
JURISDICTION : CORONER'S COURT OF WESTERN AUSTRALIA
ACT : CORONERS ACT 1996
CORONER : Rosalinda Vincenza Clorinda Fogliani, State Coroner
HEARD : 4 JULY 2023
DELIVERED : 6 MARCH 2024
FILE NO/S : CORC 605 of 2022
DECEASED : KENNEDY, TONY WAYNE

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Ms S Markham assisted the State Coroner

Ms L Italiano (State Solicitor's Office) appeared on behalf of the Western Australia Police Service

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

Nil

*Coroners Act 1996
(Section 26(1))*

RECORD OF INVESTIGATION INTO DEATH

*I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of **Tony Wayne KENNEDY** with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 4 July 2023, find that the identity of the deceased person was **Tony Wayne KENNEDY** and that death occurred on 8 March 2022 at Kwinana Freeway, northbound near Thomas Road, Bertram, from multiple injuries in the following circumstances:*

Table of Contents

INTRODUCTION 2
TONY WAYNE KENNEDY 4
EVENTS LEADING TO DEATH 5
FIRST AID 9
CAUSE AND MANNER OF DEATH 9
COMMENTS ON ACTIONS OF POLICE 10
 Communication training 10
 Quality of police response 11
CONCLUSION 12

INTRODUCTION

1. Tony Wayne Kennedy (Mr Kennedy) died on the morning of 8 March 2022 after jumping from a freeway overpass near the intersection of Kwinana Freeway and Thomas Road, Bertram. He landed on the ground below and his injuries were extensive and non-survivable. He was 52 years old.

2. Earlier that morning, police received a ‘000’ call from a concerned member of the public reporting a male person perched on the outside railing of the freeway overpass. It appeared to the caller that the male person was going to jump off. This was followed by other calls to the same effect. Police were dispatched and promptly arrived at the location with the intent of calling upon Mr Kennedy to come over to a safer location and assisting him to do that.

3. When police arrived, Mr Kennedy was in a precarious position on the outside edge of the freeway overpass, holding on to the railing. Within seconds of one of the police officers stepping out of the police vehicle, Mr Kennedy let go of the railing and fell backwards onto the road below the overpass. It was a willed act on Mr Kennedy's part, with his intention being to take his life. There was no time for police to interact with, or speak to Mr Kennedy, before he fell to his death.
4. Mr Kennedy's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (WA) (the Coroners Act) and it was reported to the coroner as required by the Coroners Act. By reason of s 19(1) of the Coroners Act, I have jurisdiction to investigate the death.
5. This matter involved a death following police attendance, and in police presence. Police have a duty to act to preserve and/or maintain life when confronted with a critical incident. They commenced to undertake that duty, but there was no time for them to take any meaningful action that might have prevented the death.
6. Mr Kennedy was aware of the presence of police, and he will have inferred that the purpose of their presence was to act so as avoid him jumping (or falling) from the freeway overpass. He did not want to be prevented from taking his life. He let go of the railing and fell off the freeway overpass.
7. Under s 22(1)(a) of the Coroners Act an inquest was mandated into Mr Kennedy's death, because he was "*a person held in care*" within the meaning of that phrase as defined in s 3 of the Coroners Act. This is because at that time, under paragraph (a)(iii) of that definition, he was a person under or escaping from, the control, care or custody of a member of the Police Force.
8. My primary function is to investigate the death. It is a fact-finding function. Under s 25(1)(b) and (c) of the Coroners Act, I must find, if possible, how death occurred and the cause of death.
9. Under s 25(2) of the Coroners Act, in this finding I may comment on any matter connected with the death including public health, safety or the administration of justice. This is the ancillary function.

10. Section 25(5) of the Coroners Act prohibits me from framing a finding or comment in such a way as to appear to determine any question of civil liability or to suggest that any person is guilty of an offence. It is not my role to assess the evidence for civil or criminal liability, and I am not bound by the rules of evidence.
11. In making my findings I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 361 - 362 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter has been proved on the balance of probabilities.
12. I held an inquest into Mr Kennedy's death on 4 July 2023. I heard from three witnesses and received one exhibit into evidence, containing 22 tabs.
13. My findings appear below.

TONY WAYNE KENNEDY

14. Mr Kennedy was born in New Zealand on 14 January 1970 and had moved to Australia approximately 14 years prior to his death. At the time of his death Mr Kennedy lived in Western Australia with his partner and their two children. Mr Kennedy and his partner had one child from their union, and he had a child from a previous relationship.¹
15. Mr Kennedy's partner describes him as a great father to the children and a hands-on partner with her, contributing to the cooking, gardening and helping around the house. He enjoyed camping with his family and riding his motorbike. He was keen on home maintenance and renovation. It was clearly a close and happy family unit for a long time. However, over time Mr Kennedy withdrew from his extended family and wider circle of friends, becoming increasingly stressed and unhappy.²
16. Mr Kennedy was reluctant when it came to sharing his emotions. His partner knew there was something upsetting him, but he was not accepting of her suggestions for assistance. Despite the care and encouragement expressed by his partner, Mr Kennedy declined to seek medical attention

¹ Exhibit 1, tab 1.

² Exhibit 1, tab 22.

for the agitation and difficulty sleeping, that he experienced shortly before his death.³

17. There is no recorded mental health history for Mr Kennedy, and he was not on any medications. He did not drink alcohol and had stopped socialising. He had told his partner about the pressure he felt at work especially after being promoted to a supervisor role. She observed him working long days and occasionally on a weekend day. Together they discussed options for helping him relax, but ultimately what was needed was for Mr Kennedy to take a step towards seeking help for his stressed condition.⁴
18. Mr Kennedy's partner loved him dearly and she tried in so many ways to help him. For a time, she acted as a conduit for maintaining contact between himself and extended family. His work colleagues were supportive of him. Sadly, he continued to withdraw from social contact.⁵
19. It is understandable to want to find reasons as to why Mr Kennedy made the decision to take his life. His partner felt that he may have experienced a past trauma that he was unable to relay to her. The factors contributing to a decision to suicide are multifactorial and complex and can sometimes defy understanding. What is clear is that Mr Kennedy was loved and cared for, and that he in turn loved his family unit and devoted himself to their home life together. However, he was also deeply troubled and unable or unwilling to explore the reasons for this.

EVENTS LEADING TO DEATH

20. In the week leading up to his death Mr Kennedy had become very quiet around the home, and even more withdrawn. His colleagues observed that he had not been himself. He had been working long hours and was not sleeping well. He also reported that he was not feeling well. Despite encouragement from his partner, he did not consult a doctor or mental health professional.⁶
21. Mr Kennedy usually left for work at approximately 5.00 am in the morning. On the morning of 8 March 2022, he got up and left at this usual time, but

³ Ibid.

⁴ Exhibit 1, tab 22; ts 4 to 6.

⁵ Exhibit 1, tab 22.

⁶ Exhibit 1, tab 3.

he uncharacteristically left his two mobile phones and his wallet at home. The reasonable inference is that he did so because he was not intending to go to work as he usually did. He did take his yellow high visibility shirt. He did not inform his partner of his intentions for that day.⁷

22. Mr Kennedy drove to an area close to the Thomas Road overpass of the Kwinana Freeway at Bertram and parked his vehicle. He went up to the overpass, on the outside of the safety barrier, climbed over the railing, and went onto the narrow outside ledge. He crouched down, holding the railing. He was on the southern side of the freeway overpass, hanging above the northbound lanes, on the outside of the railing. He was wearing his yellow high visibility shirt. It was clear that if he let go, he would fall to his death.⁸
23. Mr Kennedy initially positioned himself facing inward, towards the roadway of the freeway overpass. About a minute later he repositioned himself to face outwards towards the Kwinana Freeway, and a couple of minutes after that he changed position again, and turned back to face inward, as before.⁹
24. The '000' emergency telephone calls to the Police Operations Communications Centre (POCC), from concerned members of the public, commenced at 5.22 am on 8 March 2022. First Class Constable Alexander Dartnall, now a Senior Constable (Constable Dartnall) and Constable James Hinchcliffe (Constable Hinchcliffe) were assigned the task and dispatched immediately from Kwinana Police Station by POCC, at 5.22 am under Priority 2, and a minute later at 5.23 am the dispatch was upgraded to Priority 1, at the request of Constable Hinchcliffe. Constable Dartnall was a Priority 1 trained driver. It was treated by them as a "*serious emergency*."¹⁰
25. Constable Dartnall (as driver) and Constable Hinchcliffe (as passenger) ran to their marked police car and drove to the location as quickly as possible, under Priority 1 conditions, initially with lights and sirens. As they were on their way Constable Hinchcliffe, knowing something of the circumstances, formed the view that he would try and speak with the person (who he subsequently came to know as Mr Kennedy) and get them the help

⁷ Exhibit 1, tab 3; ts 6.

⁸ Exhibit 1, tabs 3 and 12.

⁹ Exhibit 1, tab 20.

¹⁰ Exhibit 1 tabs 3, 10, 12, 17 and 18; ts 26 to 27.

they needed. They arrived at the scene in approximately four to five minutes, and there was no time for much discussion between the two police officers regarding a plan. Constable Dartnall described it as a “*a very compact timeframe.*”¹¹

26. Constable Hinchliffe reported that he was aware the Mental Health Co-Response Team would not have been on duty at that time and therefore he did not consider calling them. Through their lawyer the State Solicitor’s Office (SSO), the Western Australia Police Force confirmed that the Mental Health Co-Response Team does not work at 5.22 am in the morning and that in any event the allied health professional within this team would not have been able to approach Mr Kennedy until the situation was made safe (which in this context may have meant bringing Mr Kennedy back across the railing).¹²
27. Whilst the dispatch task had recommended contacting the Mental Health Emergency Response Line (MHERL), Constable Hinchliffe considered that his priority was to get to where Mr Kennedy was and to ascertain the situation before calling MHERL. Through their lawyer the SSO, the Western Australia Police Force confirmed that the police officers would have been able to call MHERL once they learnt Mr Kennedy’s name.¹³
28. It will be seen that there was no time to call MHERL as matters escalated immediately upon the arrival of the police. Constable Dartnall and Constable Hinchliffe arrived at the scene at 5.27 am, approximately five minutes after the first telephone call to the POCC. They approached the area driving in an easterly direction along Thomas Road. It was still dark, and the lights of the police vehicle would have been very apparent. As they neared the area where Mr Kennedy was, Constable Dartnall appears to have switched off the sirens.¹⁴
29. As he was driving Constable Dartnall first saw Mr Kennedy from a distance of approximately 50 metres, on the southern side of the freeway overpass, hanging above the northbound lanes, on the outside of the safety barrier. Constable Dartnall conducted a U-turn at the eastern end of the traffic control lights and stopped in the westbound lane of the freeway overpass,

¹¹ Exhibit 1 tabs 3, 10, 12, 17 and 18; ts 8 to 9; ts 26 to 27.

¹² Exhibit 1, tab 18.

¹³ Exhibit 1, tabs 10 and 18.

¹⁴ Exhibit 1, tabs 17 and 18; ts 9; ts 27 to 28.

adjacent to where Mr Kennedy was and approximately 10 to 15 metres away from him.¹⁵

30. Constable Hinchliffe opened the door of the police vehicle and shouted, to his recollection: “*please don’t jump.*” He wanted Mr Kennedy to hear him, but at the same time he did not want to be “*overly loud.*” He quickly realised there were a few barriers between him and Mr Kennedy. These were the safety barrier and the railing. He thought he would need to get over the safety barrier, but he did not want to get so close to Mr Kennedy that he would scare him.¹⁶
31. As he called out to him, Constable Hinchliffe was aware of Mr Kennedy staring at him, and he believed Mr Kennedy heard him. Mr Kennedy did not respond to him. Constable Hinchliffe climbed over the safety barrier and looked downwards as he placed his foot on the footpath. It was at this point, while Constable Hinchliffe was looking away (downwards), that Mr Kennedy let go of the railing and fell heavily to the bitumen below the overpass.¹⁷
32. From the driver’s seat, Constable Dartnall was not able to see Mr Kennedy. Constable Hinchliffe immediately informed Constable Dartnall that Mr Kennedy had “*jumped*” and then he ran, following the railings, down the northbound ramp in a southerly direction, to find the easiest way down to the Kwinana Freeway. He reached an area where he could jump down a couple of metres onto sand that was a few metres from the carriageway of the Kwinana Freeway. He landed on the sand and ran towards Mr Kennedy.¹⁸
33. Constable Dartnall felt that Mr Kennedy’s actions in letting go of the railing were “*instantaneous*” upon their arrival. This is established by the CCTV records that show Mr Kennedy let go of the railing at 5.27 am, immediately as Constable Hinchliffe climbed the safety barrier to access the footpath. It was a matter of seconds after the arrival of police at the scene.¹⁹

¹⁵ Exhibit 1, tab 17; ts 10; ts 28.

¹⁶ Exhibit 1, tab 18; ts 10; ts 28 to 29.

¹⁷ Exhibit 1, tabs 17 and 18; ts 10; ts 27.

¹⁸ Exhibit 1, tabs 17 and 18; ts 28 to 30.

¹⁹ Exhibit 1, tabs 12 and 17; ts 10.

34. After being informed of what happened, Constable Dartnall drove the police vehicle, against the traffic flow, down the same northbound ramp as utilised by Constable Hinchcliffe. He parked the police vehicle in such a way as to provide a safe working area, left the primary lights on and went towards Mr Kennedy, who was already being attended to by Constable Hinchcliffe.²⁰

FIRST AID

35. Mr Kennedy endured an unbroken fall from the freeway overpass and came to rest on his back on the northbound emergency lane bitumen pavement of the Kwinana Freeway. Records reflect that the police informed VKI at the POCC, that an ambulance was called for at 5.32 am and that paramedics departed promptly at 5.33 am, arriving at the scene at 5.37 am.²¹
36. Meanwhile, as soon as Constable Hinchcliffe arrived to where Mr Kennedy was, he assessed him and saw that he was breathing with difficulty, he was unresponsive, and blood was pooling next to his head. Very shortly after Constable Dartnall arrived and checked his breathing, Mr Kennedy's condition deteriorated, and he ceased breathing. At 5.32 am Constable Dartnall promptly commenced CPR, aided by guidance from St John Ambulance paramedics over Constable Hinchcliffe's telephone. Constable Hinchcliffe had previously called for the ambulance.²²
37. When the St John Ambulance paramedics arrived at 5.37 am, Constable Dartnall was continuing to perform CPR. The paramedics assessed Mr Kennedy and noted no response, no breaths, no pulse, and that his pupils were fixed. They determined that his obvious injuries were incompatible with life. Mr Kennedy was pronounced dead at 5.46 am on 8 March 2022.²³

CAUSE AND MANNER OF DEATH

38. On 17 March 2022 the forensic pathologist, Dr V. B. Kueppers (Dr Kueppers), made a post mortem examination at the State Mortuary on the body of Mr Kennedy, by means of an external examination of his body and a CT scan. These showed multiple severe injuries including "eggshell"

²⁰ Exhibit 1, tab 17; ts 11; ts 28 to 30.

²¹ Exhibit 1 tabs 10, 12, 13, 17 and 18; ts 12; ts 30 to 31.

²² Exhibit 1, tabs 3, 12, 17 and 18; ts 12 to 15; ts 31.

²³ Exhibit 1, tabs 13 and 17; ts 14.

fracturing of the skull, intracranial haemorrhage, upper neck dislocation, chest trauma and shattering of the right hemi-pelvis. Dr Kueppers considered these injuries incompatible with life.²⁴

39. Toxicological analysis was ordered, and the results became available on 4 June 2022. There was no alcohol, medications or common illicit drugs detected. On 11 July 2022, having reviewed the toxicological analysis, Dr Kueppers confirmed her opinion on the cause of Mr Kennedy's death.²⁵
40. I accept and adopt Dr Kuepper's opinion on the cause of death. **I find that the cause of Mr Kennedy's death was multiple injuries.**
41. I am satisfied that Mr Kennedy had formed the intention to take his life when he went up to the Thomas Road freeway overpass, and that he was resolute in his intention by the time he had climbed over the railing to hang off the edge of the overpass.
42. It will have been clear to Mr Kennedy that if he let go of the railing, he would fall to his death. He became aware of the presence of police, and he did not want to be brought back to a safer location. In pursuance of the intention to take his life, and contrary to the express request of Constable Hinchcliffe, he let go of the railing. **I find that the manner of Mr Kennedy's death was by way of suicide.**

COMMENTS ON ACTIONS OF POLICE

43. In accordance with the required practices, Constable Dartnall and Constable Hinchcliffe were subjected to drug and alcohol testing upon their return to Kwinana Police Station, resulting in negative outcomes for drugs and alcohol.²⁶

Communication training

44. At the inquest, Constable Dartnall was asked about the training he had received in respect of communication and negotiation skills to assist in de-escalating crisis situations. He referred to the Effective Communication as

²⁴ Exhibit 1, tab 8.

²⁵ Exhibit 1, tabs 8 and 9.

²⁶ Exhibit 1, tab 12; ts 15 to 16.

a Critical Skill Course (CS5) training that he had received. It is delivered as a full day course that includes theory and practical sessions with scenarios and exercises to put theory into practice. A component of the training is centred around building rapport.²⁷

45. Constable Dartnall explained that if there is time (and in Mr Kennedy’s case, sadly there was no time) then the interaction with a vulnerable person would be based around encouraging the person to talk, avoiding confrontation, and showing them that you are there to listen and to help. Constable Hinchliffe, who has also undergone the CS5 training, referred to the importance of “*not repeating yourself*” when trying to communicate with a vulnerable person, of using re-affirming language and having compassion. Importantly the person needs to be given a chance to speak.²⁸
46. I am satisfied that both police officers had been adequately trained to effectively communicate in order to de-escalate a crisis and had there been time to employ their skills with Mr Kennedy, they would have been capable of doing so.

Quality of police response

47. At the close of the inquest, I outlined my comments on the quality of the police response. As outlined then, I am satisfied that the police response to the emergency was quick, with Constable Dartnall and Constable Hinchliffe having arrived at the scene in approximately five minutes, driving their marked police vehicle under Priority 1 conditions. I am satisfied that there were no other steps they could have taken to talk to Mr Kennedy because he almost immediately let go of the railing just as Constable Hinchliffe called out to him, and tried to get closer to him so they could speak.²⁹
48. I am also satisfied that Constable Dartnall and Constable Hinchliffe acted promptly to call an ambulance and render first aid to Mr Kennedy, remaining with him for that purpose until the ambulance officers were able to take over the first aid.

²⁷ Exhibit 1, tab 21; ts 18 to 21; ts 36.

²⁸ ts 24; ts 29; ts 32 to 36.

²⁹ ts 40.

CONCLUSION

49. Very sadly, Mr Kennedy had reached the decision to take his own life, for reasons that are no doubt complex. He had experienced some stressors in his life, some of which are known and some which will not be known. By the time the police arrived, it is unlikely that any of their actions or interventions could have stopped his course. However, it is important to always maintain hope and employ every reasonable method to try and save someone in that position. I am satisfied the police did so in this situation.

R V C Fogliani
State Coroner

6 March 2024