne in the prone position to handcuff her?

224 A reason given for placing Ms Wynne in the prone position was because of her resistance to having her second arm handcuffed when she was lying on her right hand side. This was the account given by Officers Williams and Regan.[177] Officer O'Callaghan's account is a little different as he describes the handcuffing of both Ms Wynne's wrists occurring when she was lying in the prone position.[178]

225 The CCTV footage does not assist with determining exactly what position Ms Wynne was in when her first wrist was handcuffed. Nor does the CCTV footage assist with determining the degree of resistance, if any, Ms Wynne was displaying. That is because of the positioning of the three police officers around her. However, what the CCTV footage does show is that Ms Wynne was placed into the prone position at 07:38:19.[179] She remained in that position until she is lifted to a standing position at 07:40:09.[180]

[176] Exhibit 1, Volume 3, Tab 8R, WA Police Force – Police Manual Policy – Use of Force
[177] Exhibit 1, Volume 1, Tab 22, Statement of Sergeant Williams dated 11 April 2019, p.6; Exhibit 1, Volume 1, Tab 21, Statement of Constable Regan dated 11 April 2019, p.5
[178] Exhibit 1, Volume 1, Tab 19, Statement of First Class Constable O'Callaghan dated 2 May 2019, pp.7-8
[179] Exhibit 3, Timeline of Events as recorded on the CCTV, Event 12
[180] Exhibit 3, Timeline of Events as recorded on the CCTV, Event 27

226 I have some concerns regarding the actions of the three police officers, even before Ms Wynne was placed in the prone position. First, there was no evidence before me that anything was said to Ms Wynne immediately before, or as, the handcuffs were being applied. The Manual states that "*the cuffing officer is always the controlling officer and must use clear, audible commands to control the subject*".[181] Under the heading, "Application of Handcuffs", the Manual specifies: "*When using any technique to gain control over the subject, Tactical Communication is critical. Officers must instruct the subject and give them a chance to react to the commands and techniques being used*".[182]

227 Ms O'Connor SC asked Officer O'Callaghan if, at any time, did he try to speak to Ms Wynne. His answer was: "Y*es. When I first – on the road, when she was standing up, and trying to get off the road I tried to speak to her twice, I think and just there was no response*".[183] However, police officers are trained to use ongoing Tactical Communications which are described as "*the use of communication tools such as negotiation, commands, requests, appeals, instructions and information. The use of effective tactical communication skills can be of great assistance to members in their efforts to deal with and resolve conflict.*"[184] On the evidence before me, this tactic was only sparingly employed when Ms Wynne was first apprehended on Albany Highway.

228 Second, as pointed out by Ms O'Connor SC in her closing submissions, there was also no evidence that any police officer attempted to reassure Ms Wynne when they got her to the grass verge that they were trying to help her and get her to hospital.[185] There is some degree of force to the observation by Ms O'Connor SC that what the CCTV footage depicts "*is the way you might expect a criminal*

[181] Exhibit 1, Volume 8, Tab 8I, WAPF Handcuff Manual – Version 1.0, p.17
[182] Exhibit 1, Volume 3, Tab 8I, WAPF Handcuff Manual – Version 1.0, p.18
[183] ts 15.9.21 (O'Callaghan), p.383
[184] Exhibit 1, Volume 3, Tab 8J, Operational Safety & Tactics Training Unit - Use of Force Manual, p.14
[185] ts 17.9.21 (closing submissions by Ms O'Connor SC), p.661

to be dealt with, not someone who is only ill and they [the police] *already knew that she was only ill.*"[186]

229 Third, the Manual provides for the handcuffing of a person in ways other than the prone position. Under the heading "Handcuffing Positions", it states:[187]

> Handcuffing can take place in various positions. The prone position is the most likely position for the subject to end up in if a struggle has preceded the process of handcuffing. Additionally this position gives far greater opportunity for an officer to exercise physical control during the process of applying handcuffs.

230 The other handcuffing positions are "*back to back standing*" (when the person is handcuffed to their back), "*front and rear stack standing*" (when the person is handcuffed with their hands to the front), and "*handcuffing a kneeling subject*".[188] The relevance of these handcuffing positions is they all reduce the risk of positional asphyxia when compared to the prone position.

231 I do not accept Mr Markham's proposition that "*[i]t would appear that the officers attempted to handcuff Ms Wynne whilst she was still standing, however, due to the level of resistance she offered, this was unachievable*".[189] An examination of the CCTV footage does not support an account that attempts were made by the police officers to handcuff Ms Wynne as she was standing. Furthermore, Officer O'Callaghan only accessed his handcuffs once Ms Wynne was on the ground.

232 It is unfortunate no attempt was made to handcuff Ms Wynne in one of the other ways set out in the Manual. Although I have made that observation, I am prepared to accept that there was an attempt to handcuff Ms Wynne as she was on the ground and lying on her right hand side.

[186] ts 17.9.21 (closing submissions by Ms O'Connor SC), p.661
[187] Exhibit 1, Volume 8, Tab 8I, WAPF Handcuff Manual – Version 1.0, p.19
[188] Exhibit 1, Volume 8, Tab 8I, WAPF Handcuff Manual – Version 1.0, pp.20-28
[189] Exhibit 1, Volume 3, Tab 8, p.39

233 I accept Mr Markham's evidence that "*[t]he prone position provides greater opportunity to exercise physical control during the application of handcuffs*".[190]

234 When asked, given the number of police officers present, whether there was a way to stop Ms Wynne from running without placing her on her stomach, Officer O'Callaghan answered: "*The risk of her getting away was too great not to get her in control*."[191] He was then asked:[192]

> Is the only way you could get her in control, in your view, the only way, was to put her on her stomach? --- The safest way we thought at the time. Yes.
>
> Because wouldn't it have been just as easy if the four officers had held four limbs? She couldn't have run away? --- It just wasn't practical at the time. It's a busy road at that time of the morning. That was the danger. She had already been, the information was, highly suicidal and she had already been hit by a car[193] and she was trying to get hit by a car was the information we had been provided. So that was what we took [into account].

235 The difficulty with this questioning is that the initial risk assessments in the context of Ms Wynne's apprehension were made dynamically, without the luxury of time to reflect on the availability of alternative measures.

236 Mr Markham's opinion as to the handcuffing of Ms Wynne in the prone position was summarised in his report as:[194]

> The situational factors and the significant risk of injury to Ms Wynne, the police officers and other road users, should she escape and run back out on to Albany Highway, would support the legitimacy of the officers' actions and their use of reasonable force in the circumstances, aligned to the Powers and Policy phase of the WA Police Force STOM.

237 After careful consideration of all the evidence, and not without some hesitancy, I am prepared to find that it was appropriate for Ms Wynne to be placed in the prone position during the application of the handcuffs. The only reason I am prepared to accept this action was justified was the need to reduce any

[190] Exhibit 1, Volume 3, Tab 8, p.39
[191] ts 15.9.21 (O'Callaghan), p.378
[192] ts 15.9.21 (O'Callaghan), pp.378-379
[193] The VKI communication was that Ms Wynne had possibly been hit by a car: Exhibit 1, Volume 1, Tab 19, Statement of First Class Constable O'Callaghan dated 2 May 2019, p.2
[194] Exhibit 1, Volume 3, Tab 8, Report of Chris Markham dated 12 September 2021, p.39

opportunity for Ms Wynne to re-enter Albany Highway. My hesitation in making this finding is due to the rapid manner in which Ms Wynne was brought to the ground once she was escorted onto the grass verge. This effectively prevented police from even attempting to handcuff her when she was standing. Despite the evidence of the three police officers, I do not accept that the level of resistance from Ms Wynne alone justified the need for her to be placed into the prone position. I have relied on the CCTV footage to make this conclusion, which shows that any resistance from Ms Wynne when she was standing was being adequately controlled by the three police officers.

238 As I have not accepted that Ms Wynne was violently struggling after she was led off Albany Highway, or when she was taken to the ground on the grass verge, I want to make it very clear that the use of the prone position to handcuff her was at the very upper threshold of what I regard to be a reasonable response to reduce the threat of Ms Wynne re-entering the highway.

239 Once a decision is made by police officers to place a person in the prone position, their training requires them to be very careful that the restrained person's life is not put at risk. I will now address that issue.

Was it appropriate for Officer Williams to maintain his leg-hold across the upper back of Ms Wynne after she was handcuffed?

240 After Ms Wynne had been handcuffed, it was noted her right hand was holding what appeared to be a syringe.[195] Officer Williams then put on a pair of protective rubber gloves and used his thumb to dig into Ms Wynne's right wrist, which released her grip on what she had in her hand.[196] It was only then that police noticed it was the cannula that Ms Wynne had earlier removed from her arm after she had got out of the ambulance.

[195] Exhibit 1, Volume 1, Tab 19, Statement of First Class Constable O'Callaghan dated 2 May 2019, p.8
[196] Exhibit 1, Volume 1, Tab 22, Statement of Sergeant Williams dated 11 April 2019, p.7. Officer Williams also issued a verbal command for Ms Wynne to drop the object.

241 Officer Williams' account was that he took the cannula from Ms Wynne and "*threw it aside onto the grass*".[197] At 07:39:02 on the CCTV footage, Officer Williams is positioned on Ms Wynne's right hand side and there is a backward motion of his left hand consistent with placing or dropping something onto the ground. As this is less than half a minute after Officer O'Callaghan has got to his feet after sighting the cannula, I am prepared to find that this is when the cannula had been removed. That conclusion is also consistent with evidence Officer Williams gave at the inquest (as he was viewing the CCTV footage) that he believed the cannula had been removed by or about 07:39:00.[198]

242 I accept that this timeline is not entirely consistent with the accounts of the ambulance officers who say that as they walked towards Ms Wynne and the police, they heard a police officer ask Ms Wynne to release the cannula which she then did.[199] The CCTV footage shows the two ambulance officers walking from their ambulance towards the grass verge at 07:39:12. However, the CCTV footage also shows that the ambulance had stopped on Tate Street at 07:38:55, just a short distance from where Ms Wynne was being restrained. It is therefore possible the two ambulance officers heard and saw the incident involving the release of the cannula before they got out of the ambulance.

243 I find that the police officers' mistaken belief that the cannula was a dangerous object (i.e. a syringe or needle) was a reasonable one. I accept it had to be removed as quickly as possible before Ms Wynne could be lifted up from the prone position in order to avoid a potential injury to police. The question remaining is whether Officer Williams was the appropriate person to remove the cannula, given his leg restraint upon Ms Wynne's upper back at the time.

[197] Exhibit 1, Volume 1, Tab 22, Statement of Sergeant Williams dated 11 April 2019, p.7
[198] ts 16.9.21 (Williams), p.468..
[199] Exhibit 1, Volume 1, Tab 16, Statement of Jessica Bourke dated 12 April 2019, p.12 and Exhibit 1, Volume 1, Tab 17B, Statement of Shannan Griffiths dated 12 April 2019, p.6

244 I accept Officer Williams' evidence that the technique he used in placing his left leg alongside Ms Wynne and with his right leg across her upper back (known as a "ground pin") is consistent with police training when restraining someone who is being handcuffed in the prone position.[200]

245 After agreeing that he was the police officer mainly responsible for controlling the upper half of Ms Wynne's body, I asked Officer Williams the following questions:[201]

> Have you used that technique before on people that you were apprehending? --- Yes, sir, many times.
>
> Right. Have they included females? --- Yes, sir.
>
> And do you take that into account, whether it's a male or a female, as to how much pressure you need to apply? --- Yes, sir.
>
> And, also, obviously their builds? --- Very much so, their build and the strength they're displaying.
>
> Alright. And you also take into account your own build? --- Yes, sir. I'm – I'm well aware that I'm – I'm a big guy.
>
> Yes? --- So when I do apply pressure across someone's back with my lower leg, I always take into account the fact that I'm a heavy guy and I try to reduce that as much as I can. As I said, I had my other foot and knee on – on the ground next to her, and I can balance that – that weight between the two.
>
> And therefore you're certain on this particular occasion you did that as well? --- I – absolutely, I am certain.

246 Office Williams maintained that he was still able to control the amount of weight he had on Ms Wynne as he placed the gloves on and removed the cannula from her hand.[202]

247 In his evidence at the inquest, Officer Williams confirmed that he was aware of positional asphyxia. He correctly stated that "*positional asphyxia occurs when somebody has an increased need for oxygen and their physical position prevents them getting enough oxygen and that can lead to serious injury or*

[200] Exhibit 1, Volume 1, Tab 22, Statement of Sergeant Williams dated 11 April 2019, p.6; Exhibit 1, Volume 3, Tab 8F, WAPF Empty Hand Tactics Manual, p.10; Exhibit 1, Volume 3, Tab 8I, WAPF Handcuff Manual – Version 1.0, p.29
[201] ts 16.9.21 (Williams), p.430
[202] ts 16.9.21 (Williams), p.444

death".[203] Officer Williams was also able to identify the symptoms of positional asphyxia.[204]

248 I later asked Officer Williams the following questions:[205]

> So as I understand your evidence – correct me if I'm wrong – you placed your knee across the shoulder blades, as you are trained to do, to enable the handcuffs to be put on? --- Yes.
>
> So once the handcuffs were put on … is it part of your training to require you to still maintain your knee across her shoulder blades? --- No, but if I hadn't been notified of the thing in her hand, which I thought was a needle or a syringe, I would have got off her straightaway, but because that needed to be removed from her hands, I stayed on top of her until that was removed.
>
> …
>
> So but for that item in her hand, if that hadn't been brought to your attention, you would have got off her shoulder blades as soon as she was handcuffed? --- Absolutely. Yes, absolutely, and she would have been brought up from the prone position much earlier.

249 Officer Williams maintained that he was still required to keep his leg across Ms Wynne's upper back as he removed the cannula, stating "*it's surprising how much people can move around and twist their bodies when they're handcuffed.*"[206]

250 Notwithstanding the above evidence from Officer Williams, I am of the view there were other means by which the cannula could have been removed safely, without Officer Williams keeping his leg across Ms Wynne's upper back. I asked these question of Detective Hill:[207]

> Do you still maintain it was reasonable for Sergeant Williams to continue his restraint hold whilst the cannula was removed from Ms Wynne's hand? --- Yes, sir.
>
> You don't think there were other viable alternatives ways in which he could remove the cannula, bearing in mind Constable O'Callaghan has control of her legs?[208] --- There is [sic] other options.

[203] ts 16.9.21 (Williams), p.425
[204] ts 16.9.21 (Williams), p.426
[205] ts 16.9.21 (Williams), pp.446-447
[206] ts 16.9.21 (Williams), p.446
[207] ts 17.9.21 (Hill), pp.561-562
[208] Although the CCTV footage does not show Officer O'Callaghan having control over Ms Wynne's legs at this stage, there was nothing preventing him (or another police officer present) from placing the hold he had earlier applied on Ms Wynne's legs if it was deemed necessary.

> Well, there are other reasonable and appropriate options, are there not? --- Yes. There would be other options.
>
> For example, taking your weight off Ms Wynne and doing what he did to get the cannula out from her hands. Yes? --- Yes, sir.
>
> Because there's not an awful lot a person can do if their legs are being held to the ground and their hands are handcuffed behind them, is there? --- No.

251 Nevertheless, in accordance with the ***Briginshaw*** principle and being mindful not to insert hindsight bias, I find that it was not inappropriate for Officer Williams to remove the cannula in the manner in which he did. He was the closest police officer to where Ms Wynne's hands were and although he did not remove his right leg from Ms Wynne's upper back, Officer Williams maintained in his evidence at the inquest he was careful not to place undue weight to Ms Wynne's back.[209]

252 However, the question that arises is whether Officer Williams would have known he was placing undue weight upon Ms Wynne if she was not saying anything. Ms O'Connor SC asked this question of Mr Markham, who answered: "*You wouldn't know.*"[210] I accept the accuracy of that candid answer from Mr Markham.

253 The evidence before me was that Ms Wynne said nothing once she was apprehended by Officer O'Callaghan on Albany Highway. I therefore have some unease about this aspect of the matter. Nevertheless, in the absence of cogent evidence contradicting the account given by Officer Williams, I am obliged to accept it. However, as soon as the cannula was removed from Ms Wynne's hand, she should have immediately been brought up from the prone position. The evidence from Officer Williams at the inquest and the CCTV footage demonstrates that this did not happen.

[209] ts 16.9.21 (Williams), p.430
[210] ts 17.9.21 (Markham), p.606

254 As I have already noted, Officer Williams' backward motion with his left hand at 07:39:02 is consistent with him disposing of the cannula.

255 Officer Williams gave evidence that he could not recall if Ms Wynne was still wriggling after the cannula had been removed from her hand.[211] The CCTV footage does not support Ms Wynne wriggling or struggling at this stage. I also note the evidence of Officer Rozier, who stated that when she approached the other three police officers, "[Ms] *Wynne did not appear to be struggling with other officers and I did not hear her say anything*".[212] The CCTV footage shows Officer Rozier attending where Ms Wynne was on the ground at 07:38:35 (27 seconds before Officer Williams disposes the cannula).

256 At the inquest, Ms O'Connor SC had the CCTV footage played as she questioned Officer Williams. He was asked to indicate when it was on the CCTV footage that he removed his right leg from Ms Wynne's back. At 07:40:01, Officer Williams describes what he is doing as follows:[213]

> …so you can see that I'm in a squatting position, so I'm leaning back down on my left leg and my right leg is, the foot is, obviously, on the ground and my right leg is in the air, so that's obviously, me changing position and getting into a – getting ready, into a position to lift her up.

257 There is a gap of almost one minute from the time Officer Williams places or drops the cannula on the ground (at 07:39:02) to when he removes his right leg from Ms Wynne's back (at 07:40:01). There was no evidence as to why it took Officer Williams that length of time to remove his leg.

258 One explanation may be that Ms Wynne was still struggling. Although Officer Williams said in his evidence that Ms Wynne was still wriggling "*until I lifted her up*",[214] that is not borne out by the CCTV footage and it is inconsistent

[211] ts 16.9.21 (Williams), p.433
[212] Exhibit 1, Volume 1, Tab 20, Statement of Constable Rozier dated 19 April 2019, pp.6-7. Officer Rozier confirmed this was correct in her evidence at the inquest: ts 15.9.21 (Rozier), p.392
[213] ts 16.9.21 (Williams), p.471
[214] ts 16.9.21 (Williams), p.445

with his earlier evidence already cited that he could not recall if Ms Wynne was still wriggling when the cannula had been removed. Although one of the ambulance officers observed that "*it appeared* [Ms Wynne] *was trying to fight with Police while she was on the ground*",[215] this was when the ambulance officers were still in their ambulance as it drove along Albany Highway towards where Ms Wynne was on the ground (and before it turned into Tate Street).[216] What is more relevant is the description of what this ambulance officer saw after she had alighted from the ambulance: "*As we started to walk across the verge, I noticed the patient was no longer kicking out*". The CCTV footage registers the time of 07:39:12 when this happened.[217]

259 I find it was unnecessary and not appropriate for Officer Williams to continue to restrain Ms Wynne with his leg across her upper back after the cannula was removed from her hand. Officer Williams is a heavily-built man. At the relevant time, he was about 180 cm tall and weighed 115 kg.[218] Using those measurements, his body mass index (BMI) was 35.5.[219]

260 At the inquest, Officer Williams provided the following answers to questions from Ms O'Connor SC, which clearly demonstrated he was aware from his training of the dangers the prone position and positional asphyxia present:[220]

> In your training, … are you ever told that, once the person is handcuffed, that you must get off their body at that point? --- Yes, we are told that positional asphyxia can occur, so once we've got control and we're in control of the situation we remove ourselves off that person's body.
>
> And is that because you understand from your training that the handcuffing, the fact that a person's arms are drawn behind their back and clasped behind their back, can

[215] Exhibit 1, Volume 1, Tab 16, Statement of Jessica Bourke dated 12 April 2019, p.10
[216] This observation would have been at or about 07:38:25 on the CCTV footage where it can be seen that Ms Wynne does move her legs after she had been placed in the prone position. I would not categorise what can be seen as "trying to fight with Police" as it is described by the ambulance officer or "kicking" as it is described by Mr Markham at Event 14 in Exhibit 3, Timeline of Events as recorded on the CCTV.
[217] Exhibit 3, Timeline of Events as recorded on the CCTV, Event 22
[218] ts 16.9.21 (Williams), p.444
[219] https://www.heartfoundation.org.au/bmi-calculator
[220] ts 16.9.21 (Williams), pp.449-450

> also contribute to the difficulty that someone might have in their breathing? --- If there's weight on their chest or their chest is on the ground at the time.
>
> But aren't you told, in relation to positional asphyxia, even if you don't put weight on the body, that the prone position, of itself can be a dangerous position? --- Yes, that's correct.
>
> Regardless of weight? --- Yes.
>
> So the first thing you're told is the prone position can be a dangerous position and you should avoid it and only use it for the shortest time possible? --- Yes. Correct.
>
> Correct? --- Yes.
>
> Secondly, you're told that, even without weight on someone's back, the prone position can be dangerous in any event? --- Yes.
>
> That's what you're told. Thirdly, you're taught that placing the handcuffs contributes to the inability of [sic - or] the difficultly that someone might have in breathing, so once they're in handcuffs get them up as quickly as possible? --- Get them in a position, yes.
>
> And the last thing you're told then is you're going to increase the risk of positional asphyxia the longer you keep a body weight on top of them? --- Correct.

261 Officer Williams said he thought he had his leg across Ms Wynne's upper back for one to two minutes.[221] My finding that he maintained this restraint from when Ms Wynne was placed in the prone position at 07:38:19 to 07:40:01 falls within that timeframe. Ms Wynne was only brought to a standing position at 07:40:09. Given her symptoms at that stage, it is clear she was already in cardiac arrest. Officer Williams ought to have removed his leg from Ms Wynne's upper back at, or very shortly after, the time he disposed of the cannula at 07:39:02. Therefore, it was only necessary for him to retain his right leg across Ms Wynne's upper back for no more than about 45 seconds. Instead, Officer Williams maintained that position for about another minute.

262 On the evidence before me, there was no reason for Ms Wynne to be kept in the prone position after the cannula had been removed from her hand; let alone in a prone position with Officer Williams continuing to restrain her with his leg across her upper back. I am at a loss to understand why that was done, given the training police receive regarding the dangers that exist to a person who is kept

[221] ts 16.9.21 (Williams), p.444

in that position. Part of that training requires police to do the following when they have handcuffed a person in the prone position and have used the restraint hold that Officer Williams applied: "*Put the subject in the recovery position as soon as possible. Stand the subject up when it is safe and practical to do so.*"[222]

263 Accordingly, I find that Ms Wynne ought to have been lifted up from the prone position immediately after Officer Williams had disposed of the cannula at 07:39:02. Instead, it took another minute before she actually was, and only after Officer Williams had removed his right leg from her upper back. Officer Williams was aware that the risk of positional asphyxia to someone in the prone position meant it is a restraint that should be used for the shortest time possible. He was also aware the risk of positional asphyxia is increased the longer there is a body weight on top of the person.

264 It is impossible to say whether the unjustified delay of about one minute to lift Ms Wynne from the prone position contributed to her cardiac arrest. That is because it cannot be established, with any degree of certainty, precisely when she stopped breathing. Although a lack of movement by Ms Wynne is consistent with her not breathing, applying the ***Briginshaw*** principle prevents me from making a finding in that regard. I also do not have sufficient evidence before me to determine the level of consciousness Ms Wynne may have had when the cannula was removed from her hand.

265 However, what I am able to find is that had proper monitoring been undertaken of Ms Wynne's breathing by police officers, then her cardiac arrest may well have been detected earlier than it was. I have addressed that issue below.

266 Before I do that, there is one final matter I need to raise regarding this part of my findings. A reading of the statements of the four police officers involved in Ms Wynne's apprehension and restraint would lead the reader to conclude that

[222] Exhibit 1, Volume 3, Tab 8I, WAPF Handcuff Manual – Version 1.0, p.31

she was lifted from the prone position as soon as the cannula had been removed from her hand.

267 In his statement, Officer O'Callaghan recounted that after the cannula was removed: "*Constable Rozier was also with us and herself and Sergeant Williams had each of* [Ms] *Wynne's shoulders and went to sit her up.*"[223] He then added that the time from when he grabbed Ms Wynne on the highway to that point, "*I think would have been less than one minute.*"[224] From the digital time on the CCTV footage, it was actually two minutes and 20 seconds.

268 Officer Regan's account in her statement read: "*Sergeant Williams removed the cannula from her and we assisted her in getting to her knees.*"[225] Officer Williams described that after he removed the cannula and noticed that Ms Wynne had blood smeared on the inside of her right arm, "*I took my knee off* [Ms] *Wynne and assisted her in getting up to her knees.*"[226] Similarly, Officer Rozier's statement describes the cannula being removed and then says, "*I assisted Sergeant Williams in getting* [Ms] *Wynne to her feet by holding an arm and shoulder each.*"[227]

269 But for the availability of the CCTV footage, there would have been no evidence before the Court to challenge the inference to be drawn from these versions that there was no delay in removing Ms Wynne from the prone position once the cannula had been removed. I find that very troubling.

270 This is not the first inquest in my relatively short time as a coroner where CCTV footage has been able to clarify what has actually occurred during an incident that is part of a coronial investigation. Police officers should be on notice that if their statements and/or oral evidence at an inquest regarding an

[223] Exhibit 1, Volume 1, Tab 19, Statement of 1st Class Constable O'Callaghan dated 2 May 2019, p.9
[224] Exhibit 1, Volume 1, Tab 19, Statement of 1st Class Constable O'Callaghan dated 2 May 2019, p.9
[225] Exhibit 1, Volume 1, Tab 21, Statement of Constable Regan dated 11 April 2019, p.6
[226] Exhibit 1, Volume 1, Tab 22, Statement of Sergeant Williams dated 11 April 2019, p.6
[227] Exhibit 1, Volume 1, Tab 20, Statement of Constable Rozier dated 19 April 2019, p.7

incident is inconsistent with any footage of the same incident then it may have a significant bearing on the assessment of their credibility – not just with respect to the particular incident, but more generally.

Did police adequately monitor Ms Wynne's breathing when she was in the prone position?

271 A factsheet used by the WAPF for training its officers notes that positional asphyxia is a medical emergency and provides the following guidance:[228]

> Positional Asphyxia and Excited Delirium are well documented causes of death arising from the application of force.
>
> Careful and continuous monitoring and attention is required to support effective respiration. Where practicable, members are to closely monitor the subject's breathing and abandon any restraint at any sign of breathing difficulties or lack of pulse.

272 When handcuffing a person in the prone position, police officers are reminded: "*Remember continually monitor the subject for signs of Positional Asphyxia.*"[229]

273 For the reasons I have outlined below, the monitoring of Ms Wynne's breathing as she was in the prone position for nearly two minutes was not only woefully inadequate but I am satisfied there was no monitoring during this critical period that was effective in ensuring Ms Wynne had no breathing difficulties.

274 There was no evidence from Officer O'Callaghan that he monitored Ms Wynne's breathing. From the CCTV footage that is unsurprising; as once Ms Wynne was in the prone position, he remained at or near her feet.

275 Although Officer Williams agreed that it is important to monitor someone's breathing when they're in the prone position,[230] when asked whether he did so for Ms Wynne, he replied: "*It's hard to do when you're trying to place*

[228] Exhibit 1, Volume 3, Tab 8O, Positional Asphyxia and Excited Delirium – Factsheet for Instructors, p.1
[229] Exhibit 1, Volume 3, Tab 8I, WAPF Handcuff Manual – Version 1.0, p.31
[230] ts 16.9.21 (Williams), p.432

handcuffs on and remove what you think are needles from her hand, so no. I was focused on those things."[231]

276 Officer Regan testified that because Ms Wynne was still "*wriggling around*", she did not think it was necessary to monitor her breathing because she was moving.[232] Officer Regan was then asked:[233]

> You weren't doing anything to restrain her, though, were you? --- No. I had my hand above her in case she did get up or move.
>
> And did you feel that there was a possibility of that? --- Yes, I did. That's why I left my hand there.

277 Officer Regan agreed that of the three officers that were there to start with, she was in the best position to check on Ms Wynne's breathing.[234] Nevertheless, she maintained that as Ms Wynne was wriggling, she needed to keep her hand above Ms Wynne's head until she was lifted up.[235] I do not accept that evidence from Officer Regan. As I have already noted, the CCTV footage does not support the contention that Ms Wynne was wriggling after she was handcuffed, nor does the evidence of Officer Rozier regarding what she saw when she attended (which was just after Ms Wynne had been handcuffed).[236] Officer Regan herself agreed she only observed "*slight movement*" of Ms Wynne's stomach area and top of her arm and did not dispute the suggestion that this movement may have been because of the impact from Officer Williams moving her when he was on top of her.[237]

278 The fallacy of Officer Regan's account that because Ms Wynne was moving there was no need to check her breathing, was exposed by these questions from Ms O'Connor SC:[238]

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[231] ts 16.9.21 (Williams), p.432
[232] ts 16.9.21 (Regan), p.510
[233] ts 16.9.21 (Regan), p.511
[234] ts 16.9.21 (Regan), p.510
[235] ts 16.9.21 (Regan), p.512
[236] Exhibit 3, Timeline of Events as recorded on the CCTV, Events 16 and 17
[237] ts 16.9.21 (Regan), p.522
[238] ts 16.9.21 (Regan), p.519

> You see, checking for someone's struggle due to a positional asphyxia, you don't wait until they've stopped breathing, do you? That's too late? --- Yes.
>
> So if you were waiting for her to stop moving, that would have been the wrong thing to do if you were checking someone, wouldn't it? --- Yes.
>
> So what you're supposed to do when you're checking someone in the prone position is make sure that breathing isn't a struggle for them, is it not? --- Yes.
>
> It's not that you wait for them to be completely still so that you have to resuscitate them, is it? --- No.
>
> So the fact that you tell the court "well, she was still moving" doesn't mean that she might have not been struggling,[239] does it? --- No, it doesn't.

279 As Officer Williams was the senior officer present, I asked him these questions at the inquest:[240]

> You've said that it is important … for Ms Wynne's breathing to be monitored given the position that she was in? --- Yes.
>
> You didn't delegate that task to anyone? --- I did not, no.
>
> Was it possible for one of the police officers in attendance to be able to do that? --- Potentially, once we had control of her.
>
> Yes, yes? --- Yes. Yes, potentially.
>
> So once she was handcuffed, yes? --- Yes.
>
> Constable Regan might have been available to do that? --- Potentially, sir, yes.
>
> Or indeed you? --- I was busy with the cannula in the hand.
>
> So did you give a direction to Constable Regan? --- I did not.

280 As Officer Rozier had attended by 07:38:35, she would have also been in a position to monitor Ms Wynne's breathing at any time during the intervening 90 seconds before Ms Wynne was lifted from the prone position. However, it is evident from the CCTV footage that she did not.

281 It was very concerning to hear from the police witnesses describing their failure to properly monitor Ms Wynne's breathing. This is something that is covered in police training, and there is no evidence before me that any of these police

[239] It should be noted that Ms O'Connor SC's use of the word "struggling" is in the context of struggling to breathe in the same way the word was used in her third question cited in this transcript passge.
[240] ts 16.9.21 (Williams), p.433

officers were not aware of its importance. Mr Markham was questioned by Ms O'Connor SC regarding this matter: [241]

> Because … another concern that you must have is the failure of the police to monitor her breathing when she was in the prone position? --- That's a concern that I have.
>
> You must have a concern. You provide the training and then one of the very vital parts of training is to make sure that, if you happen to use restraint, to make sure that a person isn't suffering as a result of the restraint unnecessarily and monitoring, in your manual, is an important aspect? --- It is.
>
> And having sat in court, you must be concerned about the failure to have monitored her, surely? --- I – I think some of the issues would be more around how the officers articulate what they were doing to monitor. I think they've made assumptions in terms of she's wriggling, therefore, she – she must be breathing. No one has actually said that they were monitoring her airways or her – her chest rising and falling, and – and can actually say specifically, 'I was – I was monitoring Ms Wynne's breathing'.

I then asked Mr Markham:[242]

> And police officers aren't trained to make those assumptions that it appears these police officers made, are they? --- Yes, it's – it's a question of whether they've – they've made that assumption or they just haven't – they just haven't articulated that that's what they were doing at that time.

282 Mr Markham agreed that by the time Officer Rozier was in attendance, police training required that one of the four police officers should have been checking Ms Wynne's airway.[243]

283 I find it highly unlikely Ms Wynne coincidentally went into cardiac arrest and a state of unconsciousness at the very moment she was lifted from the prone position. If that is correct, then proper monitoring of Ms Wynne's breathing when she was in the prone position ought to have raised the alarm she was having difficulty breathing or, at the very least had stopped breathing, before it was actually discovered.

284 Although Officer Williams was the senior officer present, each of the police officers (including Officer Rozier once she had attended) had an obligation to

[241] ts 17.9.21 (Markham), pp.613-614
[242] ts 17.9.21 (Markham), p.614
[243] ts 17.9.21 (Markham), p.615

ensure at least one police officer was checking that Ms Wynne was not having difficulty breathing. That is what they are trained to do and it is deeply troubling that no officer undertook that task or requested another officer to do it when Ms Wynne was in the prone position.

285 Another concerning aspect to this matter is that Ms Wynne had no way of trying to get herself out of the prone position as Officer Williams had his leg restraint across her upper back the entire time. Any movement that Ms Wynne may have achieved before she became unconscious was most likely due to her inability to breathe, rather than an attempt to resist or escape.

286 I cannot say with any certainty that Ms Wynne's life would have been saved if it had been detected earlier that her breathing had stopped and she had then been lifted from the prone position. Although it is well known the grave consequences of oxygen deprivation to the brain are measured in minutes,[244] there is no way of knowing whether an earlier commencement of CPR would have prevented the non-survivable hypoxic brain injury that Ms Wynne sustained.

287 The apprehension and restraint of Ms Wynne at Albany Highway, including her handcuffing, was the third and final issue investigated by the IAU. The outcome of that part of the investigation was: [245]

> The handcuffing of [Ms] Wynne at this point was a reasonable action by police and justified by law and policy in reducing the threat of bodily injury [Ms] Wynne posed to herself and others with her actions of running into oncoming traffic and prior self-harming.
>
> CCTV shows that from [Ms] Wynne being placed on the ground and being handcuffed by police to SJA officers' involvement was one minute and 26 seconds. Three officers were involved in the restraint and handcuffing of [Ms] Wynne which was done in line with policy and procedures.

[244] "*What Happens After a Lack of Oxygen to the Brain*" Spinal Cord Injury Journal, 13 June 2016, pp.2-3
[245] Exhibit 1, Volume 1, Tab 30, IAU Report by Detective Senior Constable Hill dated 29 June 2020, p.39

288 It is evident from my above findings that I do not agree with the entirety of these broad-brush statements. It was unfortunate the IAU did not investigate the individual aspects of the apprehension and restraint of Ms Wynne in the manner that I have done. If it had, it may not have made the generalised conclusion that it did.

289 Another aspect of the IAU investigation that concerned me was its apparent failing to carefully scrutinise the CCTV footage. Although the above timeframe of one minute and 26 seconds is broadly accurate, it is evident from the IAU Report that more critical timeframes were overlooked. These included the one minute and 42 seconds Officer Williams had his leg restraint on Ms Wynne's back and the one minute it took police to lift Ms Wynne from the prone position after the cannula had been removed. Neither of these timeframes were referred to in the IAU Report and were not investigated as individual issues.

290 When a potential risk of the prone position includes something as serious as positional asphyxia, it is disturbing that a closer analysis was not made by the IAU investigation of the CCTV footage regarding the actions of police during the time Ms Wynne was in the prone position. This included the failure of any police officer to adequately monitor Ms Wynne's breathing when she was in that position. How it could be said that the restraint and handcuffing of Ms Wynne "*was done in line with policy and procedures*" when no officer had effectively monitored her breathing is, quite frankly, incomprehensible.

COMMENTS ON THE ACTIONS OF POLICE WHO RESTRAINED MS WYNNE AT ALBANY HIGHWAY

The Briginshaw principle and hindsight bias

291 The ***Briginshaw*** principle is neatly summarised in the following passage: [246]

[246] ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 362 (Dixon J)

> The serious of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.

292 In addition to the application of the ***Briginshaw*** principle when making findings adverse in nature, I must also be mindful not to insert hindsight bias into my assessment of the actions taken by police in their apprehension and restraint of Ms Wynne at Albany Highway. Hindsight bias is the tendency, after the events, to assume the events are more predictable or foreseeable than they were at the time.[247] The need to adhere to that principle is particularly relevant when police officers are required to undertake and act upon the risk assessments they make in dynamic situations that are often adrenalised environments.

Did the actions of Police cause or contribute to Ms Wynne's death?

293 The inquest into Ms Wynne's death was mandatory because of the operation of section 22(1)(b) of the *Coroner Act 1996* (WA), which provides:

> (1) A coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australia death and –
> …
> (b) it appears that the death was caused, or contributed to, by any action of a member of the Police Force.

294 As I have already noted, section 22(1)(b) applies whenever the issue of causation or contribution in relation to a death arises as a question of fact, regardless of whether or not there was fault or error on the part of any police officer. In the coronial context, issues of causation and contribution are determined as a matter of common-sense.[248] It has also been noted that "*superior courts will intervene to overturn an inquest finding of causation or contribution to causation in relation to matters that are adjudged too*

[247] Dillon, H and Hadley, M, *The Australasian Coroner's Manual* (2015), 10
[248] ***Chief Commissioner of Police v Hallenstein*** [1996] 2 VR 1, 18 (Hedigan J); see also Freckleton I, "Causation in Coronial Law" (1997) Journal of Law and Medicine Vol 4 289

remote".[249] Accordingly, I have approached the issue of contribution on the basis that the evidence before me needs to establish that any action by a police officer must have made a material contribution to Ms Wynne's death in order for it to be said to have contributed to her death.

295 In this case, a number of events led to Ms Wynne's death. The evidence established that Ms Wynne had a cardiac arrest due to a combination of factors; namely her methylamphetamine intoxication (which may have also caused her to experience excited delirium), her physical exertions before her apprehension and her restraint in the prone position. There is also a real possibility that Ms Wynne experienced positional asphyxia when she was restrained in the prone position. However, given the forensic pathologists' opinion that "[*i*]*t is very difficult to definitively either include or exclude positional asphyxia as having played a role in the death*",[250] I have not been able to find, to the required standard, that positional asphyxia was one of the factors that led to Ms Wynne's death.

296 Although the placement of Ms Wynne in the prone position was a contributing factor in her death, I have found that the decision by the police officers to place Ms Wynne in the prone position to apply the handcuffs was appropriate in order to reduce the very real risk of her re-entering Albany Highway.

297 Nevertheless, I have found that Officer Williams did err in maintaining his leg hold on the upper back of Ms Wynne for longer than was necessary and that this caused a delay for her to be lifted from the prone position. Furthermore, I have also found that four police officers[251] erred in failing to ensure the breathing of Ms Wynne was properly monitored when she was in the prone position.

[249] Freckleton I, "Causation in Coronial Law" (1997) Journal of Law and Medicine Vol 4 289 at 298
[250] Email correspondence from Dr Moss and Dr Ong to Counsel Assisting dated 9 September 2021
[251] Officers Williams, Regan, O'Callaghan and Rozier

298 After carefully considering the meaning of the words used in section 22(1)(b) of the *Coroners Act 1994* (WA), and applying the ***Briginshaw*** principle, I am not able to conclude, to the required standard, that the delay by Officer Williams in removing his leg from Ms Wynne's upper back after he had disposed of the cannula had materially contributed to her death. Nor can I be satisfied that the failure by the police officers to monitor Ms Wynne's breathing when she was in the prone position was a factor that materially contributed to her death. This is because it cannot be ascertained, to the standard I am required to apply, whether an earlier discovery of Ms Wynne's lack of breathing would have prevented her death.

IMPROVEMENTS SINCE MS WYNNE'S DEATH

At Joondalup Health Campus

299 Since Ms Wynne's death, a number of improvements have been introduced at JHC. These have included the following.

300 Form 3A – Detention Orders are now implemented more frequently. This is done to avoid the problem that existed when Ms Wynne absconded under a Form 1A – Referral for Examination by Psychiatrist and she therefore could not be the subject of a Form 7D – Apprehension and Return Order.[252]

301 In an environment where mental health beds are often scarce, resulting in delays for a person to be taken to an authorised hospital, it is vital that all available avenues are open to apprehend that person should they abscond before they can be taken to an authorised hospital. It becomes imperative if the person is at risk of self-harming, as Ms Wynne was.

302 Another change implemented following Ms Wynne's death is that all one-to-one monitoring of patients can only be revoked by a doctor. Previously, as was the case with Ms Wynne, a revocation could be authorised by a nurse without

[252] ts 13.9.21 (Dr Chapman), p.72

first consulting a doctor.[253] If this policy existed at the time of Ms Wynne's absconding, it is likely the one-to-one monitoring would still have been in place, which would have made it more difficult for Ms Wynne to place herself near the exit doors unnoticed.

303 Another change has been reducing the opportunity for a patient to abscond from the MHOA (even if they are not being monitored one-to-one). This has been done by installing mirrors at the end of the nursing station. This has eradicated blind spots and allows for better visibility from the nursing station of those persons exiting the MHOA.[254]

304 Another encouraging development at JHC has been improvements to the Aboriginal Liaison Officer (ALO) service. Previously, the ALO service had been outsourced, which had caused delays. Unfortunately such a delay had occurred with Ms Wynne. Dr Paparo had requested an ALO review for Ms Wynne at 2.00 pm on 25 March 2019 (which was a Monday).[255] Ms Wynne absconded at 1.15 pm the next day, without being seen by an ALO.[256]

305 The ALO service is now an internal service within JHC that is available six days a week from Monday to Saturday.[257] This means a request for an ALO would be responded to during the same shift; or if made during an evening shift, the following morning.[258] Even if a request was made on a Saturday evening, efforts would be made for an ALO to attend on the Sunday.[259]

306 I commend JHC for making these changes. As Dr Chapman said in his evidence at the inquest: "*We have learned so much from looking at this one.*"[260]

[253] ts 13.9.21 (Dr Chapman), pp.78-79
[254] Exhibit 1, Volume 1, Tab 34A, Report by Dr Chapman dated 16 February 2021, p.14
[255] Exhibit 1, Volume 1, Tab 33, JHC Medical Records
[256] ts 13.9.21 (Dr Chapman), p.106
[257] ts 13.9.21 (Dr Chapman), pp.106-107
[258] ts 13.9.21 (Dr Chapman), p.107
[259] ts 13.9.21 (Dr Chapman), p.107
[260] ts 13.9.21 (Dr Chapman), p.107

At the WAPF

307 An issue that arose at the inquest was the lack of information available to frontline officers with respect to people they encounter in their daily duties. This was best illustrated by the limited information Officer Yakacikli had for Ms Wynne when he checked the TADIS system in his police vehicle on 4 April 2019.

308 Since Ms Wynne's death, the TADIS system has been decommissioned and replaced by the OneForce Core mobile phone application. This is a more sophisticated system which provides better access to information for frontline police officers.[261] It enables police officers to obtain more relevant information than they previously had access to with the TADIS system. As Detective Hill testified: "*Every single officer now has the mobile phone that has got all these – you can access every CAD job. You can access the IMS full details so you can jump between those things*".[262] Detective Hill later explained that Officer Yakacikli was only able to access the one CAD job entry from TADIS regarding the mental health welfare check.[263] He was then asked:[264]

> And if an officer in that position today wanted to – or was performing a name check is it still the case that that limited information is available or not? --- No. It is not. You would then have access to any of these CAD job numbers that are written on there, the – the IR number, so that would then greatly enhance the details that you would have of Ms Wynne. It would give you access to her IMS profile and you could go into the links there to see recent – recent involvement and you would have had dropped down boxes with "Absconding from the mental health facility" and it was – there was a lookout to be kept for her. So you – you would have a – a whole myriad now of access available to you.

309 There is no doubt that if police officers at the unit had more information regarding Ms Wynne, there would have been a higher likelihood of her being detained under section 156(1) of the Act and taken to a hospital for a psychiatric

[261] Letter from Mr Harwood to Counsel Assisting dated 14 October 2021
[262] ts 17.9.21 (Hill), p.552
[263] This CAD job entry is the first one at Exhibit 1, Volume 3, Tab 7, Statement of Sergeant Barnes dated 10 September 2021, p.28
[264] ts 17.9.21 (Hill), p.593

assessment. Accessing IMS details would have enabled the officers to view hospital records from only nine days earlier stating that Ms Wynne's risk of harm to herself and others was "*high*", and that she was "*floridly psychotic*".[265]

310 The WAPF 2021 Annual Report noted that for the year 2020/2021, 1,065,751 pieces of evidence were uploaded by police officers from their mobile phones using the OneForce Core mobile phone application.[266] This figure clearly indicates that frontline officers are embracing this improvement in technology. The application also allows for members of the public to submit footage and 146,980 pieces of evidence were uploaded by the public during the year 2020/2021.[267]

311 Another improvement that the WAPF is continuing to develop since April 2019 is the Mental Health Co-Response model (MHCR). The MHCR is a partnership between the WAPF, the Western Australian Mental Health Commission and the Department of Health. It was implemented in late 2018, following a two year trial period from January 2016 to January 2018. A number of inquests have already identified the MHCR as being a vital mechanism utilised by the WAPF when dealing with people afflicted with, not just a drug-induced mental illness, but mental illness generally.

312 Although the MHCR was operating at the time of Ms Wynne's death, due to its hours of operation, none of its components were available for police officers undertaking a mental health welfare check at the unit to utilise.

[265] Exhibit 1, Volume 1, Tab 33, JHC Medical Records, Mental Health Missing Person Report dated 26 March 2019, 1:30 pm
[266] www.wa.gov.au/sysyem/files/2021-09/WA-Police-Annual-Report-2021.pdf, p.54
[267] www.wa.gov.au/sysyem/files/2021-09/WA-Police-Annual-Report-2021.pdf, p.54

313 A number of recent inquests have already made recommendations regarding the expansion of the MHCR, including its operating hours.[268] I sincerely hope that these recommendations can be implemented as soon as possible.

314 Finally, I have already raised my concerns regarding the IAU investigation in this matter, which found that "*the actions of involved officers were reasonable with no unprofessional conduct or breaches of WA Police Force regulations, policy or procedures identified*."[269]

315 The IAU investigation would have been more thorough had it not only analysed the CCTV footage more carefully, but then used the information gleaned from such an analysis to question the relevant subject officers in compulsory interviews. No such interviews took place in this investigation. One obvious matter that could not be adequately investigated from simply reading the statements of the police officers involved was the monitoring of Ms Wynne's breathing when she was in the prone position.

316 This matter arose in an earlier inquest before me in 2021 when no compulsory interviews of the subject officers took place. It became the subject matter of a recommendation in that inquest.[270] The IAU are already very aware of my strong views regarding the implementation of this recommendation and it is therefore unnecessary for me to repeat it in these findings.

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[268] For example: Inquest into the death of ***Andrew John Key*** [2020] WACOR 36 delivered 4 November 2020, Inquest into the death of ***Chad Riley*** [2021] 24 delivered on 30 July 2021 and Inquest into the death of ***Scott William Martin*** [2021] WACOR 23 delivered 10 August 2021

[269] Exhibit 1, Volume 1, Tab 30, Letter from Detective Superintendent Coombes - IAU to the Principal Registrar of the Coroners Court dated 31 July 2020.

[270] Inquest into the death of ***Child JP*** [2021] WACOR 42 delivered 21 December 2021. The recommendation was:

> That for IAU investigations involving a fatality that may be the subject of a mandatory inquest under section 22(1)(b) of the *Coroners Act 1996* (WA), all subject officers are to be compulsorily interviewed (whether or not they have already provided statements to another section of the WA Police Force), unless there are exceptional reasons not to do so.

RECOMMENDATIONS

317 As I have already outlined, there have been a number of significant improvements made by the JHC and the WAPF since Ms Wynne's death which are relevant to the matters that her death had raised. Those improvements have either directly arisen from Ms Wynne's death or, as would be expected of all agencies providing services to the community, have arisen because of their pathway of continual improvement. I have also noted other areas relevant to Ms Wynne's death where further improvements can be made. These have already been the subject matter of recommendations made in recent inquests and there is no need for them to be repeated.

318 I have a limited scope to make recommendations. They must be connected to the death I am investigating.[271] Ms O'Connor SC, on behalf of Ms Wynne's family, made closing submissions at the inquest (which were supplemented by written submissions after the inquest) asking that I make some broad and wide-ranging recommendations, which only had very general and/or tenuous connections to Ms Wynne's death. I have therefore declined to make any of the recommendations sought by Ms O'Connor SC. In doing so, I must stress to the family of Ms Wynne that is not because I disagreed with what their counsel was submitting, but because this inquest was not the appropriate forum for making the recommendations that were sought.

319 One recommendation that I proposed to make regarded the length of time Ms Wynne was unnecessarily held in the prone position by police. This period related to the time from when the cannula had been removed to when she was lifted up. It lasted for about one minute, during which Officer Williams maintained his leg hold across Ms Wynne's upper back. I was also concerned by the lack of monitoring of Ms Wynne's breathing and, more generally, the use of the leg hold across the upper back to restrain a person in the prone position as

[271] Section 25(2) of the *Coroners Act 1996* (WA)

it can cause a further constriction to the person's airways and increase the risk of positional asphyxia.

Comments relating to the recommendation

320 It is my practice to forward a draft of any recommendations I intend making to interested persons appearing at an inquest and invite comment.

321 On 21 March 2022, the Court forwarded a draft of the above recommendation to lawyers for the WAPF and for Ms Wynne's family.[272] A lawyer for the WAPF responded by email dated 28 March 2022 (the email).[273]

322 The email submitted that the WAPF "*believes the current training in relation to restraint has a significant focus on the dangers of positional asphyxia, particularly when a person is placed in the prone position and weight applied to them*". It was therefore felt that the proposed recommendation was not required.

323 My attention was drawn to the training material which identified one of the risk factors for positional asphyxia which read: "*The subject is restrained with the combined weight of multiple members (especially in a prone position which inhibits their breathing).*"[274]

324 The email concluded:

> WAPF share Coroner Urquhart's concerns about the dangers posed to an individual if they are placed in the prone position, particularly when pressure is applied to keep them there while handcuffs are applied, but they respectfully submit that training already in place makes it clear to officers that such restraint should only be used as a last resort and, thereby, in exceptional circumstances.

325 The four officers involved in the apprehension and/or restraint of Ms Wynne had various levels of experience (two constables, a 1st class constable and a sergeant). None was a newly graduated probationary constable, and they all

[272] Email from Ms MacDonald dated 21 March 2022. As a matter of courtesy, Mr Bourhill, counsel for JHC, was forwarded a copy of that email on 22 March 2022.
[273] Email from Ms Hartley to Ms MacDonald dated 28 March 2022
[274] Exhibit 1, Volume 3, Tab 8O, Positional Asphyxia and Excited Delirium – Factsheet for Instructors, p.1

would have been involved in a number of annual in-service Critical Skills Training and Requalification programs before 4 April 2019.

326 Nevertheless, I have found that not one of them ensured that Ms Wynne's breathing was being effectively monitored when she was restrained in the prone position. This meant no alarm could be raised should there be a detrimental change to her breathing. It can also be reasonably inferred that given the delay by Officer Williams in removing his leg hold after he had disposed of the cannula, insufficient attention was given by the officers present to the dangers of maintaining an additional weight across Ms Wynne's shoulder blades.

327 I have carefully read the relevant attachments to Mr Markham's report that cover the training with respect to the application of handcuffs and the use of the prone position. I accept that this material refers to the dangers of positional asphyxia (and excited delirium) for a subject person in the prone position and also the need for officers to monitor that person's breathing. However, the evidence before me suggests the training in this area needs to be further emphasised. That is why I have expressed in my recommendation that the training needs "reinforcing" in these areas.

328 I remain concerned that the risk factor of positional asphyxia cited above refers to "*the combined weight of multiple members*". There is a prospect that this might lull an officer into a false sense of security that the weight of only one body does not pose a significant risk factor. It is my view that training should make it clear that the use of even a single officer applying weight across the chest, back or stomach of a subject person in the prone position should only be used in "*exceptional circumstances*". No such warning appears in any of the material attached to Mr Markham's report.

329 As cited above, the email notes the training already in place makes it clear that the prone position (particularly when pressure is applied) should only be used as

a "*last resort*". I am not convinced that the officers involved in this inquest approached the restraint of Ms Wynne at Albany Highway in that manner. Notwithstanding Officer Williams' long service in the WAPF, it was concerning to hear him say that he had applied the leg hold he used on Ms Wynne "*many times*"[275] on males and females. That would suggest it is a hold he has used when exceptional circumstances may not have always existed.

330 I am therefore of the view that the following recommendation is appropriate:

Recommendation

The WAPF should ensure that training in relation to the use of the prone position as a restraint reinforces (i) the increased risk of a potentially fatal health event to the subject person in the prone position and (ii) the need for officers to effectively monitor their breathing.

Further, such training should emphasise that any physical restraint by pressing down on the chest, back or stomach of the subject person in the prone position should only be used in exceptional circumstances.

RELEASE OF THE CCTV FOOTAGE

331 At the end of the first day of the inquest, Ms O'Connor SC stated that should an application be made by any media organisation for access to the CCTV footage, she had been instructed by Ms Wynne's family that they would oppose the CCTV footage being released.[276] In those circumstances, I stated at the time:[277]

> Well, if that's the family's view, that's the end of the matter. Because in a situation such as that, the family's view is always sought by the court, and if the family are of the view that they do not want that footage released to the media, there would have to be extenuating circumstances for me to override the wishes of the family.

332 On day four of the inquest, Ms O'Connor SC advised me that after the family saw the CCTV footage played in court and heard the evidence that arose from

[275] ts 16.9.21 (Williams), p.430
[276] ts 13.9.21 (Ms O'Connor SC), p.133
[277] ts 13.9.21, p.133

that playing, they would not oppose any application by a media organisation for a copy of the CCTV footage.[278]

333 On 16 September 2021, the Court received applications by email from journalists at SBS and Fairfax Media requesting access to the CCTV footage.

334 On 17 September 2021, I determined that it would not be in the public interest for media organisations to have access to the CCTV footage at that point in time.[279]

335 On 17 and 18 March 2022, the Court invited lawyers for the family and the WAPF to provide written submissions as to whether the CCTV footage should be available for access by media organisations once my findings had become publicly available.[280] I subsequently received comprehensive and helpful written submissions from both parties on 24 March 2022.

336 The relevant provision regarding the release of evidence at an inquest is section 49(1)(b) of the *Coroners Act 1996* (WA) which provides:

> (1) A coroner must order that no report of an inquest or of any part of the proceedings or of any evidence given at an inquest be published if the coroner reasonably believes that it would –
> …
> (b) be contrary to the public interest.

337 The family of Ms Wynne strongly supports the release of the CCTV footage and argue that it is in the public interest for it to be released. The family submitted that "*[t]he public release of the footage would aid transparency and public confidence, while failing to release the footage could lead to assumptions*

[278] ts 16.9.21 (Ms O'Connor SC), pp.410-411
[279] ts 17.9.21, pp.533-534
[280] As a matter of courtesy, Mr Bourhill, counsel for JHC, was forwarded copies of those emails on 22 March 2022.

about why the evidence is not being brought to light in the public domain and concerns about accountability."[281]

338 It is clear to me the family of Ms Wynne have carefully considered whether they would support the release of footage that shows the last several distressing minutes their loved one was conscious. I have paid particular attention to this submission: "*After viewing the footage multiple times and considering their position, the family want the public to view what happened to Ms Wynne, as the tragic and confronting circumstances in the lead up to her death is the reality for the family*."[282]

339 The WAPF opposed the release of the CCTV footage, primarily on the basis of its "*limited use*", given the distance between the camera and the incident regarding the restraint. It was also noted that objects in the foreground partially obstructed the incident.[283] It was submitted that instead of aiding anyone in the understanding of my findings, the "*release of the CCTV footage will cause confusion*."[284]

340 It was contended by the WAPF that I should not release the CCTV footage pursuant to section 49(1)(b) of the *Coroners Act 1996* (WA) as it would be contrary to the public interest.

341 Having carefully considered these submissions from the parties and the authorities that are cited in the submissions on behalf of the WAPF, I have determined that it is in the public interest for media organisations to access a portion of the CCTV footage. This release is necessary in the public interest as some of my findings have relied upon what can be depicted in the CCTV

[281] Submissions on behalf of Ms Wynne's family in relation to the release of CCTV footage dated 24 March 2022, p.2
[282] Submissions on behalf of Ms Wynne's family in relation to the release of CCTV footage dated 24 March 2022, p.3
[283] Submissions on behalf of the WAPF in relation to the release of CCTV footage dated 24 March 2022, p.2
[284] Submissions on behalf of the WAPF in relation to the release of CCTV footage dated 24 March 2022, p.2

footage, and I have frequently cited the relevant reading on the digital time displayed in the top left-hand corner when describing what took place. The access will also assist with the fair and accurate reporting of the inquest's proceedings and my findings, notwithstanding the distance between the camera and the incident involving the restraint of Ms Wynne. I also note that the vision of other incidents relevant to the inquest and my findings, such as Officer Williams' manner of driving and Officer O'Callaghan's apprehension of Ms Wynne on Albany Highway, is considerably clearer.

342 I will order access to a redacted segment of the CCTV footage from the car yard at Lot 2/1110 Albany Highway that is contained in Exhibit 1, Volume 1, Tab 36. That segment is from 07:37:30 to 07:41:00 on the digital time displayed. This portion shows Ms Wynne running along Albany Highway and being apprehended by Officer O'Callaghan before she is led off the highway. It also shows Officer Williams' manner of driving as he drove past Ms Wynne. It then depicts the restraint of Ms Wynne on the grass verge adjacent to the highway, and ends shortly before resuscitation begins. It therefore includes all the CCTV footage that I have referred to in these findings and that was played at the inquest. It should be noted that the quality of the vision from the source footage was significantly reduced when it begins pixelating and freezing from 07:38:25 to 07:38:34.

343 The submissions from the WAPF also noted the two ambulance officers who treated Ms Wynne appear in the CCTV footage and that St John Ambulance (SJA) have not made submissions in relation to the footage that depicts its officers. I have considered that and have reached the view that as it is not possible to identify the individual ambulance officers and because no criticism has been made of their actions, it is not necessary to hear from SJA or pixelate the images of the ambulance officers.

344 I have determined it is appropriate to release the portion of the CCTV footage I have identified for use in a fair and accurate reporting of the inquest and my findings. Requests from accredited media organisation representatives[285] for access to the CCTV footage must be made to the Court within 14 days of my findings being made publicly available on the Coroners Court's website.

CONCLUSION

345 Ms Wynne was a troubled young woman in the period before 4 April 2019. Her two sons had not lived with her since November 2016 and although she was still looking after her daughter who was born in May 2017, her paranoia (that was most likely methylamphetamine-induced) had led her to believe her daughter could only be kept alive if she remained close to Ms Wynne.

346 I cannot imagine the distress Ms Wynne would have suffered (which would have only been exacerbated by her paranoia) when the Department of Communities made the decision to place her daughter into the provisional protection and care of its CEO on 26 March 2019.[286] On that same date, Ms Wynne absconded from JHC before she could be examined by a psychiatrist at SCGH. She then began living with her mother at a small unit in East Victoria Park. Given Ms Wynne's drug dependency and her anxiety regarding her daughter, I expect this would not have been an easy time for her mother.

347 The lack of an available mental health bed at SCGH delayed Ms Wynne's admission to that hospital. Unfortunately, this case is another example of a person in urgent need of psychiatric treatment not being able to receive it in a timely manner. The allocation of resources is obviously a matter for government. Nevertheless, I fear that unless the shortcomings arising from the

[285] See "Guidelines for the Media – Reporting in Western Australian Courts" at p.16: supremecourt.wa.gov.au/_files/Guidelines%20for%20the%20Media.pdf
[286] Given Ms Wynne's psychotic behaviour, this action by the Department would appear to have been justified.

lack of mental health beds, as identified by Dr Chapman at the inquest,[287] are addressed, the missed opportunities that existed in the treatment of Ms Wynne will be repeated.

348 An invalid Form 7D – Apprehension and Return Order meant that this option was not available for police to locate Ms Wynne and return her to hospital after she had absconded.

349 At about 5.45 am on 4 April 2019, a patrolling police vehicle in East Victoria Park saw Ms Wynne walking by herself. She ran before police could speak to her. An alert was issued over police radio communications and Ms Wynne was located by police at her mother's unit a short time later.

350 After behaving erratically and being verbally abusive towards her mother and police, Ms Wynne was handcuffed. I have found that she was restrained in handcuffs at the unit longer than was necessary.

351 Despite at least one attending officer being aware that police were to undertake a mental health welfare check on Ms Wynne, I have found that the welfare check was inadequate.

352 After accepting her explanation that she had run away earlier because she was scared and nervous, police left Ms Wynne with her mother.

353 At about 6.45 am, Ms Wynne was observed by members of the public repeatedly striking herself to the neck with a stick as she walked along a footpath in East Victoria Park. Emergency services were called and an ambulance and police attended. As she was being treated inside the parked ambulance, Ms Wynne was able to get out and run away.

[287] ts 13.9.21 (Dr Chapman), p.93

354 At about 7.35 am, police located Ms Wynne running along the lanes of Albany Highway in Bentley. Police apprehended Ms Wynne and took her to a grass verge where she was placed in the prone position and handcuffed behind her back. After one minute and 50 seconds in that position, she was lifted up by police. It was then noted she had stopped breathing and she was unhandcuffed before police and ambulance officers commenced CPR.

355 I have found that (i) a police officer erred in maintaining his leg hold across Ms Wynne's upper back for longer than was necessary, (ii) this resulted in police keeping Ms Wynne in the prone position for an unnecessary length of time and (iii) police erred in failing to adequately monitor Ms Wynne's breathing when she was kept in the prone position.

356 A pulse for Ms Wynne was eventually returned following about 12 - 14 minutes of CPR, and she was taken by ambulance to RPH. However, Ms Wynne had sustained a severe hypoxic brain injury that was non-survivable. After discussions with her family, active medical care was withdrawn for Ms Wynne and she was treated palliatively until she died on 9 April 2019. Ms Wynne had never regained consciousness.

357 I have found that one of several factors contributing to Ms Wynne's death was her restraint in the prone position by police. However, I have not been able to find whether the delay in lifting Ms Wynne up from the prone position specifically contributed to her death. Nor am I able to say whether the delay in removing the leg hold by one of the police officers from across Ms Wynne's upper back or the failure by police to adequately monitor her breathing had specifically contributed to her death.

358 In the three years since Ms Wynne's death, JHC have made a number of improvements and changes to its operations which should reduce the opportunities for a patient to escape in the manner that Ms Wynne did. It has

also extended its Aboriginal Liaison Officer service that should now ensure a patient in Ms Wynne's position would be seen by an ALO shortly after the request is made. I commend JHC for making these improvements.

359 Similarly, the WAPF has significantly improved the ability of its frontline officers to access its database by replacing its TADIS system. Relevant to this inquest, police officers now have far more information available to them when undertaking a mental health welfare check upon a person.

360 The Mental Health Co-Response model used by the WAPF, which was still in its infancy in April 2019, is a highly commendable service and I sincerely hope its operation extends to an around-the-clock service.

361 It was very troubling to view the CCTV footage of Ms Wynne placing herself in considerable danger by running along a busy Albany Highway. She was clearly a young woman in desperate need of psychiatric treatment and support. It was then even more troubling to view the length of time she was held in the prone position by police without her breathing being adequately monitored – something police officers are trained to do. I have made a recommendation to the WAPF that reinforces the training already in place regarding the dangers of restraining a person in the prone position and the need for their breathing to be constantly monitored. My recommendation also states WAPF training should stress that the physical restraint by pressing down on the chest, back or stomach of a person in the prone position should only be used in exceptional circumstances.

362 With the prevalence of CCTV footage, the introduction of body-worn cameras for frontline police officers and the fact that almost every member of the community has a video camera on their mobile phone, police actions can now be more thoroughly scrutinised than ever before. It does not reflect well on the

WAPF when a counsel acting for an Indigenous family at an inquest is able to make the following submission that is backed up by CCTV footage:[288]

> But if we're dealing with someone who wasn't arrested for a crime, everybody says at that verge she was being detained under the Mental Health Act. Now, what are you meant to be doing? You're meant to be holding someone who's at risk to themselves or others, to stop them being at risk, to get them help and treatment and what we see is the way someone who was wanted for a crime might be treated.
>
> Now, we may say, well, that's a mistake and maybe in hindsight they might have done it differently, but it's very hard if you're an Indigenous person not to see that as a systemic issue. It's very hard if you're an Indigenous person watching that if it's your granddaughter or your daughter or a relative not to think this is because we have a problem.

363 Like her father 20 years earlier, Ms Wynne suddenly died at the young age of 26 years. Like her father, she was being detained by police when she stopped breathing. Like her father's death, Ms Wynne's death has left young children without a parent. Like her father's death, Ms Wynne's death has caused inconsolable grief amongst her family.

364 I can understand the frustration and the anger felt by Ms Wynne's family that another much loved family member has been taken from them in circumstances that involved the police. Although I have found that mistakes were made by some of the police officers who encountered Ms Wynne on the morning of 4 April 2019, it must be understood there was absolutely no evidence before me that any police officer anticipated or expected, let alone wanted, the tragic outcome for Ms Wynne that followed her apprehension on Albany Highway.

365 The following words from Ms Wynne's mother are undoubtedly shared by all members of her family: "[Ms Wynne's] *death has destroyed my family. I am devastated, traumatised and still in shock … I love* [Ms Wynne] *and every day I want her back.*" [289]

[288] ts 17.9.21 (closing submissions by Ms O'Connor SC), p.646
[289] Statement of Shirley Wynne dated 8 September 2021; Exhibit 1, Volume 1, Tab 10B, p.11

366 I extend my deepest condolences to the family of Ms Wynne.

PJ Urquhart
Coroner
1 April 2022