JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	14 MAY 2024
DELIVERED	**:**	11 SEPTEMBER 2024
FILE NO/S	**:**	CORC 18 of 2022
DECEASED	**:**	SHERWOOD, STEPHEN KENNETH

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W Stops assisted the Coroner.

Ms D Van Nellestijn (State Solicitor's Office) appearing on behalf of the Western Australian Police Force.

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 ***Stephen Kenneth SHERWOOD*** *with an inquest held at Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 14 May 2024, find that the identity of the deceased person was* ***Stephen Kenneth SHERWOOD*** *and that death occurred on or about 13 April 2022 at 27 Doreen Street, Narembeen, from ligature compression of the neck (hanging) in the following circumstances:*

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INTRODUCTION

"In most cases, suicide is a solitary event and yet it has far-reaching repercussions for many others. It is rather like throwing a stone into a pond; the ripples spread and spread."
Alison Wertheimer – author

1. Stephen Kenneth Sherwood (Stephen)[1] died on or about 13 April 2022 on the back verandah of a house belonging to his parents in Narembeen. He had placed a rope around a rafter of the verandah's roof and had looped one end around his neck as a ligature. Stephen was 31 years old.

2. Stephen's death was a reportable death within the meaning of section 3 of the *Coroners Act 1996* (WA) (the Act) as it was unexpected. However, an inquest into his death was not mandatory as it did not fall within any of the circumstances set out in section 22(1) of the Act.

3. Nevertheless, on 28 October 2022, the State Coroner determined that an inquest into Stephen's death was desirable pursuant to section 22(2) of the Act. The inquest was to examine the circumstances of the death within the context of a 72-hour Police Order that had been imposed on Stephen on 12 April 2022.

4. I held an inquest into Stephen's death at Perth on 14 May 2024. The following witnesses gave oral evidence:

i. Ashling Spain;[2]
ii. Constable Jarryd Reeve;[3]
iii. Sergeant Simon Nichols; and
iv. Inspector Simon Hazell.

5. The documentary evidence at the inquest comprised of one volume that was tendered as exhibit 1 at the commencement of the inquest.

[1] As the family had requested that their relative be referred to as "Stephen" during the inquest, I will identify him in the same manner in my finding
[2] Although Ms Spain had resigned from the WAPF before the inquest commenced, I will refer to her as Probationary Constable Spain in my finding
[3] Although Constable Reeve was a probationary constable at the time of Stephen's death, I have given him his rank as at the time of the inquest in my finding when referring to his oral evidence

6. During the inquest, I requested two further reports from the Western Australia Police Force (WAPF) that were provided after the inquest was completed. One report was from Superintendent Gene Pears, the WAPS Wheatbelt District Officer, dated 28 May 2024. This report provided an explanation as to why two probationary constables from Merredin Police Station were partnered together for operational duties on 12 April 2022.

7. The other report dated 24 June 2024 was from Detective Acting Superintendent Mat Atkinson and Acting Commander Simone Van Der Sluys. This report provided further information from the WAPF Internal Affairs Unit (IAU) in relation to the IAU's practice of obtaining expert reports and the decision-making process for the IAU investigation into the actions of police officers with respect to this matter.

8. The inquest focused on the adequacy of the police response to the mental health concerns of Stephen on 12 April 2022, when two probationary constables investigated a family violence complaint regarding Stephen.

9. In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, which requires a consideration of the nature and gravity of the conduct when deciding whether a matter adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle).[4]

10. I am also mindful not to insert hindsight bias into my assessment of the action taken by police officers involved in the investigation of the family violence complaint. Hindsight bias is the tendency, after an event, to assume the event was more predictable or foreseeable than it was at the time.[5]

[4] ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 362 (Dixon J)
[5] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10

STEPHEN [6]

11. Stephen was an indigenous man who was born at King Edward Memorial Hospital in Subiaco on 29 May 1990. He was the fourth child of six and was the only son in the family.

12. Stephen lived in the Maddington area until he was 11 years old. He then moved with his family to Narembeen when his father obtained employment at the local shire.

13. Stephen left high school when he was about 14 years old. After living with one of his sisters in Perth, Stephen returned to Narembeen in 2008 and gained employment with the local shire and then for a local boom spray manufacturer.

14. In 2012, Stephen and his then partner had a son. Unfortunately, family violence issues became prevalent due to illicit drug use by Stephen and his partner. This led to the involvement of the Department of Communities and Stephen's son was placed into the full-time care of Stephen's parents.

15. In the years before his death, Stephen returned to live in Perth where he resided with other family members and associates. During this time he was in an on and off relationship with another partner. It became evident that Stephen was also using methylamphetamine during this relationship.

Stephen's mental health [7]

16. From December 2017, Stephen had several presentations to the EDs of hospitals in Perth when affected by methylamphetamine. A common diagnosis during these presentations was drug-induced psychosis. Stephen's hospital discharge instructions usually suggested he see a general practitioner for follow-up and a prescription for anti-depressant medications. He was also advised to consider drug and alcohol services

[6] Exhibit 1, Tab 2, WAPS Investigation Report dated 1 January 2023; Exhibit 1, Tab 12, Statement of Sandra Pickett dated 14 April 2022
[7] Exhibit 1, Tab 14, Previous medical records

to address his illicit drug use. It would appear that Stephen did not follow these recommendations.

Stephen's suicide attempt on 30 March 2022 [8]

17. On the afternoon of 30 March 2022, Stephen self-harmed with suicidal intent by cutting his right wrist with a razor blade. He only stopped after a relative became aware of his actions. Emergency services were notified, and ambulance officers later found Stephen after he had left the address.

18. Stephen reported to the ambulance officers that he was dealing with childhood trauma. He also admitted to having used methylamphetamine the previous day. Stephen confirmed he did not have a mental health diagnosis or any current treatment for mental health issues. He also disclosed that he had not spoken to a health service provider about his childhood trauma.

19. Stephen was taken by ambulance to the ED at St John of God Midland Hospital. He was placed in the ED just before midnight.

20. While being treated in the ED, Stephen admitted feeling suicidal recently. However, he denied any current thoughts of self-harm or suicide, and denied having any plans or intent. He guaranteed he was safe and referenced his son as a protective factor. ED staff assessed that as there was no evidence of psychosis or acute depressive features, they had no grounds to involuntary detain Stephen should he not consent to treatment. Stephen later became agitated towards ED staff and kept saying he could not be kept in hospital against his will.

21. Although he was encouraged to remain in hospital so he could receive further treatment, Stephen refused. Against medical advice, he left the ED at about 1.45 am on 31 March 2022.

[8] Exhibit 1, Tab 14, Previous medical records

Stephen's threat to suicide on 4 April 2022 [9]

22. On the night of 3 April 2022, Stephen and his partner unexpectedly arrived at his parents' Narembeen address with an intention to stay there.

23. At 12.16 am on 4 April 2022, Stephen's mother contacted emergency services to report that Stephen had left the house with two knives and was threatening to kill himself.

24. At about 12.20 am, the two police officers stationed at the Narembeen Police Station (a sergeant and a senior constable) were recalled to duty to conduct a welfare check for Stephen. One of those police officers was Sergeant Steven Szokolai (Sergeant Szokolai).

25. At about 12.45 am, the two police officers arrived at the address of Stephen's parents. By this stage Stephen had returned to the house and appeared calm and responsive. He showed the police his previous self-harm injuries and admitted to having thoughts of hurting himself that night but had not done so, and had thrown the knives away.

26. Stephen's mother asked police to take her son to hospital to be assessed. However, Stephen said that he did not want to go to hospital and just wanted to have a shower and go to bed. The police officers advised Stephen's mother that based on his current behaviour and conversations they had with him, they did not have grounds to detain Stephen for a mental health assessment.

27. Instead, Sergeant Szokolai arranged for Stephen to have contact with the Mental Health Emergency Response Line (MHERL). MHERL is a 24-hour telephone service for people experiencing a mental health crisis. It aims to keep individuals safe during a mental health crisis by connecting them with appropriate support services. If police officers hold any concerns in regards to a person's mental health, MHERL should always be contacted for advice.

[9] Exhibit 1, Tab 17.2, Incident Report dated 4 April 2022; Exhibit 1, Tab 23, Wheatbelt Risk Assessment Management Plan dated 4 April 2022. Exhibit 1, Tab 16, Report of the IAU by Sergeant Simon Nichols dated 25 July 2022; Exhibit 1, Tab 17.2, Incident Report dated 4 April 2022, p.1

28. Sergeant Szokolai also provided Stephen with telephone numbers for after-hours support services.

29. The two police officers located the knives that Stephen had taken and left him in the care of his mother. Stephen was still having a telephone conversation with MHERL when the two police officers left at about 1.30 am.

30. At 1.43 am, one of the police officers drove past the address of Stephen's parents on the way home and noted that the living area lights were now off, with only the front bedroom light on.

31. On 4 April 2022, Stephen's case was referred to the Wheatbelt Mental Health Service (WMHS) for ongoing support. The referral noted he felt depressed, had been suicidal due to childhood trauma, had previously attempted suicide by slashing his wrist and had then left hospital against medical advice. It was also recorded he was not on medication, had feelings of hopelessness and worthlessness, was not sleeping and had a fear of nightmares.

32. On 5 April 2022, WMHS spoke to Stephen's mother to advise that the service would provide ongoing support for Stephen. Stephen's mother reported he was a bit more relaxed, not in a distressed state and denying thoughts of self-harm.

33. On 6 April 2022, Stephen's allocated mental health case manager called him. During that conversation Stephen denied any current risks and gave assurances that he felt safe and would use crisis contacts if needed. He was advised during that conversation an appointment had been made for him to see a psychiatrist and his case manager at the Narembeen Medical Centre at 2.00 pm on 12 April 2022.

EVENTS LEADING TO STEPHEN'S DEATH [10]

34. Stephen did not attend his appointment at the Narembeen Medical Centre on 12 April 2022. A telephone call was made to Stephen's mother; however, she had left Narembeen that day with Stephen's father for a holiday in Kalbarri.

35. At 5.19 pm on 12 April 2022, police were requested to respond to a family violence incident where Stephen had allegedly hit his partner on her elbow with an axe handle (the family violence complaint). This call was taken by the Police Operations Centre in Perth which then contacted the Narembeen Police Station. Neither police officer at the station was on duty. The senior constable was on leave and Sergeant Szokolai was off-duty, and he advised his attendance would be delayed due to his location. As a result, the police attendance was dispatched to two probationary constables who were the only police officers on duty at the Merredin Police Station.[11] These two probationary constables were Probationary Constable Ashling Spain (Probationary Constable Spain) and Probationary Constable Jarryd Reeve (Probationary Constable Reeve).

36. On the way to Narembeen, Probationary Constable Reeve spoke to Sergeant Szokolai. The sergeant referred to the incident in Perth on 30 March 2022 and also recalled advising that he had seen Stephen on 4 April 2022 in response to a welfare check. Probationary Constable Spain, who had previously worked in prisons, knew Stephen from when he had been imprisoned in 2020. That information was provided to Sergeant Szokolai and he was also told Probationary Constable Spain had got on well with Stephen. Sergeant Szokolai said he would "*kit up*" and provide assistance to the probationary constables if they required.

[10] Exhibit 1, Tab 2, WAPS Investigation Report dated 1 January 2023; Exhibit 1, Tab 9, Statement of Dean Whitley dated 14 April 2022; Exhibit 1, Tab 10, Statement of Crystal Sherwood dated 15 April 2022; Exhibit 1, Tab 11, Statement of Probationary Constable Ashling Spain; Exhibit 1, Tab 16, Report of the IAU by Sergeant Simon Nichols dated 25 July 2022; Exhibit 1, Tab 24.1, IAU managerial interview with Probationary Constable Jarryd Reeve dated 2 June 2022

[11] Merredin is approximately 77 km north of Narembeen

37. Contact was also made with Stephen's partner to obtain further information regarding the incident and to ascertain whether she required any medical assistance.

38. The probationary constables arrived at the house of Stephen's parents at about 6.00 pm, less than 40 minutes after receiving the task. They activated their body-worn cameras and spoke to Stephen about the alleged assault of his partner.

39. Stephen denied assaulting his partner, saying they had an argument before she went to his sister's house which was within walking distance. The two probationary constables saw Stephen's 10-year-old son and spoke briefly with him. He appeared fine and was not in any distress. Stephen was advised he was likely to receive a Police Order and that the probationary constables would be speaking with his partner.

40. Throughout this interaction, Stephen was calm, polite, and respectful. He recognised Probationary Constable Spain, and it was evident from the body-worn camera footage that there was a good rapport between them. After advising Sergeant Szokolai they did not require his assistance, the probationary constables spoke with Stephen's partner at about 6.19 pm. Once again, police body-worn cameras were activated during this conversation.

41. Stephen's partner advised she was not injured and there had been no bruising. She also said that Stephen was the type of person to be suicidal. Probationary Constable Spain responded: "*I'd worked with Stephen before, and I know him quite well, and I know he does have those mental health concerns.*" The partner told police she was worried about Stephen and had asked his sister to check up on him. Stephen's sister was also present and told the police: "*He has been suicidal recently. He has come here [Narembeen] to deal with his mental health, but so far he hasn't taken any steps.*" Stephen's partner then advised police that he did not go to his "*appointment*" that day.

42. As to Stephen's son, his sister advised the police officers that there were no child protection orders in place; however, she believed her brother

was not in a right frame of mind. Stephen's partner also indicated that she intended to leave Narembeen and stay with family in Kalgoorlie. She was advised that a Police Order would be placed on Stephen in order to protect her.

43. The two probationary constables reattended Stephen's parents' home. At their request, Stephen retrieved his partner's personal belongings for police to take to her. Probationary Constable Reeve then issued the Police Order to Stephen, which prevented him from having any contact with his partner for the next 72 hours. He did not express any concern or distress when he was provided the Police Order. The probationary constables did not ask Stephen any questions about his mental health or why he had not attended his appointment earlier that day. They then left the address.

44. The two probationary constables went back to Stephen's sister's house, where his partner had remained. They returned her personal belongings, and she advised that she did not want Stephen to get into any trouble. Probationary Constable Spain advised the partner to obey the conditions of the Police Order and not speak to or visit Stephen for the duration of the order. As Stephen's partner did not want him charged, the probationary constables then returned to Merredin without taking any further action.

45. At 10.04 pm, Stephen sent a text to Dean Whitley (Mr Whitley), his sister's partner, asking if his son could stay the night at their house. Mr Whitley responded with a text which said, "*send him over*", and shortly after that Stephen's son attended the address by himself.

46. When Stephen's son returned home late the next morning, he discovered Stephen hanging from the rear verandah. He ran back to the other house and told Mr Whitley. Mr Whitley immediately rang emergency services. Ambulance officers attended the scene a short time later and observed that rigor mortis had already been established to Stephen's body and

there were no signs of life. Stephen was subsequently declared life extinct at 12.25 pm on 13 April 2022.[12]

CAUSE AND MANNER OF DEATH [13]

47. On 19 April 2022, Dr Jodi White (Dr White), a forensic pathologist, conducted an external post mortem examination on Stephen's body. Part of this external examination included a CT scan and Dr White observed a ligature mark to Stephen's neck. Dr White also observed sharp force injuries that were in the process of healing to both of Stephen's inner wrists.

48. A toxicological analysis of blood and urine samples from Stephen detected methylamphetamine and amphetamine at levels consistent with normal "recreational" use of these drugs. No other common illicit drugs or alcohol were detected.

49. At the conclusion of her investigations, the forensic pathologist expressed the opinion that the cause of death was ligature compression of the neck (hanging).

50. I accept and adopt the opinion expressed by the forensic pathologist as to the cause of Stephen's death.

51. Based on all the information available, I am satisfied that Stephen was in a very depressed state in the period before his death, and that he most likely had an intention to end his life when he arranged for his son to stay at his sister's house. After his son was at that address, Stephen used a rope to hang himself from a rafter of the rear verandah's roof at his parents' house.

52. Accordingly, I find that Stephen's death occurred by way of suicide.

[12] Exhibit 1, Tab 5, Life Extinct Form dated 13 April 2022

[13] Exhibit 1, Tabs 7.1-7.3, Full Post Mortem Report, Supplementary Post Mortem Report and Interim Post Mortem Report to the Coroner dated 19 April 2022; Exhibit 1, Tab 8, Toxicology Report dated 15 August 2022

INVESTIGATION OF THE POLICE OFFICERS' ACTIONS BY THE IAU [14]

53. Following the death of Stephen, an IAU investigation examined the actions of Probationary Constables Reeve and Spain, and Sergeant Szokolai to determine whether there was non-compliance with WAPF policy and/or WAPF's Code of Conduct (the IAU investigation). It was carried out by Sergeant Simon Nichols (Sergeant Nichols).

54. With respect to police actions on 12 April 2022 relevant to the inquest, the IAU investigation found that (i) Probationary Constables Reeve and Spain, "*neglected their duty in breach of Western Australia Police Force Mental Health Policy MH-01.01 Mental Health, by failing to adequately investigate the mental health concerns for [Stephen]*" and (ii) Sergeant Szokolai, "*neglected his duty to appropriately supervise Probationary Constable Ashling Spain and Constable Jarryd Reeve, during their attendance at [the family violence complaint]*." [15]

55. The relevant section from the WAPF Mental Health Policy referred to above was cited in the report from the IAU investigation:[16]

> The following procedure is to be followed when police officers identify a person suspected to be suffering from a mental illness within the community.
>
> The Mental Health Emergency Response Line (MHERL) is a 24-7 telephone service, staffed by mental health practitioners and provides professional and accurate advice to acute mental health issues. Practitioners at MHERL can provide telephone triage, consultancy and support for people experiencing a mental health emergency and if required, referral to a local mental health service.
>
> If police officers hold any concerns in regards to a person's mental health, MHERL should always be contacted for advice. MHERL can be contacted by police officers both pre-attendance and/or in attendance at [the] scene. In the first instance, the attending police are to contact MHERL in order to:

[14] Exhibit 1, Tab 16, Report of the IAU by Sergeant Simon Nichols dated 25 July 2022
[15] Exhibit 1, Tab 16, Report of the IAU by Sergeant Simon Nichols dated 25 July 2022, p.5
[16] Exhibit 1, Tab 16, Report of the IAU by Sergeant Simon Nichols dated 25 July 2022, p.33; see also Exhibit 1, Tab 29.2, MH-01.01 Mental Health (effective from 27 November 2018 to 7 September 2022), p.2

- Advise them of the situation and location of the person
- Provide the details of the person
- Establish whether the person is currently receiving treatment or has previously received treatment for a mental illness
- Obtain relevant risk information
- Establish a course of action required for the person to receive appropriate treatment

56. As to the above finding against the two probationary constables, the IAU investigation accepted that Stephen, "*showed no overt signs of mental illness or being at risk to himself.*" [17]

57. However, the IAU investigation was satisfied of the following: [18]

> Both [Stephen's sister and partner] disclosed [Stephen] was suicidal, with [his sister] further stating he had missed an appointment that day. [Probationary Constables] Reeve and Spain at no time considered asking further questions of [Stephen's sister and partner] to explore the seriousness of these statements. They did not consider contacting MHERL for further information or guidance, and they did not consider putting these matters directly to [Stephen] when they served the Police Order, rather they relied solely on the casual observations of [Stephen] to deem he was not suffering a mental health illness and was not a danger to himself.
>
> Both [Probationary Constables] Reeve and Spain were clear they were assessing [Stephen's] mental health but did not identify they had other available sources of information to assist in this task. At minimum, they had the option of utilising MHERL to assist in this assessment.

58. After a review by an Evidentiary Assessment Meeting,[19] it was determined that a verbal guidance for Probationary Constables Reeve and Spain was the appropriate sanction.[20] This is the lowest sanction that can arise from an IAU investigation that has found there was a failure to comply with WAPF policy.

[17] Exhibit 1, Tab 16, Report of the IAU by Sergeant Simon Nichols dated 25 July 2022, p.31
[18] Exhibit 1, Tab 16, Report of the IAU by Sergeant Simon Nichols dated 25 July 2022, p.31
[19] Now known as an Independent Review Panel
[20] Ts (Sergeant Nichols), p.82

59. As to the finding against Sergeant Szokolai, the IAU investigation noted that during its interview with Sergeant Szokolai, he:[21]

> … displayed he had capability to direct [Probationary Constables] Spain and Reeve to take more comprehensive actions, particularly with the mental health concerns, however as he failed to proactively seek information, he was not in position to provide the guidance the officers needed.
>
> There is no evidence any officer has been wilfully negligent or lazy. [Probationary Constables] Reeve and Spain were too inexperienced to deal with the multi-layered task, including not being aware of what deficiencies they did have in response to the required actions. At the same time, [Sergeant] Szokolai was over-confident in the officers, based on his limited interaction and assumed they were capable of completing the tasks unsupervised and would know when to seek assistance or guidance.

60. Although a coroner must always give close consideration to the outcomes of an IAU investigation with respect to the death the Court is investigating, the coroner is not bound by the conclusions that have been reached. My own conclusions, and the reasons for them, are outlined below.

ISSUES RAISED BY THE EVIDENCE

Whether Probationary Constables Reeve and Spain should have contacted MHERL

61. With respect to his conversation with the two probationary constables as they drove to Narembeen, Sergeant Szokolai recalled advising them of the welfare check he had conducted on 4 April 2022.[22] He also recalled mentioning that Stephen had been in possession of knives on that occasion. As to linking Stephen with MHERL that night, Sergeant Szokolai said: "*I would of mentioned it I'm sure, <u>but I don't recall</u>*."[23]

[21] Exhibit 1, Tab 16, Report of the IAU by Sergeant Simon Nichols dated 25 July 2022, pp.31-32
[22] Exhibit 1, Tab 24.4, IAU managerial interview with Sergeant Szokolai on 15 June 2022, p.10
[23] Exhibit 1, Tab 24.4, IAU managerial Interview with Sergeant Szokolai on 15 June 2022, p.10

62. At the inquest, Probationary Constable Spain gave evidence that she was not aware of the incident on 4 April 2022 as she made the journey to Narembeen.[24] I accept that evidence.

63. At the inquest, Constable Reeve only recalled Sergeant Szokolai advising him of the incident involving Stephen on 30 March 2022 and information that if Stephen was intoxicated, he might be hard to deal with, otherwise there should be no difficulty.[25] Constable Reeve did not recall being provided with information regarding the welfare check for Stephen on 4 April 2022.

64. Given Sergeant Szokolai's lack of recollection as to whether he definitely mentioned the involvement of MHERL on 4 April 2022, I am not satisfied to be required standard whether this information was actually conveyed to Probationary Constable Reeve before he attended Narembeen. Even if he was aware of the involvement of MHERL on 4 April 2022, Constable Reeve testified at the inquest that he would not have contacted MHERL as he was investigating a family violence report and therefore he, "*had no mental health concerns for Stephen at that stage.*" [26] I accept that explanation.

65. However, there was another occasion when it was contended that the probationary constables ought to have contacted MHERL. That was after Stephen's sister and his partner had provided additional information regarding their concerns for his mental health. As Sergeant Nichols testified:[27]

> In my personal opinion I would have thought probably the best time to call [MHERL] would have been once they've at least spoken to and received the extra information from [Stephen's] sister and his partner.

66. I accept this evidence from Sergeant Nichols. Given the provisions of the relevant WAPF policy which I have already outlined above,[28] I am satisfied that there was a missed opportunity by the two probationary

[24] Ts (Probationary Constable Spain), p.33
[25] Ts (Constable Reeve). p.54
[26] Ts (Constable Reeve), p.57
[27] Ts (Sergeant Nichols) p.79
[28] See [54] of this finding

constables to contact MHERL for advice after they had spoken to Stephen's sister and his partner. In making that finding, I note Probationary Constable Spain accepted, albeit with the benefit of hindsight, that contact with MHERL would have been wise after Stephen's sister and his partner had disclosed his mental health issues.[29]

67. Similarly, Constable Reeve accepted that had information been provided to him from MHERL, "*there's every possibility I would have asked him that question about how he was feeling*." [30]

68. For the benefit of these two probationary constables, I must stress that my observation there was this missed opportunity is not an adverse finding against them. It is simply noting that they did not avail themselves of the opportunity to contact MHERL.

Whether Probationary Constables Reeve and Spain should have reviewed WAPF electronic records of recent police contact with Stephen

69. Potentially, the probationary constables could have accessed relevant information regarding Stephen from previous police data entries. One such entry were the details regarding the welfare check on 4 April 2022.[31] In addition, there was an entry made at 5.23 pm on 12 April 2022 that included a warning Stephen was a "*self-harmer*." [32]

70. Although police officers have an app on their mobile phones that enables them to access a significant amount of information from WAPS records, the two probationary constables did not have direct access to the above information as they travelled to Narembeen.[33] Access to this material was only available from a WAPF desktop computer. As there was no police officer on duty at the Merredin or Narembeen Police Stations, a call would have to be made to the Police Operations Centre in Perth in order to get that information.[34]

[29] Ts (Probationary Constable Spain) p.35
[30] Ts (Constable Reeve), p.62
[31] Exhibit 1, Tab 17.2, Incident Report dated 4 April 2022
[32] Exhibit 1, Tab 17.1, Incident Report dated 12 April 2022, p.1
[33] Ts (Sergeant Nichols), p.78
[34] Ts (Sergeant Nichols), p.78

71. I am not satisfied it was necessary for this line of inquiry to be undertaken by the probationary constables. I am satisfied they were entitled to assume that Sergeant Szokolai had provided them with all relevant information regarding prior police contact with Stephen.

Whether Probationary Constables Reeve and Spain should have questioned Stephen about his current mental health

72. As outlined above, I am satisfied there was a missed opportunity by the two probationary constables to contact MHERL. However, the IAU investigation went further and found that questions should have been asked of Stephen regarding his mental health after the concerns had been raised by his sister and partner. After careful consideration of the information available, I am not prepared to make the same conclusion the IAU investigation has made with respect to this matter. In so finding, I have relied on two factors.

73. The first is that the concerns expressed by Stephen's sister and his partner did not indicate that Stephen had any current suicidal ideations or risk of self-harming. Consequently, no alarms were raised that there was an imminent risk.

74. With respect to this, Probationary Constable Spain was asked the following question at the inquest: [35]

> Did you understand the concerns expressed by [Stephen's sister and partner] to relate to Stephen's mental health at the time? --- No. I guess nothing said to me that it was right now that – like this is right now that's being experienced. I guess I took it more generically [that] he has been dealing with mental health. A lot of suicidal ideation.

75. The second factor is that Stephen's interactions with the probationary constables on 12 April 2022 gave no indication that he had suicidal ideation or was at risk of self-harm.

76. As Probationary Constable Spain outlined at the inquest, Stephen did not present with any indicators of at-risk behaviour. He showed no overt

[35] Ts (Probationary Constable Spain), p.44

signs of distress or hallucinations. He did not avoid eye contact or speaking and was not dishevelled or withdrawn.[36] In contrast, Stephen, "*looked really well. He looked content. He presented fine.*"[37]

77. Similarly, Constable Reeve explained that he was not concerned about Stephen's current mental health, notwithstanding what his sister and partner had said. As he said at the inquest:[38]

> …I was seeing that he had a very calm demeanour. He had a positive-like body language. He wasn't aggressive or anything like that. I believe at that stage we had already spoken to him about employment and stuff. I don't believe Stephen was employed at that stage, but he was looking for employment. And he had a potential lead on a mines job. So they were all things that obviously we take into consideration when having a look at someone's mental health and whether we believe there's any imminency. And the fact that he already had plans for the future made me feel more comfortable of the situation.
> …
>
> So, from my view point he had plans for his future which greatly decreased my concerns for Stephen.

78. Even after Stephen had been given the Police Order, Constable Reeve noted that his demeanour remained: "*Very calm. Very compliant. Very understanding. Not aggressive or anything like that.*" [39]

79. Suicide is generally very unpredictable. It is a rare event, and it is impossible to predict rare events with any certainty. Factors complicating a prediction are that a person's suicidal ideation can fluctuate, sometimes in a relatively short timeframe.

80. Although I am satisfied Stephen had an intention to end his life when he arranged for his son to stay overnight at his sister's house, that intention was only apparent some hours after the two probationary constables had last spoken to him.

[36] Ts (Probationary Constable Spain), p.42
[37] Ts (Probationary Constable Spain), p.43
[38] Ts (Constable Reeve), pp. 60-61
[39] Ts (Constable Reeve), p.61

81. It is therefore entirely possible he had no thoughts of self-harm on the two occasions he interacted with the probationary constables. If that was the case, then any questions that could have been asked by the probationary constables regarding his mental health would have been met with assurances that he was feeling fine. If that was not the position and he had current thoughts of self-harm, then he was very convincing in his efforts to indicate to the probationary constables that he had no current mental health issues. It is very likely that had this been the case, then he would have continued with the very effective masquerading to the probationary constables that he was fine had they questioned him regarding his mental health. In those circumstances, it would have been virtually impossible for the two probationary officers to take any further action.

82. That is because police officers may only apprehend a person with a mental illness if the conditions set out in section 156 of the *Mental Health Act 2014* (WA) are met. Section 156(1) provides:

> A police officer may apprehend a person if the officer reasonably suspects that the person –
>
> (a) has a mental illness; [40] and
>
> (b) because of the mental illness, needs to be apprehended to –
>
> (i) protect the health or safety of the person or the safety of another person; or
> (ii) prevent the person causing, or continuing to cause, serious damage to property.

83. If a person is apprehended in accordance with the above, then a police officer is authorised to detain the person for the purpose of arranging an assessment by a medical practitioner or an authorised mental health practitioner as soon as practicable.[41]

84. At the inquest, Inspector Simon Hazell (Inspector Hazell), Head of Facility at the WAPF Policy Academy, was asked the hypothetical question that if Stephen had assured the probationary officers he was

[40] A person is defined as having a mental illness if they have a condition that: "*is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and significantly impairs (temporarily or permanently) the person's judgment or behaviour."*: *Mental Health Act 2014* (WA), s 6(1)
[41] *Mental Health Act 2004* (WA), s 156(3)

mentally well, whether there was sufficient evidence to detain him under the *Mental Health Act 2014* (WA). Inspector Hazell answered: "*I don't think, under those circumstances, they would have had the power or the grounds to detain him under the Mental Health Act.*"[42] I completely agree with this assessment from Inspector Hazell.

Whether Probationary Constables Reeve and Spain were appropriately supervised by Sergeant Szokolai

85. As I have already outlined above, the IAU investigation found that Sergeant Szokolai had *"neglected his duty to appropriately supervise"* the probationary constables on 12 April 2022. After careful consideration of the information available, I am not able to agree with this assessment, as I am satisfied there was appropriate supervision of the two probationary constables. To find otherwise would not take into account the ***Briginshaw*** principle and would also insert impermissible hindsight bias. I have reached this conclusion for the following reasons.

86. First, Sergeant Szokolai spoke to the probationary constables on no less than three occasions. The first conversation was when he rang them as they drove to Narembeen. He provided a summary of his contact with Stephen on 4 April 2022 and the previous self-harm incident on 30 March 2022. He was reassured by the fact that Probationary Constable Spain knew Stephen from her previous employment in prisons. He also advised the probationary constables that he would attend the Narembeen Police Station to "*kit up*" and be available if required.[43]

87. The second conversation Sergeant Szokolai had with Probationary Constable Reeve was after the probationary constables had seen Stephen for the first time. Sergeant Szokolai was advised the situation was calm and that he was not required for backup. Nevertheless, Sergeant Szokolai repeated that he would remain "*kitted up*" and would be ready if he was required. After that conversation, he drove past the house of Stephen's parents to make sure the situation was remaining calm.[44]

[42] Ts (Inspector Hazell), p.118
[43] Exhibit 1, Tab 24.3, IAU managerial interview with Sergeant Szokolai on 15 June 2022, p.5
[44] Exhibit 1, Tab 24.3, IAU managerial interview with Sergeant Szokolai on 15 June 2022, p.6

88. Sergeant Szokolai's final conversation with the probationary constables was when they were preparing to leave Narembeen after serving Stephen with the Police Order. He was assured by the probationary constables that Stephen was "*well at the house*" and consequently Sergeant Szokolai "*didn't have any triggers going off per se.*"[45]

89. Secondly, Sergeant Szokolai was not advised of the concerns expressed by Stephen's sister and his partner. In those circumstances, Sergeant Szokolai was perfectly entitled to form the view that, "*as they [the probationary constables] updated me along the way that the incident had been resolved and without incident … was seriously where it got to.*"[46]

90. Finally, I am of the view that the IAU investigation failed to give adequate weight to the following facts:

- Sergeant Szokolai was off-duty;
- he had been attending a family event when he became involved;
- he was the only police officer in Narembeen at the time;
- he had remained kitted up and was prepared to provide a physical presence if requested by the probationary constables; and
- at no time did the probationary constables provide any information that they were having difficulties with the task or that the investigation had extended beyond the family violence complaint.

91. Given the above, I have no hesitation in accepting the following explanation from Sergeant Szokolai: "*I thought that the updates that he [Probationary Constable Reeve] was providing me were sufficient. I mean, there was not a lot of doubt in anything that they were doing in this*." [47]

[45] Exhibit 1, Tab 24.3, IAU managerial interview with Sergeant Szokolai on 15 June 2022, p.6
[46] Exhibit 1, Tab 24.3, IAU managerial interview with Sergeant Szokolai on 15 June 2022, p.6
[47] Exhibit 1, Tab 24.3, IAU managerial interview with Sergeant Szokolai on 15 June 2022, p.8

The partnering of two probationary constables to perform operational duties

92. After graduating from the Police Academy, police graduates are required to serve an 18-month probationary period. Probationary Constable Spain had been on probation for about 14 months as of the time of Stephen's death,[48] and Probationary Constable Reeve had about two more weeks before he completed his probation.[49]

93. As to the number of occasions when two probationary constables were partnered up for operational duties, Probationary Constable Spain said, "*It would happen quite frequently*" when she was stationed at Merredin.[50]

94. The partnering of inexperienced police officers performing operational duties has been a concern of mine for several years now. It has led me to make recommendations in this area in two previous inquest findings delivered in 2021 and this year.[51] This is the reason why I sought an explanation after the inquest as to why two probationary constables were partnered together on 12 April 2022.

95. Superintendent Gene Pears (Superintendent Pears), District Officer with the Wheatbelt District Office, provided the explanations for the above in a memorandum dated 28 May 2024 that was provided to the Court.

96. Superintendent Pears advised that as of 12 April 2022, Merredin Police Station had three vacant positions: two officers on leave, one officer on restricted non-operational duties, and one officer undertaking training. This meant that although the Merredin Police Station was allocated a full–time equivalent of 15.5 police officers, there were only eight available police officers, three of whom were probationary constables, available for operational duties.[52]

[48] Ts (Probationary Constable Spain), p.9
[49] Ts (Constable Reeve), p.48
[50] Ts (Probationary Constable Spain), p.46
[51] ***Inquest into the deaths of Trisjack Preston Simpson and Mervyn Drage*** [2021] WACOR 36; ***Inquest into the death of Petra Michelle Marquis*** [2024] WACOR 25
[52] Memorandum of Superintendent Gene Pears dated 28 May 2024, p.1

97. For the afternoon shift on 12 April 2022, there was a senior constable and two probationary constables initially rostered to work that shift. However, the senior constable sought approval shortly before the shift to clear their time off in lieu on that day.[53] That request was accepted by the officer-in-charge because of (i) the pressures police officers were experiencing at the time, (ii) the day in question was traditionally not a high demand time and (iii) the confidence he had in the capabilities of the two probationary constables.[54]

98. I am satisfied these explanations justify the partnering of Probationary Constables Reeve and Spain on this particular day, notwithstanding their lack of operational experience.

99. As to the recommendation I had made in the inquest finding delivered this year, I was referred to the WAPF's policy HR-13.09 (the Policy) that relates to probationary constables. Relevant passages from the Policy include the following: [55]

> It should be recognised by those responsible for deployment that probationary constables are still developing and require ongoing support throughout their probation periods
> …
>
> Unless specific operational requirements exist, probationary constables should not be deployed to work together without adequate supervision being made available to them by a permanently appointed police officer.

100. I note that the second paragraph cited above was added to the Policy in August 2022, i.e., four months after Stephen's death.[56]

101. It remains my firm view that every effort should be made to avoid, where possible, the partnering of inexperienced police officers for operational duties. With that in mind I made the following

[53] Memorandum of Superintendent Gene Pears dated 28 May 2024, p.2
[54] Memorandum of Superintendent Gene Pears dated 28 May 2024, p.2
[55] ***Inquest into the death of Petra Michelle Marquis*** [2024] WACOR 25, p.20
[56] ***Inquest into the death of Petra Michelle Marquis*** [2024] WACOR 25, p.20

recommendation at the inquest finding that was delivered on 12 June 2024:[57]

> That the Western Australian Police Force introduces a rostering guideline to the effect that, whenever possible, probationary constables performing operational duties and who do not have operational experience in another jurisdiction, be partnered with a police officer with a post-probationary operational experience of at least nine months.

102. The Court received a letter dated 13 August 2024 from the Minister for Police in response to this recommendation (the letter).

103. The letter stated that the WAPF acknowledges probationary constables "*should be afforded adequate supervision*" and that there were already enhanced supervision avenues available to them (all of which required the probationary constables to communicate with a senior officer who is not physically present).[58] It also referred to the paragraph that amended the Policy in August 2022.

104. The letter concluded: "*The WA Police Force advised that the current policy regarding the rostering and supervision of probationary constables is appropriate and therefore does not support the proposed Recommendation being made.*"[59]

105. I was disappointed by this response from the WAPF. The amendment to the Policy does not prevent the partnering of two probationary constables if *"adequate supervision"* was "*made available to them by a permanently appointed police officer*." Presumably, "*adequate supervision*" would mean the permanently appointed police officer is contactable by telephone or radio and is not required to be actually with the probationary constables.

[57] ***Inquest into the death of Petra Michelle Marquis*** [2024] WACOR 25, p.22
[58] Letter from the Hon Paul Papalia to the Court dated 13 August 2024, p.1
[59] Letter from the Hon Paul Papalia to the Court dated 13 August 2024, p.2

106. Unfortunately, such remote supervision will not always offer practical assistance to probationary constables. One obvious example is when a "spur-of-the-moment" operational decision has to be made. Such decisions would not be infrequent.

107. It would also have no effect if, due to the inexperience of the probationary constables, they had not deemed it necessary to seek advice about the actions they are taking. This inquest illustrated a perfect example of that regarding the missed opportunity by the probationary constables to contact MHERL. They did not consider whether or not they should contact MHERL, and therefore no contact was made with the supervising senior officer to seek advice as to which course of action should be taken.

108. Given the current stance taken by the WAPF, I will not repeat the recommendation I made only three months ago, as I expect I would receive exactly the same response. However, what I will do is repeat my previous warning made in that inquest finding:[60]

> If efforts are not made, whenever possible, to avoid the outcome of inexperienced police officers being partnered for operational duties, then I fear it will only be a matter of time before there is a person "*held in care*" by police whose death was "*caused or contributed by*"[61] the inexperience of police officers who were responsible for the care of that person.
> …
>
> It is always better to make a proactive change with an aim to reduce the risk of a future death, rather than having to make a reactive change to reduce the risk of another death occurring again.

[60] ***Inquest into the death of Petra Michelle Marquis*** [2024] WACOR 25, p.21
[61] *Coroners Act 1996* (WA), s 22(1)(c)

CONCLUSION

109. Stephen was a young man with undiagnosed mental health issues that had not been treated. Despite strong family support, these issues, together with illicit drug use, had led to episodes of self-harm and suicidal ideation. In addition, during the weeks before his death, Stephen was preoccupied with his memories of childhood trauma.

110. Sadly, just when efforts had been made to have his mental health treatment needs addressed, Stephen ended his life on or about 13 April 2022.

111. I was satisfied that the actions of the two probationary constables in their contact with Stephen on 12 April 2022 were appropriate, save and accept for a missed opportunity to contact MHERL after Stephen's sister and his partner had disclosed their concerns regarding his mental health. However, I am not satisfied that had this opportunity been taken, the outcome for Stephen would have been different.

112. Notwithstanding the contrary conclusion by the IAU investigation with respect to the actions of Sergeant Szokolai, I am satisfied that his supervision of the two probationary constables on 12 April 2022 was appropriate.

113. Although I have not found that the actions of the two probationary officers contributed to or caused the death of Stephen in any way, I remain concerned regarding the partnering of inexperienced police officers, particularly probationary constables, for operational duties.

114. Unfortunately, previous recommendations I have made in other inquest findings to address this issue have not been supported by the WAPF and have therefore not been implemented. Consequently, I have formed the view that as my latest recommendation was only made several months ago, it would be an exercise in futility to make that recommendation again as the response would be exactly the same.

115. I can therefore only hope that the WAPF will pay closer attention to what I have said in this finding (particularly at [104] to [107]), and maybe a reconsideration will take place with respect to the rostering guideline that I had proposed in June of this year. A guideline that would be so simple to implement.

116. On behalf of the Court, and as I did at the conclusion of the inquest, I extend my condolences to the family of Stephen for their sad loss.

PJ Urquhart
Coroner
11 September 2024